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.

ANNOUNCEMENTS

FORTHCOMING EVENTS

12th Decennial Club Dinner

The annual dinner will take place in the Great Hall on Saturday, 30th June at 7.00 p.m. for 7.45 p.m. Dr Oliver Garrod will be in the Chair.

Violin Recital

Great Hall on Thurday, May 22nd. Andrew Watkinson —violin, Miriam Jiviler—piano. Tickets 25p from the Flower Shop/Patients' Library.

Ward Closures 1973

A number of the wards in Bart's are to become temporarily closed during the coming year for redecoration and improvement of facilities. Further details may be obtained if needed from the Journal Office.

JOURNAL RETIREMENTS

At the beginning of this year Mr Harvey White retired after many years service to the JOURNAL. We would like to thank him for all his help and to wish him well in the future.

Changes of Address

Miss L. M. HOLT, from Internal, to 22 Cadogan Square, London, S.W.1.

Dr. Deidre LUCAS, to Nelson Hospital, Nelson, N.Z.

Engagement

BREESON — BOND — The engagement is announced between Dr Anthony J. BREESON and Miss Nicola J. BOND.

Error

Dr. A. MAPLES of East Cobham, Hants. The number of his house is 81 *not* 61.

LETTERS

Dear Sir,

I recently spent a fortnight as a student locum on a Surgical Firm at Bart's. I enjoyed myself, learnt a good deal, and miraculously was never woken at night. Ideal in fact for me but not so for the other housemen on the firm. Students at Bart's are not allowed to sign for any drugs, so should any occasion arise at night or weekends where drugs may be necessary, the qualified houseman is called, whether or not he is on duty, and whether or not he is subsequently paid for this extra duty.

The alternative is to obtain the signature of a houseman from another firm who is expected to sign up drugs for patients he does not know or may not have time to see, and is then expected to take responsibility for this signature.

Other London Teaching Hospitals and provincial hospitals allow student locums to sign for drugs. If Bart's is going to employ student locums it should be willing to accept responsibility for their prescribing rather than shift the burden of extra work and responsibility onto the other housestaff who would be quite justified in not signing for these drugs.

Yours, etc.,
ALAN SEARLE.

Newland, Sherborne, Dorset.
12th March, 1973.

Dear Sir,

The invasion of the Casualty Department after the incident outside the Old Bailey last week is comparable to an occasion on about 13th July, 1917; a bomb was dropped by a Gotha, upon a train in Liverpool Street Station; about 200 casualties came into the Hospital as well as about 40 b.i.d.

There was no set major disaster drill, nor measures for resuscitation: cases were taken immediately to the theatres as they arrived: I gave C & E anaesthetic to a young man whose two legs were amputated simultaneously, by Girling Ball and R. C. Elmslie.

Returning students had more knowledge of battle casualties than members of the staff who had not been abroad.

I served as a dresser in a Casualty Clearing Station in Southern Volhynia, with Geoffrey Jefferson who was imperturbable. Our Russian casualties had to be transferred lying in straw, in cattle trucks, to Kieff, which took three days. Those who survived and were discharged from the army were given official certificates entitling them to beg in the streets.

Your faithfully,
J. WHITTINGDALE, F.R.C.S.

Dear Sir,

I was interested to read the article "Bartholomew Unfair" in the February issue of the *Journal*. There were those 35 years ago, making comparable criticisms though they were fewer and less vocal.

With regard to selection, I am very doubtful of the apparent implications—examination success rate is used as a criterion while later examinations are subject to criticism. As you should know examination success is not a good indication of future efficiency. There is also implied the fallacy that there is just one thing called Medicine. Even yet selection techniques for a defined and limited purpose are far from satisfactory. I agree there is much room for improvement but it is not such an easy subject. There might be a case for no two medical schools having the same method, and Bart's changes its method fairly frequently I believe.

With regard to teaching you are on stronger ground, though I always liked and still like lectures. What does bother me is that in my day it was rare for the honorary to cut a round whereas it almost seems the opposite now from what I hear. Doubtless the reasons are and were financial but it all helps towards the loss of respect for the profession about which we are so alarmed.

The 2nd M.B. is an ancient Aunt Sally—all Arts and Crafts Sciences have their tedious early stages which are nevertheless vital. Admitted the 2nd M.B. is a particularly harmful stage but the alternative may be to make the patient even more of a bag of organs than he is now. But the 2nd M.B. is indeed a very real problem and we must continue to search for a satisfactory answer.

On the question of "toughening up" I think you have only stated one side; on the other there is an absolute necessity to develop means of coping with one's feelings for the patient's sufferings—maybe there are better methods but it must be done. You should press for more conscious study of this. As to sociopathic amoral behaviour, this goes on during the five years but dies away rapidly thereafter. Unfortunately though, one must admit that it is replaced by other undesirable traits. Most doctors seem to feel that they are over and above the law by virtue of their position as doctors treating patients, and this overflows so that they feel as persons they are sacrosanct—and sometimes the sanctity is odorous!

One of your main targets, and quite rightly, is nepotism. Nepotism, favouritism, patronage and all kinds of unproper preferment are far too prevalent and should be attacked again and again, though I fear they are far too strongly entrenched for any impression to be made by *Journal* articles. The system in fact selects for and perpetuates greed, selfishness and self-aggrandisement, i.e. "get on, get honour, get honest"!

Which brings me to research, where I am only half with you—it is the "in" thing but not the only thing—researchers are sometimes callous and by no means necessarily good clinicians or caring doctors. The example of care, integrity, conscientiousness and humility is at least as important.

I hope you make an impact but I fear you will merely get a headache from a brick wall.

Yours faithfully,

E. A. BURKITT.
Darlington.

Horley, Surrey.

Dear Sir,

In June 1967 under the heading "Unfair to the Fair Sex" you published my letter commenting on the fact that Recent Papers by Bart's Men ignored the female contribution.

On receiving the March *Journal* I was pleased and interested to note that *five years and nine months* later you have changed the title to Recent Papers by Bart's Alumni!

Yours faithfully,
PAMELA ROGERS.

London, N.2.

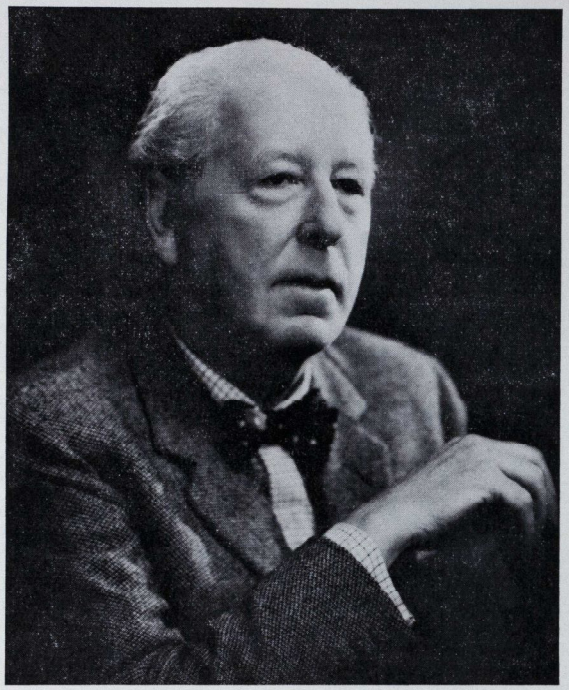
Dear Sir,

I refer to an article published in the February issue of this *Journal* entitled "Disease and Illness—a necessary distinction to make". The author suggests that 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 family life, sleep well, fit in and conform with the views of the majority, etc. He goes on to point out that normality is based upon "our own social and cultural ideas". This latter is surely incontrovertible. However, whilst I accept that the inability of a person to sleep is undesirable in that it may seriously impair his performance, I cannot say the same about an inability to conform with the majority view. Neither do I accept that in our society, which is based on the principles of democracy, the social ideal is to regard dissent as anything other than our right and privilege. Normality, I hope, can never be assessed using such a criterion.

Whilst I am sure that those who read this article must remain convinced of the author's humanitarian and progressive principles, which are clearly evident from his conclusions, I suggest that his definition of a sick person presents an element of authoritarianism of which, in our role of correctors of the abnormal, we must be constantly aware.

Yours faithfully,
BRYAN D. SHEIRMAN.

OBITUARY



Charles Brooks Vaughan Tait, M.B., B.S.(London), D.O.M.S., was born on April 29th, 1902 into a charming and courteous family whose cultural interests in painting, music and literature enriched their way of life.

He was educated at University College School and at St. Bartholomew's Hospital. In 1927 he was appointed H/S to Le Bathe-Rawling and J. E. H. Roberts whom he served with characteristic zeal, good humour and devotion.

In 1928 he became H/S to the Eye Department in which appointment his admiration for the many fine qualities of our Chief Robert Foster Moore, were to develop into a life-long friendship, mutually enjoyed on the basis of worth-while common interests.

Charles' forthright manner, his openness, absolute integrity and constant loyalty gained him many friends.

From 1934 he was consultant ophthalmologist to the Savernake Hospital, Marlborough, and to three hospitals in the Metropolitan Region Boards North Western and one in the South Western.

He published in the Bart's *Journal*, Lancet and British Journal of Ophthalmology papers on Osteomyelitis of the ischio-pubic ramus; on Ophthalmoplegia associated with bony changes in the region of the sphenoidal fissure; uveo-parotitis and Boeck's sarcoidosis.

Charles had always hoped that he might be a consultant at Exeter, where he had family associations. The loss of this appointment by a very narrow margin saddened him considerably as indeed the ill-luck that followed at Windsor where he acquired a private practice in the belief that he would be made Consultant to the King Edward VII Hospital, Windsor. At this time it was decided to appoint in future an Eye surgeon who would come out from London.

In large measure a very happy marriage with his charming wife Roselle eliminated the severity of such professional adversities. There followed the happy compensations of a delightful family. At 7 Park Street, Windsor they enjoyed a charming Georgian home with an exquisite garden, impeccably planned and cared for.

In middle-age the blows of recurrent ill-health from endocrine and cardio-vascular disorders added to the burdens that Charles and Roselle had to bear. Roselle's constant, cheerful and unfailing care of him was admirable. Our sympathy is for her and their family of three in their loss of one who in the fullest sense was a gallant and courteous gentle man.

H.B.S.

BART'S NEWS AND VIEWS

This photograph has recently been turned up in the *Journal* office. It bears no title or date—being marked only by the signatures of those portrayed. What does it represent? Is it the last ward round of some long forgotten physician of this hospital? Is it a view of the platform on some Nurses' Prize Giving of years gone by? Or Bart's Ballroom Dancing Society? A *Journal* Publications' Committee Meeting perhaps? The possibilities seem limitless, and it remains only to ask if any of our readers can assist.

We would be happy to print the most convincing story behind the picture—or even the truth, dull though it might be.

You may (or may not if you are a student) have noticed that the pictures of the newly cleaned North block of the hospital appear to have been somewhat over-exposed—especially when compared with those taken prior to cleaning. This error—fortuitous it might appear—was entirely unavoidable, and any suggestion to the contrary is a grave slander on a noble and ingenuous enterprise.

The Bart's student is traditionally a crowd animal, and one of the most consistent features of his behaviour is his eating and drinking—classically "downing a few Foster's and taking in a curry". Social anthropologists are therefore noting with great interest a recent change in this trend, viz. the substitution of kebabs for curry. Colonel Martin Goropolis—one of the students who instigated this trend—told me: "Rumours that Aristotle and I are pressurising people to eat kebabs in an attempt to bolster the failing Greek kebab market are totally unfounded. Anyone who suggests this better not take a Greek holiday this year or they could be staying longer than planned."

Meanwhile Mr. Ramjet Vindaloo (off the bone) was reported as saying: "We are not being very upset by the lack of Bart's students in our Curry Houses. We are finding greater peace." And as the saying goes "Kebabs are coming and going, but curry is going on for ever."

Before

CLEANING OF BART'S

1972 — 1973

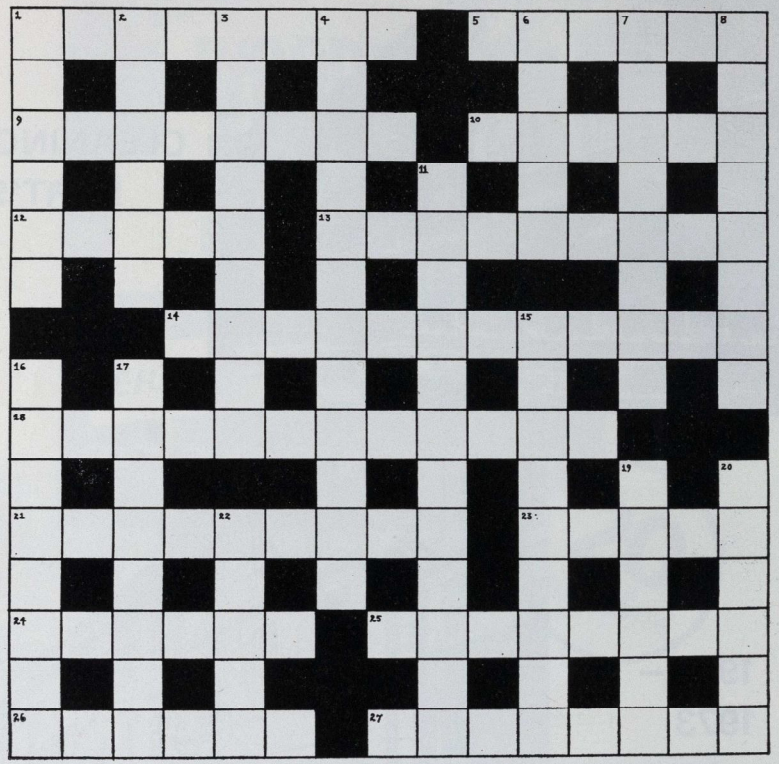
After

The front elevation of the north wing of St. Bartholomew's Hospital has taken on a sparkling new look as the result of the completion of the first phase of a three-months cleaning and restoration programme. Peter Cox Limited, the building preservation and restoration specialists, are putting the finishing touches to the cleaning of the Portland stone fabric and the restoration of portions of cornice and balustrading which have eroded through years of exposure.

"Bart's" Square built in 1730, was designed by James Gibbs and is an outstanding example of 18th Century English architecture. The north wing, containing the main entrance and Great Hall forms one side of the quadrangle, one of the most pleasant and beautiful in London.

It is the first time that the north wing has been cleaned—but it is not the original 1730 stonework. Owing to earlier damage by London's atmosphere (before modern stone cleaning techniques were developed) the Bath stone of the Gibb's buildings had to be refaced with new Portland stone in 1850-52. The work is being carried out under the supervision of Mr. James Knowles, F.R.I.B.A., F.R.I.C.S., M.R.T.P.I., architect to the Fabric of St. Bartholomew's Hospital.

JOURNAL CROSSWORD - No. 2 by DOGSBODY



ACROSS

1. A hundred U.S. girls get involved pointlessly — operational (8)
5. Not on erstwhile opening bids (6)
9. Being placed by a number we hear, and get cut off (8)
10. The quiet 'boyfriend' flyer (6)
12. ∂ ∂ (5)
13. Culture I'm changing for a cell type (9)
14. Did late-in schoolboy show this sign? (7, 5)
18. The statue may change when cells may go astray (2, 4, 6)
21. That a shortened miscellaneous mixture is inclined to wheeze (9)
23. In which singers, we hope, raise their voices (5)
24. Can this usually be found in the kitchen? (6)
25. Healing wounds without a short vacation? They should know better! (8)
26. Being issued out of order, might well fall into this (6)
27. Two complete sequences of transportation (8)

DOWN

1. Wells "manuscript" in stops and starts (6)
2. Dances quietly in, but drives back out (6)
3. One and nine trial in guts (9)
4. This "Eve" business might be so described (1, 7, 4)
6. Loud coil unwinds a vital acid (5)
7. Even Pole could enclose a missive (8)
8. G.S.G.E. cookery? (8)
11. Cost-price cot for bugs! (12)
15. Un-static photo Algy studied at Barts (9)
16. Quietly dry contains a negative mental disorderliness (8)
17. S.S.S. — peaks (8)
19. Opposite of decapitate but still might be significant (6)
20. Jack's American foot! (6)
22. Comes upon staunch direction in reverse (5)

Solution on page 139

THE ROYAL COLLEGE OF PSYCHIATRISTS

By Alexander Walk

Nominally, the Royal College of Psychiatrists is the youngest of the medical colleges, having received its Charter in June, 1971. But, unlike the other colleges of recent foundation, it is not a new creation, but came into being by the transformation of an already existing body with a history going back for over 130 years. In fact our Charter was a supplemental one, modifying that granted in 1926 to the Royal Medico-Psychological Association.

It was in July, 1841, that on the initiative of Dr. Samuel Hitch, physician to the Gloucester Lunatic Asylum, a society was formed which at first bore the title of "Association of Medical Officers of Asylums and Hospitals for the Insane" and with which the present college is directly continuous.

Treatment of "the insane" (for psychiatry had not yet expanded into other fields) was at that time carried out in a small number of "hospitals"—charitable foundations similar to the voluntary general hospitals; a not much larger number of county "asylums", which it had been optional for county justices to establish since 1808; and an immense number of private "licensed houses". "Hospitals", "asylums" and "houses" were statutory terms for these three categories, and persisted as such until the middle of this century, though, of course, they were all meant to have the same purpose. In the previous two decades there had been striking progress in many of these institutions, both in material conditions and in the spirit in which they were run—changes originating from the pioneering work of hospitals like The Retreat at York, from the exposure of scandals, from the supervision, in London, of the Metropolitan Commissioners, and most recently from the "non-restraint" movement initiated by Gardiner Hill at Lincoln, Conolly at Hanwell, and others. Dr. Hitch was himself a man of many progressive ideas. But, since only 15 counties had made any provision for their patients, there were still great numbers of the poorer mentally disordered who were exposed to "community neglect" or were herded indiscriminately into workhouses, or sent to the cheapest and nastiest of licensed houses. A few years later, in 1845, Ashley's (i.e. Lord Shaftesbury's) Acts brought about further reforms—the Commissioners' powers were extended to all England and Wales, and the provision of county asylums was made mandatory.

The terms "psychiatry" and "psychiatrist" were almost unknown in this country, though they had long been in use in Germany. Many of the Visiting Physicians were in fact general physicians who gave their services to both the general and the mental hospital (which were often in close proximity); and the resident medical officers were usually of inferior status. There were, however, a few West End consultants, like Sir Alexander Morison, who did profess to be specialists, and who might be Visiting Physicians to hospitals such as Bethlem or St. Luke's, and also dispose of beds in one or more private licensed houses. It was some years before the resident medical officers became generally recognised as the real specialists, and were given the enhanced status of Medical Superintendents, this being considered to be the best way of ensuring the progress of both "asylums" and "hospitals" as places of treatment.

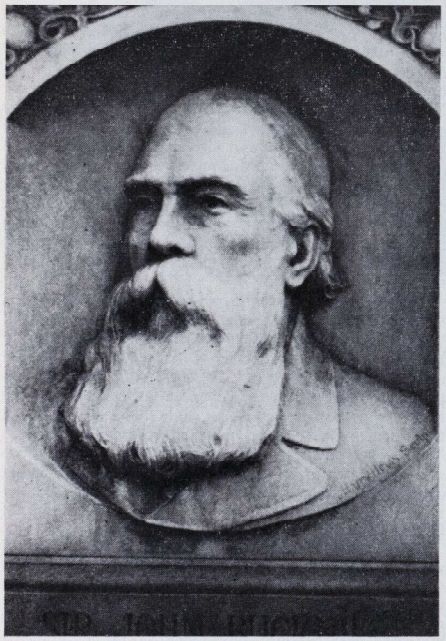
Hitch's circular letter proposing that an Association should be formed was addressed to no more than 83 "medical gentlemen", representing 26 institutions in England (there was none in Wales), seven in Scotland and 11 in Ireland, and of these doctors only 44 positively agreed to the proposal. Nevertheless, the founding members who met at Gloucester declared the Association to be constituted, and its aims to be "the improvement of the management of institutions and of the treatment of the insane, and the acquirement of a more extensive and more correct knowledge of insanity"; and a first annual meeting was held at Nottingham later in the same year.

The Association could claim to be the oldest medical society in its field; the French, German and American societies were all founded during the following decade and on the same model. But it cannot be said to have really come to life until the 1850's, partly because of increased membership consequent on the building of many new asylums, but more decisively through the influence of its Journal, first published in 1853 and

vigorously conducted in its first 10 years by Dr. (afterwards Sir John) Bucknill, of Exeter.

In the first issue, Bucknill stated the claim of psychiatry to be recognised as a speciality:

"Circumstances have tended, not indeed to isolate cerebro-mental disease from the mainland of general pathology but to render prominent its characteristics and to stamp it as a specialty. . . . In the psychical mode of cure the vehicle, as it were, in which the medicine is exhibited is the person of the physician himself. The psychiatric physician (this is almost the first example of the use of 'psychiatric' in English writing) must therefore be able to devote himself more or less exclusively to this branch; the treatment in most instances demands *a second education*. The necessity for this would by itself constitute diseases of the mind into a strict specialty". He promised that the Journal would be "a record of improvements and experiments in psychotherapeutics, whether in medicine, hygiene, diet, occupations and recreation, or in the construction and management of institutions". A few years later he persuaded the Association to alter the title of the Journal from the original modest *Asylum Journal* to one with an implied wider scope: *The Journal of Mental Science*. Defending the choice he wrote: "Metaphysics may be called one department of mental science, but mental physiology and pathology, with their vast range of inquiry into insanity, crime,



Sir John Bucknill, of Exeter, first Editor of the Journal of Mental Science.

education, and all things that tend either to preserve mental health or to cause mental disease are not less questions of mental science in its practical, that is in its sociological point of view."

Affection for a distinctive and unique title kept it in being long after "mental science" had become an obsolete term; but since 1963 it has been retained as a sub-title only, and the main title of the Journal has been *The British Journal of Psychiatry*.

In 1865 the Association itself adopted a new name, again intended to indicate a widening of the scope of psychiatry beyond the bounds of institutional care. Presumably in imitation of the "Société Médico-Psychologique" of France, the title chosen was "The Medico-Psychological Association" — a tongue-twister which year after year gave welcoming civic dignitaries at our provincial meetings fine opportunities for after-lunch humour.

During the remaining years of the century the pattern of the M.P.A's activities gradually become settled: an annual Presidency, annual and quarterly general meetings, Scottish, Irish and three English regional Divisions, and Educational and Parliamentary Committees. In 1885 the General Medical Council was persuaded, after much opposition, to include mental diseases as a compulsory subject in the medical curriculum, to be tested by an occasional question in the medicine paper. A little later the M.P.A. initiated a "Certificate in Psychological Medicine" an elementary forerunner of the D.P.M. More successfully, the M.P.A. took in hand the training of mental nurses; in 1891 a scheme of instruction was introduced leading to an examination for a "Certificate of Proficiency". This was, in fact, the first nursing qualification to be organised on a national scale, and set an example which contributed towards bringing about the State Registration of nurses. Even after the General Nursing Council had established its own examinations the great majority of mental nurses preferred to take that of the Association ("the Psycho") because the curriculum was more suited to their needs, and these examinations continued to be held until 1951.

Then, in 1908, the M.P.A. took another step to promote the better education of junior doctors entering the specialty by submitting to the Universities and Royal Colleges a draft training scheme intended to lead to a post-graduate diploma; this met with a remarkably prompt response, so that by 1911 five examining bodies were granting D.P.M's, the standard of these diplomas was gradually raised and they completely superseded the Association's own Certificate.

On the parliamentary and administrative side the M.P.A. continually campaigned for reforms in the lunacy laws (as they were then called): better facilities for early treatment, power to admit voluntary patients, creation of psychiatric clinics attached to Universities, financial support for research. These efforts met with little or no success in the years before the first World War, but all the reforms asked for were gradually achieved in later years.

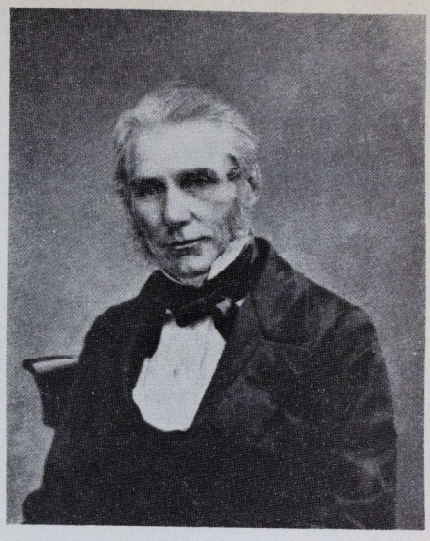
Up to this time the M.P.A. could claim to be representative of the specialty as a whole. Psychiatry was almost entirely institutional, and superintendents and medical officers of mental hospitals made up the great majority of the M.P.A's 700 members, but London consultants were also prominent in its affairs, and there

were the beginnings of an academic element in the form of part-time lecturers, and even one or two Professors in medical schools. Among its outstanding personalities, whose names figure in psychiatric history, there had been John Conolly of "non-restraint" fame; Daniel Hack Tuke, of the York Retreat family; Henry Maudsley, whose foresight and generosity led to the foundation of the Maudsley Hospital; and Sir James Crichton-Browne, now perhaps remembered only as a legendary nonagenarian and an exponent of the Grand Old Manner, but in his earlier days a pioneer of neuro-pathological research. All these were in their turn Presidents of the Association, and one other president who ought to be mentioned here is Sir Robert Armstrong-Jones, who was for many years Lecturer in Psychological Medicine at Bart's. He is described somewhat facetiously in Geoffrey Bourne's *We met at Bart's*, but his writings show far more wisdom than one would infer from these anecdotes. He inaugurated the hospital's first psychiatric out-patient department, and the present writer can recall his teachings with pleasure and affection.

After the first World War, however, the situation was considerably changed. Increased interest in the neuroses and in psychotherapy, stimulated by war experience and by the rise of psychoanalysis, led to a number of doctors recruited from neurology, internal medicine or general practice specialising in this field; these men felt that they had little in common with the staffs of mental hospitals and did not seek to become members of the M.P.A. Thus there was an unfortunate division between psychiatrists, which persisted until some years after the second World War, and during this period the M.P.A. tended to be labelled as representative only of institutional psychiatry.

Nevertheless, the Association and its members took a prominent part in the development of the mental health services during these years. It was able to add to its prestige and dignity when in 1926 it obtained a charter of incorporation and became "The Royal Medico-Psychological Association". The campaign for legal reform was continued, and extensive evidence was given to the Macmillan Commission of 1924-26, which led to the Mental Treatment Act of 1930. Mental hospital staffs were now liberated from their confinement to the care of "certified" in-patients; voluntary admissions multiplied, and extra-mural services were extended in the shape of out-patient clinics at general hospitals. In a few places, in fact, the mental hospital became a centre for a comprehensive district psychiatric service. Responding to these new trends the R.M.P.A. set up various committees which studied the problems involved or sponsored research projects.

The second World War gave wider experience still to many hospital psychiatrists, and broke down to some extent the barriers within the specialty. "Planning" became a national watchword, and the R.M.P.A. joined with other bodies in framing proposals to ensure that mental health should form an integral part of the projected National Health Service—with the condition that integration should not lead to degradation; the danger being that psychiatry might constantly find itself low in the priority list when available resources were being assigned. Thus the R.M.P.A. repeatedly urged that mental health should have a certain degree of autonomy within the N.H.S.; this, however, has never been ac-



Samuel Hitch, Physician to the Gloucester Asylum, founder of the Medico-Psychological Association.

cepted, and continued vigilance has been needed on behalf especially of "Cinderellas" such as the older mental hospitals and the mental deficiency hospitals, the subjects from time to time of Press "revelations" followed by Ministerial promises.

In spite of these handicaps, development and progress of psychiatric services since the war has been on an unprecedented scale, both within and outside the traditional mental hospitals. Here is the place to mention the contribution of a Bart's man, T. P. Rees of Warlingham Park Hospital, whose "open door" system has had an influence as great or greater than Conolly's "non-restraint" of a hundred years earlier. He was, moreover, one of the mental hospital superintendents who in advance of others developed a full psychiatric service for his community, including child psychiatry, as well as the more usual facilities for adults. He was President of the R.M.P.A. in 1956.

Child psychiatry clinics were, in fact, being established everywhere, to be followed by a slowly increasing number of in-patient units for disturbed children. Then, for adult patients, there came into being day hospitals and psychiatric in-patient units in general hospitals; it came to be believed, taking into account modern methods of treatment and better social support in the community, that these might eventually supersede the traditional mental hospitals—a prediction that is still the subject of much controversy. A tremendous expansion of the staffing and training facilities at the Maudsley Hospital and its associated Institute of Psychiatry provided a supply of well-trained candidates for senior posts in hospitals, and these posts were made more attractive by being graded as of consultant status. From the Maudsley's staff were also filled many of the Chairs

of Psychiatry established at the provincial universities and at several of the London Teaching Hospitals; these Professorial Departments in turn serving as training centres in their own regions.

Recognising the expanding fields in which its members were now working, the R.M.P.A. created four specialist Sections—for Research and Clinical Studies, Social Psychiatry and Psychotherapy, Mental Deficiency and Child Psychiatry respectively. The last two soon established themselves as the national representative bodies in their sub-specialties; and the existence of a Psychotherapy Section encouraged many of those who had hitherto remained aloof from the R.M.P.A. to join actively in its work. The Association also expanded its educational activities on behalf of its junior members by means of seminars and lecture courses; for some time it even conducted a D.P.M. examination of its own. During these last two decades, also, the R.M.P.A. was constantly being called upon to make known its views to a succession of Government Commissions and Committees, and afterwards to comment on the resulting Reports and if necessary to try to influence any action the Government proposed to take.

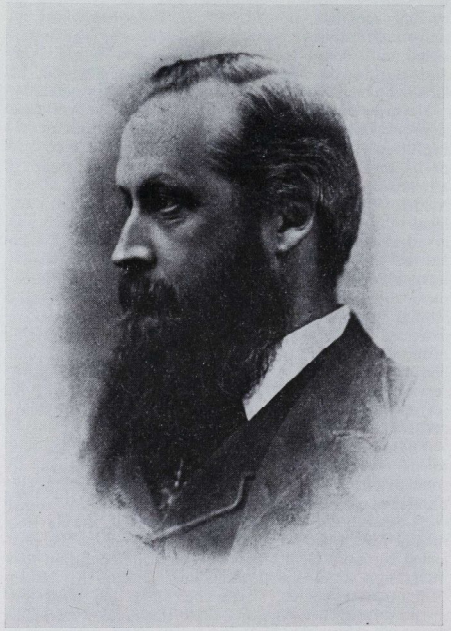
Perhaps the most important of these exercises was the giving of evidence to the Royal Commission on the Law relating to Mental Disorder, 1953-57, and the discussions which followed, up to the passing of the Mental Health Act of 1959. To the great satisfaction of the R.M.P.A. the Act went even further in liberalising the law than the Association had thought would be acceptable to Parliament. Then there were Committees on aspects of hospital administration and hospital staffing; a Royal Commission on divorce; proposals for reforming the laws relating to suicide, to homosexuality and abortion; several Committees on the problems of children, neglected, delinquent or maladjusted; Committees on the organisation of social work; and lastly the repeatedly modified proposals for the reorganisation of the Health Services—all these requiring the production of lengthy memoranda as well as personal discussions and negotiations.

As the scope and potentialities of psychiatry seemed to widen, there was a general feeling that there was a need to raise further and safeguard the standards of training in psychiatry. There was at first a suggestion that the R.M.P.A. might institute a higher qualification (a Fellowship), as its Charter gave it powers to do; but this was soon superseded by the movement for the foundation of a Royal College. The basis for this movement has been well explained by the former General Secretary of the Association and first Registrar of the College, Dr. A. B. Monro as follows: —

"The heart of the matter is this: it has become clearer year by year that the ground to be covered by a doctor aspiring to be a consultant in any specialty is so great that very few can achieve this competence in more than one major branch of medicine. It was therefore illogical to continue with a situation in which psychiatrists should be required to possess qualifications granted by specialists in internal medicine. . . . The matter has been presented by some as if it was really one of status or prestige. These were threads in the pattern, but never had the overriding importance of the main themes.

"In the late 50s there was influential support within the Royal College of Physicians for the contention that an aspiring psychiatrist should be trained in general medicine to a higher level than that required for qualification, but not to the level required for a specialist physician. There were informal discussions about the possiblity of a Faculty of Psychiatrists within the College of Physicians. But it became clear that the College was unlikely to make the concessions that would have made this acceptable, and so opinion among psychiatrists swung round to the only reasonable alternative, the achievement of a Royal College of Psychiatrists."

The decision to petition for a Supplemental Charter transforming the R.M.P.A. into a Royal College was taken after a ballot of its 2,500 members in 1964, and there followed seven years of arduous negotiations with the Privy Council. One difficulty which held up progress for a long time was inherent in the previous constitution of the R.M.P.A. Membership of the Association had been open to any doctor sufficiently interested to wish to join; thus it included not only a large number of junior doctors in the training grades but also a sprinkling of general practitioners, pathologists, medical officers of health and others who were not professional psychiatrists. The R.M.P.A. would have liked to retain this comprehensiveness in the new College; the Privy Council, however, made it a *sine qua non* that precedent should be followed, and that the College should consist essentially of Fellows and



Henry Maudsley, one-time President; founder of the Maudsley Hospital.

Members, the latter, after the initial "Foundation" grading, to be admitted strictly after examination. As a concession, the Privy Council agreed that existing members of the R.M.P.A. not graded as "Foundation Members" should constitute a closed body of "Affiliates"—a category which would eventually disappear; and that junior psychiatrists in training might, for an experimental period of 10 years, join a class of "Inceptors", but without a statutory voice in the affairs of the College.

Apart from these changes the constitution of the College does not differ greatly from that of the R.M.P.A. The Officers and most of the Council are now directly elected by ballot, and it is intended that the Presidency should be held for more than one year—normally for three. The Specialist Sections are to continue, and so are the Regional Divisions. It is noteworthy that, as with the R.M.P.A., there is a single Irish Division covering both Northern Ireland and the Republic, and that it has never been the wish of psychiatrists in Ireland to separate themselves from an organisation based in Britain and bearing the "Royal" title.

The first, and present, President of the College is Sir Martin Roth, Professor of Psychological Medicine in the University of Newcastle-upon-Tyne. Professor Linford Rees, of Bart's is one of the Vice-Presidents. The College has as yet no home of its own; its present headquarters are at Chandos House, Queen Anne Street, an Adam mansion which is the property of the Royal Society of Medicine.

Now nearly two years old, the College has since its inauguration been mainly concerned with setting up the machinery for conducting its Membership examinations (the first of which have already been held)—and for the accreditation of hospitals as participants in training programmes. It has carried out special investigations into psychiatric manpower, and into existing facilities for training and how they can be improved. On the medico-political side a Report on the psychiatric implications of the new Health Service set-up has been produced by a tripartite committee of the College, the B.M.A. and the Society of Medical Officers of Health.

To quote Dr. Monro once more—and the resemblance to Bucknill's words of 100 years ago is apparent:

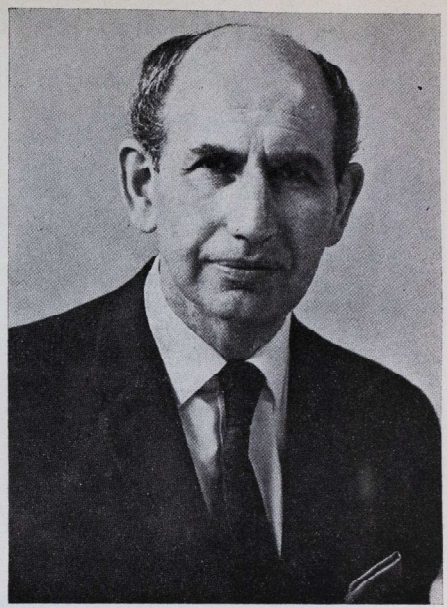
"We should not forget that as an Association we combined the words 'medical' and 'psychological' in one title. Psychiatry cannot be only a medical discipline —it must be related to psychology and sociology to a degree unlikely ever to be necessary for general medicine. We have always had an obstetric and nurturing function in regard to psychiatry: clinical psychology, psychiatric nursing and occupational therapy owe much to the R.M.P.A. It is to be hoped that this tradition will continue, and that one of the main activities of the College will be to identify those areas which may be points of departure for new disciplines or even new professions."

Author's Addendum:

By the time the Supplemental Charter was granted the membership was over 4,000.

Editor's Note:

Dr. Walk is the late Hon. Librarian and Past President of the Royal Medico-Psychological Association.



Sir Martin Roth, Professor of Psychological Medicine, University of Newcastle upon Tyne, first President of the College.

Solution to Crossword No. 2

ANSWERS

Across	Down
1. surgical	1. spasms
5. offers	2. repels
9. amputate	3. intestine
10. plover	4. a sternal myth
12. males	6. folic
13. reticulum	7. envelope
14. dilated pupil	8. scramble
18. as they mutate	11. streptococci
21. asthmatic	15. pathology
23. opera	16. paranoid
24. opener	17. stutters
25. scholars	19. detail
26. disuse	20. tarsus
27. bicycles	22. meets

FIFTY YEARS ON

By Homo Heidelbergiensis

Barts at the time of the Octocentenary

I suppose the Bart's student of today will regard the Bart's of 50 years ago as being in the era of antiseptic surgery or of crushing for stone, but that would hardly be accurate. Indeed, and superficially, it is very easy to sit at the edge of the fountain, to close one's eyes and to reopen them almost in the expectation of seeing the small figure of Thomas Jeeves Horder, with his accompanying H.P., coming through the arch to take us on a ward round, some apology for the lateness of his arrival being tempered by a reference to the difficulty of working in the visits to Sandringham in the midst of his busy life. The buildings round the Square remain much the same, except for the George V block, the only concession to modern ugliness being the use of the Square as a car park. There were few cars then and the consultants' cars had to be parked at the entrance to the Path block.

Beginnings

I entered as a student in October, 1922. Having passed the necessary "prelim" as we called it, (there were several) one chose a particular hospital for various private reasons, saw the Dean and signed the Register. The then student population could be divided into two distinct categories, those, older than the rest of us not only in years, who had served in the First World War, and the normal entry straight from school. I suppose there would be about 80 of us in the latter category, many of us doctors' sons and most of us with the conventional background of the day.

A year was allowed to prepare for the first hurdle, the First M.B. in Physics, Chemistry and Biology, few of us had done any Biology at school. All subjects were taught within the hospital confines but bombing during the last war destroyed the two large lecture theatres and the biology lab.

The old chemistry lab, traditional site of the first meeting between Sherlock Holmes and Dr. Watson, is now occupied by offices near the photographic department. Practical physics was taken in a rather makeshift lab in a basement, the entrance to which remains just outside the library.

It was considered then that teachers in a medical school should have medical qualifications and both the Professor of Biology, Dr. T. W. Shore, who was also the Dean, a venerable figure with a white beard and always attired in a frock coat, and Dr. Womack, the Professor of Physics, held a M.D.

The first necessity was to make the acquaintance of Mr. E. Bridle, nominally head of the Biology Department personnel but, in reality, rather more than this. He was, indeed, a power with whom it was advisable to maintain good relations even to the, possibly fruitless, extent of ill-afforded alcoholic libations at The Viaduct after school hours. One of his responsibilities was to see that every student had a suitable microscope and books. I do not doubt that this chore reacted to his considerable pecuniary benefit.

However, I don't think anyone on the staff of the medical school had an unduly difficult task. The Victorian medical student had a reputation for wildness but I doubt whether this was deserved, I believe that many students at St. George's arrived in top hats up to 1914. Anyway, the Bart's student of the 1920s was a very docile animal. Most of us were fresh from school and found the discipline of the medical school far from onerous. Politically we were quite unconscious, except for the prevailing loyalties of the period, and none of us felt that we had anything to protest about.

Only once a year did the placid mood simmer and that was Hospital Cup Final day. In those days the standard of hospital rugger was high, with blues, trial caps and even internationals not uncommon. Bart's and Guy's had a virtual monopoly of the final and one could look forward to an annual celebration on the Richmond Athletic ground. The various London hospitals had each their own traditions concerning "ragging" which I would define as boisterous, but not vicious, behaviour against the members of another hospital, preferably on private property. Guy's was one of the chief ragging hospitals, Bart's students had a tradition of decorous behaviour in public. The result of this was an annual confrontation at Richmond between many Guy's men, not content to leave hostilities to the field of play and usually dressed in some fancy dress variation of the hospital colours of dark blue and orange, with challenges to physical combat against hapless Bart's people whose refusals were always misinterpreted. This became intolerable to the extent that an extraordinary meeting of the Students' Union was called to debate, and vote on, the proposal that policy be changed and ragging permitted. It seemed an important matter at the time and the verdict was a narrow majority one way, but which way I cannot remember.

The hospital

The world of the student was then centred on the Abernethian Room, or A.R. as we called it. This was a large ground floor room facing Giltspur Street. In an annexe was a small billiard table which more than once served me as a bed for the night. The site has now become the various rooms of Casualty Dept. Underneath was what we called the "Catering Company" and, above, the resident staff quarters. Windmill Court was then a cul-de-sac terminating in an iron railing with a window above. Through this window was the traditional route whereby Bart's nurses, having remained out longer than allowed by their passes, could regain the hospital grounds.

So traditional, indeed, was it that I can't help feeling that Matron knew all about it but was wise enough to turn a blind eye to the very occasional breach of discipline.

I cannot say that sex was any great problem. Most of us subscribed to what were considered to be reasonable standards and were none the worse for that. In any case anyone who thought of straying had the grim warning of two of our number. According to legend these two had had an evening out in the West End and subjected themselves to what I will call politely the risk of infection. Sobering up they had taken fright and rushed to the Surgery there to subject themselves to the antiseptic properties of strong carbolic acid. The resulting hospitalisation must have been intensely embarassing and neither student survived, in an academic sense, his first year.

In any circumstance most of us were too poor to depart from a pretty narrow path. I shared a room, with two friends, in Hampstead. The charge was 35/- a week for this and morning and evening meals. I had 15/- a week also to pay for all other extras but there was occasionally a few shillings left over, usually spent on a seat at the Coliseum (2/4) and the cheapest meal possible at Stone's Chop House, in Panton Street. We were, in fact, a pretty impecunious lot. Only a derisive laugh would have greeted the suggestion that the time was soon coming in which the public would meet the costs of our education and that the unqualified would be able to marry, and produce families, on public money and, even then, complain.

The celebrations

Incredible as it may seem today, Bart's was then a "voluntary" hospital (one supported by the voluntary contributions of the public), and finance was a constant worry to the administrators. The London teaching hospitals were maintained by grants from a central fund, itself the product of public effort and each hospital relied on its devoted friends to produce separate appeals. In our case one of these events, certainly the most ambitious, was a recurrent "Fleet Street Week for Bart's". As the title suggests this was a series, organised by Fleet Street, of West End matinees, various special performances, a bazaar at the Mansion House and a Flag Day in the City. The Co-Optimists, one of the leading stage shows of the time, even produced a special song extolling the virtues of Bart's nurses, who were described as "Queens of Hearts". Once again, how little things change!

The high spot of such celebrations came with the Octocentenary junketings of 1923 which were essentially similar to those of this year. A friend and I decided that we would promenade Bartholomew Fair on stilts and the hospital carpenter fitted us out. Preliminary practice in the Square followed, much to the enjoyment of convalescent patients.

Instead of the play of today we had what were called, I think, Tableaux Vivants in the Great Hall. The President of the Royal Academy, with some of his brother Academicians, had offered to design tableaux on themes connected with Bart's history, and as they would have painted a similar picture. Some of us imagined ourselves as suitable material to represent outstanding characters in the hospital's history and volunteered. We attended the Royal Academy in Piccadilly, there to be allocated to a tableau and its designer. My dreams of stardom got no further than a part as a mendicant in a tableau called, I think, the Dream of Rahere.

The medical school had recently moved the Department of Physiology to premises in Giltspur Street, now

Rahere and "The Poore, Sykke, Blynd, Aged, and Impotent Persones." from the *Journal* of July 1923.

Brinton's Carpets, which had been purchased, and suitably converted. Possibly the planning of the labs on the first floor was not ideal. The windows facing Giltspur Street proved too suitable a target for some men to resist for the disposal of their used muscle nerve preparations. The high spot of such activities came when the contents of a bottle of haemotoxylin followed and homed on an unfortunate woman underneath. Thereafter we were warned that anyone repeating such an offence would be expelled instantly.

The chair of Anatomy was temporarily vacant and lectures were taken by the Senior Demonstrator, L. R. Shore, a brother of the Dean but utterly unlike him. He had an ironic touch and arrived for one lecture with a copy of Wood Jones' "Principles of Anatomy as seen in the Hand". He produced, also, a book on palmistry and we were treated to an hilarious exposition of the significance of flexure lines as interpreted by the different authorities.

The dissecting room is now the Clinical Lecture Theatre and memories of past glories can be seen in the iron gallery, with the spiral staircase, skirting the room and once full of museum specimens. This was an age of individuals, none more so than Hallet, the dissecting room attendant, a terrier of a man both in appearance and temperament. None was more jealous than Hallet in guarding his professional secrets and no student dare enter his sanctum. Absolute propriety was insisted on in the room, and a laugh would bring him out of his room like a guard dog from its kennel. Anyone daring to enter with a hat on was for it, but only once did I see him really upset and that was when a new student produced his lunch sandwiches to be eaten, as he thought, while dissection proceeded.

Sometime later, and having attained the dignity of Student Prosector, I asked Hallet whether matters had ever got out of his control. He assured me that they had, once and once only. This was shortly after the outbreak of the First World War when the dissecting room had been invaded by a group of students carrying Union Jacks, which they proceeded to drape over the corpses and hang from the gallery. "I saw some of them come back much later" said Hallet. "Believe me they wasn't laughing on the same side of their faces then". At that time the Primary Fellowship was in Anatomy and Physiology only and usually taken immediately after passing the Second M.B. Normally one would allow six months, possibly a year, to prepare for it but for some this was a waste of time since, having passed on to clinical work, one became more interested in medicine than surgery.

On the wards

On the commencement of clinical work the hospital issued us with a copy of the Hospital Pharmacopoeia, virtually all prescribing was done by time honoured remedies therein contained, and a copy of Notes for Dressers.

One's first "appointment" was six months as Surgical Dresser. A surgical "firm" in those days consisted of an Honorary Consultant, his Assistant Surgeon, a Clinical Assistant, two housemen, about 10 dressers and two Path clerks. A Clinical Assistant could serve for two consecutive years, but no more, before he had to retire but he could return for another spell after a suitable interval, often spent as a Demonstrator of Anatomy. There were five "firms" each having, in rotation, a three day "duty" period each 15. During the period the firm had to accept all surgical cases accruing. The Junior Dresser in his first three months attended the appropriate "box" in the Surgery there to treat, under the supervision of the Junior House Surgeon, the minor cases admitted as out-patients. He had, also, charge of some cases in the two "septic" wards, usually cases of the osteo-myelitis type.

"Ye Worshipful Master"

"Ye Eminent Criminologist"

The Senior Dresser had five or six patients in the wards on whom to make notes, attend to dressings and so on, and his high spot came with his turn as Night Dresser. There was then no Casualty Department as such, all casualties being treated by the "duty" firm. One's day started by attention to the ward patients. Early in the afternoon operations, routine and emergency, would start and sometimes continue until the late evening. The unfortunate Night Dresser would then return to the Surgery to find up to 20 cases waiting for his attention. If he was lucky he might get to bed about 2 a.m. Usually to be disturbed almost at once by the buzz of the intercom and the voice of the porter calling him back to the Surgery. For our services the hospital provided us with a free bedroom over the Surgery and a free breakfast next morning in the Catering Company, but the bedroom was a dead loss. It overlooked the Post Office yard where the mail vans were parked overnight. At about 5 a.m. someone arrived to hose the yard and not long after the van drivers would attempt to hand crank their vans. It was a noisy room and I don't think many of us got much sleep there. At 10 o'clock normal routine would restart so that one could be on duty continuously for 30 hours or even more.

Generally speaking, and if one booked early enough, one could choose one's firm and I elected to honour Sir Holburt Waring, then Senior Surgeon, with my services. We had the use of the hospital's main operating theatre, a recently built theatre surrounded by a glass fronted gallery. It had been furbished by the relatives of a former Bart's student called Etherington Smith and was properly so called, although usually termed Theatre "A". The site is now occupied by the Department of Anaesthetics. The steps near the entrance led down to a basement passage flanked by small side rooms. This is now the lay staff quarters but was then Casualty Ward, where fractious or noisy patients could be placed temporarily and so that they did not disturb other patients in the wards.

Down the slope leading to the Block, and on a site now occupied by the Finance Department, were two small theatres, "C" and "D". Having completed the six months surgery one passed on to the first of two three-month periods as Clinical Clerk to one of the physicians. Here again the organisation was one of five "firms". I elected to join that of Sir Thomas Horder, as he then was, about whom much has been written and who was, indisputably, a genius in the art of diagnosis. This was a day when the medical profession contained doctors ranging from those with shop premises used as a surgery and charging one shilling for a consultation and bottle of medicine, to a few people in the position of Horder, reputably earning in the region of £30,000 a year, a vast sum in those days. Entirely by his own efforts, and genius, Horder had raised himself from humble beginnings to a position of great, and well deserved, eminence. Aided by experience, the stethoscope and the Path Lab, the only diagonstic weapons of those days, there was little that escaped Tommy Horder.

The nature of treatment

I suppose most doctors today would consider that the last 50 years have produced more progress in medicine than the millenium before but I would not agree. In 1923 the scientific approach of the 19th Century was already producing outstanding results. The principles of aseptic surgery were well understood and quite advanced surgery, such as interference with the pituitary gland, was being done at Bart's. Chemotherapy was already well established by the use of a mercury preparation called salvarsan in the treatment of syphilis, aptly described as "five minutes with Venus and a life with Mercury". Vitamin deficiency was being put on a scientific basis and primary anemia could be actively treated. We were quite familiar with the significance of endocrine secretion and the possibilities of replacement therapy. Insulin had recently been discovered and was coming into use.

Indeed, and considering the great advances already made, it is surprising that many basic problems remain unsolved and new ones have arisen. Cancer of the lung was then virtually unknown and the cardiac accident quite rare.

Indeed I think it is not entirely unfair to feel that, if nature intended to kill in 1923, she will, just as assuredly, do so in 1973, but that does not mean that the lot of the living patient has not improved enormously. If, superficially, medical and surgical wards do not seem to have changed very much there has been an enormous advance made in mental hospitals.

In 1923 is was considered sufficient for the Bart's student to attend a course of three demonstrations of psychotic illness at Bethlem Royal Hospital, now the Imperial War Museum, and so that we could, at least, recognise the commoner forms of psychosis. I say demonstrations because there was little to learn about treatment, it hardly existed, and if we except the kindness and compassion of the physician, a dose of chloral hydrate and, when necessary, physical restriction. Rudiments of Freudian psychology, usually misquoted, were, however, becoming lay property and a few psychiatrists, if the term then existed, were followers of the Freudian path. Nevertheless this was not a path devoid of unseen snags. I recollect a Consulting Physician, having referred one of his patients to psychological outs, invading the department to demand which of the staff had been talking "dirt" to his patient.

If we accept that the good of the patient is the paramount consideration then, undoubtedly, these 50 years have been ones of advancement, but I cannot say that the lot of the doctor has improved that much. Materially he is not as well off as he used to be and he has lost many intangibles which made his life so rewarding. He is now caught in a bureaucracy which will increase its power over him until it is his master. He is going to be asked to prescribe on a basis of social policy rather than of clinical necessity, and no one knows where that path may lead. He may find that, on matters affecting his professional life, his patients may wish to have as much say as the G.M.C.

Nevertheless the student of today enters a profession which is, as it was 50 years ago, a most rewarding one and if he has the good luck to enter it through Bart's, he is doubly lucky. I have no doubt that, while times and places may be bad. Bart's men and women will continue to flourish. Although the medical student of today is a vastly different person to what we were, I am sure that many will love the place as we did and look back on their association with the hospital as on of the happiest events of their lives.

A CASE OF GARGANTUAN FIBROIDS

by TIM HUNT

A case is described of unusually large Uterine Fibromyomata. Despite the size of the tumour mass it caused remarkably few symptoms and little difficulty in removal.

HISTORY

The patient, aged 44 was a part-time singer and Legal Secretary. She attended her doctor because of an increasingly large swelling of her abdomen, which had been present for some 18 months. Apart from the inconvenience of her clothes being too tight and some mild discomfort, the swelling had not bothered her, although suggestions by her friends that she might be pregnant had caused her no little embarrassment.

The patient was nulliparous but had used no contraception. Her menarche occured at the age of 12, and her menstrual cycle was of 28 days with a seven day loss and had always been regular and the loss not unduly heavy, there was no passage of clots. She had mild dysmenorrhoea for the first two days of the cycle. There were no abnormal gynaecological symptoms and no pressure effects on the bladder or bowel. There was no significant past medical history.

EXAMINATION

She was a pleasant, healthy looking woman of average build. The breasts were normal and there was no lymphadenopathy.

On abdominal examination there was a large irregular mass arising from the pelvis and extending up to the costal margin on the right and almost as far on the left. The mass was non-tender and freely mobile, dull to percussion with no demonstrable ascites.

On Vaginal examination it was difficult to be certain whether the mass was attached to the uterus or of ovarian origin.

INVESTIGATIONS

HB 13-1 gm.%
ESR.: 2
Chest X-ray normal
Ultrasonic Scan confirmed an abdominal mass reaching as far as the costal margin on the right, but was unable to establish the relation of the mass to the uterus.

LAPAROTOMY

Laparotomy was undertaken on January 5th, 1973, through a paramedian incision extending from the pubic symphysis to the xyphisternum.

The findings were of a large mass of uterine fibroids filling the whole abdomen. The ovaries and tubes were quite normal and there were no other abnormal findings except that a small amount of free fluid was present. The mass was removed by total abdominal hysterectomy and ovarian conservation with no great difficulty.

POST-OPERATIVE PROGRESS

This was uneventful, there was no pyrexia. She left the hospital over a stone lighter.

HISTOLOGY

Macroscopic Description. The hysterectomy specimen was 31 cm. in maximum diameter. The cervix appeared normal and the endometrium was bulky. The specimen contained numerous fibroids the largest being 23 cm. in maximum diameter, marked degenerative changes were apparent and it contained gelatinous cysts up to 5 cm. in diameter.

Microscopic description:—The Endometrium appeared mildly proliferative and rather hypertrophied for so early in the cycle. The fibroids sectioned were all benign but the largest shows marked degenerative change.

DISCUSSION

Uterine fibroids are benign tumours of muscle and connective tissue.

They frequently occur in nulliparous patients though to be present in pregnancy is by no means unusual. It is the commonest tumour found in women, at least 5 per cent of woman have fibroids, some claim that they occur in 35 per cent of negro women. The aetiology is unsure, but there is evidence that the tumour is oestrogen dependent, as the majority atrophy after the climacteric. The tumour starts as single or multiple seedlings and may grow to 10 Kg. or more, although tumours of 42 Kg. have been reported. The largest at Bart's was 42 lbs. (19.05 Kg.).

The structure of the tumour is of interlacing bundles of involuntary muscle lying in a network of connective tissue. The tumours are poorly supplied with blood vessels and tend to outgrow their blood supply. This causes some but not all the degenerative changes found in them.

Hyaline degeneration occurs in all but the smallest fibroids. Asceptic necrosis follows inadequate blood supply. Cystic degeneration follows the hyaline degeneration with extensive liquification of the hyalinised area. Sarcomatous change occurs very rarely the incidence being about 0.2 per cent.

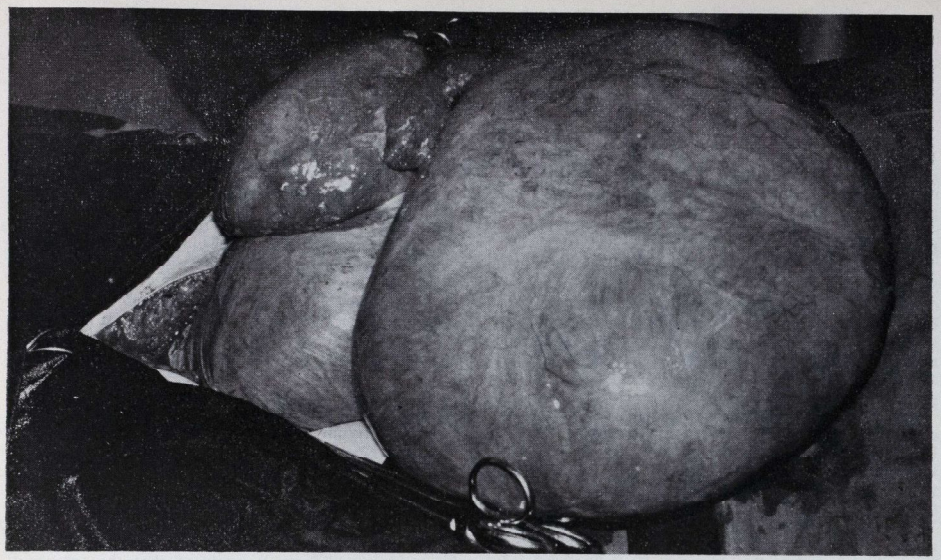
Rarely and usually as a complication of pregnancy red degeneration occurs due to obstructed venous return, and extravasation of blood through the tumour to give the "raw beef" colour.

Symptoms depend on the size and position of the tumour. Most small and many large tumours are symptomless. The tumours may produce menorrhagia or pressure symptoms on the bladder or bowel. Fibroids are also associated with infertility. Pain is only a symptom in red degeneration or torsion of a subserous polyp.

Diagnosis is reached on finding an enlarged smooth mass or masses in the uterus which is non tender and moves with the uterus.

Management can either be conservative, with no treatment, or surgical with hysterectomy or myomectomy.

Small symptomless myomata require no treatment, but if the myomata is larger than a 12 week pregnancy,



or distorts the unterine cavity or is in the lower part of the uterus and is likely to obstruct labour, operative treatment should be considered.

Total hysterectomy is indicated in women over 40 years, who desire no more children usually with ovarian conservation.

Myomectomy is indicated in women under the age of 40 who require surgery but wish to conserve their uterine function.

AUTHOR'S NOTE: I would like to thank Mr. D. Fraser for permission to publish his case, and Mr. M. Setchell for his assistance in the preparation of this article.

THE SMOKEROO REVOO

For 849 and ⅞, it bears its age well. Apparently from time immemorial, or at least nine years there have been Smokers, dedicated to, once a year at least, taking and alleviating the heavy spirits of the average medical student, laid low by the winter's excesses of rugby and beer. Fortunately this year, it is well up to standard, and if the standard of rugby and the quantity of beer do not quite measure up to previous years, the Smoker was still providing enough laughs per minute, to be labelled real vintage stuff.

Rob Robertson and his team had a large, some would say oversize, target at which to aim their flashes of humour, the 850th Celebrations. The final sketch was a clever and amusing take off of the proposed play on William Harvey, in fact, from someone who has read the script, it seemed almost better at times. A sharp dig at the financial side of things, followed by Janet Dinwiddie, and a little reading from the *Daily Telegraph*, always good for a laugh, was capped by the story of Rahere, writhing with the Musical Plague. William Harvey was portrayed by Martin Gore, who appeared the very image of that great Gentleman, and Paul Cooper played the Left Ventricle, with, one suspects, a degree of Aortic Incompetence.

The First Half was a little disappointing, at any rate on the night that I saw it, with a subtle parody of the Drama Club in the Bar, and a mock Shakespearian extravaganza, but the laughs were a little too far apart for them to have full impact.

In the second half, particularly memorable items were Doug, Mart and the Band in a high camp rock offering, Rob with 3000 terrible puns, and Alison's weather forecast. The quickies were well done, and anyway are always good for a groan, and the pace never really flagged, with audience responding to every nuance.

One regret is that there was not nearly enough music. The group seemed very capable, and the songs that were there all went down very well. Rehearsal time is always very short with the Smoker, and Music is the best way of ensuring a slick show.

Finally, thanks to the Wine Committee for sponsoring the whole thing, and very sensibly abolishing the Stag Night, substituting a mixed doubles night with a disco afterwards. A distinct improvement, and one which I hope will continue, for it ensures a civilised performance in the auditorium as well as on stage.

Quatrevingts quatre.

BOOK REVIEWS

CHINA SHAKES THE WORLD
Penguin.

I am half way through this book, and I wish I could tear it in half. One half I would throw away. Jack Belden is an American journalist who writes of his visit to the communist areas of China during several years from 1946, during the time when the communists struggled for success against the regime of Cheang Kai Shek. The author has been unable to resist the temptation to stamp his political interpretation on the events he describes. I find this extremely annoying as it is so difficult to remove his colour from the scene, so from one's own ideas. Perhaps this marks Jack Belden as a successful journalist. His ideas about communism, revolution and why these events occur is I suspect passée and typical of a certain set in post-war America. Not having read "Fanshen" or "Red Star over China", two other books about China at about the same time in her history, by two different authors, probably means that the significance and interest for his views has escaped me. His continual reference to people, places and events, vertically and horizontally in time, make a map of China and the events to which he refers indispensable. It is very aggravating of the editors to have decided otherwise, as I cannot find the places on any map I have examined.

The description of the Chinese people is fascinating and delightful. It is worth reading this rather thick book for this only. I have scoffed at Mao's little red book, but now I wonder how one could disseminate startlingly new ideas among 700 million people at smaller cost. Those who can read have learnt only in the last 20 years, by characters pasted on the objects in their homes, or fixed on the plough or hedge. The ingenuity is surprising and refreshing. Perhaps Mao's little book of sayings is the natural progression of those written by the people themselves on their village walls publicising their new way of life. It seems the "revolution" in China was the process of village after village discarding the old way of life for new freedom and awareness. Is Jack Belden unique? The only man from the West to understand and observe so closely this remarkable event.

P. WATKINS.

HAEMATOLOGY, RUDIMENTAL, PRACTICAL AND CLINICAL
F. Nour-Eldin, Butterworths, London.

It is difficult to discover what particular section of the medical public this book is aimed at but in any case it cannot be recommended. The treatment advocated is often out of date and the black and white pictures of blood cells are ghastly. Although medical students might be expected to find the section entitled "rudiments" helpful, in practice this leads to a rather confusing splitting and duplication of the material presented.

M. BEARD.

DEAR DR. HIPpocrates
Eugene Schoenfield. Penguin, 25p.

Anyone who has been to San Francisco and has picked up a copy of the Berkeley Barb (their equivalent of the International Times) will know all about Dr. HIPpocrates.

Dr. HIPpocrates is a column in the Barb to which anyone with a medical problem can write in, and have it answered by Dr. Schoenfield. This however is a doctor column with a difference. The questions are not about acne and constipation but are more concerned with the health aspects of fellatio or the teratogenic properties of peyote. I bet you did not know that anolingualism is a prominent source of infectious hepatitis, or that bad L.S.D. may cause cramps.

In this book Dr. Schoenfield answers questions on all the subjects that the establishment of the A.M.A. did not know even existed; and he does it with humour sympathy and medical competence. He takes great pains to point out the dangers of taking any drugs in pregnancy; he warns about venereal disease and the problems of modern treatment. He never advocates breaking the law, but his allegiance is obviously towards the kids who write to him, and the fact that they do at a rate of 1000 letters a week is testimony to his acceptance.

One suspects that the British medical profession is just as out of date and unapproachable as their American counterparts, and this book which has been corrected to correspond with British law, will fill a large gap in the popular medical literature.

Rightly or wrongly the problems of L.S.D.: STP: M.D.A., abortion and Gonorrhoea all exist and it is no good to pretend that they are not there. With a little help from Dr. Schoenfield perhaps more people both lay and professional will be aware of these problems and able to cope with them in a slightly more practical and less moralising way.

A. PEACOCK.

GLOSSARY OF HAEMATOLOGICAL AND SEROLOGICAL TERMS
Sampson. £1.73.

GLOSSARY OF HISTOPATHOLOGICAL TERMS
Law and Ohrir. Butterworth. £1.95.

These two paperback books were written by prominent laboratory technicians at the London and Brompton Hospitals as small dictionaries which would assist anyone trying to understand the vast secret language that medical and scientific people use to confuse the layman.

The glossaries are directed at doctors, students and laboratory technicians and I think this is how they have failed. Medical are not taught, nor do they need to know about, the obscure equipment used in a serological laboratory, and nor do technicians need to know about the genetic basis of thalassaemia.

If anything the glossaries would be a good deal more useful to laboratory staff, and hence their rather stiff price. I would not recommend any student to buy either of them.

A. PEACOCK.

HUMAN EMBRYOLOGY AND GENETICS
Beck. Blackwell Scientific Publications. £4.25.

The habit of giving a branch of science a root of its own when it gets too big and heavy for the parent tree is a natural one. Biophysics, biochemistry and even physiology have arisen in this way. Each such newly-planted science cannot be blamed for wanting to occupy more ground and more time in the training of a biologist. There is a tendency for a parent science to be crowded because it has no room to grow.

The different disciplines of this book must involve different concepts—the molecules of biochemistry—the millenia of genetics and the millimetres of organogenesis and when taught separately these features may tend to be exaggerated. It is therefore refreshing and stimulating to have them brought together again in one book and made to serve one end—the provision of a general account of humand development "in the fullest sense of the word" (see the preface).

The script is well set out and easy to read although one is naturally aware (from the style) of the major contribution of one author to each section. The diagrams are more than ordinary. Most of them are bold and simple and therefore very clear. The efforts at three dimensional representation as in 13, 9, 11 and 14, in 18, 9 and 20, 2, 3 and 4, are praiseworthy. These particular concepts are teasers for the illustrator.

Applied science is a proper study but should not be exaggerated in a book of this sort—here the content of clinical reference is proper and sufficient. Finally the listing of references as "interesting and important" is a habit which could well extend to other bibliographies with advantage.

This book should be within the reach of medical students and many of them will soon find themselves possessing their own copy.

M. M. BULL.

JAMIESON; I.R.A. SECTION 3, ABDOMEN, 9th Edition. (Paperback). £1.00. Revised by Robert Walmsley and T. R. Murphy.

The authors of this edition of a long tried favourite have successfully concentrated on a reduction and rearrangement of legends and leaders in the diagrams to fit in with the trend of the times—the requirement of a knowledge a very much less detailed topographical anatomy than heretofore.

A feature of these illustrations has always been the stark use of vivid colours most of which are "conventional". Many people criticse this and would prefer touched-up black and white photographs, but we must remember that this book is based on the coloured blackboard diagrams of one teacher.

As "illustrations of regional anatomy" there are some pages which could be a little confusing. They illustrate specimens and sections which are seldom seen. Nevertheless they form excellent jigsaw puzzles for the revising student and exercise him in three-dimensional thinking—examples are 20.35 and 40.

One feels one would have liked to have listened to the lectures which went with some of these unusual diagrams. The illustration have benefited generations of students. There is no reason why they should not benefit many more.

M. M. BULL.

SYNOPSIS OF NEUROANATOMY
Howard A. Matzke and Floyd M. Foltz. Oxford University Press. £1.80.

The authors have been true to the title of "synopsis" in that they have given a good general review of the subject and a tabulation of details which is sufficient, concise and factual. It may sound unimaginative to say so but it is refreshing to come across a book of readable English in sentences of reasonable length giving accounts which are little more than lists of definitions and known facts. It is necessary that we should be reminded every now and again of the basis of knowledge on which research is founded.

The illustrations in this book are clear and simple. Inventing new ways of portraying three dimensional arrangements is a fascinating occupation with which the authors have had reasonable success. They have at least stayed simple.

The eight pages of text on clinical applications are quite sufficient in a book of this size.

So long as he realises that this is a synopsis the student should know that this useful book certainly deserves to go into its second edition. It is of a handy size and its price is not unreasonable.

M. M. BULL.

MUSIC

1) Bargain Records - Hector Berlioz (1803-1869)

by ALLEGRO

Whilst the popularity of some composers has shown considerable fluctuation, Berlioz has always remained a popular concert hall favourite: his fate in the opera house, at least until 1969, has been much more problematical. Berlioz caused a major stir at an early age when his professor (Cherubini) and he had a violent disagreement over an early composition "Le Mort d'Orphelia", at the Paris Conservatoire, where Berlioz studied composition. Wrangles with Cherubini were to continue for as long as Cherubini lived—a lot of this was due to inate jealousy because Cherubini, a middle of the second division composer must have appreciated the genius of the young man. Even for Berlioz to get his compositions performed at all in Paris was difficult and his press, in the early years was intensely hostile. Imagine, however, the conservative Parisian audience, nurtured as it was on a happy diet of gallante suddenly subjected to the opium induced and inspired Symphony Fantastique. This extraordinary masterpiece, written in 1830, has become a standard part of the orchestral repertory. It is not totally inspired—the Witches Sabbath, although novel, contains a vulgar use of the Dies Irae plain chant melody: also, in this writers opinion, the March to the Scaffold is a naive idea. However, the use of an idée fixe really pre-empts all ideas of Leitmotives by 40 years and the "scene aux champs" movement captures the atmosphere so well of the country—the simple but so effective impressionist idea of the two timpani producing near and far thunder. The valse movement is the French version of the Viennese Waltz—cornets in the score too. The harp too, figures prominently. Clearly an extraordinary work of which numerous records are available. Best of all cheap label ones are by Barbirolli and the Halle (Pye, GSGC 14005: 92p) or Von Otterloo and the Hague Philharmonic (Fontana 6540014: 82p).

When Paganini approached Berlioz for a viola concerto, the financial incentive was too great for the composer to turn down. However, he was not too keen to write a pure concerto and he had been greatly drawn to the Byronic scene. He conceived the idea of a symphony based on "Childe Harolde" and his mountain wanderings. In this work there was to be a part for a solo viola—not too extended. Again an uneven masterpiece resulted—the genius lies in the marvellous first movement where the viola part is extended. The end of the second movement reveals Berlioz's evocation of pilgrims and bells (pizzicato strings and stark woodwind lines and viola accompaniment). The last movement is an extended "orgy of the brigands"—a somewhat less than inspired movement. I've always enjoyed Bernstein's record of this work—his rhythmic drive being just what the work needs, with the New York Philharmonic Orchestra (CBS 61091: £1-42)—well recorded too.

Nothing remotely small scale from this composer—his Requiem is a vast work that was first performed in the Invalide in Paris. It is a massive conception, requiring brass upon brass in an extended stereophonic concept. The work relies on a full chorus and the only soloist is a tenor. It needs good stereo (in fact quadraphony may be the best of all for this sort of work) and the Munch recording on RCA (the older of his two recordings) is still most acceptable—better played and at least as well recorded as his more modern German recording (RCA VICS 6022: £2-37).

Romeo and Juliet attracted many great composers—Prokofiev and Tchaikovsky as well as Berloiz. The result was a cantata for chorus, two soloists and orchestra, an odd blend of opera and symphonic writing, yet as a whole, most effective. I find the orchestral parts the most enjoyable—the famous "Queen Mab scherzo" and "Romeo alone" being most beautiful. Colin Davis has been recording all the major Berlioz works and the orchestral excerpts of this work have appeared on an excellently played and recorded record of the London Symphony Orchestra (Phillips Universo 6580052: £1-16).

Opera involved Berlioz deeply—I would strongly urge those interested in this fascinating character to read his letters which are available in a cheap paperback edition which gives an insight into his complexity. Listening now to "The Trojans", one finds it difficult to understand the total oblivion this work suffered. It was first resurrected here by Rafael Kubelik in 1957 and Colin Davis took it up later on. It has been performed by the Scottish National Opera company with Janet Baker and Alexander Gibson. This is the work of an extraordinary genius and the Davis recording with Jon Vickers and Josephine Veasey reveals its true stature—for me, it is the essential Berlioz and although expensive, I would recommend it most strongly as my full price recommendation (Phillips 6709002:). This was one of four operas—"Benvenuto Cellini", "Beatrice and Benedict" and "The Damnation of Faust" were the other three (all available now on disc). This is indeed a treasurable time for Berlioz enthusiasts.

2) The Gondoliers - G & S Society

Enthusiasm is the most important single ingredient of any Gilbert and Sullivan production, and the Bart's presentation of the Gondoliers last week certainly didn't lack in it. I thoroughly enjoyed the evening. Having said this, however, there were several performances that had much more than gusto, James Griffiths was an excellent Marco, and only his laryngitis on the first night detracted from his rendering of "Take a pair of sparkling eyes' which received an encore nonetheless.

Christine Prime and Clara Hunter, were deliciously seductive as Gianetta and Tessa, and used both the stage and their looks to considerable advantage.

Among the character parts, John Gamble played a very effete Duke of Plaza-Toro and sang rhythmically with a very well covered tone. Nick Millard as Luiz, a drummer boy from the Duke's household, was very innocent and appealing. Paul Cooper, I think, was designed to act Gilbert and Sullivan—he *was* the Grand Inquisitor. He has a tremendous sense of the absurdity of the part and frivolity of the music.

In fact praise is due to the entire cast, and especially to the chorus of Gondoliers and Contadine who sang well and musically.

Turning to the technical side of the production. particular credit must go to the scenery makers and painters, who produced two convincing sets—although the practical gondola appeared to run aground in the middle of Act I. By the way, who was Colin?

The lighting was unobtrusive, that is to say, excellent. The costumes were well made, and showed the actors to their best advantage; I am pleased to see that Miss Thrower is building up a collection of costumes to obviate the need and cost of hiring.

The musical direction was very good. John Lumley gave a clear and precise beat, and had obviously schooled his musicians well. Unfortunately, the second violins played consistently flat, which was rather distressing, but the wood section was superb, as was the percussion.

The hallmark of a good production is the smooth interaction of the various departments on the first night, and a director's job is far from easy. he must cope with the foibles and fits of pique of everybody from the lead singer to the ticket sellers, and still be fit to live with. Miss Thrower directed splendidly, and gave us all a delightful night's entertainment.

3) Lunchtime Recital

The Thursday lunchtime recital at St. Bartholomew's the Great was given on 22nd February by members and friends of St. Bartholomew's Hospital. This provided the public with an opportunity to hear some of the musicians who have delighted the hospital community over the last year.

The Purcell cantata "When night her purple veil" brought together for the first time the violinists Richard Gullen and Cyril Nimmon. The building did little to help their first meeting, being highly demanding on intonation, in music which gave the performers little chance to shine. Nevertheless both players demonstrated their ample skills and we look forward to hearing them on many future occasions. The "friends" of the hospital took the form of Alan Reddish—spinet, and Delia Fuchs—cello. these artists added much to the performance. Alan Reddish directing the ensemble from the keyboard and Delia Fuchs providing a beautiful string bass. Regrettably even the broad lovely tones of John Gamble—baritone, could not provide the cantata with that sparkle usually associated with Purcell's music.

The Poulenc sonata for oboe and piano enabled Richard Carver and Tony Nethersell to demonstrate their excellence. They were joined by Douglas MacMillan—treble recorder, for the Trio Sonata Op. 1 No. 1 by Loeillet, when Tony Nethersell turned his hands to the spinet. This work proved a joyous conclusion to a recital which did much to enhance the reputation of hospital musicians. Congratulations all.

JOHN LUMLEY.

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.

SPORT

CRICKET CLUB

Fixtures arranged at the end of March were:

Date	*Opponents*	*Start*	*Venue*
APRIL			
Sat. 28	U.C.H.	2.30	H
Sun. 29	Carnegie	2.30	H
MAY			
Wed. 2	University of Sussex	2.30	A
Sat. 5	Crishall	2.30	A
Sun. 6	London House	2.00	H
Wed. 9	Royal Veterinary College	2.30	H
Sat. 12	No match	—	
Sun. 13	President's XI	11.30	H
Wed. 16	Medical Sickness Society	2.00	H
Sat. 19	Old Erithians	2.00	H
Sun. 20	Southend	2.00	H
Wed. 23	St. George's	2.30	A
Sun. 27	Woodpeckers	2.30	H
Mon. 28	Crishall	2.30	A
JUNE			
Sat. 2	Hampstead	11.30	A
Wed. 6	Trinity, Cambridge	11.30	A
Sat. 9	Incogniti	11.30	H
Sun. 10	Loughborough Park	2.30	H
Sat. 16	Jesters	2.00	H
Sun. 17	Guy's	11.30	H
Sat. 23	Temple Sheen Eccentrics	2.00	H
Sun. 24	University College School O.B.	2.00	H
Wed. 27	City of London Police	2.30	H
Sat. 30	U.C.H.	2.30	A
JULY			
Sat. 7	Nomads	2.30	H
Sat. 14	West Kent	11.30	H
Sun. 15	Blackheath	2.00	H
Sat. 21	Petts Wood	2.30	H
Sat. 28	RNVR	2.30	H
AUGUST			
Sun. 5	Ferring	2.30	A
Mon. 6	Burgess Hill	2.00	A
Tue. 7	Rottingdean	2.00	A
Wed. 8	Cousley Wood	2.30	A
Thu. 9	Seaford Seagulls	2.30	A
Fri. 10	Brook House	2.30	A
Sat. 11	Streatham	2.00	H
Sun. 19	Arkesden	2.30	A

At the time the above list was compiled there were still several vacant dates, but most of these should now have been filled. Anyone wishing to play this season should indicate their availability on one of the lists at College Hall or in the Students' Cloakroom.

ST. BARTHOLOMEW'S HOSPITAL STUDENTS UNION
WINE COMMITTEE

announce the XI Annual

BARBECUE BALL

to be held on

FRIDAY 29th JUNE

at

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

FURTHER DETAILS MAY BE OBTAINED FROM THE SECRETARY OF THE WINE COMMITTEE

SAINT BARTHOLOMEW'S HOSPITAL JOURNAL

Founded 1892. Vol. LXXVII No. 6

Editorial

Having recently visited one of Her Majesty's more famous prisons in London, I felt inspired to write an editorial on the subject of criminals and criminality. I had expected to do this by a more or less rigid application of the medical model: the subject presents with his symptom (or crime), is examined to determine its basis in reality, and with due regard to its severity and aetiology, a plan of management is drawn up. After this has been carried out, the subject is followed up to check on success and to guard against recurrence. It was in this way, rather than by suggesting that all criminals are ill in the more widely accepted meaning, that I planned to apply my model.

In reality the approach is completely inapplicable to the subject as it stands today. Whilst accepted by theorists as being a subject as wide as disease itself, criminality is dealt with in practice almost as a single entity. Aetiology is couched mainly in terms of morality and constitutional disposition, and consequently treatment is irrational and ineffective. Recurrence for all but the most serious crimes is in the order of 40 per cent.

To treat all criminals with prison is like treating all disease by bleeding. Many argue that this is true, but that at present there are no adequate alternatives. To do so is not only incorrect for a significant number of cases, but is indefensible as the basis for long-term policy. Prison has been a stop-gap in the treatment of crime for too long. To regard it as satisfactory either from the point of view of treatment of the individual or as an instrument for the attainment of public well-being is to accept standards that were considered inadequate in the medical world of a hundred years ago.

It is not at all inappropriate that the medical profession should take an active interest in these matters, and one would hope that any of its members with a social conscience would regard this as an important field for study and action.

STUDENTS UNION LETTER

Dear Sir,

I intend this month to take the opportunity of replying to the criticism or "challenge" which the Editors presented to the Students' Union in the April *Journal*. I regret that this is the earliest occasion on which my reply can be printed and the Editors may of course have the last word for another two months if they choose to respond now. I would hope, however, that if they do continue the discussion, they will have the courtesy and sense to turn up to at least one meeting, either of the Students' Union Council, the Teaching Committee or the Constitution Committee—all of which are open—to see just what does go on. Informed criticism is welcome, but the Editors seem to delight in ill-informed destructive criticism, offering us nothing for the future except "a more open form of government". If the Editors would discuss the practicalities of such glib phrases with us, perhaps we could make some progress.

This is not to deny that there are defects in the system. We *are* changing our Constitution as I "announced" in my last letter, and we will be making the notices of meetings more prominent, as previously requested. I believe that elected year representatives are an important feature of our organisation and I further believe that these people must take on a greater rôle as sources of information to the students and opinion from them. This is easier preclinically where representatives must report after each meeting. The charge that we are unrepresentative will of course be levelled against us—we are unrepresentative in that we are committed to think about the position of students in this hospital—but tell us how we can improve. Are your elected representatives trustworthy or do we need government by plebiscite? As the Editors remark, such questionnaires tend to be ignored. I believe that Bart's students are apathetic. I would welcome any response that proved me wrong.

We must, obviously, also improve the distribution of information to the students. How should this be done; newsletters, minutes or just by persuading people to read the notice-boards? Do we perhaps need an Information Officer to take on these responsibilities and to widen the Executive? Certainly we would welcome anybody interested on to the Council but such people are not forthcoming.

The teaching committee is becoming more and more active. Anybody interested in the educational process at Bart's should contact Gerard Bulger, the new Chairman. This is what we require:— ideas, constructive criticism and active involvement. Only then will the views that we put to the College Committee, Curriculum Committee, Library Committee, Preclinical and Clinical Student/Staff Committees and occasional Boards of Studies be seen to be representative as we believe they are.

Yours etc.,
PAUL TAYLOR.

ANNOUNCEMENTS

Changes of Address

Dr. BARBARA MORGAN has moved to 10, Plowden Park, Aston Rowant, Oxon.

Miss LISBETH ADAMS has moved to 6, Finchams Close, Linton, Cambs.

Mr. ANTONY F. WALLACE has moved to "Mill Green Cottage", Mill Green, Ingatestone, Essex CM4 0HX.

Dr. and Mr. GEORGE LADD (Dr. E. S. Priddle), have moved to 99, Westmoreland Road, Bromley, Kent BR2 0TQ.

Births

BARNHAM—On February 8th, 1973, to Michael and Trudy Barnham a son, James.

Engagements

NAUNTON-MORGAN BRADSTREET The engagement is announced between Thomas C. Naunton-Morgan and Rosemary A. Bradstreet.

Election

Former graduates of St. Bartholomew's Hospital who are also Fellows of the Royal College of Surgeons will be interested to know that Mr. I. P. Todd is standing for election to the Council of the Royal College.

Thanks

For the photograph of Charles Green's painting of Bartholomew Fair, which appeared in the April *Journal*, we are indebted to the landlord of the "Hand & Shears."

Appointment

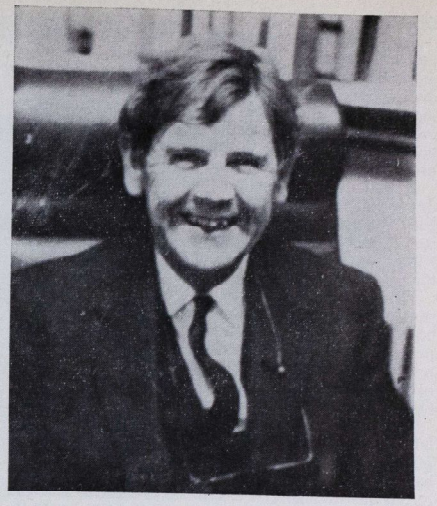
Mr. G. M. Rees has been appointed Consultant Thoracic Surgeon to the Hospital. He takes up his new appointment on June 1, 1973.

Appointments

Dr. A. G. M. Weddell has been appointed professor of Human Anatomy at the University of Oxford.

Dr. Weddell was a student at Bart's and graduated M.B. from the University of London in 1933. After a period as a House Surgeon at Bart's, he was awarded a Commonwealth Fund Fellowship in 1935 and worked at Rochester University, New York, and at Washington University, St. Louis. He returned to England as demonstrator in Anatomy at University College, London. He served with the RAMC during the war, and worked for some time in Oxford at the Military Hospital for Head Injuries. In 1942 he was elected Hunterian professor of the Royal College of Surgeons of England and in the following year he was awarded the John Hunter medal and tie triennial prize for his research on the ultimate distribution of the sensory peripheral nerves. Since 1947 he has been reader in human anatomy at the University of Oxford. In 1961 he was Chaffer lecturer at the University of Otago Medical School, Dunedin, New Zealand.

Dr. Weddell is presently engaged in work on the problems of peripheral nerves in leprosy. He is a Fellow of Oriel College, Oxford.



LETTERS

Dear Sir,

I know that at this time
Modern poetry doesn't rhyme,
And that (although it seems absurd),
Scansion is a dirty word;
But what you Editors don't know it's
A death-knell for us old poets,
Not to have your patronage
To use a fraction of a page
For sometimes quite amusing verse,
Which pleased the Student and the Nurse.
I mean those days, so far away,
When "Round the Fountain" held its sway.
I used to do my little bit,
But now there's come an end to it.
But what's the purport of this letter?
Let's have some verse, the more the better!
Maintaining anonymity,
I simply sign myself
A.B.

Dear Sir,

I was very pleasantly surprised to read a news item, with a write-up, on Good Old St. Bart's! This was in the "Globe & Mail", a Toronto, Canada, based morning paper.

It was an honour to have been a patient in your hospital during the first world war. I was a casualty in December of 1916 and was brought home to St. Bart's on December 17 of 1916.

It was then called "The Darker Ward" as we knew it, but if that was not correct please blame my poor memory. I spent some four months I believe in the bed next to the open fireplace in the center of the ward. I have been very grateful ever since for the treatment that I received there and later at the recuperation center somewhere in the country.

I have many pleasant memories of the hospital and the outings we "returnees" attended, being entertained by people whom we did not know we appreciated all the more the fact that they must have given up both time and food ration tickets to give us the feeds that these outings closed with. Our welcomes were always warm and happy, these memories more than balance the memories we have of the "welcomes" we received in the trenches!

Now at the age of 75 I can look back and smile and remember—

"With the going down of the sun
And in the morning
We will remember them."

My most sincere best wishes to you, the hospital and the staff. May the Old Place remain for many years to come.

In Canada since 1920.

Very sincerely yours,
G. J. GRIPPER.
(Ex-Private 30865, 1st Batt. Essex), 1916.

Dear Sir,

I am amazed at the amount of work and enthusiasm put into organising the 850th Anniversary. An office, secretaries, a large committee who frequently meet to discuss proliferating arrangements and publicity extending to a Press conference. I am very pleased that these celebrations are being made with such gusto and it is good that we feel able to reflect on the past with such pride and wish to mark it well.

Amidst this self-congratulation we should also think of the students of Bart's, present and future. Apathy has been attributed to the students for the past decade; the staff I think have equal claim to this adjective. However, I think we should boot this old label and excuse out as the Editors so rightly suggest in the April issue.

The Teaching Committee has been trying to obtain student opinion in a shy way. It has not been successful because its questionnaires are limited by their questions, posed and planned from inexperience, and because a response of 30 per cent has been the norm. Questionnaires we feel are artificial any way, and certainly have not proved satisfactory in our hands.

I think we should have an "Undergraduate Studies" office with secretaries and publicity which is carefully planned. Facilities for all callers, students and staff, to have a discussion over coffee and refreshments and to record their thoughts. A committee of students and staff coordinating inside efforts with outside advice and help from educational experts.

To date energy has been directed into creating a plan for a course which is ideal and will never need changing. I think this concept is erroneous—we students would all rattle out the other end as fossils. "Teaching" is a sensitive experiment between learners and teachers. Self-examination by each will naturally lead to the desire for improvements on present methods and the adoption of new ways.

May the Teaching Committee bag the 850th Anniversary offices when May is past.

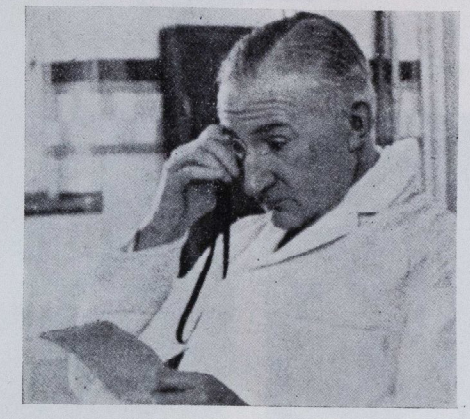
PRIMROSE WATKINS,

Lyme Regis—December '71

Do you remember summer?
Stepping through the striving joymakers in their vari-
coloured deckchairs.
on the sandcastled beach
Bunches of mackerel hanging from hands—
grapes in a Neptunian orgy,
Now only the tide pulses here, the beach is smooth
and silent, the harbour empty
and
Ebbing and flowing drift dead diseased
disowned aquarium fish
and lollysticks
Nets strung out in the drying wind
Trawlers helpless as stranded whales
The seagull spattered cobb juts its way
into the hard blue sea
Shivering we turn our backs and wait
for summer

PETER GLANVILL.

OBITUARY



Dr. Malcolm Donaldson, consulting gynaecologist to St. Bartholomew's Hospital, died at Oxford on March 16th at the age of 88. He was a loyal and devoted member of the consulting staff for 31 years. He served with the RAMC in the 1914-18 war as a surgical specialist, and was elected to the staff in 1921 as Assistant Physician Accoucheur when that historic title was still in use.

After Charterhouse, he went up to Trinity, Cambridge, and soon distinguished himself as an oarsman, winning the University sculls and rowing against Oxford and Harvard in 1906. Since then he was often to be found on the river and strongly supported the St. Bartholomew's Hospital rowing club where his experience, advice and leadership were greatly appreciated.

Dr. Donaldson was a distinguished gynaecologist and from the beginning of his career developed a tremendous interest in the early diagnosis and treatment of cancer in his speciality, with particular emphasis on the treatment of carcinoma of the cervix by irradiation. He was Director of the Cancer Department at St. Bartholomew's and also on the staff of the old Radium Institute in London. For many years he was consultant gynaecologist to the Mount Vernon Hospital, Northwood, where he was a loyal ally to the active and forward-looking department of Radiotherapy. In the early days, he experimented with the insertion of radium needles around the cervix by the abdominal route—a precarious approach in the cachectic patient for the abdomen had to be reopened in 10 days times for the removal of the needles. This was soon succeeded by more efficient methods of inserting intravaginal and uterine radium with pelvic deep X-rays. St. Bartholomew's has always pioneered in the use of radiotherapy and in the early days Dr. Donaldson worked in collaboration with Dr. Finzi when the 250 KV X-Ray machines were introduced into the hospital. Efforts were always being made to improve upon the standard radium treatment which stemmed from the Radium hemmet in Stockholm. He was vice-chairman of the National Radium Commission and a member of the Radiology Committee of the Medical Research Council.

Dr. Donaldson will be well remembered also for his tremendous interest in the education of the public about cancer. It was his life-long ambition to explain to all that the more the public knew about cancer the less fear of it there would be—thus patients would consult the doctor early and the results of treatment would be greatly improved.

During and after the 1939-45 war, and throughout his years of retirement, he was indefatigable in lecturing to members of the public on this theme. In wartime he drove hundreds of miles in the blackout to distant villages to address the Women's Institute and other associations. When he retired to Oxford he became honorary director of the Cancer Information Association. During the war he was a member of the Emergency Medical Service based on the Mount Vernon Hospital, Northwood. It is an indication of the man's character that he volunteered to be a member of a surgical team which was sent to Southampton to deal with casualties ferried out from the Normandy landings. He also travelled to Japan by the Trans-Siberian Railway to speak at a conference when he was nearly 80 years old.

Dr. Donaldson took a great interest in the growth of the Royal College of Obstetricians and Gynacologists and was made a foundation fellow serving on the Council for many years. He was the author of a book on "Radiotherapy in the Diseases of Women" (1933) and joint author of a treatise on "The early diagnosis of Malignant Disease" (1936).

Everyone who knew "Dottie" will be sad to lose a loyal friend who was greatly respected for his total integrity, self-discipline and dedication to the subject of his choice.

J.B.

MEDICINE IN ART

Paediatrics

by YVONNE HIBBOTT

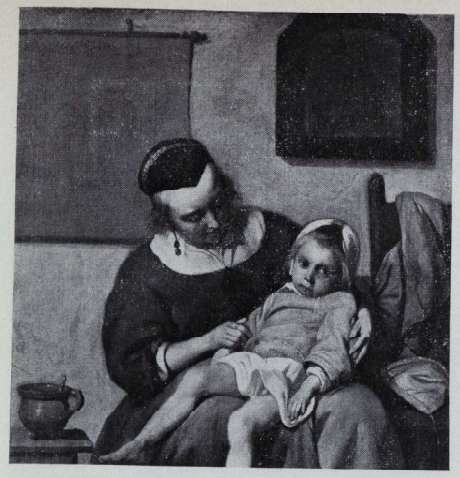
1. RAPHAEL (RAFFAELLO SANZIO)
(1483-1520)
THE TRANSFIGURATION
(Detail)
(The Vatican, Rome)

A detail showing the healing of the epileptic boy. The Transfiguration fills the upper half of the painting—contrasting with the noisy excitement of the crowd in the lower half who are witnessing the miraculous cure.

In St. Matthew's Gospel the account of the cure follows the account of the Transfiguration. The boy's father came to Christ—"Lord, have mercy on my son: for he is lunatick, and sore vexed: for ofttimes he falleth into the fire, and oft into the water." (*St. Matthew*, xvii, 15.)

2. JUSEPE DE RIBERA (1591-1652)
THE CLUB FOOT
(The Louvre, Paris)

This cheerful Neapolitan waif has unilateral leg and arm deformities, which suggests infantile hemiplegia. The boy may be aphasic, as he carries a paper in his left hand on which is written "Da mihi elimosinam propter amorum dei" (Give me alms for the love of God).



left:
3. GABRIËL METSU (1629-1667)
THE SICK CHILD
(The Rijksmuseum, Amsterdam)

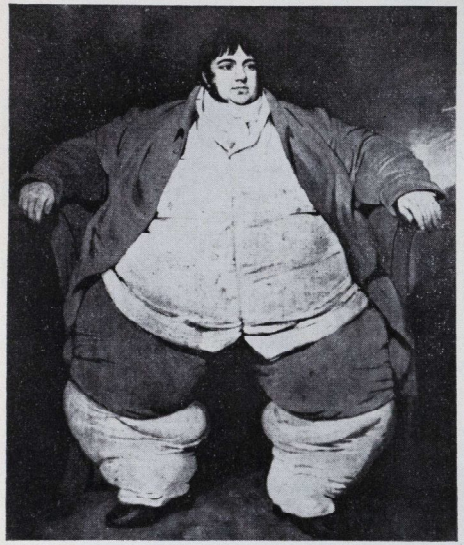
below:
4. JACOB EPSTEIN (1880-1959)
THE SICK CHILD
(Private Collection of Mr. Arnold Haskell)
Bronze, 1928

The model for this sculpture was the artist's 10-year-old daughter, Peggy Jean, who was suffering from an eye complaint.

ACKNOWLEDGEMENTS

Illustration No. 1 is reproduced by permission of The Vatican, Rome; No. 2 by permission of The Louvre, Paris; No. 3 by permission of the Rijksmuseum, Amsterdam; and No. 4 by permission of Lady Epstein and Mr. Arnold Haskell.

MIND OVER MATTER



Weight Watchers—"The World's most respected weight control organisation" recently sponsored a talk at the R.S.M. by Professor Schachter of Columbia University. He is particularly interested in eating patterns and the stimuli or "cues" which make normal people eat normal amounts and overeaters overeat.

Obesity is of course the subject of a great deal of attention at the moment, and Professor Schachter's work covers really only a small area. It is now being realised that there may be people who get fat without overeating—the doctor's dismissal of his overweight patients with the remark "There were no fat people in Belsen" is unacceptable today. Recently Dr. Galton and colleagues at this hospital have described an overweight mother and daughter with detectable abnormalities of the lipolysis mechanism. A distinction is now being made between hypertrophic obesity, where the fat cells are larger, and hyperplastic obesity, where there is an increased number of cells. The controlling function of hypothalamic areas and the metabolic controls of fat synthesis and breakdown are gradually being elucidated.

This is not an attempt to review recent trends in the study of obesity, but it is important to understand that Professor Schachter's findings described below are relevant to the *overeaters* rather than every obese person.

By various ingenious experiments, designed to manipulate the stimuli that might make people eat, he has detected a difference in the eating behaviour between normal and obese subjects. For example, an obese person will eat when the clock shows "dinner time", or when there is food readily available, or when he is attracted by the sensory manifestations of food. A normal person will eat when the various physiological parameters of hunger—decreased blood sugar, increased gastric motility, etc., indicate that he needs food. He will then eat until his true need is satisfied with less regard for the aesthetic satisfaction of good smells, taste, etc.

The conclusions are obvious—if you place an obese person in an environment where the external cues of sight and smell of food are eliminated, e.g. by feeding him an unappealing low-calorie emulsion, he will eat less than a normal person and lose prodigious amounts of weight, but as soon as he returns to the world filled with external cues his weight returns to its previous level.

Secondly, filling himself up with low calorie bulk such as salads before going to a party where food cues will be in abundance (as suggested by weight watchers) is unlikely to help the obese person as he pays little attention to physiological or internal cues of satiety. Similarly, anorexigenic drugs, such as amphetamine, are unlikely to be effective in overeaters.

Dr. Trevor Silverstone, who chaired the meeting, gave a brief indication of his work at Hackney which could be the logical treatment of this type of obesity. The patient must train himself to avoid or ignore external cues. Some examples of this behaviour therapy are training the person to only eat in certain rooms and to always lay the table even if only to eat a chocolate. By eating slowly and purposefully they can identify the stimulus or "temptation" they are trying to ignore and will perhaps be able to ignore next time. They are encouraged to think of rewards (visions of themselves lying on the beach in bikinis) or punishments (memories of their most embarrassing moments when fat) to dispel their temptations.

It is along these lines that weight watchers operate. They are undoubtedly the most successful "weight control organisation" since the Irish Famine and their methods are weekly group classes with planned diets including almost all foods and special programmes allowing members to eat illegal foods. In some areas financial penalties are imposed if the goal weight is not achieved and maintained.

From talking to several worthy ladies who belong to weight watchers one is left with several impressions. Undoubtedly many of them lose a lot of weight. Up to one third of members are recommended by doctors so it is reasonable to assume that successful members are healthier if not wealthier and wiser. However some of these ladies—and it is predominantly a female organisation—appear to have become almost obsessive about their weights, and talk of little else. Even though they now look quite attractive some of them still think of themselves as *overweight*.

There is no doubt however that the increased interest being shown in obesity should dispel many of the myths surrounding the great god of fashion, and the pounds of human flesh which are sacrificed to him on the altar of abstinence.

M.H.J.

RAHERISM

Sir T. PROLAPSE—POLYP, Prof of Altruism

J. P. DEADY, Lecturer, Dept. of Medical Mythology

Summary

With the 850th Anniversary of the foundation of the Royal and Ancient Hospital of St. Bartholomew falling upon us this year, it was deemed appropriate that a new disease be invented and named in honour of that most esteemed and venerable institution aforementioned.

We took it upon ourselves to isolate a particularly virulent and underhand bacillus that we have named Perciella Bartholliform. Infection gives rise to a syndrome called Raherism, so called to commemorate the Monk who founded the Hospital in 1123 during a fit of madness.

Thirty Raheretic patients were detained at St. Bartholomew's on January 25th, 1973, following a dawn swoop on the unsuspecting population of Penge, where outbreaks first occurred. Penge was later declared a disaster area. These subjects underwent the Beamish Regime, which produced 100 per cent remission.

Introduction

The severity of an attack of Raherism to which patients or cadavers can succumb may not be apparent from medical examination. Occasionally cases may present with no symptoms whatsoever, investigations revealing no trace of infection with P. Bartholliform. This so-called "Subterfuge Raherism" is really indicative of an underlying and serious form of health (Kealey 1973). However, this form of Raherism is rare and we will not discuss the better known features such as the moria, morbid tooth-fixation, worm baiting, etc.

Raherism is far commoner in women despite the fact that 93 per cent of Raheretics are males, an interesting anomaly. In the aetiology constitutional and environmental factors are important, but religion and politics are of no relevance. We note with interest the observation of Pfnigl and Bwlch, who spent 3 years camouflaged in the uninhabited Gobi desert studying interrelationships between the desert environment, the bacillus and the indigenous population. They discovered a complete absence of Raheretics there.

Disease has been suggested as an origin by Noon (1973) and Rats by Leung (1973).

The obvious localisation of the infection to the immediate vicinity of Penge did not escape our notice, an observation evidently not apparent to Pfnigl and Bwlch, who do seem rather obsessed with deserts. We suggest that an inherent factor peculiar to Penge is somehow implicated, although its true nature is, like Penge, obscure.

The latest hypothesis, by Pfnigl and Bwlch, that the Kalahari Desert is responsible is probably unlikely, as Penge has been found to be totally devoid of deserts.

Experimental Findings

In an interesting study using live rats as guinea-pigs, Von Recklesshausen has shown (Appetites in Live Rats. B. J. Biochem. 1972 2 719), that the appetite of a live rat fed upon P. Bartholliform soaked farmer's silage is related to the quantity of silage consumed by that *same* rat, and not by other rats whether Raheretic or not. The implications of this finding to the Raheretic Syndrome are obvious. Recent evidence shows, however, that Von Recklesshausen may have been working with hamsters instead of rats.

Snidecrusher came close to demonstrating the answer (1971), and became very excited. But he had to retire from research, in vivo, due to illness (B. J. Biochem. 1972 5 596). He now devotes his time to gardening (*The Guardian*, March 2nd, 1973).

Jynehopper, in a dream, discovered that the release of inhibitions into Ringer's Solution caused Raheretic enzymes to congregate into small prosthetic groups. Inhibition Releasing Factor (IRF) has recently been isolated, polished and purified and found to be a polypeptide not unlike haemoglobin. In 1968, at the School of Thought, IRF was found to be identical to haemoglobin, and only three years later it was found to *be* haemoglobin.

However, this is basically irrelevant to the study of Raherism. We justify its inclusion as it may possibly add to the general confusion that now exists over this subject. We anticipate with a little apprehension the emergence of new enlightening facts, which will reveal more about Raherism, but just as much about us, unfortunately.

Treatment

This has altered drastically since the days of Rahere, particularly with the introduction of the National Health Service, when the Barber-Surgeons finally moved to Smithfield Market. Treatment entails removal of the cause, which as explained above, we do not know. To admit failure is counter-productive, we concluded, so the all-encompassing Beamish Formula was employed. This is pretty harmless and may even be beneficial. It comprises:

1. Bed rest and intermittent reassurance.
2. Removal from Penge and transfer to hospital, which must not be in a desert.
3. Indiscriminate radiotherapy to all areas, except, of course, the feet.

Chaining of patients to their beds is of no value, in our opinion. C. C. Noon used to prescribe penicillin until in 1973 he discovered Smirnoff; all patients received this in vitro. Aware of the fact that the blood is the body's main transport system and lifeline (*Reader's Digest*, May, 1973), we gave transfusions ad. lib.

Results

Our criterion for complete remission was that patients should not return back to us for further treatment. We achieved 100 per cent success. Investigations revealed typical can-can rhythms, raised iron and steel binding capacities, obvious concubines and sarcastic tumours of the bladder. In addition the positive Harvey Smith sign was obtained.

Two patients presented with acute abdominal distension. Laparotomy confirmed a large obstruction at the Watford Gap region of the terminal section of the ileum. A heavy bolus had obviously been travelling at high speed, despite the treacherous conditions of the mucosal surface and dense inflammatory exudates, which reduced visibility to a few inches. The rush-hour traffic of chyme was held up, and the bolus, which was carrying a large quantity of P. Bartholliform had discharged its contents causing enormous congestion. The Greater Omental Police had sealed off the area by the time we arrived on the scene. We were obliged to perform a by-pass operation, as there was no alternative route for through traffic.

Complications

(a) Statistics. These should be avoided at all costs; once established they create enormous problems. There has been a marked increase in the Raheretic population recently. This is only of importance when considered logically and seriously, which is beyond the scope of our capacity. Likely causes are:

1. The urbanisation of deserts
2. More accurate methods of wrong diagnosis
3. The rise in the number of computers in the population
4. Newer, more modern statistical errors

(b) Fishing. Patients in the advanced stages tend to become addicted to fishing. There is irrefutable evidence that fishing can cause carcinoma of the rectum (Leung, Kealey et. al.), and the layman is aware of the shortened lifespan associated with the habit. The Government intends to engage in a 5-year campaign by the end of which all the country's rivers should be irreversibly polluted. Every doctor has the responsibility to explain to the Raheretic the real dangers fishing can do to his health.

(c) Behavioural abnormalities. Many persons infected with P. Bartholliform seem to be prone to some form of Standard Deviation. This is perfectly normal and should *not* give rise to anxiety.

Discussion

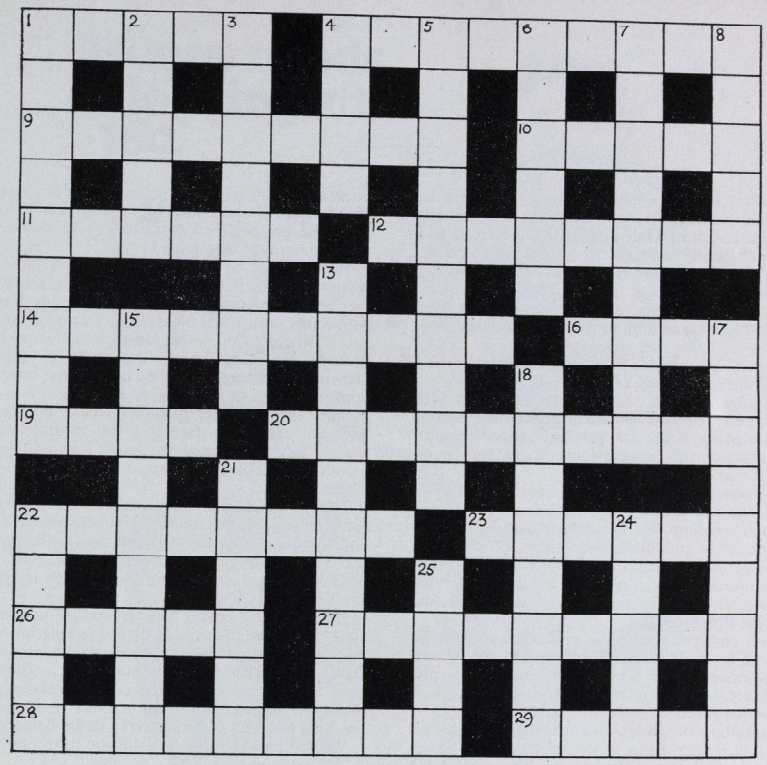
The prognosis is grave, due to more accurate diagnosis. Comparisons with past mortality rates are odious, so we omitted to publish figures. Our critics imply that the analysis is unscientific, but we deny 84 per cent of such allegations. Most of the evidence seems to suggest that Raherism is not the result of chance or a primary delusion, as Vrimobitch (Applied Delusions, 1973) would infer. But equally, this may not be true.

From this study it is clear that Raheretics should stop consuming turnips. Also vegetables such as artichokes, autoclaves, and swedes should be avoided like the Plague, the Black Death and Syphilis respectively. Dietetic advice is helpful. With the development of cheap, easily obtainable cystoscopes (such as recently marketed by Sainsbury's), the public can be educated, helped by real experts, like ourselves, in self-treatment. Agreement on the eradication of likely breeding areas, such as deserts, could help in stemming the spread of Raherism. Being realistic, we know that this is an impossible pipedream, but that is not the point.

We wish to thank C. C. Noon, G. T. E. Kealey, D. Leung and the people of Penge for their insulting criticism, Mrs. Leucine Probe for the grind in Biochemistry and the loan of her computer, which we unfortunately broke. May we express disgust to the editor of "The Scalpel", which refused to publish our paper. The Medical Insurance Society and the GMC, without whom anything is possible, deserve special thanks for their sympathetic treatment of our problems. We extend warmest appreciation to our secretary Mrs. Ethylene Hipcurve, and to all those too numerous to mention, such as our wives, who have contributed to this publication.

Requests for reprints should be addressed to: Sir T. Prolapse-Polyp, 131, High Street, Fistula-in-Ano, Surrey.

JOURNAL CROSSWORD - No. 3 by DOGSBODY



ACROSS

1. Dried; there's help round about (5)
4. Out-lined once for sloth (9)
9. This gent's showing no sign of slackness (9)
10. Warnings of depressions (5)
11. See 2 Down
12. Sends out a hundred in songs (8)
14. Thenceforth threatfree possibly (10)
16. A resting place in it (4)
19. Iron perhaps? One of a suit (4)
20. Producing negatives, a number after the day before taken in by nobblers (10)
22. An afterthought on alms it could be his song writing (8)
23. That business of a very loud tune (6)
26. Being somewhat innocent, I am in church . . . (5)
27. . . . while the Rev. with debts is substituted (9)
28. Father figure son forces out (9)
29. Dimensions we hear in whispers (5)

DOWN

1. Season a second sound self-activated (9)
2. 11 Across. Or its grim or its bad stiffness of late (5, 6)
3. Docked and itemised (8)
4. I'm 10, claims the goat ungrammatically (4)
5. Found a record, perhaps above the editor (10)
6. Round a hundred lust about the insect (6)
7. Ill-gain about 5 can be sailed in (9)
8. Alleviates and sees a change (5)
13. Such attacks are frequently strains, we hear (10)
15. Roman coin I found in an age of instruction (9)
17. Can't rely on a small locality being eaten away (9)
18. Falls in line with a number on the benches (8)
21. Stop! I'm over deep trouble (6)
22. Godly terror (5)
24. Morning on a note of togetherness (5)
25. Sign of damage (to the service corps?) (4)

Solution on page 178

IS THERE A DOCTOR IN THE HOUSE?

by J. WATKINS

The allocation of house jobs is a most inflammatory subject, both for those concerned with the selection and those subjected to it. One undisputed fact is that a system which barely manages to fill all the posts, yet alone select an appropriate House Officer for every job, is badly in need of change. Mr. A. Fuller (Sub Dean) has devised a new scheme of selection, effective from January, 1974, in an attempt to eliminate just this problem.

The details are yet to be finalised, but the main features of the new system are these:—

1. In future, at Bart's and at hospitals with jobs reserved for Bart's graduates (circuit jobs), there will be only two starting dates for pre-registration appointments, instead of the existing four. These will be on January 1st and July 1st of each year.

2. Graduates wanting Bart's or circuit jobs will be graded by the Sub Dean, "in order of merit". In the future, such grading will be determined by a very rigorous system of continuous assessment, as well as by firm grades, examination results, honours passes, prizes, etc. An important new feature of the system is that extra curricular activities and responsibilities will rate as a criterion for grading.

An as yet unsolved problem is what academic criteria will be used to grade this year's graduates, as no continuous assessment has been undertaken; and many firm grades still reflect, at best, a student's attendance rather than his ability.

One suggestion has been to distribute a circular to the final year, asking them to list their contemporaries in order of suitability as housemen. The graded list would then be computed from the results of this "popularity poll". (The system has evidently been used elsewhere fairly successfully.)

3. Applicants will be asked to list a maximum of 15 jobs in order of preference and also to include a list of jobs they definitely do NOT want. The Committee of Physicians and Surgeons will then meet and allocate the jobs to the candidates in the order that they appear on the Sub Dean's list. Applicants at the end of the list may additionally be appointed to any unfilled posts, if all their selections have been taken, provided the job has not been listed as one the candidate does not want. The relative speed of this processing will mean that any candidate who is not found a job at Bart's or on the circuit, will know in plenty of time and be able to apply elsewhere.

Consultant staff will retain the right to veto a candidate for their job, but must explain their objection to the Joint Committee.

4. As many candidates applying for circuit jobs may never have even been to the hospital concerned, an integral part of the new scheme will be to make details of *all* facets of these jobs freely available. Where possible, the prospective candidate will be encouraged to visit the hospital beforehand.

5. There are 66 jobs at Bart's and on the circuit at the present time, and efforts are being made to greatly increase this number, so that ultimately any Bart's man who wants one, would be assured of an approved job.

6. The transition period between the two systems has brought some hardships, especially to this year's Oxbridge graduates. Traditionally, they have always applied for the October jobs, giving them two or three months vacation after qualifying. Now they are faced with the option of starting a job in July as student locums (on an "if qualified basis") or waiting for six months till January to compete with this year's London graduates.

This problem is to some extent a temporary one as the ever-growing incompatibilities between the Oxbridge and London courses have meant that in the near future the entire Bart's clinical intake will take the London M.B. in October, regardless of where they received their preclinical education.

7. When the circuit has expanded sufficiently, the time may come when, as at other teaching hospitals, the best applicants will be encouraged to apply outside Bart's, the weaker candidates staying on as Bart's housemen to gain more confidence and experience, whilst under supervision. The future status of house jobs at teaching hospitals is undoubtedly in the balance.

We will publish a fuller discussion next month.

After visiting Kew

I sometimes yearn to send the city to a green destruction:
Leaves blotting out the sky
bringing the green coolness of summer woods
Pavements disappearing under autumn leaves
ivy strangling parking meters, phone kiosks becoming minute green houses—
clematis round the cables
Here and there cathedrals and skyscrapers tear through the emerald canopy
their ruined floors filled with groping plants
crushing filing cabinets and sapping the life from executive desks.
From the drains come scarlet fungi and etiolated ferns
Down at the river, seaweed grows in luxury, overshadowed
by crisp new oaks feeding on rusting pipes and cars.
The traffic lights fade from red to gold
on the autumn highway

BMSA REPORT

By GERARD BULGER

BMSA has been moving towards a more poltical role in recent years, and this reached a new epoch at the association's AGM in Cardiff this April.

The main points to come out of Cardiff were:

1. Private practice should be outlawed
2. The GMC should be dissolved
3. £300 to go towards a National Association of all Health Students
4. £25 to go to the Health Workers' Strike fund
5. No more BMSA sponsored 7-a-side matches: "They are too rowdy."

Despite the outlandish things said at the conference there was no gripping debate. There was an interesting alliance of reactionary capitalist pigs in the back row that were antagonistic to most of the "poltical" motions put forward. This alliance was made up of Bart's, Belfast, Leeds, Sheffield, Cardiff and occasionally Edinburgh.

Contrary to most I believe that Bart's and Guy's are not so different institutions, the Bart's chap being of the same genus (i.e. A1, A2) as the Guy's animal. Yet Guy's consistently voted in the opposite way to Bart's at the AGM. This interesting discrepancy prompted Bart's to question how representative the BMSA reps were of student opinion at their schools. We passed a motion to the effect that the AGM realised that the views expressed in the motions passed were not necessarily those of the majority of students at the present time, and suggested ways to change this. The basic problem is that BMSA reps are not elected with the same competition and gusto as the chairman of the students' union at most schools. The average BMSA rep. is rather politically motivated. Bart's finds the London Medical Schools Presidents' Council more relevant and representative than the London region BMSA group.

Most of our time at the AGM was profoundly boring, as the conference rubber stamped executive motions. Even the elections for the executive was dull, there were few nominations so we sat back and saw the executive re-elected after a kind of musical chairs.

Everything had to be taken so seriously. "We are only here for the beer" attitude was not appreciated by most of the reps. The most pathetic scene was the AGM reception and dinner. This was to be a black tie do, but this year immature little people insulted the hosts and benefactors by coming along in polo neck sweaters, just because they resented such bourgoise enjoyment. Some could not enjoy the after-dinner speeches, the Mary's rep. in particular just sniggered at our honoured guests and Vice-President throughout, reading political innuendos into everything that was said. We were sombre and sober throughout, the free beer available the following evening took a long time to be polished off. There was no games cup, because the majority of the reps. were huddled together talking verbal diarrhoea about NUHS. Has the medic lost all his powers of enjoyment?

The activities of the BMSA regions will be directed towards education, National Association of Health Students (NAHS) and grants.

Grants

BMSA is actively supporting the NUS claim hoping that they will also sort out the medics' special case. There will be a BMSA organised march and parliamentary lobby in October. This must be well supported. Grants are to be reassessed by the DES in February 74.

NAHS

The principle behind this is the concept of the health team, the doctor, nurse, physio, radiographer, social worker et al should work closer together without barriers. A start towards this ideal is if all these students should come together and share the same facilities and even a common first-year course(!) The other students at present have many problems like petty rules and a worse grant system than medics, a large united union of all health students would be able to fight these issues. There are other more nefarious political aims as well. If anybody wants to set up a Bart's branch contact the author.

Education

The education sub-committee is the hardest working and most down to earth part of BMSA at present. An office is to be set up with the help of an education foundation. The great problem at present is to educate fellow students of the new ideas.

IFMSA

The international department and exchanges will be as before, but BMSA wants IFMSA to become more political, dig at South Africa and all that jazz.

BMSA is becoming more poltical and divorcing itself from the average medic in the process. The medical student has not been renown as a political activist and is not one at the moment. Liverpool medical school have threatened to leave BMSA. Perhaps others will follow since the membership fee is going up by 66 per cent to 15p a head in order to pay for all that was recommended at the AGM.

Perhaps medical student opinion is really changing in the same way as BMSA policies.

2001?

Sharing my remaining soya sausage with you
on the five mile tenement,
Evesham dust bowl clouds the red night sky
Goodbye pears and plums,
Walking in the clean moonlight
on the stinking shore sand oil and sewage,
Hencoop houses at night,
Dusty light bulbs and cold stone stairways—
Remembered the day we ate the last dog
Whilst chewing a stringy rat,
sucking the fragile bones
dry.

THE ORIGIN OF WARD NAMES

part 1

COMPILED BY NELLIE J. M. KERLING

Vicary Ward

In 1540 the Company of Barber-Surgeons in the City of London was incorporated. The first Master was Thomas Vicary, Barber-Surgeon. At that time he was probably already established as Surgeon to St. Bartholomew's Hospital though we do not know in which year he accepted this post. He must have been an important man in those days for he was also Surgeon to Henry VIII. The King had appointed him in September 1535 at an annual fee of £20. According to the Wardrobe Accounts Thomas Vicary was paid fairly regularly which was rather unusual in the 16th century.

In September 1548 his name appears for the first time in connection with the Hospital. In the City records of that month he is mentioned among those who were appointed to be Governors of the newly established Hospital of the Poor, formerly known as St. Bartholomew's Hospital. From the start Vicary, already a Surgeon of the Hospital, took a very active part in the administration being daily on the spot as he lived in a house within the Hospital's walls. In 1554 the Governors asked him to be supervisor of all the paid officials and in 1558 he put before the Board "certen articles for the good order of the poore" which were accepted. Unfortunately they have not survived.

In 1561 Thomas and his wife Alice took a joint life lease of a house in Duck Lane belonging to the Hospital. This lane which no longer exists led from Little Britain to Long Lane and in his old age Thomas was therefore still living near his beloved institution. He died in 1562.

He wrote a work on anatomy but though it was much used even after his death, it is not an original work. He will not be remembered because of his writing but because of his devotion to the Hospital. He attended almost all Governors' meetings, personally executing their orders as for instance the buying of copes and altarcloth for the church of St. Bartholomew-the-Less in February 1554, a delicate task, for with the accession of Mary the church had to be brought back, as quietly as possible, to pre-Reformation days. In the years between the suppression of the Priory in 1539 and the grant of the Hospital to the City in 1546, Vicary was in attendance to the King. How much he influenced the King's attitude towards the Hospital and in how far he assisted the pressure brought to bear on the King by the City to keep this institution open for the poor and sick and to keep its property we shall never know. It seems likely that he did support the City in this matter for he was a much honoured person in the Hospital and it is right to remember his name by giving it to one of the Wards.

Annie Zunz

In 1913 the Governors received the promise of a gift of £10,000 from the Trustees of the late Mr. Siegfried Rudolf Zunz on condition that a Ward of not less than 20 beds would be named, in perpetuity, the Annie Zunz Ward. Consequently in January 1914 it was decided to re-name Faith Ward in the South Wing and call it Annie Zunz Ward. When the South Wing had to be replaced by the George V Block, the name of Anne Zunz was given to one of the new Wards.

It is strange that there is no Will of Mr. Siegfried Rudolf Zunz in Somerset House. I could only find an English summary of a German will of David Adolf Zunz who died in 1911 in Frankfurt. He must have been a very rich man who had one married daughter and two sons. I have not been able to trace whether any of his sons lived in England, but it is quite likely they did or at any rate that the family had English connections, for why else was this Will translated into English and entered into the Registers of Somerset House? Perhaps Siegfried was a grandson of David Adolf who wanted to commemorate his wife or daughter? Apparently he left also money to other voluntary hospitals where one now finds Annie Zunz Wards.

Stanmore Ward

After the death of Viscount Sandhurst, Lord Stanmore, Privy Councillor, was elected Treasurer. During his time the George V Block was planned, the South Wing of Gibbs' design was demolished and a new Medical Block was built in 1934 followed by a Surgical Block finished in 1937, the year in which Lord Stanmore resigned.

Harvey

William Harvey was born at Folkestone in 1578 and he studied medicine at Cambridge and at Padua in Italy. When he finished his studies in 1604 he settled down in London as a practitioner. In 1609 he was appointed Physician to this Hospital at a salary of £25 a year which in 1626 was raised to £35. He was also Physician to James I and afterwards to Charles I and therefore he was often out of London following the King on his journeys. In 1633 the Surgeons of the Hospital complained that he was neglecting his duties because of this service and they pressed the Governors to appoint one Dr. Andrewes to take Harvey's place during his absence. During the Civil War Harvey travelled with the King's army and eventually accompanied the King to Oxford. Here he lived at Merton College of which he was made a Warden in 1645. When Oxford surrendered to Cromwell's army, he returned to London in 1646. There he lived quietly in his brothers' house until his death in 1657 leaving £30 to the Hospital in his Will. His service to the King made him suspect in the eyes of Cromwell's government and after 1643 his name is no longer mentioned in the Hospital's records, for the Governors, themselves keen Royalists, had to be extremely careful not to offend the new authorities.

Between 1609 and 1633 Harvey was an active Physician for the Hospital. He attended the poor regularly once a week, giving his opinion and prescriptions. Only one of the latter is left, namely for complaints of scurvy for which he ordered a strange mixture of scurvy grass, watercress, horseradish, pepper and nutmeg mixed in beer. He also drew up regulations for the patients and their care. They were drafted specially to provide a clear division between the duties of the Physicians and those of the Surgeons giving such rules as "All chirurgians . . . in all difficult cases, or wheare inward physick may be necessary, to consult with the doctor at the tymes he sitteth once in the weeke". Also the patients were subjected to a stricter discipline and "any who refuse to take their physic are to be discharged". When they were cured they had to leave the Hospital and "none lurke heere for releife sake only, or for slight causes". Harvey did not, however, become famous because of his work at the Hospital but because of his great interest in human anatomy. In 1628 he published an extensive work on this subject in which he told the world of science of his great discovery: the motion and functions of the heart resulting in the circulation of the blood. This knowledge now explained for the first time after long and carefully planned research was going to bring a new insight into the cause of many complaints and diseases. Harvey's methods of research were quite different from those of his predecessors and also in this way he was a leader for the new generation.

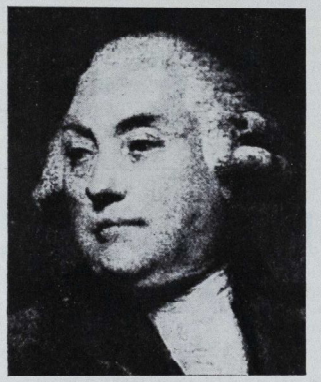
His bust is standing on the staircase of the James Gibbs' House and his picture hangs in the Treasurer's Room.

W. G. Grace Ward

This Ward has the name of the famous cricketer William Gilbert Grace (1848-1915) who was a medical student at this Hospital. He qualified in 1879.

Percivall Pott Ward

Percivall Pott born in 1714, was apprenticed to Edward Nourse, a Barber-Surgeon, in 1729. After serving him 7 years Pott was admitted into the freedom of the Barber-Surgeons' Company. This Company had been incorporated in 1540 but in the 18th century when surgery began to develop as a science in its own right, the Surgeons did no longer wish to be associated with barbers and in 1745 they founded the Company of Surgeons which was dissolved in 1797. Pott joined the new Company from the beginning and was elected Master in 1765. After having been Assistant Surgeon at Bart's for three years, he was appointed Surgeon in 1749. He gave the first description of what was called after him Pott's disease and also of Pott's fracture of which he suffered himself after a fall from his horse in 1756. He resigned in 1787 and died the next year. His portrait painted by Sir Joshua Reynolds hangs in the Guild Room in the James Gibbs' House.



Percivall Pott

Garrod Ward

In 1887 Sir Archibald E. Garrod was appointed Casualty Physician and 8 years later, in 1895, he became a medical Registrar, a post which he held until 1903 when the Governors elected him an Assistant Physician. In 1904 he became the first Physician in Charge of the new Department for Children's Diseases and in 1911 he was one of the Physicians in charge of Out-Patients. He taught on Chemical Pathology and became greatly interested in students and methods of teaching. His textbook *Materia Medica* was much used at the time. In 1919 professorial units were organised in this Hospital. Sir Archibald was the first director of the unit for medicine. He left the staff in 1920 to become Professor of Medicine at the University of Oxford but he did not altogether cut the ties with his old Hospital for in the same year he was elected a Governor and an Honorary Consultant. He died in March 1936.

ALLEGRO

MOZART'S REQUIEM K626 (Great Hall Concert. April 18th, 1973

Mozart's Requiem was not only his last church work—it was his last composition of any kind. It appears he wrote the work for a commission, probably for Count Franz Walsegg zu Stuppach whose wife had recently died. Mozart wrote some 40 pages and was eventually only to finish the Requiem and Kyrie and to sketch the eight sections from the Dies Irae through the Hostias (the sketches contained voice parts, bass and hints for instrumentation). The last three movements were unfinished. Mozart's widow appealed to many musicians to finish the work for fear of losing the fee, partly already paid, for the commission, eventually finding Sussmayr willing to do so—he admitted to composing the close of the Lacrimosa, Sanctus, Benedictus, Agnus Dei and repeating the Kyrie fugue at "cum sanctus". Thus the Requiem is a mixture—part inspired, part drab and repetitive; part composed by a genius, part by an artisan. For Mozart, the Requiem was full of questioning—of almost rebellion—the masonic links are maintained by the basset horn and trombone orchestration. It remains of interest that Mozart's other great mass—K427 in C minor was also left unfinished.

Much of the power of the Mozartian conception was present in John Lumley's marvellous account of the music. Here, within our ranks, is not only a first rate musician but someone who can by means of an economic and sensible style produce a brilliantly trained precision chorus. Even more than any of this, he communicates enjoyment and it was clear that everyone, including the large audience, was really involved by this performance. Little concession was made for amateur forces. In many ways, I was reminded of Barenboim's interpretation of the work—hair-raising speeds for the Kyrie and Dies Irae with everyone stretched to bursting point, contrasted with a very beautiful Recordare. Presumably basset horns are a rare breed but clarinets sufficed. Use of a small orchestra meant that one was able to hear the full choral line and the excellence of the choral attack—it was brave to use only 12 sopranos—but what noble ladies they were! The soloists were all good—the alto exceptionally so. It was a pity that the bass and trombone player were slightly unnerved by a tape recorder suddenly discharging a tape spool during the Tuba Miram. Orchestrally the strings were particularly fine—the chording of the Dies Irae stands out for its unanimity—not always so in professional performances. Literally, a heavenly performance and it was great to see queues for it.

A large audience proved further, should such proof be needed, that there is a vast audience for concerts in the Great Hall. I sincerely hope John Lumley will bring his excellent forces over from Woburn Square again. Rumour has it that scores of the Handel Coronation Anthems are being dusted in readiness. In the meantime, we are promised a violin and piano recital in May and the Barbican Orchestra will reappear by popular request on October 18th.

ALLEGRO.

EDNA O'BRIEN

The Literary Society, despite its somewhat serious name, kicked off its existence with a delightfully informal gathering to hear and talk to Edna O'Brien. She was more than we deserved really. We happily filled the Wellcome Library, coming in late in dribs and drabs, creaking the door and shuffling about. We listened to some poems, part of a new play, and many revealing asides. We laughed in pleased embarrassment when she spoke of her admiration for doctors. We asked her about her favourite writers, how she worked, "literary life", "spontaneity", etc. But it was she who was moulding herself to us, while still retaining so much refreshing, heartfelt honesty. She talked of the "lunatic courage" needed by writers, and how the idea of "attachment" was the basis to much of her writing; and she read her work with a forceful intensity and a fine Celtic lilt to every syllable on the page. What came across, overall, was her immense sanity and love of people, her sense of sadness and her sense of humour. Her parting cry was "let's go and put a bomb in the Old Bailey"; and with that tumbled Irish-red hair still glinting in our eyes we departed, refreshed, to our own world.

March 20th

T.H.T.

A DICTIONARY OF MNEMONICS

A dictionary of mnemonics has recently been published by Eyre Methuen. Mnemonics are, of course, a favourite *aide-memoire* of medical students, but unfortunately this dictionary doesn't include many medical examples. The publishers ask, "How many people would use those fearsome anatomy mnemonics given to medics?" But then, how many people would use the delightful mnemonic they give for the names of the zonal index fossils of part of the lower Carboniferous System of Great Britain? viz.: **K**ing **Z**og **c**aught **s**yphilis **a**nd **d**ied. This refers k, Z, c, s and d zones which acquire their initials from the fossil names Cleistopora, Zaphrentis, Caninia, Seminula and Dibunophylum. As two of these have the initial c, geologists decided to call the lowest zone k. Or again, do you want to remember the starting-time of the Indian ninety-minute "auspicious period for new undertakings" (such as setting out on a journey, signing contracts, meeting new people), which repeats on a seven-day cycle? Simply remember that, **E**nglish **b**oys **h**ave **a** **g**ood **f**ootball **c**lub. E = 5th letter. Take half of its value and add to full value = 7½. Therefore, on Mondays, Rahukalam, as it is called, runs from 7.30 to 9.00 a.m. Repeat this process for remaining days!)

One of the medical ones they have included will instantly remind you *(and I quote as printed)*, of the order of nerves that pass through the superior orbital tissue in the skull: **L**azy **F**rench **t**arts **l**ie **n**aked **i**n **a**nticipation (lacrinal, frontal, trochlear, lateral, nasociliary, internal, abduceir).

The publishers propose to produce a second edition of the dictionary including mnemonics left out of this first edition. Do any of our readers know some that might be suitable (or unsuitable)?

PREGNANCY

A REVIEW by G. L. BOURNE

With the advent of smaller families, pregnancy is a less commonplace occurrence in a couple's life. Accordingly the interest in pregnancy and childbirth would seem to have increased, and this interest is now shared more by the father. It is therefore opportune that Mr. Gordon Bourne's book has appeared at this time when the public thirst for knowledge seems insatiable. There are plenty of short books on the market about the practical aspects of pregnancy, labour and "natural childbirth", but there has been a notable lack of more detailed works for lay readers. Most of the books available have been written to satisfy a broad section of society, and have tended to be aimed at the lowest common denominator of intelligence. Mr. Bourne's book fills this hiatus. It is much more than a book about just pregnancy, for it includes chapters on the male reproductive system, menstruation, fertilisation, contraception, abortion, infertility, and genetics, as well as chapters on the baby and its care.

Although the book is absolutely packed with information, and some of it quite technical, it is written in a style of such clarity and simplicity that it *is* easy to understand. There has been great care not to be sensationalistic or controversial, and indeed it is written so carefully that the only criticism might be that it is a little dull in places. There are no photographs, and the few simple line drawings would not shock or embarrass the most prudish, but by their simplicity they illustrate their point.

The book is almost 600 pages long, and there will be few women who want to read every page—indeed to do so might demonstrate an almost morbid interest. Rather it will serve as an encyclopaedia, the introductory and general chapters to be read by all, and the more specialised chapters only if they are relevant to a particular reader. Initially it may find its place alongside *The Guardian* on the coffee tables of Chelsea and Hampstead, but there is no reason why it should not find a wider readership (especially if a cheaper paperback edition is produced).

Mr. Bourne has been a practising Obstetrician for a good many years and has obviously learnt a lot from his patients about the sort of fears and anxieties they may have. Some of the information, particularly the psychological and emotional matter cannot be found in standard textbooks of Obstetrics or Midwifery, and it might well behove doctors and midwives to peruse the book. There is incidentally virtually all the knowledge necessary to pass the M.B. or S.C.M. exams.

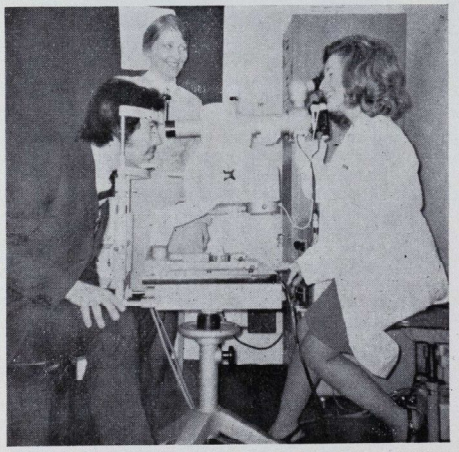
"A little knowledge is a dangerous thing", and we all know how harmful it can be for patients to pick up and extract mis-information from medical textbooks. However, if a woman and her husband read all or parts of "Pregnancy", they will have much more than a little knowledge, and this will give them greater confidence, make them better able to understand their ante-natal care and labour, and enhance the joy of parenthood. Fears that it will induce anxiety are not in practice founded.

Solution to Crossword No. 3

ANSWERS

ACROSS
1. aired
4. indolence
9. tightness
10. caves
11. See 2 Down
12. consigns
14. thereafter
16. abed
19. club
20. developers
22. psalmist
23. affair
26. naive
27. vicarious
28. confessor
29. sighs

DOWN
1. automatic
2. 11 Across, rigor mortis
3. detailed
4. ibex
5. discovered
6. locust
7. navigable
8. eases
13. offensives
15. education
17. distrusts
18. conforms
21. impede
22. panic
24. among
25. scar



Dr. Jo Ide demonstrates the retinal camera to the newly-housed migraine clinic in Charterhouse Square.

RECENTLY QUALIFIELD BART'S STUDENTS

AGIUS-FERRANTE, Miss M. T. (M.B., B.S., L.R.C.P., M.R.C.S.)
APPLEBY, Miss B. J. (Mrs. Snell) (M.B., B.S., L.R.C.P., M.R.C.S.)
BAKER, D. J. (M.B., B.S., L.R.C.P., M.R.C.S.)
BAKER, I. H. (M.B., B.S.)
BARRETT, R. F. (M.B., B.S.)
BECKETT, Miss J. E. (Mrs. Bogdanor) (M.B., B.S., L.R.C.P., M.R.C.S.)
BLACKLEDGE, G. R. P. (M.B., B.Chir.)
BRAMWELL, Miss V. H. C. (M.B., B.S.(Hons.), L.R.C.P., M.R.C.S.)
BULLOCK, P. J. (M.B., B.S.) (L.R.C.P., M.R.C.S. 1971)
CARROLL, J. (L.R.C.P., M.R.C.S.)
CLEMENT, A. (M.B., B.Chir.)
CLOSE, J. B. (M.B., B.S., L.R.C.P., M.R.C.S.)
CORNER, T. R. J. (M.B., B.S., L.R.C.P., M.R.C.S.)
COTTRELL, P. W. A. (L.R.C.P., M.R.C.S.)
CROSBY, M. E. (M.B., B.S.)
CROSSE, S. M. (M.B., B.Chir.)
DAVIES, G. (M.B., B.S., L.R.C.P., M.R.C.S.)
DAVIES, J. R. (L.R.C.P., M.R.C.S.)
DAVISON, S. D. K. (M.B., B.S.)
DE SILVA, N. E. (M.B., B.Chir., L.R.C.P., M.R.C.S.)
DIXON, A. K. (M.B., B.Chir.)
DOUGLASS, A. W. R. (M.B., B.S.) (L.R.C.P., M.R.C.S. 1971)
DUREY, P. N. J. (M.B., B.S., L.R.C.P., M.R.C.S.)
DYMOND, D. S. (M.B., B.S., L.R.C.P., M.R.C.S)
ERITH, M. J. (M.B., B.Chir.)
FAIRHURST, N. P. A. (M.B., B.S., L.R.C.P., M.R.C.S.)
FENTON, T. R. (L.R.C.P., M.R.C.S.) (M.B., B.S. 1971)
FLETCHER, M. J. F. (L.R.C.P., M.R.C.S.)
FOSTER, P. (M.B., B.S., L.R.C.P., M.R.C.S.)
FURNESS, P. J. (M.B., B.S., L.R.C.P., M.R.C.S.)
GALLOWAY, Miss R. E. (M.B., B.S.)
GILLARD, M. G. (M.B., B.S.(Hons.), L.R.C.P., M.R.C.S.)
GILLETT, M. B. (M.B., B.S.)
GLENNIE, H. R. (M.B., B.Chir.) (L.R.C.P., M.R.C.S. 1971)
GOLDSMITH, M. J. (L.R.C.P., M.R.C.S.)
GRAY, A. J. G. (M.B., B.Chir.)
GREW, R. C. (M.B., B.S.) (L.R.C.P., M.R.C.S. 1971)
GUNDRY, D. R. T. (M.B., B.Chir.)
HACKETT, Mrs. G. H. (L.R.C.P., M.R.C.S.)
HAMBLY, A. T. (M.B., B.Chir.)
HANNING, C. D. (M.B., B.S.)
HARD, P. L. S. (M.B., B.S.)
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Unless stated, all qualifications obtained in 1972.

HAVING AN OPERATION

A guide to the Hospital System

HAVING AN OPERATION

A Consumer Association Publication. Price 85p.

Besides *Which?*, the Consumer Association publishes a series of booklets designed to help people cope with the increasing complexity of living. The topics covered range from "Pregnancy" and "The Newborn Baby" to "What to do when someone dies" with medical advice included in "Health for old age", "Treatment and care in mental illness", "Infertility", "Eyes right", and "Caring for teeth".

The latest of these, "Having an operation", is described as a patients' A-Z guide to hospital procedure from admission to discharge giving advice on anything from sickness benefit to how to recognise a doctor. Hospital hierarchy and routine is fully outlined, and the name and nature of the principal operations on the main areas of the body described in layman's terms. There is also a section dealing with complaints and how to make them! The publication gives, wherever appropriate, the names and addresses of specialist, often voluntary, organisations who might be able to help patients with problems arising out of their operations or conditions.

Overall, the book is written in clear style with a refreshing absence of jargon. It gives very helpful explanations of such matters as sickness and social security payments which many doctors may be unclear about. Although at times it may strike the medical ear as being simple to the point of facetiousness, it deals with many difficulties which a patient might have.

The medical profession is dealt with extremely kindly. No criticism is made about the organisation or effectiveness of the hospital system, 'though an intelligent patient who has read this book will be able to pinpoint failings with more conviction if he knows how the system should work. It gives very sound advice for outpatients, . . . "Experienced out-patient attenders who want to be seen on time come early for their appointment and bring a book to read or something else to do to while away the time."

There are those who condemn the interest shown by the public and the media in medical matters, either because they believe the public may misinterpret what knowledge they gain, or because an informed patient cannot be easily fooled. But increased awareness by the public is inevitable, and it's better that books such as these should give clear and accurate information, than that people should pick up distorted accounts from newspapers, TV or local gossips. However, I have some misgivings about the section in the book giving details, with diagrams, of whole series of operations. There are no glaring errors, but I think details of each operation are better explained by the surgeon to the individual patient. Indeed, the consent for operation form they reproduce, has to be signed by the doctor to confirm that he has explained the nature and purpose of the operation. This could profitably be introduced at Bart's. The booklet also gives helpful details about some investigations which the patient should certainly be informed about. But should the book include details of the Caldwell-Luc operation or sub-mucous resection? Furthermore, certain statements though strictly true, may suggest the wrong diagnosis to a patient who naturally expects the worst, e.g. "A partial or total gastrectomy to remove part or all of the stomach, where possible, is carried out if the patient has a cancer of the stomach." On the other hand, details of the time the patient is likely to spend in hospital and the purpose of physiotherapy could well be very helpful to an interested patient.

It remains to be seen how many people will read this book. Will patients appear in a few months time asking for a trans-aural polypectomy because they have sac-like extensions of their nose or sinuses caused by swelling due to allergy or chronic infection? Without doubt they will be conversant with the reasons they have been kept waiting, and they'll know their way round the hospital system.

The book includes details for those who have bequeathed their eyes or other organs to medical science, so perhaps if the patient finds the book helpful he will suggest that his relatives read the companion volume, "What to do when someone dies."

THE FAIR COMMITTEE THANKS ALL STALLHOLDERS AND ALL THOSE OTHER PEOPLE WHO WORKED SO HARD TO MAKE THE FAIR THE ENORMOUS SUCCESS IT WAS.

George Ellis
(Chairman, Fair Committee)

BARTHOLOMEW FAIR 12th May 1973

Part of the Bart's Journal stall.

We will publish reports and more photographs next month.

Some of the children watching the displays in Charterhouse Square.

WHAT ARE DOCTORS DOING IN THE NAVY?

As a naval doctor, you'll normally serve for five years on a Short Career Commission, some of the time at sea and some on land.

Naturally, you'll travel.

And you'll also be a naval officer.

AT SEA.

You can expect to get to sea as a Surgeon Lieutenant within six months after registration. Probably, you'll be the only doctor in your ship. In a frigate, for example, you'll have some 300 men to take care of. And you'll be responsible for all their medical needs, from a cold in the nose to tropical illnesses.

To help you, there will be a qualified staff on board. And your medical quarters will be small but modern and well equipped. (In some cases, including an operating theatre).

Your practice, however, won't be confined to your ship. If there's a natural disaster anywhere within a thousand miles, you could get involved in relief work. If there's an accident at sea, you could be taken to it by helicopter.

Often, you'll have to rely entirely on your own resources. So the work can be difficult. But it will certainly be varied.

ON LAND.

Usually, you'll spend more than half your time with us on land. Either at home or overseas — in Europe, the Mediterranean and even as far afield as Mauritius or Hong Kong.

You'll be doctor not only to the naval personnel, but when abroad to their families as well. General practice, in fact, with the advantages of naval pay and a ready made naval social life.

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SPECIALISATION.

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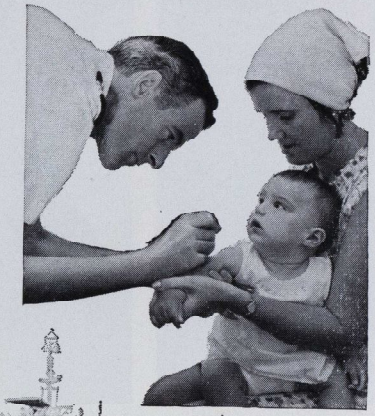
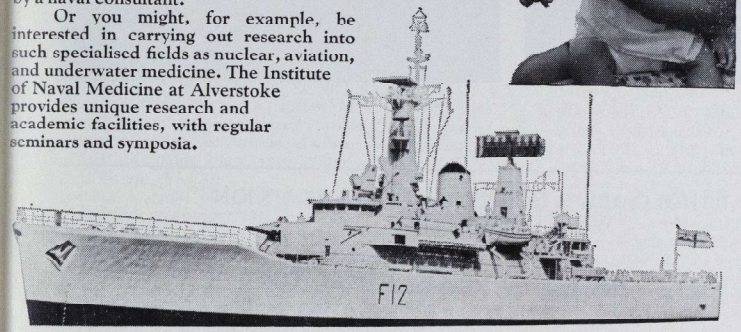
Or you might, for example, be interested in carrying out research into such specialised fields as nuclear, aviation, and underwater medicine. The Institute of Naval Medicine at Alverstoke provides unique research and academic facilities, with regular seminars and symposia.





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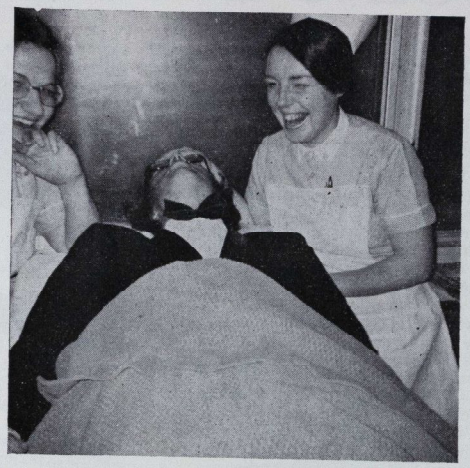
ROYAL NAVY

BARTHOLOMEW BALL 5th May 1973

Full report will appear in July Journal.

Dining at Pete's before the ball.

Reclining in Casualty after the ball.



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

BART'S SPORT REPORT

JUDO CLUB REPORT

This season has been a good one for the Judo Club. A small keen nucleus, led by Bob Woodrough (Black Belt) have been practising, both at College and outside among strong competition. This hard work has been rewarded in the upgrading to higher belts of Mark Podkolinski, Ron Jacob, Bob Miller, Charles Hamilton, and Louis Blanche, not to mention our glamorous physios Trish and Irene.

The Club has made a point of welcoming anyone in the hospital, male or female, who cares to take an interest. As a result, we now have members from many different departments of the hospital, and hope that this trend will continue as it has done much to strengthen the Club. Organisers of the new hospital sports club, please note.

On the mat the Club visited King's, University and Chelsea Colleges. The main event of the Calendar was the inter-College championships, early in March. Here we were able to field an A and a B team, no other hospital even fielding one. The B team did well to come third, beating two teams from King's College convincingly. Charles Hamilton proved to be the strong man of the team, while Roger Tackley put up a good fight against some of the strongest opponents.

B Team: Bob Miller, Pete Mackay, Charles Hamilton, Ron Jacob and Roger Tackley.

In the A team match, we were fortunate to have the services of Willy Fischer from Munich (who has been one of the key men of the Club during his year over here), and he was unbeaten in his three contests. Together with Bob Woodrough, Eric Noren, Mark Podkolinski and Bob Miller the Bart's A team was a useful line-up, and proved it with good wins over King's and Chelsea College, before bowing to the eventual winners, University College, in the semi-final.

The Club practices in the Charterhouse gym on Tuesday evenings at 5.30 p.m. and welcomes both men and women. Anyone interested can contact Bob Woodrough on Ext. 696.

CLUB SECRETARIES!

Please send your reports to the Journal. Our readers want to know what you are doing.

SAINT BARTHOLOMEW'S HOSPITAL JOURNAL

Founded 1892. Vol. LXXVII No. 7

Editorial

A new Curriculum has been proposed for students starting their clinical training in October 1974. In this issue we are publishing an interim report by one of the students on the Curriculum Committee.

We tend to feel that the best medical or other courses are the product of one man with two assets. Firstly, a bee in his bonnet about teaching and secondly, enough power and perseverance to establish his own ideas. Obviously, these circumstances cannot apply at Bart's these days, where most decisions are taken in committee, so the end result is predictably a collection of compromises, with all the interested parties, professors, consultants, students, et. al., indulging in what Paul Taylor calls "free collective bargaining for time." In such a situation, it is difficult to know who knows best. The head of each department, is, of course, convinced that his teaching is the most important and interesting, and that any reduction of the time in every student's life which is allotted to his subject would result in inadequate doctors. At the same time, it is abundantly clear to him that students are spending far too much time doing other things, are becoming bored, and are therefore not keen to attend his course. Furthermore, he is perfectly aware that the housemen he meets or works with feel that they have been inadequately prepared for the job they want to do, and he probably met a G.P. last week who said that it would have been of more benefit to him to have spent his student years playing golf or working in a pub, in terms of relevance to his work. The students, meanwhile, have picked up some fancy jargon at an education conference and are seeking to replace lectures with two-way verbal ideational exchanges. They are acutely aware of the frustrations they feel, but haven't any experience of alternatives. Thus, the medical college is faced with a host of conflicting interests from the teachers' side and with astonishing ambivalence, seems to expect a single student voice, and relies on two or three spokesmen to express "student opinion", pointing out with poorly-concealed glee that the students themselves don't know what they want.

Detailed criticism of the proposals will develop as they become more generally discussed. One or two points, however, spring to mind on a first reading. Firstly, although some students feel that their first clinical appointments are wasted through lack of knowledge and technique which should be provided by an introductory course, most students at hospitals where there is an introductory course would rather get on with working on a firm. The two times when students are particularly keen to work on the wards are immediately after 2nd M.B., and just before finals. It is surely sensible to do general medical and surgical firms at these times, and not to lose the students' enthusiasm by lecturing to them about techniques of venepuncture and so on.

Secondly, although it is obviously desirable to reduce the number of students on each firm, mere reduction of numbers is no panacea, and indeed some firms work well with quite large groups of students. More teaching at peripheral hospitals leads inevitably to fragmentation of each year of students, so that social contact is lost, with each student on an isolated teach-yourself medicine course. It is important,

therefore, that a much stronger student community is established at Bart's, with better social facilities, to try to approach a University atmosphere.

Thirdly, proposals for introduction of a clinical tutor scheme have already been made and must be implemented without delay. Such a system would always have shortcomings in the Bart's set-up, but it cannot but help to bridge the gap which has developed in recent years between staff and students.

Finally, the time allotted to special subjects will be a source of controversy for many months, and has been occupying the committee in both meetings. Hopefully, the allocation of twice as much time to Obstetrics as to Psychiatry does not reflect the importance attached to these subjects by the committee.

In the next issue, we hope to print reactions to these proposals from several people involved at different stages of medical training. The students on the curriculum committee are pledged to canvass the opinions of anyone concerned. We hope everyone is concerned.

ANNOUNCEMENTS

Birthday Honours

Knight Bachelor. Professor Eric Frank Scowen.

Appointments

Mr. E. G. Tuckwell has been appointed Serjeant-Surgeon to the Queen, in the room of Sir Edward Grainger Muir who has retired.

Mr. Geoffrey Flavell, head of the Dept. of Cardio-vascular and Thoracic Surgery at the London Hospital (and who was Editor of this *Journal* from 1936 to 1937) has been elected a Fellow of the Royal College of Physicians.

Prof. R. J. Harrison, F.R.S. (Prof. of Anatomy at Cambridge), was elected F.R.S. on March 15th.

Dr. B. M. Hibbard has been appointed to the chair of Obstetrics and Gynaecology at the Welsh National School of Medicine. Tenable in October 1973.

Sir Ronald Bodley Scott has been awarded the silver medal of the Society of Cosmetic Chemists of Great Britain.

Retirement

Alan Searle has retired from the *Journal* staff. He has contributed a great deal to the running of the *Journal* in the last few years, but he will be especially remembered as the man who brought you:—

The report on married accommodation for housemen;
The Editorial declaiming on the subject of dogs and pavements; and, most notably . . .
Spiro McChaete.

Consultant Appointments

Mr. G. M. Rees, M.S., F.R.C.S., M.R.C.P., Consultant Thoracic Surgeon June 1st, 1973.

Dr. G. Nancekievill, M.B., F.F.A., R.C.S., Consultant Anaesthetist June 1st, 1973.

Mr. W. S. Shand, M.D., F.R.C.S., Consultant Surgeon July 1st, 1973.

Deaths

BLACKLOCK—On April 7th, Prof. J. W. S. Blacklock, M.D., M.B., Ch.B., F.R.C.P.

BENNION—Dr. J. M. Bennion died recently. He qualified M.A., M.B., B.Ch., in 1902 at Bart's, and at the age of 96, we believe he may have been the oldest living man to have qualified at Bart's.

BODLEY SCOTT—Gilbert Bodley Scott died on May 11th aged 89. He qualified at Bart's in 1907, one of the third generation of his family at Bart's. He served in the Royal Navy as Surgeon Captain, and then joined two brothers in general practice in Bournemouth.

BOYD—On April 7th, Prof. Alexander Michael Boyd, M.Sc., M.B.B.S., F.R.C.S. Qualified 1931.

DONALDSON—On March 16th, Dr. Malcolm Donaldson, M.A., M.B.B.Ch., F.R.C.S., F.R.C.O.G. Qualified 1909.

EVANS—On March 25th, Lewis Philip Jameson Evans, M.D., F.R.C.S. Qualified 1931.

GILDING—On February 15th, H.p. Gilding, M.A.M.D., B.M., B.Ch. Qualified 1934.

REAVELL—On February 27th, Dr. Denys Clowes Reavell, M.B.B.S., M.R.C.S., L.R.C.P. Qualified 1934.

WHITCHURCH-HOWELL—On April 12th, Bernard Whitchurch-Howell, M.B.B.S., F.R.C.S. Qualified 1912.

WICKES—On March 10th, Ian Goodson Wickes, M.A., M.D., F.R.C.P., D.Ch. Qualified 1941.

ZEITLIN—On April 11th, Reginald Albert Zeitlin, M.R.C.S., F.R.C.Path. Qualified 1928.

Marriage

FROGGATT—SMITH—The marriage of Dr. Clive Froggatt with Miss Paula Smith took place on June 23rd, at Newent, Gloucestershire.

Part two of the article on the derivation of Ward names by Nellie Kerling will be published in the August *Journal*.

LETTERS

LOCUMS

Abernethian Room,
May 20th, 1973.

Dear Sir,

In reply to the letter by Mr. Searle, published in April's *Journal*. I most certainly agree with him that locums are an enjoyable form of learning a lot of medicine. I must, however, disagree with his view about signing for drugs.

I have undertaken locums in two other hospitals, which I agree is not a great number; but in neither was I officially allowed to sign for drugs. I entirely agree with the hospital policy, since I would not welcome the responsibility of signing for potentially lethal drugs without having the dose, etc., checked by a qualified person. Therefore, I do not think the hospital should have to accept the responsibility.

Also, in both jobs, I could always refer to another member of the firm about drugs required. I, therefore, feel that the change should be that another member of the firm should cover the student, rather than allowing him/her to prescribe. The student could still perform a vast amount of useful work, both for the hospital and himself, without any danger to patients.

Yours faithfully,
J. H. HOUSE.

P.S.—I would like to congratulate and thank everyone who worked so hard to make the 850th Celebrations so enjoyable for myself and others.

STUDENTS' UNION COUNCIL

Dear Sir,

Step down from your pedestal of uninformed self-righteousness. We insist that at least the pre-clinical members of the Students' Union Council are given an apology after your incorrect and misinformed April editorial.

Referring to the issues you raised concerning our representation of student views, we think if you had taken the trouble to make any enquiries, you would have found that pre-clinical students at least are informed after each Students' Union Council meeting, at the end of which we ask and look for any reactions or views. At the following council meeting we make known the year's majority and minority feelings, never restricting these to just our own.

You blame the lack of attendance at Council meetings on *our* failure to inform; might it not be that we inform and represent the year so well that our attendance as their representatives is sufficient?

To illustrate our points: last week we informed our year twice of a meeting arranged for them with Professor Woods concerning the new, controversial Paediatrics course. Previously a petition had been signed by over 95 per cent. of the year expressing deep concern about the arrangements for the new course, yet only about 15 per cent. of the year turned up to the discussion. Thus we find that the issue remains at the stage of "coffee table discussion."

In view of this situation, surely complaints about student apathy are justified.

Yours etc.,
ROBERT SLACK
GILLIAN MASTERS
JULIET BRITTON
Pre-clinical Student Council Representatives.

COD-PIECE

Dear Sir,

We the undersigned wish to express our sympathies with a small country trying to protect itself against the imperialist forces of Western Europe.

We pledge our support to the Icelandic peoples in their gallant struggle to reduce the supplies of cod to the United Kingdom—and specifically to the canteens of St. Bartholomew's Hospital.

Yours etc.,
T. M. BIRD, B.A.Cantab.
T. KEALEY
A. E. TAYLOR, B.A.Oxon.

OBITUARIES

MISS I. D. WYNN

"Have you had your Chest X-Ray done?"

On reading these words, the thoughts of generations of Bart's men and women all over the world will immediately flash back to Miss Wynn—probably visualised against some remembered familiar backcloth in Charterhouse Square. Her completely unexpected and sudden death on April 18th came as an incredible shock to us all.

This familiar greeting of hers—"So-and-so, have you had your Chest X-Ray/routine medical/T.B. Test/etc.?"—illustrates two things—her prodigious memory for personal detail and her real concern for each individual student. It was probably the combination of these two qualities that determined the nature of her enormous contribution to Bart's life over the years.

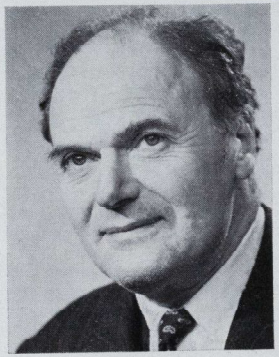
She came here in 1942 from the WAAF, for whom she had been driving all sorts of vehicles for RAF Transport Command—including ambulances in the London Blitz. At this time the Pre-clinical School was lodged at Queen's, Cambridge, and she came to Bart's there as secretary to our Vice-Dean, Professor Hopwood. Back at Charterhouse Square after the War, Miss Wynn's work continued under Dr. Gardiner Jamieson, the Pre-clinical Sub-Dean. When his term of office ended, Miss Wynn took on the responsibility for the whole of this work, and shortly after took over as secretary to the Student Health Service when this post became vacant. The juxtaposition of these two jobs could have produced endless problems but, in fact, she managed both so as to obtain maximum help and advantage for any student in need. She often acted as a sort of two-way go-between, approaching members of the Staff on behalf of any academic lame dogs to plead their cases and, at the same time, as likely as not, chasing up the laggards and urging them to get down to some solid hard work.

Her time was given unstintingly to help and advise any students finding themselves in difficulties, and there must be many Bart's doctors today who remember with gratitude the encouragement she gave them during their student years.

Miss Wynn died on holiday in Alderney, an island she loved. She was nearing the age of retirement, and many who knew of her busy and active life will feel that she might have found this a difficult time to accept. Her passing leaves a gap that its uniquely "her-shaped". One might almost say that her job primarily consisted of being "Miss Wynn" to thirty years of Bart's students—and it is unlikely that any one person could ever quite fill it again.

PROFESSOR MICHAEL BOYD

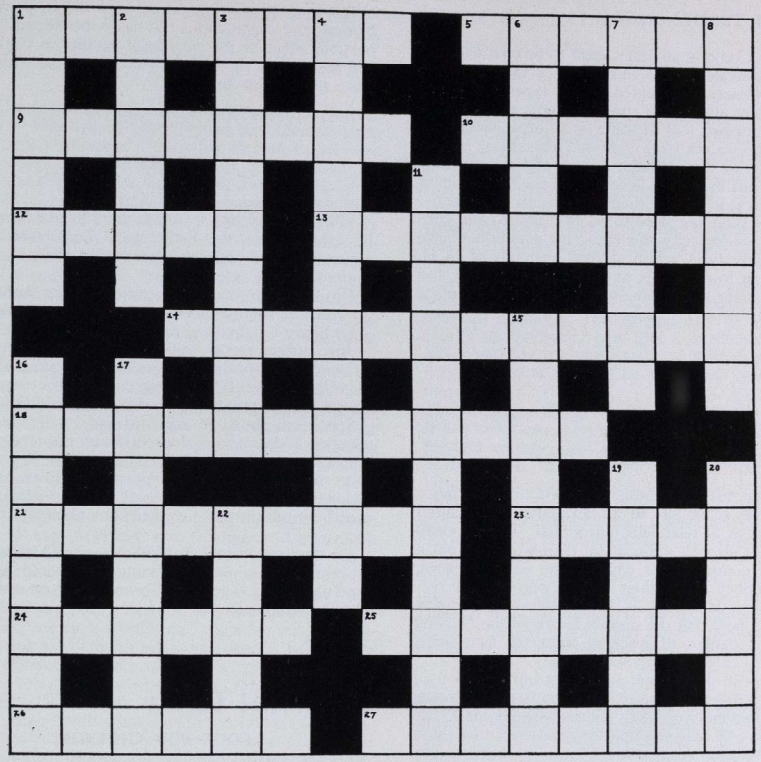
Professor Alexander Michael Boyd, emeritus professor of surgery in the University of Manchester, died on April 7th. He was born in 1905 and educated at Haileybury and Bart's, where he qualified M.B., B.S. in 1929. He became F.R.C.S. in 1931, and returned to Bart's as second assistant in the surgical professorial unit, being promoted in 1936 to chief assistant. He developed a particular interest in peripheral vascular surgery and the use of angiography. In 1940, he joined the RAMC, and served in the Middle East. On demobilisation in 1946, he returned for a while to Bart's but was soon appointed to the chair of surgery at Manchester which he occupied until his retirement in 1970.



He built up a centre for peripheral vascular surgery in Manchester, with accompanying research into cardiovascular disease. He was president of the International College of Angiology and senior editor of Angiology and of Vascular Surgery. He was a colourful and popular teacher, and his lectures, whether on the Middle East or on Arterial Surgery, were always crowded and entertaining.

Michael Boyd was a keen gardener and exhibited in local flower and vegetable shows, and his house was the home of many strange animals, including a monkey. Unfortunately, his energy and outdoor interests became restricted by ankylosing spondylitis in later years. He will be remembered in Manchester as a kind and generous man, and a talented and very colourful teacher.

JOURNAL CROSSWORD - No. 4 by DOGSBODY



ACROSS

1. Bart's stop one perhaps in Henry (8)
5. Bronchitic jest (6)
9. Brain too muddled? Result is short-lived (8)
10. Glib nonsense in Old English? Do me a favour (6)
12. In situ dormant dynasty (5)
13. Fretful is the claim to be in one (9)
14. Get Truism all out of order for his work (12)
18. Basic salary? (6, 6)
21. Heeled over head . . . schematic failure (6, 3)
23. Feature round round loop (5)
24. Tart changes litmus (6)
25. Pass on one to a learner living abroad (8)
26. Labelled a horse in to make hay (6)
27. Foolish female or taxman (8)

DOWN

1. Cardiac quarter-pack (6)
2. Have a word aboard about weapons (6)
3. Restricted persons see some point in doctors (9)
4. An explosive device in people's hearing . . . they're disgraceful (12)
6. Customary dress (5)
7. It won't sweep the country well (8)
8. Garden-gallery shows no bite (8)
11. Requests for plastic piano (12)
15. Feature of Italian capitalist (5, 4)
16. Out and out standard rage (8)
17. Swing about nude results in faintness (8)
19. Poisons sound alarming (6)
20. Time the great one? (6)
22. No one's point causes a row (5)

Solution on page 214.

BART'S NEWS AND VIEWS

CONJOINT TENDENCIES

Attitudes to Conjoint at Bart's seem to be characterised more by ambivalence and inconsistency than by commonsense. Generally accepted as an expensive superfluous and not always fair exam by most students, the majority of finalists still sit some or all of it. The teaching staff, who do not send continual assessment reports or examiners to the Conjoint board, and are officially actively against the exam, nevertheless use the results of those who sit it as part of their assessment.

Surely the time has come to adopt a unified and consistent policy—logically the complete rejection of the exam—as already in action at such hospitals as UCH. The first step towards this might be a more open and honest argument from both sides than has taken place in the past.

NIGHTS IN WHITE SATIN

As a rule, the metamorphosis of a Bart's nurse from a timid, gauche schoolgirl to an attractive, self-assured qualified nurse is relatively untroubled. The majority of nurses put up with the trials of their work without a murmur of complaint, or envy of the extra freedom, time and money which their friends who became secretaries enjoy. It comes as something of a surprise, therefore, to hear that the smooth facade of the Nursing School is in danger of cracking from the heat being generated by recently proposed changes.

Nurses spend three years as student nurses and then usually stay for a fourth year as a staff nurse. During this year they enjoy greater respect and responsibility which begins to ease the inferiority feelings they have developed during three years as student nurses. The staff nurse also learns more about running a ward, giving drugs, etc., which provides invaluable experience for when she looks for a job elsewhere. At present, staff nurses spend nine months working on days only, and three months working nights, when they're given the quaint name of "Flash Belt". Three months on nights is apparently not as bad as it might appear since the off-duty given is generous.

It is now proposed to make qualified nurses work on a rota with student nurses, working one week of nights in every four. This has been condemned by the nurses soon to qualify whom it will affect, and many who would have liked to stay on are now threatening to leave after their exams. The effect on the hospital of the drastic reduction of qualified nurses this would produce can only be imagined.

Student nurses have a system of representatives, whereby complaints and difficulties can be sorted out with the Nursing School Officers. The representatives are usually concerned with slightly more traditional grouses such as why a girl of 21 mustn't take any man, including her brother, to her room in the Nurses' Home at any time of day. (Apparently the most recent reason blames Fire Regulations.) It is to be hoped that the possible effect of the proposed changes in Night Duty will ensure that the Nurses' voice is treated with a little more respect this time.

75 YEARS AGO

From the Journal of July 1898

Pathological Department of the Journal.

SPECIMENS sent by subscribers to the *Journal* will be examined in the Pathological Laboratory, and a report furnished under the supervision of Dr. Andrewes, at the following rate:

Ordinary examination, Bacteriological or Pathological, such as tumour, membrane, or sputum—2s. 6d.

Ordinary (qualitative) urine examination—2s. 6d.

Any further report will be charged at a special rate. If a mounted specimen be required an extra charge of 1s. will be made. If a telegraphic report be required the cost of the telegram will be charged in addition.

Specimens must be accompanied by the fee and a stamped addressed envelope in which the report will be sent as soon as possible. Specimens, with, if possible, a short history of the case, must be addressed to the "Manager of the *Journal*" with "Pathological Department" written in some conspicuous place on the wrapper.

On application to J. Russell, Museum Assistant, a set of bottles containing hardening fluids, and ready for sending away by post, can be obtained on remitting a postal order for 2s. 6d.

Journal Quiz

FOOD FOR THOUGHT

There can be few who have not noticed the pathologist's morbid fascination with describing everything he sees by a resemblance to food. The *Journal*, ever willing to oblige, has prepared a menu for the department's annual dinner. Can you say what else the fortunate participants might have described thus?

Bread & Butter
Anchovy Sauce
or
Melon Seeds

Beef Steak with Sausage & Onions
Redcurrant Jelly
Salad

Strawberry & Orange with Sugar Icing & Chocolate

Cafe au lait
Swiss Cheese

Port Wine

Answers on page 215

THE ACCIDENT & EMERGENCY DEPARTMENT ITS FUNCTION AND DESIGN WITH SPECIAL REFERENCE TO ST. BARTHOLOMEW'S HOSPITAL AND THE PART IT PLAYS IN CARING FOR THE COMMUTER POPULATION

By D. B. CARO, F.R.C.S., Consultant in Charge

The function of an Accident and Emergency Department is to care for all patients who find themselves in an emergency situation. That is for all patients who are unable to use their normal general practitioner's service or the out-patient consultant service of the hospital. This will mean all patients who sustain an injury whether that be in the street, in the office, in the factory or at home. It will also include all patients who collapse in the street and many patients who collapse at home. By tradition too, the Accident and Emergency Department will deal with a large number of cases of minor sepsis. Many of these will be septic hands but they will also treat superficial abscesses in other situations.

St. Bartholomew's Hospital, situated as it is in the City, has an added problem. The City has a very large commuter population. These people often have journeys of two hours or more by train. They may not be sure when they leave their homes whether they are feeling quite well or slightly ill, and often on arrival in London they are quite sure that they are not well, and will come to St. Bartholomew's Accident and Emergency Department for diagnosis and treatment. A proportion of cases coming to any Accident and Emergency Department should really have consulted their own general practitioner but they usually have a good reason for coming to the department. Many doctors consider a large number of these cases are trivial but they cannot be trivial to the patient or they would not come to the hospital. While being reluctant to act as the general practitioner for the district, I would advocate a reasonably liberal approach to any patient who comes to the Accident and Emergency Department. A patient with pain must be seen. A patient with a longstanding condition should be encouraged to return to their own general practitioner and the patient who has come because they are really not satisfied with the treatment advised by their general practitioner should be encouraged to return to the doctor and ask for a second opinion.

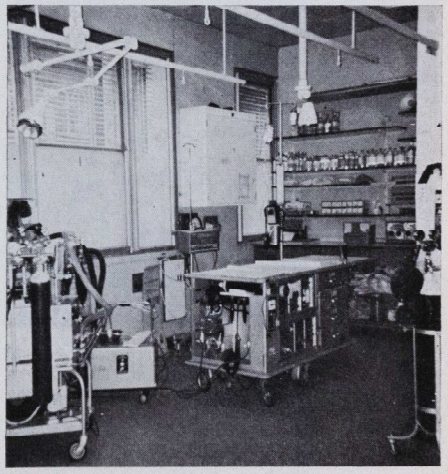
The Organisation of the Work in an Accident and Emergency Department

An Accident and Emergency Department in a large teaching or District General Hospital should be self-contained and should be able to cope with all these patients who find themselves in an emergency situation. It is interesting to note that at many Metropolitan Hospitals, whereas 60 to 70 per cent. of all attenders could be classified as surgical, about 60 to 70 per cent. of the urgent admissions from the department are medical. A large Accident and Emergency Department should be able to serve a population of 200,000 to 300,000 and be able to deal with from 30,000 to 40,000 new cases a year. It is desirable to keep the return visits to the department to a minimum and it is desirable that the proportion of old to new cases should never exceed 1 to 2. Where possible cases which have been seen and diagnosed and treated should be referred back to their own general practitioner, or, if necessary, on to an Out Patient Clinic at the hospital. To facilitate this, a good relationship must be established with the General Practitioners in the area and they should be notified by letter whenever their patients attend. The position of St. Bartholomew's with its service to the City makes a close liaison with the General Practitioners served more difficult. However, letters can always be sent to a doctor about any patient who is seen.

Another complication caused by the commuter population is the difficulty of sending patients home with a doubtful diagnosis. This is especially so with cases of chest and abdominal pain and it is often necessary to admit patients for observation to this hospital who, if they lived locally, could be sent home to be observed there.

The Staffing of the Accident and Emergency Department

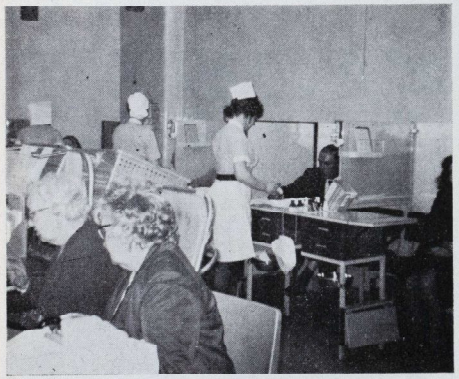
It has now been accepted by the Ministry of Health, at least for an experimental period, that consultants should be appointed to the larger Accident and Emergency Departments. The people appointed to these posts will need a wide general experience and should desirably have a higher degree though the specialty in which this degree is taken is not important. The type of work in an Accident and Emergency Department will vary from place to place, and while we in the City will see a high proportion of medical and psychiatric problems, the hospital near the motorway will get more than its fair share of major trauma. The Consultant will need to be supported by one or two Senior Registrars who are



training in the specialty. A large department, in order that it may give a 24-hour cover, seven days a week, will require from four to six Senior House Officers. There is really no place in the routine of the Accident and Emergency Department for the pre-registration House Officer though he can gain considerable useful experience in these departments if he is supervised at all times.

The Design of the Accident and Emergency Department

The most important room in any Accident and Emergency Department is the resuscitation room. This should be large and well lit and equipped with all the instruments which are necessary for resuscitation. These will include laryngoscopes and intratracheal tubes and the facilities for setting up intravenous infusions. There should also be equipment to assess and resuscitate cardiac arrests. This is the "life saving" room in the department and doctors working in it should be well versed in the use of the laryngoscope and know how to cope with a cardiac arrest. Other areas must be set aside for the reception of the patient and his registration, and all notes should be stored in the department. There must be adequate waiting space and it is desirable if many children attend that mothers and children should be offered a separate waiting area. There must be rooms for the examination and treatment of those cases which do not need to go into the resuscitation room. These rooms should provide reasonable privacy and there should be equipment in them for the ordinary examination and treatment of all emergencies. Privacy is often rather limited in an Accident and Emergency Department, and while patients cannot be enclosed in four-walled single rooms the ideal department will have three-walled cubicles with curtains on the fourth wall. A corridor along this side will enable a number of patients to be observed by nurses and doctors walking up and down as they go about their duties.



We have said that the Accident and Emergency Department receives all patients who find themselves in an emergency situation and it is the function of the Accident and Emergency Department to remove these patients from the emergency situation and to make them safe and comfortable so that they can be transferred to the care of the appropriate specialist without danger.

The availability of a 24 to 48-hour observation ward in close proximity to an Accident and Emergency Department is a very great advantage. In my view the best way for the observation ward to be used is for the staff of the Accident and Emergency Department to admit suitable cases to the ward, then to inform the appropriate specialist of this admission and invite him to come and see the patient. He then takes responsibility for the patient and may decide to transfer the patient at once to the general wards or to observe him for up to 48 hours in the observation ward.

To summarize, the Accident and Emergency Department of a large teaching or District General Hospital must cope with all patients who find themselves in an emergency situation. These patients must be received, examined, diagnosed if possible, and resuscitated if necessary. They must then be either admitted to the hospital or directed to the appropriate doctor for follow up. A few will return for reassessment or for further dressings. The department must be large enough and sufficiently well staffed for this work to go on smoothly without overcrowding or commotion. The special situation of any hospital will alter the type of work done and St. Bartholomew's Hospital having a special relationship with the City will have a high proportion of medical emergencies and will have to admit for observation more cases than will the District General Hospital which treats only patients living nearby.

It has been said many times that the Accident and Emergency Department is the shop window of the hospital and certainly an efficient and polite Accident and Emergency Service gains a hospital a happy reputation in its district.

THE RELATIONSHIP OF SUICIDAL INTENT TO REPEATED ATTEMPTS

By DEAN SCHUYLER, M.D.* and A. G. LEWIS, M.B., B.S., D.M.P.**

*Clinical Research Branch, National Institute of Mental Health, Rockville, Maryland

**St. Bartholomew's Academic Dept. of Psychiatry, Hackney Hospital

Abstract

This study attempts to measure suicidal motivation retrospectively and to utilise this measure to predict suicidal behaviour in a two-year period subsequent to the key attempt. A modified Suicide Intent Scale successfully predicts repetition in six of seven patients who made a repeat attempt. The issues of overinclusion and underinclusion are discussed relevant to the nine false positives and one false negative identified by the scale. An explanation is offered for repeated suicidal behaviour in a patient with a seemingly minimal intent to die. The perils of retrospective assessment are enumerated and the relationship of intent to medical lethality is explored. An assessment of suicidal motivation may contribute to the clinician's ability to evaluate and formulate a prognosis for the recently suicidal patient.

The Relationship of Suicidal Intent to Repeated Attempts*

There is, by now, a collection of follow-up studies in various countries of patients who have attempted suicide. (See Table I.) In most of these studies, epidemiological variables are assessed and related to the likelihood of repetition of suicidal behaviour. This approach to attempted suicide was critically reviewed and found to be helpful but probably not sufficient to predict suicidal risk with confidence (Schuyler and Back, 1971).[1] A group of factors derived largely from the circumstances of the suicidal act was presented in this manuscript as a measure of suicidal intent.

* Material contained in this paper does not necessarily reflect the views of NIMH.

The purpose of the present study is to evaluate the usefulness of assessing intent subsequent to attempted suicide. It was carried out retrospectively, eighteen to twenty-four months after the key suicide attempt. It is submitted to support the contention that intent can be assessed objectively and to encourage further research in the area of suicidal motivation.

Method

Fifty consecutive consultations done by one of us (A.G.L.) during the period of March to September, 1969, were selected as the cohort sample. The available medical and psychiatric notes were reviewed for each patient. A description of the sample is presented in Table II. All patients were initially admitted to a medical ward of Hackney Hospital (a large general hospital in the London area), subsequent to attempted suicide. The method employed was uniformly found to be drug overdosage, with barbiturate tablets the predominant choice (46 per cent).

Eighteen to twenty-four months after the initial admission, a letter was sent to each patient asking him or her to see one of us (D.S.) at the hospital. The home of each patient who failed to keep his appointment was visited. When no one was at home, confirmation that the patient still resided at the address or had moved away was obtained from neighbours. For those patients who had moved and could not be traced, the general practitioner of record was contacted.

At the interview, information relevant to past history, a description of the key suicide attempt, an assessment of intent and measures of outcome were sought. A structured order of inquiry was maintained so that data relevant to intent would not be biased by outcome.[2] A social

Table I
Percentage of Suicide or Repeated Attempts Following Previous Suicide Attempts*

Reference and Place of Study	*Attempted Suicide* (No. of cases)	*Duration of Follow-up*	*% of Total Cases committing suicide*	*% of Total Cases making repeat attempt*
Batchelor & Napier (1953) Scotland	200	1 year	2	3.5
Eisenthal et al. (1966) U.S.A.	912	8 years	6	17
Hove (1953) Denmark	500	2-3 years	5	10
James et al. (1963) Australia	100	6 months	3	3
Jansson (1962) Denmark	476	1 year	1	8
Schneider (1954) Switzerland	372	9-18 years	8	33
Stengel & Cook (1958) England	138	3-5 years	0.8	18
Szymanska & Zelazowska (1964) Poland	81	6 months-2 years	1	9

* *Prevention of Suicide.* Public Health Papers No. 35. W.H.O. Geneva, 1968. Pp. 53-54.

Table II
Description of Cohort Sample

		Male (15)	*Female (35)*
Age:	Less than 20	1	4
	21-30	5	13
	31-40	1	7
	41-50	2	5
	51-60	4	1
	More than 60	2	5
Nationality:	British	11	30
	Other	4	5
Marital Status:	Married	12	24
	Never Married ...	2	5
	Separated	1	2
	Widowed	0	3
	Divorced	0	1
Previous Attempt:	Yes ...	6	20
	No ...	9	15
Level of Consciousness:	Unconscious ...	8	15
	Conscious ...	7	20

evaluation was made utilising a questionnaire adopted from Greer and Cowley.[5] Suicidal intent was assessed from the circumstances of the suicidal act using a scale derived from Beck et al.[4] (See Table III.)

Table III
Suicide Intent Scale

1. *Isolation*
   0. Somebody present
   1. Somebody in contact (as by phone) or nearby
   2. No one present
2. *Timing*
   0. Timed so that rescue is probable
   1. Timed so that rescue is unlikely
   2. Timed so that intervention is highly unlikely
3. *Precautions against discovery and/or intervention*
   0. No precautions
   1. Passive precautions: avoiding others but doing nothing to prevent their intervention.
   2. Active precautions (e.g. locked door)
4. *Action to gain help*
   0. Notified potential helper
   1. Contacted, but did not specifically notify potential helper
   2. Did not contact potential helper
5. *Final acts on anticipation of death*
   0. None
   1. Partial preparation or ideation
   2. Definite plans made (e.g. wrote a will)
6. *Degree of planning for suicide attempt*
   0. No preparation
   1. Incomplete preparation
   2. Extensive preparation
7. *Suicide Note*
   0. Absent
   1. Present
8. *Concept of the method's lethality*
   0. Patient did less to himself than he thought would be lethal
   1. Patient wasn't sure whether what he did might be lethal
   2. Act equalled or exceeded the patient's concept of its medical lethality

Results
Sixteen (32 per cent.) patients attended for interview as requested. Sixteen of the remainder were seen in their homes. An additional patient visited at home refused to be interviewed.

Outcome
Nine patients (26 per cent.) are known to have made a repeat suicide attempt in the eighteen to twenty-four month period. Two of these resulted in death. As an assessment of intent could not be made for these two, they have been eliminated from further analysis. Fifteen patients (47 per cent.) reported symptoms of emotional illness since the attempt, and six (19 per cent.) of these had been hospitalised for psychiatric reasons. Depressive illness was the primary diagnosis for one half the interview sample. (See Table IV.)

Table IV
Primary Diagnosis

Depressive Illness	16
Personality Disorder	8
Situational Reaction	5
Schizophrenia	2
Mental Subnormality	1

Intent
Satisfactory information on intent was obtained for thirty-two patients. Intent was categorised as "Low" when the scale score was four or less, and as "High" when the score was five or more. Seventeen patients (53 per cent.) were in the Low intent category; fifteen (47 per cent.) in the High intent category.

Table V
A Comparison of Repeaters and Non-Repeaters

	Repeaters	*Non-Repeaters*	
1. *Intent*			
0-4	1	16	$X^2=3.55$
5+	6	9	$.05<p<.10$
2. *Parental Absence*			
Yes	2	12	p=n.s.
No	5	13	
3. *Sex*			
Male	1	9	p=n.s.
Female ...	8	16	
4. *Previous Attempt*			
Yes	6	9	p=n.s.
No	3	16	
5. *State of Consciousness*			
Unconscious ...	6	7	
Conscious ...	1	18	$X^2=5.26$ $p<.05$
6. *Self-Report*			
Wished to die ...	6	14	p=n.s.
Ambivalent ...	0	4	
Denied suicidal intent	1	7	
7. *Social Evaluation*			
0.0-1.5 (poor) ...	2	9	p=n.s.
1.6-2.0 (moderate)	4	11	
2.0-2.5 (good) ...	1	15	
8. *Primary Diagnosis of Depression*			
Yes	5	11	p=n.s.
No	4	14	

Table VI
Correlations among Depression, Intent and State of Consciousness

1. *Intent*	*0-4*	*5+*	
Primary Diagnosis of Depression	4	12	$X^2=8.02$
Other Primary Diagnosis	13	3	$p<.05$
2. *State of Consciousness*	*UCS*	*CS*	
Primary Diagnosis of Depression	13	3	$X^2=4.66$
Other Primary Diagnosis	6	10	$p<.05$
3. *Intent*	*0-4*	*5+*	
Unconscious	7	12	
Conscious	10	3	p=n.s.

Repeat Attempts
The seven patients who made a repeat suicide attempt are contrasted on a variety of measures with those who did not repeat (See Table V). Differences are apparent with regard to intent and state of consciousness. The latter achieves statistical significance ($p<.05$), while the intent measure approaches it ($.05<p<.10$).

Correlations (See Table VI)
Patients with a primary diagnosis of depression had significantly higher intent scores ($p<.02$) than those with other primary diagnoses. The relationship between an unconscious state upon admission and a primary diagnosis of depression was less striking, but significant ($p<.05$). The state of consciousness was not significantly correlated with intent.

Discussion
Suicidal motivation has been described by Stengel as conflicting and complex, with conscious and unconscious components.[5] It would be expected, therefore, that uniformity of outcome would be unlikely even for patients with similar intentions. There are always interventions by chance, inadequate knowledge of the toxicity of poisons and heroic emergency medical treatments to account for the survival of someone who intended to die.

To disregard the potential value of assessing intent because a patient's self-report may not correlate with outcome or because a suicide attempt aimed at affecting a change in a patient's environment may result in death is to bypass the path of scientific inquiry. Perhaps we should look first at what the patient does, and then listen to what he says!

If intent is operationally defined on the basis of the circumstances of the suicidal act, six of seven repeaters in the present study fall in the high intent category. Patients with a primary diagnosis of depression make up 80 per cent. of the High intent group. Four of the repeaters are localised among this 80 per cent. The relationship of depression to suicidal intent, measured on a similar scale, has been previously demonstrated by Silver et al.[6]

High suicidal intent in this study indicates a higher probability of repetition of suicide attempts. Nine patents with High intent scores, however, did not make another attempt. One patient with minimal suicidal intent did repeat within two years. It is important to account for the nine false positives and one false negative.

Much can occur in eighteen months. A clinically depressed person appropriately treated with antidepressant medication, electro-shock or psychotherapy may enter a state of remission of his illness. The predictive power of an intent measure in a depressed person may decrease once he has recovered from a depressive illness. In the present sample, eight of nine patients fall into this category. Where a situational disturbance is an important precipitant of the decision to attempt suicide, the resolution of the crisis coupled with growth and the learning of alternative coping methods may make repetition less likely, despite a return to the crisis situation. For the remaining false positive, this is a fitting explanation.

If suicidal intent is defined as the "wish to die", how can one account for a patient with Low intent making a repeat suicide attempt? There are a group of persons for whom suicidal behaviour has a primary "instrumental" or communicative motivation. Achieving their purpose depends upon making a suicide attempt consistent with ultimate survival. They usually score low on the Intent scale. Unless intervention succeeds in altering their reliance on this mode of communicative behaviour, they can be expected to "try again" when the need arises. The risk of death in this group relates more to the product of multiple probabilities of miscalculation than to a high intent to die.

Suicidal intent would be most appropriately assessed as soon as possible after the attempt. Retrospective assessments after a lengthy time lapse incur the problems inherent in the present study. Location of the patient sample was difficult due to mobility (nineteen of fifty patients in our study moved within a two-year period). More subjective factors related to intent (i.e. degree of premeditation, concept of the reversibility of the act, ambivalence toward living) may be more accessible immediately subsequent to the attempt than two years later. Intervening events and changes may cloud the relevance to the present of an assessment of intent based upon the distant past. Early assessment of intent would also allow the relationship to subsequent death by suicide to be studied as a dependent variable.

Since the state of consciousness correlated even more highly with repetition, why not adopt this criterion as a predictor instead of intent? This is the approach that was traditionally employed in emergency room care of the suicide attempter. Physiologic damage incurred, however, relates to several factors, including availability of lethal resources, time elapsed between the act and intervention, as well as the patient's concept of the effect of the drug he took. While many persons with High intent might be expected to inflict significant physiologic damage upon themselves, persons with high intent who inflict trivial self-injury are too often ignored. Another group, with Low suicidal intent, may inflict considerable damage and be treated and referred inappropriately to their needs based upon the sole consideration of medical lethality.

No single dictum has proven accurate in predicting the repetition of suicidal behaviour. Demographic considerations, diagnostic categories and medical lethality may all be helpful in the assessment of the individual patient. This study supports the contention that the assessment of intent, based upon the circumstances of the suicidal act, is a potentially valuable addition to evaluation and prognosis in suicidal patients.

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TOWARDS A NEW CLINICAL CURRICULUM

From THE CHAIRMAN OF THE STUDENTS' UNION

The aim of this article is to summarise briefly the progress made in two meetings of the new Curriculum Committee, which was set up in February of this year to consider proposals put forward by Mr. Fuller, Sub-Dean. This Committee comprises the Dean, the Sub-Dean, the Professors of Surgery and Medicine, 14 other clinical teachers and four student representatives. The changes discussed here are intended for the 1974 Preclinical Entry, though any practicable improvements may be introduced earlier. It is the hope of the students involved in these discussions that this report will act as a stimulus for a feedback of comment from past and present students of Bart's on the proposals. Obviously we would welcome any reaction to these proposed changes, since we are only too aware that we may be unrepresentative in welcoming or rejecting various suggestions.

Background

A revised curriculum for the revised MBBS exam has to be submitted to the University of London for the October 1974 Entry. In the light of extensive criticism of the present course by both staff and students it was felt that this was a good opportunity to develop a more satisfactory clinical curriculum and, as an alternative to free collective bargaining for time from the outset, it was thought that the Curriculum Committee should be presented with a proposed course and challenged to amend it. In the light of the new University regulations the clinical course would be shortened to 33 months. The basis of the new curriculum is the reduction of student numbers on a firm from the present 16 to 5 or 6. This, it was accepted, would entail teaching students at hospitals other than Bart's. Preclinical teaching of some pathology would also be necessary, and this would be introduced in 1973.

First Draft—March

The principal suggestions put forward at the first meeting of the Curriculum Committee were as follows:

First Year Clinical

—Introductory "block" teaching for 10 weeks
—Two weeks' fixed holiday at Christmas
—Ward work in medicine and surgery (alternating) until Easter, at Bart's and peripheral hospitals
—2 months of block teaching at Bart's before Pathology finals in June
—August fixed holiday/revision

Second and Third Year Clinical

—Treat as 21 modules of 1 calendar month each. 3 modules for exams/revision/holidays
—15 compulsory special modules (e.g., 2 in Obstetrics, 1 in Gynaecology, 1 in Orthopaedics, 1 in Paediatrics, 1 in Psychiatry, 1 in ENT, 1 in Cardiology, etc.)
—3 elective modules (e.g., 2nd month Psychiatry, 2nd month Paediatrics, etc.)

The above suggestions were discussed at length, the general consensus agreeing with the formula particularly the principle of reducing student numbers on firms. It was agreed to work along these guidelines but to ask for the following amendments to the above scheme.

—provide more general medical and surgical experience later in the clinical course
—consider combining certain special subjects to produce more time for other subjects
—consider a system of clinical tutors to provide continuity

Second Draft—May

The module system has been extended to include the first clinical year. 33 Clinical months are divided thus:

General	Medicine	4
	Surgery	3
	Introductory Block	3
	Path/Med/Surg. Block	2
	Revision	3
	Special subjects	14
	Compulsory holiday	1
	Elective	3
		33 modules

The 14 compulsory special subjects are:

i. Neurology and Neurosurgery
ii. Paediatrics
iii. Psychiatry
iv. Geriatrics
v. Community Medicine
vi. General Practice
vii. Clinical Oncology, Skins and V.D.
viii. Anaesthetics
ix. Cardiothoracic Medicine and Surgery
x. Orthopaedics
xi. Gynaecology and Urology
xii. Obstetrics A
xiii. Obstetrics B
xiv. ENT/eyes

Other points:—

—10 week introductory course until Christmas using general medical and surgical beds at Bart's
—January General Medicine/Surgery } Bart's and
—February General Surgery/Medicine } Periphery
—March—Special subjects start
—April/May/June—block teaching then Pathology finals
—July—Special subject
—August—fixed holiday
—Special subjects through second year clinical
—Final year to include General modules (medicine/surgery), Special subjects and revision
—Order in which parts of finals are taken will depend on the students' own curriculum

Criticism of Second Draft

The following further improvements to the second draft were proposed by the Curriculum Committee:

—consider the possibility of two compulsory months each in Paediatrics and Psychiatry
—reduce the introductory course from 10 to six or four weeks
—consider reducing the time allocated for Anaesthetics
—extra time may be required for Pathology

The third draft, with these amendments, is to be presented to the next meeting of the Curriculum Committee.

Summary

Despite the application of computer techniques (as here) to the planning of a new curriculum, several problems remain, involving both the theories of medical education and the practicalities of organising a course. As stated earlier, this course is designed to reduce student numbers per firm. This may lead to a return of the "medical apprentice" who trails his master all day, learning by example. Would this regression be welcome? Would the student cry for more involvement be satisfied, or do more students now feel that they would learn more if left to their own devices?

The reinstitution of an Introductory Course is another example of opinion travelling full circle in a short while. The reduction of general medicine and general surgery to one month a piece in the first year seems a profoundly new piece of thinking. Pathology Finals will give real impetus to the first year of Clinical studies. What we now require is a student reaction to these and the other proposals mentioned here.

We must consider also, in broader terms, the type of doctor we intend to produce. A study of the proposed compulsory Special subjects reveals a significant swing to "community medicine", in place of the more traditional specialities of hospital medicine. Since by far the greatest number of the students will become general practitioners this is perhaps wise, though we must ask how much of such training should be at the undergraduate level. We must also consider, not just allocation of time month by month, but how much each subject can offer a student and the "objectives" of a student in that subject. Practically, we can also think in terms of combining "modules". This must decrease the flexibility of a course, and such combinations should involve using teaching beds at the same hospital, otherwise the student will find himself spending all day on the bus, between Hackney and Bart's. Another question appears—do modern students prefer to have a full planned day offered to them by their department or do they prefer plenty of free time for library work? We must surely organise a course to cater for both.

I have attempted to demonstrate the process of constructing a new clinical curriculum. It is likely that a module system will be passed in some form or another, but many details are yet to be decided. The Students' Union representatives of this Committee have to put forward a "Student's view"—not only a consensus but also any original ideas not mentioned here. I hope that this article will stimulate thought about the course and that you will contact your representatives—Primrose Watkins, Gerard Bulger, Colin Lewis, Rory Shaw, Paul Taylor, with any comments or for more information.

PAUL TAYLOR,
Chairman, Students' Union.

SOMETHING ABOUT THE TEACHING COMMITTEE

By PRIMROSE WATKINS

I have been on the teaching committee for nearly 5 years. I'm not sure why I should have been on it for so long. Perhaps my interest in teaching springs from a very poor education at my public school, in the face of which I was powerless except to try to teach myself enough to pass exams in the weakest subjects. Here, at St. Bartholomew's, I feel that someone interested in improving the parts which are universally unpopular can if he joins the teaching committee provoke a change and contribute useful ideas. Staff are unaware perhaps of some shortcomings.

I first joined the teaching committee before 2nd M.B. I had found the preclinical course boring and frustrating. I soon discovered that big changes, which would have to be very fundamental, just could not be accomplished by us. Besides quite what these should be I was not certain. The conflict then centred round whether a student should receive a scientific introduction to each of the subjects, or whether his acquaintance should be clinically orientated and concise. We never sorted out this question.

At that time the teaching committee had only existed for a few years. The idea that students should have a say in teaching was new. Many among the staff and students were undecided—one felt some people dubbed one as rebellious and impertinent. Now every one accepts that it is right for student representatives to express opinions about the present course, to put forward suggestions of improvements they feel should be made, and ways in which they would like to be taught.

Student/Staff meetings have been held during the last $2\frac{1}{2}$ years, 3 or 4 times in a year. At these, four students from the teaching committee present proposals to the Dean, Sub-Dean and a few members of staff. We have had one representative on the last curriculum committee. We now have four on the new curriculum committee which was formed this year to work out a new preclinical and clinical course. This number, we feel, enables our opinions to be put over to the array of consultants and professors present with greater courage and conviction. The Dean sees anyone who would like to speak to him about anything on Friday mornings for coffee.

Problems have arisen from student/staff meetings because they have been the first opportunity for us to be effective.

Three things have produced much of our lack of success. How are we to be sure that we represent the year's opinion? How to prove that this is what we uphold? Such opinions can be put forward with added weight as compared to idiosyncratic opinions rightly regarded with scepticism. When we thought a proposal was a good idea, how could we put it into action? Can the Dean tell other members of staff what to do? It seems he may only exert influence. Some people used to think that an ideal course could be found so that changes would not be necessary for an unforseen number of years. Also change itself was often resented and opposed. I feel that change is implicit in teaching. Fundamental changes obviously cannot be made every year. However, change is not now resented. Another obstacle to a new idea is that some stick to what should happen, in the face of what actually happens—whilst the proposers are wishing to glean from reality grounds for future plans. I now feel, that quite apart from the above, when we present proposals they somehow seem to disguise themselves as complaints to staff, who despite themselves, feel a little in the position of school masters. These precious hours are not fully used. Discussion is what should happen. We, also, should be faced with staff dissatisfactions, and draw these too to a constructive conclusion.

The teaching committee have been criticized for their exclusiveness. We have not meant to be so, yet have slipped into it. I would like to outline the remedy we are going to try. In future all teaching committee meetings will be open to anybody who wishes to attend and they will be advertised widely. The meetings are informal, no minutes are taken. Some of the present members are elected from the Students' Union, others join privately. No special ability is needed to become a member.

Examples of the things achieved are: The Audio-Visual room, to which other departments had laid strong claims and looked as though they would be successful; the experiment of pathology tutorials for first year clinical students, which unfortunately failed not because of a fault in the idea, but because of the way it was carried out; changes at Hackney for the students allotted an obstetric month there; 2-month firms in the 1st clinical year with random reallocation after 6 months without duplication of firms with very similar interests.

The aim of the student/staff meetings has been to decide on something, as many of the proposals as possible, and to try to accomplish the changes agreed upon. Perhaps too little time has been spent talking over the difficulties mentioned above. So far our efforts have been as realistic as possible in that changes have been proposed within the existing curriculum. We now have a substantial contribution to make to the new curriculum. We also have a new tool, the objective: an objective states what a student must be able to do (see the April *Journal*). With this way of thinking it would be ideal for staff and students to meet and plan out what they thought the most important things were that a student should be able to do at the end of a module (little section of the course), also the ways of teaching and learning this which would be most interesting and enjoyable.

The proposed curriculum is a timetable, specifying the time for each subject and its position in the course (i.e., psychiatry). It is arguable which way it is most practical to decide a course; the general before the more detailed objectives or the other way about. The generality of objectives ranges from institutional—that of this medical school—to specific—those for a particular skill, i.e., cardiology. At the first curriculum meeting they discussed what sort of doctors Bart's should train, though not so clearly that this could be written down as a general objective. Medicine relevant to the community as a whole rather than to the hospital is to be emphasised, the students apprenticed to teachers in small groups of six. Thinking in objectives is new and none of us have any experience of it, so to plan a curriculum by allocation of time for subjects is a way familiar to all. When this is decided, it will be our opportunity to form small groups of staff and students to plan out the specific objectives for the courses. This is happening in many medical schools throughout the country, for instance, I read that UCH are doing this for emergency medicine, pathology and bacteriology.

The detailed curriculum, which the curriculum committee is now working on, is going to be duplicated and a copy handed to everybody with an opportunity for you all to note your ideas which will be put forward at curriculum meetings. The teaching committee will try to correlate the ideas so that those of the majority would be strongly represented. Discussion should reveal the good ideas that only a few people have thought of rather than many, and whether one's own opinions, when differing, distort the presentation of the overall view. The assumption in the present timetable with its large numbers, that the keen few will take opportunities for experience not available to the crowd is unjust. These few it is reasoned do well under this system, indeed would do well under any. Yet the new course will be planned, we hope, so that each person will have equal opportunity to gain all the experience he wishes.

I think we need a room, a sanctuary for discussion in comfort, a place I would label "Undergraduate Studies". I have my eye on the 850th anniversary office; it is a pleasant room with a view and a kitchen attached. There, I propose students and staff would meet over delicious refreshments to work out ways of doing things and record their thoughts. I list the reasons why all could make good use of this room.

1. Students or staff could invite each other to discuss their views. There is little opportunity in a large group to put forward opinions or to know the teacher well enough to do so.
2. Going away from Bart's on a course may result in experience worth recording for a future traveller.
3. Groups designing objectives for courses.
4. Teaching committee meetings.
5. Student/Staff committee meetings.
6. Just talking about teaching, instead of loosing ideas for ever in a cup of tea or coffee.
7. Finding out what the general opinion is.

The purpose of having such a room is that none should be excluded. This room will not work unless both teachers and students are whole-hearted in their effort to use it. In many ways this room would be similar to the audio-visual aids room. Ways of making these projects work have to be sought. Imagination and experiment will discover the excellent contribution they can make.

BARTHOLOMEW FAIR

Nine o'clock saw the final preparations being made. The smoothies with their stalls already prepared, the rest of us hoping nobody turned up before 10 o'clock and caught us out. Still, a few borrowed hammers, minor disasters, scuffles for stall space later there we were ready and waiting. All due in no small measure to Brian Galton-Fenzi—at last somebody you could talk to without feeling you were interrupting a hotline conversation with the Pentagon.

The minutes ticked away somewhat uneasily. Where was everybody? And anyway who would want to buy

this load of rubbish when they did come? Would the whole thing flop? Then suddenly—almost while you were asking the question—there they were, in numbers never before conceived by the imagination of man!

And so it was all day. The sun shone on and off but the people just kept on coming. They were people of all types jostling laughing and coping with grizzling children, but always enjoying themselves, and the only bawdy coming from the stallholders. The cutpurses and vagabonds either stayed at home or did their job so quietly that nobody saw them!

Indeed who could not enjoy himself at the Fair With Something For Everyone?

"Be a real Doctor for only 20p."

"Come along Sir, win some Naughty Knickers for the wife." The roundabout and the helterskelter and the ox went round and round, and the swings and little balls none of which had No. 7 on went up and down, and somebody said there was an epileptic in a sack over the road but it was only the escapologist. Soldiers fought the Commies, Knights in armour fought for Fair Maidens, and Fair Maidens fought each other for the Title of Miss Bartholomew and a Kiss from Callan (prox. access, Martin Gore and the Bear). Everything—even Ian Baker's pancakes—sold (dare one say like hotcakes?). Somebody even bought a copy of the *Journal*!

Still the crowds grew you could walk on their heads down Central Avenue—and ugly rumours abounded. The coconuts were nailed to their posts, the gingerbread had run out, Alan Fuller was wearing a stick-on beard.

As the day wore on the occasion reminded one more and more of those great innocent fairs of childhood where the man with the corkgun seemed to be enjoying it almost as much as you were and nobody was on the make. Only this was about 10 times as big and a hundred times better and nobody *was* on the make—difficult enough to believe considering the avowed intention of the enterprise at its conception.

Who did not enjoy it? The man who was chewed up by the police dog? The knight who was cut up by his adversary? The ox? Even they must have felt from a cursory glance at those present that the whole thing had been worth while, and that the Fair was a fitting highlight to the celebrations. Here indeed was "A thing worth seeing, and mightily followed".

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

BARTHOLOMEW BALL

PLEASED TO MEAT YOU

Some of the guests carrying their food away on China-Foam "Cari-All" tray.

RETIREMENT

I've an electric clock. The second hand
Is red, and night and day it goes around.
I set the silly buzzer nightly, and
Each day it wakes me with its raucous sound.
No *need* to set it; yet I'm still alive!
Habits die hard, though years may take their toll.
They made me give up work at sixty-five,
And all I do is wake—and fetch the coal.
What ambition, love, career, desire meant
I knew; but now I'm on the compost-heap.
They say "Are you enjoying your retirement?"
I fume and envy—then I go to sleep.
The Red Hand goes around; Year, day, and minute
Second and hour. Maybe I'll reach my goal
And know the scheme of life and all that's in it
That day when I—no longer carry coal.

A.B.

Bartholomew Ball was held on Saturday, May 5th, 1973, and attended by some 7,000 of the people associated with St. Bartholomew's Hospital at the time of its 850th anniversary. If 7,000 sounds like a lot of people, it seems even more when you are actually among them, even in the large cut of Smithfield Market taken over for the purpose.

The joint was in fact so well "disguised" that it was possible to forget completely that one was in a Meat Market at all, and the venue was generally a great success—if a little nippy round the edges later in the evening.

The main musical attraction of the evening was Ray Ellington—a smooth performer who came over well even in the huge Central Avenue. A number of less well known names (apologies to Bruce Campbell) provided diversions from the Centre—musically and physically—throughout the evening. Unfortunately the escapologist seemed to escape not only his straitjacket but the attention of about 6,950 people.

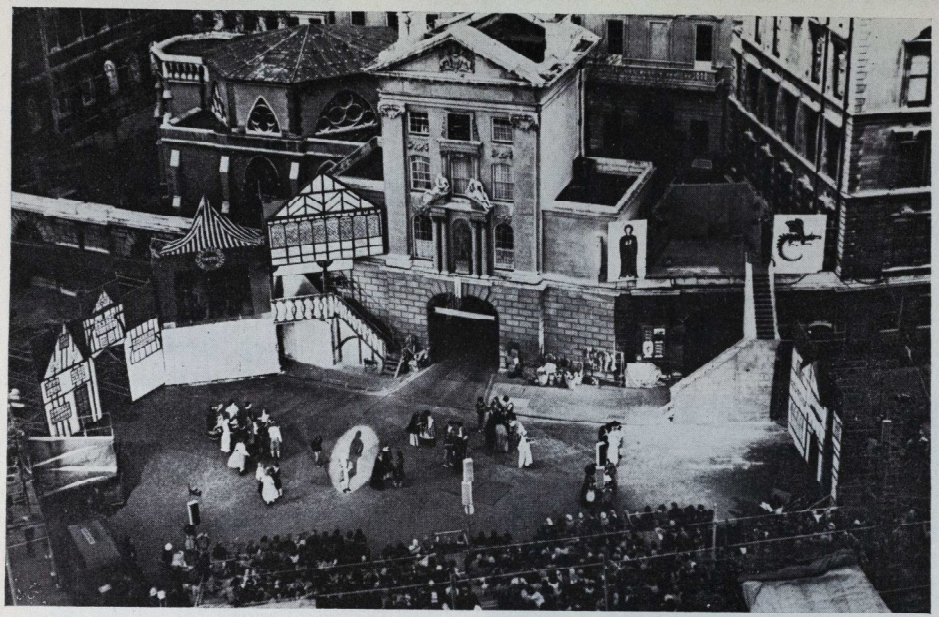
Food and drink were available in great variety and on a large number of stalls, and were considerably easier to obtain than any of the prizes in the raffle!

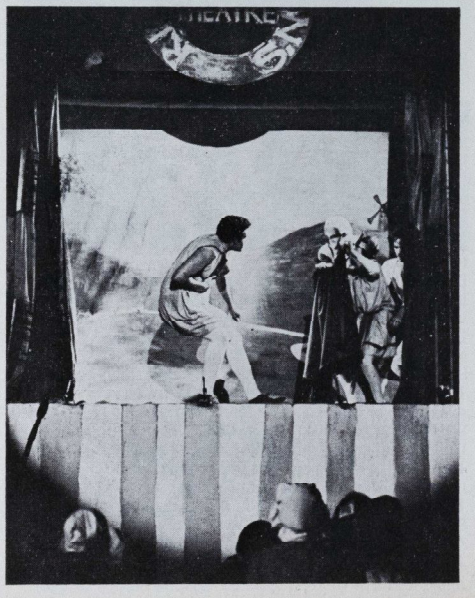
Fancy dress was asked for, and indeed many obliged with excellent costumes. Henry VIIIs and Raheres abounded, but my prize must go to the bloodstained dishevelled wreck who drew so many alarmed second looks early in the evening, and who must have been the only one present whose outfit looked more impressive at the end of the Ball than at the beginning.

Perhaps the only disappointments engendered by the large numbers were the virtual impossibility of bumping into somebody more than once or twice during the night, and the occasional overwhelming congestion in the Central Avenue.

Otherwise the evening was a most enjoyable one—a tribute to the considerable time and effort that must have been spent in its organisation.

WILLIAM HARVEY REVOLUTIONARY CIRCUS





1973 at Bart's may be well remembered for the Queen's visit, the Ball in Smithfield Market, the Fair, but surely most of all for George Blackledge's William Harvey Revolutionary Circus.

Against a remarkable set, which incorporated the Henry VIII gate, the tale of the life and times of William Harvey was unravelled in an intriguing and often amusing manner. The guide and narrator throughout was a bewigged .Hieronymus Cowper, who James Griffiths seemed to enjoy being as much as he enjoys being James Griffiths.

In parallel to this, Medieval Miracle plays, superbly directed by Rob Robertson and cunningly woven into the theme, recorded the history of mankind from Adam to the end. "The Fall" in the garden of Eden where Adam and Eve were finally revealed as being truly naked, and the tableau of Noah and wife sheltering under an umbrella whilst the godless perished in the wet, were particularly noteworthy.

Meanwhile, William Harvey (otherwise Jonathan Frappell who *almost* sings as well as he acts, and is to be commended on accomplishing four costume changes in ten minutes without once forgetting his doublet) had gone up to Cambridge as a student, swept successfully and nobly through his undergraduate days and finally settled at the doors of St. Bartholomew's Hospital as chief physician. (Promotion, you understand, was somewhat swifter in those days.) Little was seen of his stay

here, other than a somewhat slapstick and prolonged ward round, which seemed more appropriate to a Christmas Show or Smoker.

The members of the Royal College of Physicians, to which this son of the hospital was subsequently elected, were delightfully bumbling and colourfully regaled in academic robes. as they showed that everyone. especially a doctor, loves to dress up.

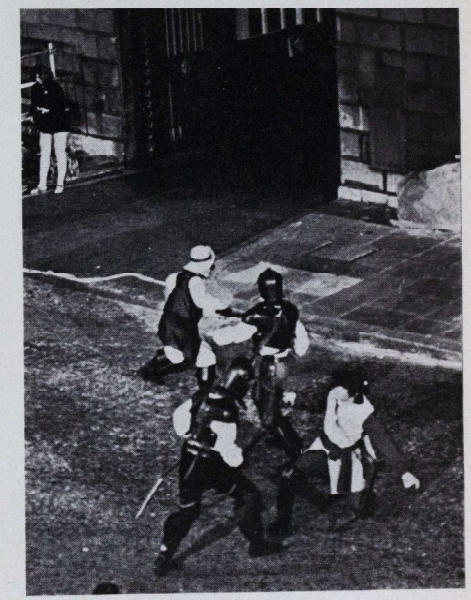
The crowd, which during the dancing and fighting scenes might easily have been an embarrassing rabble, instead became a dynamic mass of believable peasants. All credit here to Geraldine Stephenson whose professionalism obviously showed throughout.

Our hero eventually became Physician to Charles I and here breeding told as Alberic Fiennes blended into the Part Royal as to the manner born. His slightly foppish and bored manner when in bed (was the damsel with him really *"deshabille"?) and his noble bearing on execution seemed especially appropriate.

The story culminated in the final acceptance of William's theories upon the Circulation of the Blood. On this occasion he was persistently opposed by a contemporary, Alexander Reid, an ardent advocate of the ancient and until then blindly accepted theories of Galen. Doug Russell played this fierce Scotsman with such convincing vehemence that at times Harvey's theories seemed almost in doubt.

One of the most amazing things about this production is that anyone could contemplate such an undertaking, let alone both write, direct and devote so much time as George Blackledge has obviously done. Dr. B. who the programme politely tells us was born "shortly after World War II" is by no means unknown to Hospital dramatical productions, but this must surely be one of the most successful of his efforts.

The impact and professionalism of the whole production reflected the hard work of the great number of students involved. A particular word of congratulations



is due to the programme designers for producing a novel and fascinating package.

Those who missed W.H.R.C. can only gnash their teeth in anguish and wait until the 900th anniversary when a slightly greyer but extremely eminent Dr. Blackledge will doubtless be asked to revive this extravaganza.

P.F.

* Yes . . . Editor.

Bargain Records — Sergei Rachmaninov (1873-1943)

By ALLEGRO

Sergei Rachmaninov is still probably best known as the composer of a famous piano concerto, an etude and a set of variations on a famous violin caprice of Paganini. This centenary year should be used to emphasise the importance of his other works and already a crop of new issues have appeared, mainly on full-price LP.

Rachmaninov's opus 1 is a piano concerto: his major student composition and in many ways, his first major work was his first symphony (op. 13). Here is the harmony and luscious orchestration which was to become the hallmark of the future. It is hard to believe that this work had a disastrous premiere under the direction of Glazounov, director of the Moscow Conservatoire where Rachmaninov was a student at the time. It was not to be heard again until the 1950's. The last movement has become famous as the theme music which was once used for "Panorama". It is a work of irresistible youthful surge. This debacle led the composer to severe depression, so much so that he did not produce another work for years. The next major composition was the second piano concerto, op. 18, which truly established the composer's world status.

It was as a great pianist that Rachmaninov made his American debut. His virtuoso playing of Schumann and his own Mendelssohn arrangements are justly famous and were available on LP. He stayed in America, playing, conducting, but composing little. He became exceedingly homesick, but had very little desire to return to post revolution Russia. The second and third symphonies, third and fourth piano concertos, Symphonic Dances, "The Bells", many solo songs and songs with orchestra which were performed in his lifetime are now rarities. Even such a musician as the critic Martin Cooper has recently written Rachmaninov off "the composer who came to the same old party but all the guests have gone away". This dismisses a composer who may have added little to enhance musical form but who undoubtedly graced existing style with beautiful melodic invention.

Records are much more plentiful this year, although mainly at full price. I wish there was a cheap record of the first symphony—in the absence, I turn to the gorgeous second symphony. This 60 minute symphony is quite as melodic as the second concerto: it has a yearning quality, the orchestration is marvellous, particularly the clarinet solo writing in the slow movement. There is a vital scherzo and the last movement reaches a staggering climax. Unfortunately, only one full price record is not disfigured by cuts, allegedly sanctioned by the composer. However, Boult and the LPO wear their hearts on their sleeves and their version is highly recommendable despite cuts (Decca Eclipse ECS 594, £0.94). Full price, Ashkenazy's records with Previn and the LSO are worth their price (all the concertos): Byron Janis is a virtuoso of considerable power. His performance of the 3rd concerto, if without the refinement of the Ashkenazy, is still admirable: he is well supported by the LSO and Dorati (Philips 6582006, £1.28). The third concerto is in many ways more exciting than the second—both are masterpieces and perhaps the recordings I should recommend are those of the composer with the Philadelphia Orchestra recorded in the 1930's. Marvellous playing but swoony heinous sound! Undoubtedly authentic (available on RCA at £1.79 a record LSB 4011-3).

Surprisingly, I am unable to recommend any records of the piano music at less than full price. Peter Katin lacks the flamboyance on his Unicorn records to make his set of the Etudes recommendable and Moura Lympany's Ace of Clubs set is sonically too ancient. Equally, Rostropovitch and Oborin's record of the 'cello sonata is too ancient to bring much pleasure—better to pay full price for Tortelier and Ciccolini. The songs are still unavailable on record and unbelievably, no recording of the marvellous Vesper Mass is available—its true quality was recently appreciated at a live performance by the Bruckner-Mahler chorus under Wyn Morris.

Two orchestral works, both worth buying, are the Symphonic Dances and the symphonic poem "From the Isle of the Dead". The former is a marvellous three movement symphony, full of waltz-like rhythms—orchestration includes a saxophone. The work was written for Ormandy and the Philadelphia Orchestra. Their record is splendid (CBS 61347 £1.49) but there is better at full price on HMV Melodya. Another masterpiece is "The Isle of the Dead," a captivating work, always exciting, coupled with the Listz Totentanz (on RCA VICS 1205 £0.94), well played by the Chicago Symphony under Fritz Reiner.

I must end by recommending Ashkenazy's marvellous set of the piano concertos and Paganini Variations. This pianist has added to his beautiful pianissimo playing a power and command. Previn is totally sympathetic and Decca's recording is a model of good concerto balance—like sitting in the best stall seat (Decca SXLF 6565-67, £5.75). I feel sure that by the end of this year Rachmaninov's true contribution will be better established which can only be to the musical public's advantage.

CROSSWORD SOLUTION

Across		Down	
1.	Hospital	1.	Hearts
5.	Wheeze	2.	Swords
9.	Abortion	3.	Internees
10.	Oblige	4.	Abominations
12.	Tudor	6.	Habit
13.	Impatient	7.	Epidemic
14.	Metallurgist	8.	Edentate
18.	Lowest Income.	11.	Applications
21.	Ground nut	15.	Roman nose
23.	Noose	16.	Flagrant
24.	Acidic	17.	Swooning
25.	Colonial	19.	Toxins
26.	Tagged	20.	Healer
27.	Assessor	22.	Noise

BOOK REVIEWS

A COLOUR ATLAS OF RENAL DISEASES. George Williams. Wolfe Medical Books 1973. Pp. 240. Price £4.

This atlas is the fifth of an expanding and now well known series. As stated in the introduction, it is directed mainly at undergraduates, and on the whole it fulfills this purpose admirably though its specialised nature and price make it a luxury for the average student.

It is produced from the viewpoint of a pathologist and is, therefore mainly concerned with the structural aspects of renal disease. This is presented as a series of gross specimens and microscopical preparations supported by radiographs and electron micrographs where appropriate. Each chapter has a brief introductory text.

For a small atlas, it covers a wide range of renal disorders, including chapters on renal transplantation and renal biopsy. The arrangement of illustrations and captions on opposite pages facilitates quick reference and has much to commend it.

An atlas stands or falls on the quality of its illustrations and the majority in this book are of a uniformly high standard. The selection of fields of magnification are well chosen to display the essential features of the lesions. The colour, however, is of variable quality and some photomicrographs are rather pale. The technical staining of certain sections is unsatisfactory. Many of the low-power views neither show architectural pattern or cellular detail. In addition, the captions could be expanded to provide more information and utilise the space available.

In spite of these minor criticisms, this atlas can be thoroughly recommended to all those interested in renal disease. It offers considerable assistance to the understanding of the fundamentals of renal pathology when used in conjunction with standard text books and histological preparations, but naturally, it is no substitute for them.

J. J. LUCEY

LORD ARTHUR SAVILE'S CRIME AND OTHER STORIES. Oscar Wilde. Penguin 30p.

It is difficult to write a review of this collection of eight short stories written between 1887 and 1891 since none of them are new, and a few are famous. However, the stories are well chosen, and, apart from the fascinating title piece written in Wilde's polished style, include The Canterville Ghost and the Happy Prince, one of two children's stories. Perhaps these children's tales could have been omitted but their inclusion does help to emphasise the scope of Wilde's imaginative and creative powers. This collection shows both his ability for concise, simple description and for the witty cynicism with which he delighted late Victorian society, and which is no less entertaining today.

A. I. SEARLE

The book review in the June *Journal* should have been headed, "PREGNANCY, Gordon Bourne. Cassell & Co. £3.00." We apologise for confusion caused by this mistake.

RECITAL
GREAT HALL, MAY 22nd, 1973

Two products of the Yehudi Menuhin School with strikingly different and individual musical styles, entertained a large audience in the Great Hall. Andrew Watkinson, clearly a violinist with a considerable future, has a marvellous tone to his playing. The warmth is clearly a credit to Joseph Szigetti, the great violinist with whom he studied. So far, any animal passion or real bravura is missing but with such a beautiful basic technique, the rest will come naturally. Andrew Watkinson is to go to the Moscow Conservatory next to study with David Oistrakh, and he is certain to add steel to the soul. Miriam Juviler is a somewhat enigmatic pianist. At the moment, all sounds Brahmsian. She has a big technique, using sound occasionally for sound's sake. She is capable of a beautiful ravishing half-tone, also capable of being less than wholly sensitive to her violin partner's playing.

In Mozart's sonata K380, it was the variations of the last movement which brought the best playing. The romantic indulgence of the pianist seemed out of place with the simple harmonies of the first two movements. Mozart did not make life easy for the violinist, most of the best movements going to the pianist, but in good duo playing this can be disguised.

Bach's big second Partita received an excellent performance, particularly the dance movements (Corrente, Giga). The Ciaccone, this dazzling violinistic display piece, was well, if carefully played. One felt some degree of reserve, but this was still a fine performance.

Brahms' sonata op. 78 is a luscious work which really brought the pianist's best qualities out, her sensitivity and passion being particularly beautiful in the slow movement. The violinist's lack of passion, obvious here, was even more noticeable in the gloriously tuneful Bartok rhapsody. I would love to be able to compare this rending with the rending he will give in two or three years' time.

This recital was a most pleasant experience. We hope soon to welcome Mr. Peter Wallfisch, a fine international pianist for a future recital.

ALLEGRO

Answers to "Journal" Quiz

We are giving the most generally known association. More obscure answers may also apply.

Bread & Butter—pericarditis.
Anchovy Sauce—amoebic liver abscess.
Melon Seeds—in Pott's disease of the spine.
Beef Steak—tongue in pernicious anaemia.
Sausage—Carcinoma of the Fallopian tube.
Onions—onion-skin vessels in malignant nephrosclerosis.
Redcurrant Jelly—stools in intussusception.
Salad—word salad in e.g. severe schizophrenia.
Strawberry—gall-bladder, or tongue in scarlet fever.
Orange—peau d'orange in carcinoma of the breast.
Sugar Icing—spleen and liver e.g. in Concato's disease.
Chocolate—cyst in ovarian endometriosis.
Cafe-au-lait—spots in von Reckinghausen's disease.
Swiss Cheese—endometrium in metropathia haemorrhagica.
Port Wine—stain, one type of capillary haemangeioma.

SPORT REPORTS

CRICKET CLUB REPORT

Predictably, the fine Spring weather came to an abrupt end with the opening of the cricket season. Nevertheless, performances in April and May were sound and augur well for the remainder of the season. All the batsmen have made at least one good score, but the bowling has tended to be steady rather than penetrating.

April 28th. Bart's v. UCH at Chislehurst. Match drawn.

A fine innings by Furness enabled Bart's to declare at 128 for 6, despite a two hour interruption for rain. Tight bowling and fielding prevented UCH from scoring at the required rate, but Bart's could only take six wickets by the close of play.

Scores: Bart's 128 for 6 dec. (Furness 78 not out, Cooper 18, Flather 19).
UCH 64 for 6 (Rowland 1-10, Flather 2-13, Munro 2-2).

May 2nd. Bart's v. University of Sussex at Isle of Thorns, East Grinstead. Bart's won by 8 wickets.

The University won the toss and elected to bat on a good wicket; they found scoring difficult, however, and had to bat on after tea. Set to score 145 in two hours, Cooper and Flather gave Bart's a sound start with an opening partnership of 52. Firmin and Capper then took over and, pacing themselves well, saw Bart's home with five minutes to spare.

Scores: University of Sussex 144 for 8 dec. (Joshi 4-57, Munro 2-45, Barrison 1-14).
Bart's 146 for 2 (Cooper 41, Firmin 48 not out, Capper 37 not out).

May 9th. Bart's v. Royal Veterinary College at Chislehurst. Royal Vets won by 6 wickets.

Despite a good innings by Capper, a weakened Bart's side could only make 95. Hopes were raised when some excellent catching reduced the Vets to 32 for 4, but the fifth wicket pair, with a little luck, played increasingly well and the Vets ended comfortable winners.

Scores: Bart's 95 (Capper 46).
Royal Vets 98 for 4 (Joshi 1-22, Burston 1-6, Cooper 1-18, Barrison 1-13).

May 13th. Bart's v. Blue Star. Match drawn.

Once again, the early part of the innings was dominated by one batsman. This time, Rowland scored a hard-hitting 84, but Bart's were still in a precarious position when he was out at 139 for 8. Blue Star were at first a little surprised but eventually visibly downhearted as number ten Barrison smashed an exciting 39, well supported by Anderson. A couple of early wickets raised hopes of a Bart's victory, but the Blue Star third wicket pair batted steadily and appeared to have played their side out of trouble. Spinners Barrison and Munro then snatched a couple of wickets each and a Bart's win again seemed likely. The medium-pacers failed to finish off the tail, however, and an enjoyable match ended in a draw.

Scores: Bart's 186 (Rowland 84, Barrison 39, Capper 17).
Blue Star 103 for 7 (Brann 1-9, Rowland 1-24, Anderson 1-19, Munro 2-7, Barrison 2-10).

May 19th. Bart's v. Old Erithians. Match drawn.

Another aggressive display by Capper was the backbone of the Bart's innings, supported by a solid 38 from Davies. The innings was played in a continuous drizzle which slowed the outfield and hence the scoring rate. The innings was eventually closed at 181 for 7, leaving the opponents 130 minutes to score the runs. Slow scoring by the opening pair seemed to put the target beyond reach, especially when three wickets fell in rapid succession. The Old Erithians' number five had different ideas, however, and was scoring well until trapped lbw by Munro for 42 with the score at 108. This took the steam out of the challenge, and Old Erithians finished 25 runs short.

Scores: Bart's 181 for 7 dec. (Davies 38, Capper 64).
Old Erithians 157 for 5 (Barrison 2-21, Flather 1-38, Munro 1-27).

May 20th. Bart's v. Southend at Chislehurst. Match drawn.

Accurate Southend bowling curtailed the Bart's scoring rate in the early stages; Cooper grafted well and provided the basis for aggressive hitting by Lindsell, Rowland and Husbands. Lindsell scored a scintillating 80 which included three sixes. Following a similar pattern to the previous day's match, Bart's challenged Southend to score 177 in just over two hours. Brann and Joshi opened the bowling well, each taking a wicket, but the other bowlers failed to capitalise on this fine start, and the Southend third wicket pair gradually assumed command. A Southend victory was becoming increasingly possible until Husbands dismissed both the batsmen, for 72 and 46, at just the right time.

Scores: Bart's 176 for 5 dec. (Cooper 32, Lindsell 80, Husbands 28 not out).
Southend 143 for 4 (Joshi 1-20, Brann 1-7, Husbands 2-28).

May 21st. 1st round UH Cup. Bart's v. Royal Dental Hospital at Chislehurst. Match abandoned.

Playing their third game in as many days, the Bart's team were confident of progressing to the next round. Accurate bowling by Joshi and Rowland restricted the RDH score to only 48 for 4 in the 26 overs before lunch. Further play was impossible because of rain, and the match was abandoned.

Score: RDH 48 for 4 (Joshi 2-23, Flather 1-1).

May 27th. Bart's v. Woodpeckers at Chislehurst. Bart's won by 7 wickets.

May 28th. Bart's v. Crishall at Crishall. Match drawn.

May 30th. 1st round UH Cup replay. Bart's v. Royal Dental Hospital at Chobham. Bart's won by 8 wickets.

Sports Reports must be typed and submitted to the Clubs Editor before the 24th of each month.

SKI-ING AND HIGHLAND PENTATHLON

For the fourth year running Bart's has maintained its position as best ski-ing college of London University.

This year's Inter-College race was held on Sunday, March 11th, in beautiful sunny weather. The race consisted of two runs of a thirty gate open Slalom, three people in each team (two to count). Bart's had three teams: 1st—Christopher Trower, Tony Lipscomb, Graham Aitken; 2nd—Mike Anderson, Oliver Bastard, Carol Dow; 3rd—Peter Smith, Norman Bradley, David Patuck. Despite the fact that the Bart's 1st team contained both the present and a past captain of London University there was very strong opposition from Imperial College whose captain, Robert Cohen, was in last year's national team. He was also supported by two good racers, one Norwegian. After the first run Bart's 1st had only a 0.9 sec. lead over Imperial 1st but managed to lengthen this by another 2.4 sec. on the second run.

University College Hospital came third and Bart's 2nd did very well to come fourth out of the nine teams entered. The individual event was won by Robert Cohen in 53.4 secs., followed by Chris Trower in 57.2 secs. and Tony Lipscomb in 64.4 secs. Graham Aiken came seventh and did well enough to be selected to race for London in the British Universities championships in April.

Although London had the skills of Robert Cohen for the first time the team was somewhat depleted with Nigel Findlay-Shirras (Bart's) away ski-ing in Colorado and Chris missing the team slalom event on Monday, April 9th, for a less enjoyable reason. However Chris did manage to come fourth in the individual slalom on the Tuesday and this should give him a good chance of being selected for the British University team next winter, the year of the World University Games.

Bart's have opened up new frontiers this year by becoming the first hospital to compete in the annual Highland Pentathlon. This competition held in Aviemore over the weekend April 26th-30th was for teams of three with each competitor performing in the five events of swimming (100 metres), ski-ing, target curling, shooting and running (2,000 metres cross-country). There was a bogey 1,000 points score estimated in each event.

Bart's were lucky to be accepted for this event as fifty-three teams applied for the thirty places. A third of the teams being selected from the Services, a third from ski clubs and a third from colleges and universities.

The team, the same as the 1st ski team, predictably did well in the ski-ing, coming fourth. They surprisingly came sixth in the curling, none of them having curled much before. Their tenth position in the shooting was aided by Chris's 1,000 point score and their twelfth position, in the running by Tony's 10.30. Swimming was the only weak sport with the Bart's team coming 21st.

However, the final ninth position was very satisfactory beating as it did all the university teams including Loughborough College and all the Service teams except for the Royal Army Training Corps and ensuring Bart's of a place in the competition next year.

BOAT CLUB REPORT '72/'73

Believe it or not, the Boat Club still exists, in spite of rumours to the contrary circulating during the year.

The start of the year was most promising, a lot of novices coming forward. But, as usual, enthusiasm waned and by the end of the Michaelmas Term, the Boat Club was back to its accustomed level of activity. Nevertheless, several fours and other small boats were entered for the United Hospitals' Winter Regatta.

The Club then hibernated over winter, with a spark of life in March when it combined with the Royal Dental and sent a crew to the Reading Head.

From the start of the Summer Term, the Boat Club, as did everyone else, had to compete with the 850th celebrations. Consequently, preparations for what is perhaps the major event in the Hospitals' rowing calendar, the Bumps did not get under way as they might have done in other years. Even so, Bart's put seven crews on the River for the Bumps on May 12th-14th.

The 1st VIII surprised many people, not least themselves, by lasting the course for two nights and making a bump on the last night, so bringing Bart's back to a more respectable position. Inexperience and lack of coaching resulted in the other six crews going down more places than they went up, an exception being the 6th VIII (The Tripedes) who were awarded an oar for their three bumps.

The First VIII

On the Sunday following the Bumps, the Milk Marketing Board sponsored a regatta, the Pinta Handicap, the handicap being half-pints of milk to be drunk during the race (I would prefer to walk for Guinness!). The 1st IV earned themselves a 56lb. Cheddar cheese by winning the IV's event. The other crews also did well, the Argonauts (heavily disguised as the Rugby Club) came second in the fancy dress competition, the Noryema crew came third in the fancy dress race, and the loveable Miss Bartholomew was runner-up for the Pinta Girl title. A good time was had by all.

We say Goodbye to Mr. Tubbs as our President, thanking him for all he has done in the past and wishing him the best in his retirement, and we welcome Mr. Hudson as our new President.

It is all very well to have novices willing to be taught to row at the beginning of the year, but with mounting academic pressures on students, especially in their pre-clinical years and because of the time it takes to train oarsmen from scratch, hospital boat clubs will aways have to rely on oarsmen who have had their basic training at school or at an Oxbridge college to hold the clubs together. The failure of St. Bartholomew's Hospital Boat Club in recent years is perhaps due to a lack of experienced oarsmen being admitted into the Medical College. The Club is one of the oldest in the country and unless more experienced oarsmen are admitted or academic pressures are relieved (the latter is somewhat unlikely) it will never again rise to its former heights, indeed, it will die an ignominious death.

Needless to say all is not gloomy as this year's modicum of success has shown. We had a record number of crews on the river for the Bumps and we look forward to a new interest in the Boat Club which is, perhaps, now starting.

SAILING CLUB REPORT

The month of May has seen much sailing in Enterprises. We raced against Wraysbury Lake S.C. in the first round of the RYA Dunhill Championship. Our team of six was captained by Alban Blunt. We were beaten convincingly by a strong team, but Tom Moore with Chris Waite as crew must be commended for their sailing.

The Harvey-Wright Gold Bowl was held at Burnham-on-Crouch on May 19th-20th. We have held it for the past two years and therefore we had to organise the weekend racing. Seven teams were entered from five Hospitals, including two teams from Bart's. Racing started by 11.00 hours on Saturday, eight Enterprises being fully rigged, surely a record! In the first round Bart's I easily beat the Westminster team, Richard Harris-Jones winning well with Chris Waite in second place. Bart's II were beaten by London II, David Patuck sailing into a good second place, which should have been a clear first had he remembered the course! In the repêchage, Bart's II beat Westminster and Charing Cross to qualify for the semi-final, which was sailed on Sunday. Unfortunately, Bart's II were closely beaten by London I, and Bart's I closely beaten by London II, both matches clinched by ½ point. London I went on to beat London II in the final. Mrs. Quillian kindly presented the trophy. We were glad to see both Professor Quillian and his wife on the weekend. Tom Moore, aided by Ian Jack, organised the racing with great success amidst many breakages. I should like to thank everybody from Bart's—a party of 16—for helping to make the weekend run so well.

Sailing at Burnham is now becoming popular again. We have the strongest following of all the Hospitals at Burnham. The two Enterprises are in excellent working order for the summer Percival Pott is still one of the fastest Enterprises in the United Hospitals fleet.

TENNIS CLUB REPORT

Owing to Exams at the end of May and June, the Tour was played at the beginning of the season. Three disastrous Tours to Oxford and Cambridge, in as many years, had persuaded the tennis club to travel further afield to Devon.

Four matches were arranged over the weekend of April 27th-29th, the first being on the Friday against St. Luke's College, Exeter. As it was an evening match, play was restricted to two rounds of doubles and at the close Bart's were in a winning 4—1 lead.

Two matches were arranged for the Saturday. The first, in the morning, was against the Exeter Golf and Country Club. A late start prevented the match being completed but when play stopped Bart's were in a 4—1 lead.

After being entertained to a very enjoyable lunch beside the banks of the River Exe, the team made their way to the University for the afternoon match. Here the 1st VI met what turned out to be a very strong side, and Bart's were defeated 6—3.

The climax of the Tour came on the Sunday when the team travelled to Exmouth for the final match against the Cranford Club. Under perfect conditions, with the sun shining and very little wind, a round of doubles was played in the morning on the hard courts. Owing to the very good weather the players were fortunate to be able to play on the grass courts in the afternoon. However, four hard fixtures in under 48 hours were beginning to take their toll and the 1st VI succumbed to another 6—3 defeat.

Nevertheless, the players agreed that the Tour had been highly successful, both socially and tennis wise. If anybody had any criticism it was that too much tennis had been played!

On Tour were: N. Perry, P. Mortimer, D. Stewart, J. Howell, J. Wellingham, J. Cooper, J. Derudra and A. Colver.

Other Results this season:—

1st VI

League (Inter-Hospital)

Wed. 9th May v. WESTMINSTER HOSPITAL I. Won 6—3.
TEAM: J. Smallwood, D. Stewart, T. Dale, J. Wellingham, J. Cooper, S. Grainger.

Wed. 16th May v. GUY'S HOSPITAL I. Won 9—0.
TEAM: P. Mortimer, J. Smallwood, T. Dale, J. Wellingham, D. Stewart, J. Cooper.

Wed. 23rd May v. MARY'S HOSPITAL I. Won 7—2.
TEAM: N. Perry, P. Mortimer, J. Smallwood, D. Stewart, T. Dale, J. Wellingham.

University of London Cup

2nd Round:

Sat. 19th May v. WESTFIELD COLLEGE I. Won 5—1. (a.m.)
TEAM: N. Perry, J. Smallwood, P. Mortimer, J. Howell, T. Dale, J. Wellingham.

Friendly

Sat. 19th May v. IMPERIAL COLLEGE I. Leading 3—0 (p.m.) (Abandoned—rain).
TEAM: N. Perry, J. Smallwood, T. Dale, J. Wellingham, P. Mortimer, P. Fowler.

2nd VI

League (Inter-Hospital)

Wed. 19th May v. MARY'S HOSPITAL II. Won 6—3.
TEAM: R. Dove, J. Derudra, D. Price, A. Smith, P. Fowler, P. Donaldson.

SAINT BARTHOLOMEW'S HOSPITAL JOURNAL

Founded 1892. Vol. LXXVII No. 8

Editorial

The place of the orthodox religions of this country in everyday life is not what it was. One can imagine the reaction of 100 or even 50 years ago to the Lambton affair, and yet the recent discussion of it has been couched almost solely in political and social terms rather than moral ones. Even that bastion of conservatism, the legal profession, has been talking recently of removing the religious element from oaths taken in court, as having no meaning for the majority even of those who opt to swear on the bible rather than to affirm.

What of Bart's? The man who founded the hospital in a fit of depression 850 years ago is remembered more as a monk than as a court jester, and since then the place has always been—at least in name—religiously orientated. Today the hospital's links with the two churches of St. Bartholomew are more structural than spiritual, and contact with "living religion" resides in the chaplains to the hospital and in a vociferous Christian minority among the working body. Both impinge more upon the daily lives of those around them than their importance justifies. The difference between them is that while one may readily ignore the strident advertising of the Christian Union, the patient has to accept willy-nilly that confidential details of his progress may be obtained by, and that he may receive an uninvited visit from, a representative of a religion the views of which he does not hold and with which he may in fact violently disagree.

A person who is actively religious in health will readily express the desire to remain so in sickness, and one who is not should not be expected to make the point when he is least able to cope with controversy.

This is not to say that there is no place in a hospital for those whose functions are not strictly medical, or that many patients do not gain some comfort from talking to those whose interest is not solely professional. Most students realise that if they do nothing else for their patients then a friendly chat once a day is appreciated. The critical difference lies in the more or less transparent motives of the different visitors.

Should this point, be taken as an oversensitive attempt to make a mountain out of a molehill, then I would suggest that it is not generally realised to what extent apparently trivial details acquire importance in a sick person's life. It is in any case a subject that does not receive adequate attention.

ANNOUNCEMENTS

Appointments

Mr. Nicholas Roles has been appointed Consultant Orthopaedic and Traumatic Surgeon to the Westminster group of hospitals.

Dr. J. V. Collins has been appointed Senior Lecturer in Medicine/Consultant Physician (St. Leonard's Hospital) with a special interest in respiratory disease as from July 1st, 1973.

Dr. D. S. Tunstall Pedoe has been appointed Senior Lecturer in Medicine/Consultant Physician (Hackney Hospital) with a special interest in Cardiology as from July 1st, 1973.

Dr. Peter Sleight has been appointed Field Marshal Alexander professor of Cardiovascular medicine at Oxford University. He graduated M.B., B.Chir. from Bart's in 1953.

Situations Vacant

KENYA—Well-equipped, single-handed General Practice to be taken over in January 1974. Close association with cottage hospital, surgeon, physiotherapist, laboratory and X-Ray facilities. Obstetrics optional. Good income and extra mural facilities. Further details from Dr. J. B. Thompson, P.O. Box 240, Nakuru, Kenya.

Change of Address

Mr. & Mrs. COLIN WILLIAMS have now moved to Arran House, Orams Lane, Brewood, Stafford. Telephone 850022.

Engagements

SHARPE — DARKE — The engagement is announced between Christopher Sharpe and Rosemary Darke, S.R.N.

SADLER — WILLIAMS — The engagement is announced between Dr. Jonathan Sadler and Miss Rosalie Williams.

LETTERS

Editor's Note: The JOURNAL will not publish anonymous letters.

Dear Sir,

My first impression of your photograph of George Robey with his company of artistes (May *Journal*) was that this must be a photo of our own lads portraying that great King of Mirth during one of the Ward Shows.

And yet! And yet! Surely that must be Robey himself in the centre. Though mathematics is not my forte, I have reckoned that, duly made up, Robey could have still looked like that during our 800th Anniversary celebrations in 1923. The expression is Robey to perfection.

Then comes his troupe of artistes! Could this great comedian have appeared on the legitimate stage with that lot?" I doubt it! I expect that Robey's proverbial generosity allowed him to support our 800th Anniversary by entertaining our patients and their relatives supported by a troupe of our own students. Even in those days girls could never have looked like that lot!

No, it's George Robey himself with a supporting cast of students!

Yours sincerely,
ANTONY BRETT,
Steward.

Dear Sir,

Poor old Gerald Bulger! How my heart went out to him after reading his BMSA report (June 1973). There he was in Cardiff at the BMSA meeting evidently expecting to debate the rising cost of beer and the colour of next season's rugby posts, when what do you know, he finds he's thrust into a group of students who actually hold views about petty matters like private practice and the value of the GMC. And what is worse they were medical students too; now there's a turn-up for the trousers!

Of course his real tear-jerker was the discovery that not everybody shared his taste for the free beer. And as for talking about NUHS while he was drinking; what a staggering faux-pas. What more damning evidence does one need of the irresponsibility current among certain medical students.

He ends up, just to keep the tear ducts full to the brim, with the surprising, nay devastating, news that the IFMSA might shortly be considering, possibly daring to question, some of South Africa's little foibles such as, dare I mention it, apartheid.

Yours sorrowfully,
D. A. ISENBERG.

Teaching Committee

Dear Sir,

I would like to follow my June letter by another; this time about the case for a professional in medical education at Bart's.

I would like to make a clear case for some new sap for the old tree.

1. The Teaching Committee, and its Aims

The organisation and approach of the Teaching Committee is the same now as at its inception, and I believe rudimentary. If we wish to sway the authorities we must demonstrate that the body of student opinion supports an idea—one which is therefore widely known and accepted. In trying to apply ideas which are popular we may be missing the really worthwhile innovations which could be made, where an idea a little strange to all is tried and found out for what it is—good, bad or in need of modification to make it useful. So at present scientific invention is precluded from teaching, where an idea (hypothesis) is formulated on past experience, the imagination constructing the new and exciting element. At the moment our movement forward seems so pedestrian.

It is possible to condone our failure to sparkle. The confusion that is caused by the absence of any acceptable way to estimate the value of these brighter ideas is stultifying. A personal opinion is prejudiced, and statistical analysis of questionnaires inhuman. A way of managing teaching projects that might work is on the spot discussion between all involved, staff and students.

2. Unspoken Problems Bind Us

Is it right for Bart's to have a failure rate of about 40 per cent. in one subject or another at Final M.B.? If so, why? Do we believe that to maintain a standard some must fail? Is it possible to make a clinical course where failure at Final M.B. would be exceptional? The present failure rate can be seen to be economically illogical; a student is failed after three years only to be passed a few months later. The absolute failure rate is very small indeed. At the moment there is no way of talking out such a dilemma; we are unpracticed, there is no opportunity, and we don't know enough about what has happened elsewhere. How do they solve this problem in other places? I think we should be able to try out changes without waiting for the prevailing wind to swing opinion.

3. Dissemination of Ideas

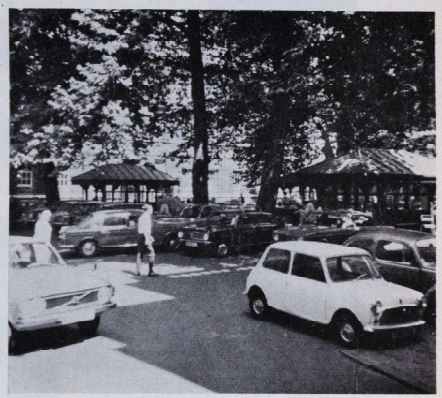
Something when quite new may seem foreign: but when already heard and talked of so that it is understood and appreciated, it may be interesting enough to try out, at any rate on a hint of enthusiasm from others. Because our time is limited and our imagination fettered we could at least peruse the ideas of the medical education professionals. Even if we rejected them, they would be enlivening.

4. What is our Present Teaching doing to the Student?

We may find we wish for the guidance of an expert and need to give him a permanent place at Barts. At present the belief is that if we carry on in the same old way of learning by personal apprenticeship and imitation, all will be well. However one result, I think, is a patchy acquisition of knowledge, another the adoption of concealed tactics in the face of authority (as each person knows he must do on ward rounds) and another the embarrassment caused to patients while laid out for examination before the whole ward round. Tighter organisation of the course, objectives and examinations are only a means to an end—checking that knowledge is acquired. Like the I.Q. test the assessment is limited, particulars only being found out and extrapolated vaguely to convince one that doctorship is attained at M.B., etc. I suspect that over application of these methods will lead to a restriction of individual development and banish freshness of mind. We ought to know what influence our manner of teaching has on a person's response and his turn of mind. How do we know the same old ways are going to be of any use to a doctor at 2000 A.D.?

Yours sincerely,
PRIMROSE WATKINS.

Cars in the Square



Dear Sir,

Many people, I am sure, would agree that the aesthetic value of our hospital square is marred by the presence of an assorted collection of cars. Even without the extra shrubbery provided for the Queen's visit in March, the square void of cars, as seen on many Sundays, always looks exceptionally attractive.

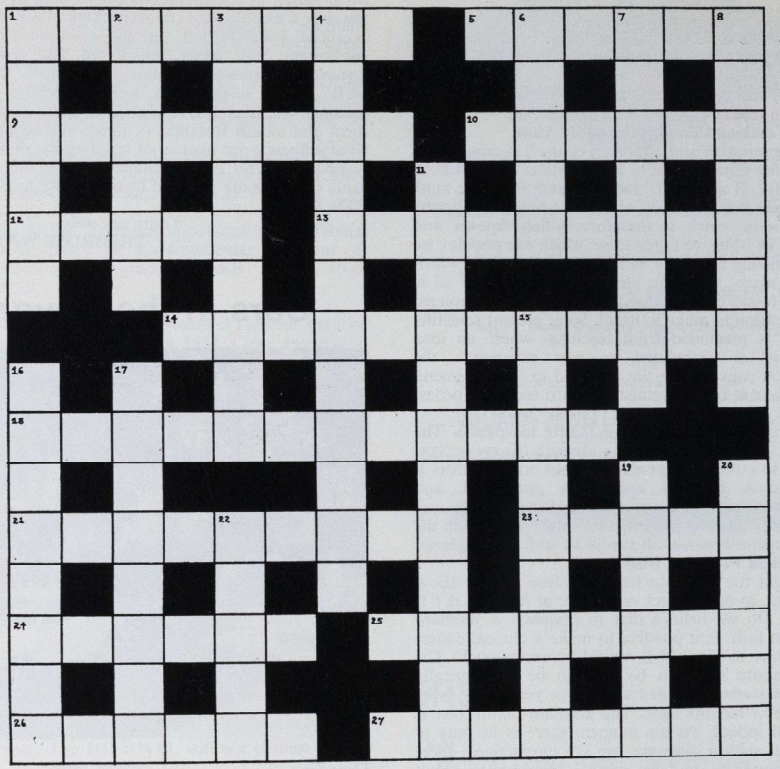
Several of the senior members of staff who regularly park in the square, were selected on a semi-random basis and asked whether they would agree to park in the underground carpark immediately across the road from the Henry VIII gate. One hundred per cent. of the sample agreed that they would, providing that they were guaranteed room, and given financial terms similar to the Junior House Staff.

I would be most interested to know how other *Journal* readers, from patients to porters and parkers, feel about having our square as a no-parking zone.

Anyway, if we do have cars here why not those of the people who live here?

Yours sincerely,
JOHN WELLINGHAM.

JOURNAL CROSSWORD - No. 5 by DOGSBODY



ACROSS

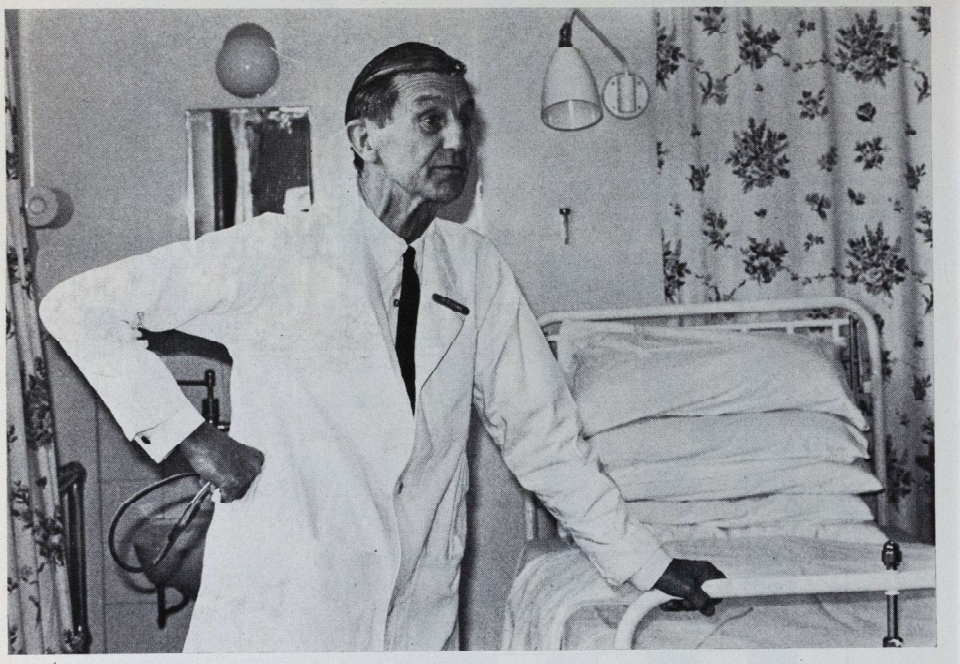
1. Once love to father, your old disease (8)
5. The artist came after (vice versa) to capture the scene (6)
9. Make use of training (8)
10. Forms, she's got a quiet letter in (6)
12. Underground place! (5)
13. Epidemics of spinning wicket-takers (9)
14. Showing rebellion, I go to bed in one dice's shake-up (12)
18. Constellation Road? (5, 7)
21. Nervous partly because seeing bra' in street has me looking round (5, 4)
23. Clothe poor red ship (5)
24. Rules the wavery singer (6)
25. Is cacti a bad complaint (8)
26. Can this French number annul? (6)
27. In the last month ten have gone astray. Improper (8)

DOWN

1. "ye lied" Tarsus (6)
2. Oleic Acid compound (6)
3. Instrument of agreement charge (9)
4. His lists go to pathologists (12)
6. Detest what you see in Arab horses (5)
7. Elucidates panel six (8)
8. Helped as Ted got round his little sister (8)
11. Potty mincers antibiotic (12)
15. Throw light on 50 per cent. of Radicals in a state of anger (9)
16. Is nought but 99 relating to the pressure line (8)
17. A Roman road gets into trouble through air travel (8)
19. Lines return to point of old age (6)
20. Last out about an un-upright line (6)
22. Not of the Church on this occasion (5)

Solution on page 225.

MR. O. S. TUBBS—AN APPRECIATION



O. S. Tubbs came to Bart's in 1929 from Caius College where he had distinguished himself rowing, a sport which attracted him at Shrewsbury and in which he has maintained an active interest ever since—and a tradition he has handed on to his son, Nigel, also a doctor. He also admits to a transient interest in rugger; but confesses that this was prompted by his future wife, Betty, who at that time seemed more in favour of the field rather than the river.

Qualifying in 1932 he held house posts at Bart's both in gynaecology and general surgery. He was early attracted to surgery as a career and for a time thought of plastic surgery; but his house surgeoncy to J. E. H. Roberts on the Green Firm in 1934, when H. P. Nelson was Chief Assistant brought him into contact with early specialist thoracic surgery and determined his future career. He was one of several surgeons in London who were greatly affected by Nelson's untimely death in Bart's in 1938 just before the advent of effective antibacterial chemotherapy.

Os obtained the Fellowship in 1935 and later became Chief Assistant on the Green Firm. In 1937 he was awarded the Dorothy Temple Cross Scholarship which enabled him to spend a year in the Lahey Clinic in Boston where he came under the influence of Ed Churchill. The enthusiasms generated in this period have always remained with Os and started many friendships that he has renewed on subsequent visits to the U.S.A. and on his return he was appointed one of the first surgical registrars at the Brompton Hospital.

In 1943 he was elected a Hunterian Professor of the Royal College of Surgeons and his subject was the ligation of the persistent ductus arteriosus to cure subacute bacterial endarteritis, and it is probable that he was the first person to do the operations with this object, and in the pre-antibiotic era.

With the outbreak of war he was made a Surgeon in the EMS in the Brt Unit at Hill End Hospital, under the charge of J. E. H. Roberts and rather to his disappointment was retained there throughout the period of hostilities and he had to forgo the apparent glamour of service with the Forces.

In this post he carried out a vast amount of work, not only at Hill End, but also at outlying sanatoria and established a firm connexion with Papworth, where he remains a consulting surgeon. In 1946 he was appointed to the Honorary Staff of the Brompton Hospital and shortly after this was made Thoracic Surgeon to Bart's—the first Thoracic Surgeon to an undergraduate teaching hospital.

At Hill End, under his enthusiastic direction the Bart's Thoracic Department flourished, developing a reputation for advanced work done to a meticulously high standard, and the load eventually becoming too great even for Os' Herculanean shoulders, an assistant surgeon and a second houseman were appointed in 1950. At this time direct heart surgery was being introduced, and Os embraced these techniques extending them until with ample experimental work in the laboratory at Charterhouse Square, open heart surgery was started in 1959, a year before the Unit moved back to the Q.E.II block in Bart's. This was a great joy to Os after 22 years of partial isolation in the wilds of Hertfordshire: but this was, after all, his native County and in common with the remainder of the band of specialists who worked so happily at Hill End, frequently looked back on those days with nostalgia.

At Bart's his work in the Thoracic Department attracted an unusually high calibre of houseman (at one time it almost looked as though it was an essential stepping stone for a man to reach the staff) and his painstaking and meticulous assessment of every patient and non-partisan view of the aspects of any problem inspired strong loyalty in all the staff who worked with him. His impartiality and fairness made him a much sought after chairman of committees and it was this that made him so respected as a member of the Board of Governors of St. Bartholomew's and he did yeoman service as Chairman of the Study Leave Committee and of the Medical Council at Bart's and the Medical Committee at the Brompton and Academic Board at the Institute of Diseases of the Chest.

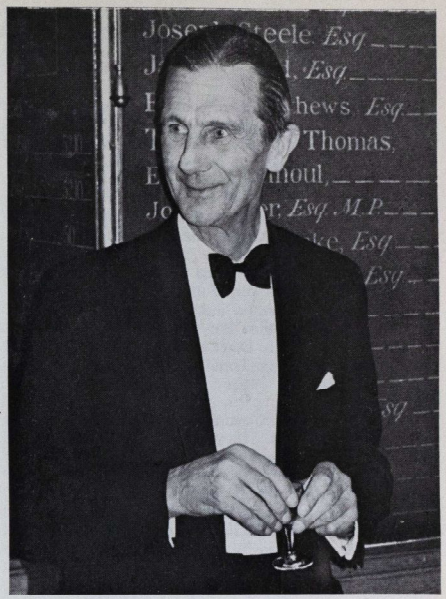
Os was always a staunch supporter of the principle of a consultant holding appointments at both undergraduate teaching and postgraduate specialist hospitals, maintaining that this was a system of mutual help to both and it is sad that with his retirement a long standing surgical link with the Brompton Hospital is broken.

His professional work consumed much of his energy and most of his time; but he still found opportunity to enjoy his meticulously neat garden and his fishing holidays with congenial friends. Only the initiated can appreciate the incursion that Os' chosen speciality of Thoracic Surgery makes on domestic life and he has been fortunate in having as his wife, Betty, who understands Bart's well and has done so much for the Guild and Flower Shop. These activities have no Government determined age bar and she maintains that she has no intention of retiring from Bart's, so we hope that in what seems to many of us a premature retirement we shall not for some time lose sight of Os and Betty Tubbs.

I.M.H.

CROSSWORD SOLUTION

Across		Down	
1.	Exopathy	1.	Eyelid
5.	Camera	2.	Oleate
9.	Exercise	3.	Accordion
10.	Shapes	4.	Histologists
12.	Inter	6.	Abhor
13.	Outbreaks	7.	Explains
14.	Disobedience	8.	Assisted
18.	Seven Sisters	11.	Streptomycin
21.	Brain stem	15.	Irradiate
23.	Dress	16.	Isobaric
24.	Reigns	17.	Aviation
25.	Sciatica	19.	Senile
26.	Cancel	20.	Aslant
27.	Indecent	22.	Nonce



TEACHING COMMITTEE REPORT

A reply to the questionnaires put in the path rooms in January 1973, to find out what first year students think about G.P.'s, the pathology course and pathology tape slides:

General practice
Apart from a theoretical maximum of eight mornings with a G.P. during psychiatry there is no other provision for this in the present course. Although the return was less than 30 per cent. all wanted to spend more time with G.P.s. The new clinical curriculum is to include a month G.P. and another in public health. However, the arrangement at present is that Dr. Melotte (CONTACTED THROUGH the Sub Dean's office) will arrange for those who wish G.P. and small-group discussions.

Pathology
So far the Teaching Committee has not been able to provoke any changes. The audiovisual aids room have ten new programmes on Path subjects chosen from a compendium of programmes for purchase (incidentally there are very few on pathology). Programmes of visual instruction—for instance individual cells labelled on photographs of slides of tissues or blood, bacteria cultures or pots—could easily and quickly be made. I think that programmes could be a way of small-group teaching, which many would like. Programmes for small groups of students may be more palatable than those to be digested individually. I think the newly acquired course of sixteen programmes on radiology is excellent. I have so far worked through four. I find them very interesting and enjoyable. A small group of four or so select each other and return to see the course through. I wonder if four students find this so much fun because there is no leader, we can say anything; raise questions on which we are ridiculously and shamefully ignorant, pounce on muddled thinking and laugh about it. The programmes are made on the principle of giving a piece of information then posing a question—diagnostic problem—which we discuss amongst ourselves for one minute while we have stopped the tape. The pathology department say that any changes we suggest are to be within the present scheme of things. This blocks any idea of more personal instruction. The reason for this is that staff are too busy to give more time to teaching.

The most recent student staff meeting
I outlined in detail the ideas—pros and cons—of four of the topics; which everybody received before the meeting. I hoped our views known to all would start a discussion less inhibited than previously. However, fewer people than I expected came and I was disappointed that no really biting talk took place I'm not sure why.
The outcome of the four proposals was:

(i) A clinical examination will be held at the end of the first year on short and long cases in surgery and medicine presented as in finals; the idea is that students should experience this before finals and their performance constructively discussed with them.
(ii) The Dean will propose we have a room for undergraduate studies to the relevant committees (WITH BEER AS WELL AS COFFEE).
(iii) Prizes are to be deferred to the end of May next year for the benefit of Bart's students. Discussion did not throw much light on why arrangements could not be different to those at present, surely red tape can be cut to make the contest fairer.
(iv) The cardiology month in the last year was found to be a misnomer: understood by teachers to be for cardiac and thoracic surgery particularly, yet by the student as medical cardiology. The disappointment felt by students is to be mitigated as Dr. Hamer is even now increasing teaching on this subject.

Members of the Teaching Committee are Tim Packer, Doug Russell, Peter Richards, Gerard Bulger, Colin Lewis and Primrose Watkins.

UP WOMEN!

This article by a female medical student comes at a time when the subject of female equality—or more accurately inequality—is being discussed more seriously than it has been since the days of the suffragettes. Of it she says: "I wrote to express only one side of a many sided argument, and therefore it is, deliberately, prejudiced and exaggerated in places. I do not wish to offend the majority of male medical students and doctors (which includes my friends) who could never be labelled "male chauvinist pigs". I do however wish to shake up their ideas about a subject which it is easy to dismiss as unimportant."

Dear Juliet Mitchell,
I have been reading your turgidly boring book, "Woman's Estate", and would like to correct you on one very small point. On page 129 of the Penguin edition, you say that women "as doctors . . . specialise in obstetrics and gynaecology". I would like to show that in this statement you make the position of women in medicine appear better than it is (which I am sure you would hate to do).

The first women doctors in the mid-nineteenth century, came to medicine firstly, from a wish to alleviate the condition of poor women and children and secondly, because they realised that they were capable of the medical course. When they qualified (after much trouble, rudeness and opposition), they set up, with private money, hospitals, clinics, and dispensaries for sick women and children. They probably had a varied practice, as they treated all diseases, not only paediatric and gynaecological ones, and their ventures were successful. But these women were regarded by the profession as dabbling in glorified voluntary work. Queen Victoria's attitude is typical of the times. She began to think that training women for medicine was a good idea when it was pointed out that they could all go to India to treat women in purdah, who would not see a male doctor.

Nowadays the position is different. Intelligent girls are brought up to expect a university education and to follow a career. They also expect to marry and have children. To take myself as an example—I came from a medical background, my father and most of my father's friends being doctors, and my childhood friends naturally thought of medicine as a suitable career for both girls and boys. My secondary school was an unusual one, in that it was a charitable boarding school for girls whose fathers had died. This meant that we were all encouraged and expected to have careers, as without the back-up of parental money, we couldn't afford not to. Amongst my contemporaries at school, medicine wasn't considered an unusual career, but perhaps a rather pedestrian one. Others saw it as involving a lot of learning by rote, being "scientific" rather than "artistic" (and therefore less "interesting") and being cut off even from the "interesting" aspects of science—pure maths., theoretical physics, etc. But we who intended to do medicine saw it as I expect our schoolboy equivalents did—a fascinating subject in its own right, not just "science with human interest", a respected profession with a strong element of vocation, we'd never be unemployed, like other graduates. We certainly imagined that we could take full part in any of the wide range of medical specialities and take a place in the spectrum from primarily human involvement to academic research. We never thought that being female would influence our career choice.

I soon discovered this drawback, when I arrived at medical school. Men said "but you'll get married and never complete the course, or drop out when you qualify, so why are you doing medicine?", which was astonishing, because I'd never imagined that marriage would make a difference, or "why didn't you do nursing?" which was odd, because I was obviously over-qualified for nursing, and had never contemplated doing it. The attitude, sexually, was that of a quote in your book (page 126), "Either they got a special cheer for being delightfully feminine, or were suffered because they were not". We were soon sized up as "feminine" and "non-feminine". "Feminine" girls were also classified as "dolly birds" or "good potential wives". All "feminine" girls were soon in demand for shirt-washing, coffee-making, occasional cooking and shoulders-to-lean-on. In addition, "dolly birds" were treated to an obsessive interest in their physical "points", their dress, their possible sexual habits. "Good potential wives" were discussed in soupy, sentimental terms—"she's so understanding, so nice, the best girl in the year, I wish she'd only condescend to go out with me" and soon attracted a devoted protective following of male students whom she treated to occasional cups of coffee and favoured one with herself as girlfriend and sometimes wife. "Non-feminine" girls were in general, laughed-at, resented, tolerated, and sometimes made the grade as "one of the lads".

As the course progressed, we all got to know each other better, and these categorisations, although still present, became submerged beneath friendships. As we all learned more about the actual career structure and conditions in medicine, the friendships led to discussion about specific aspects of medicine in relation to women, and it became clear that male attitudes, and the "system" itself (which has been generated by men) discriminated against women. The prestigious specialities of general medicine, general surgery, obstetrics and gynaecology, paediatrics, etc., all require a long training period in which the hours are long and night duty frequent, so that any off-duty is spent sleeping and working for exams. This system has arisen because of the high competition for jobs in these fields, so doctors are willing to work very hard to ensure success. The system excludes married women with children, because they have more domestic responsibilities than their husbands (within the conventional marriage). So a lot of myths have grown up around women doctors—that they are less able to take decisions, more emotional, less stable—which "justify" their exclusion from the prestigious specialities. If women do opt for these fields they are, if unmarried, masculine freaks who want to compete to compensate their need for a man, or if married, cold and unnatural, denying their femininity and denying their husbands and children the benefits of that femininity.

Faced with these attitudes, women students and doctors become rather sad realists—sad, because youth should be a time for trying all the possibilities and believing in one's capabilities, and also sad, because the "realities" are so unjust. They look for jobs in "safe", uncompetitive specialities, where part-time work is accepted. They do general practice without night calls, they are anaesthetists, they are part-time doctors in specialities with little or no night work, like dermatology, venereology, psychiatry, they work in pathology and public health which have office hours, they run the family planning and infant welfare clinics. Their jobs lack the spurious "glamour" of night calls, emergency operations, life-saving procedures. Because of the nature of their jobs, and their inability to devote their whole selves and time to them (a dubious quality of the "good" doctor, inspiring hero-worship and an aura of saintliness) they very rarely become "great names" and "leading members of the profession". The attitude is therefore that they are inferior doctors, doing mundane and boring jobs because they are incapable of better. They form a sub-class within the medical profession.

It is high time that this educated "liberal" profession eradicated such prejudices from its thinking. With the present shortage of doctors, we cannot afford to waste women graduates. The opinions of young doctors on pay, hours and working conditions show that the image of the "good" doctor as a full-time (read all-the-time) doctor is crumbling. So now is the time for equal opportunity to be given to women, in practice as well as in theory.

KATHERINE M. VENABLES.

BART'S NEWS AND VIEWS

Candid Camera

Who put the glue in the sausage rolls?

WINECO

Some people may have been surprised by the entrepreneurial activities of the Wine Committee displayed in last month's *Journal* by their advertising of 300 bottles of Burgundy. Is this to be the first of a series of such operations? I asked Mr. Bob (Tiny) Jones, secretary of what is now known as the WINECO group what plans they had for the future. "We have, of course, considered going public, to allow all the students to profit from WINECO's activities, but this would necessitate publication of our trading figures and accounts, which we are obviously loath to do. We have moved out of the entertainments field to some extent, because we were required to run parties at a loss. However, we have retained a controlling interest through our subsidiary, the Entertainments Committee. We are hoping to move on into the lucrative property market, perhaps renting College Hall from the medical College and letting it out, at a more realistic rent, to offices, visiting Americans, etc.". he said. On the rather delicate subject of recent allegations of excess profits, etc., he emphasised, "We are very anxious to improve our image which has become a little tarnished. Stories of French holidays and drunken orgies can only harm our relationship with our customers. We must therefore put a stop to them at once (the stories, I mean). Only by eliminating all outsiders, that is non-members of WINECO, can we re-establish our family-firm image."

Readers who enjoyed the poem "Uribaggy" in a recent *Journal* may be interested in the following verses. They appeared in an ephemeral wartime publication at Bart's known as Argent & Sable.

"Grabberwocky"

'twas Danzig, and the Swasti coves
Did Heil, and Hittle, in the Reich.
All hazi were the Linden groves,
And the Neuraths Juliustreich!
And as the Polish oath they swore,
The Grabberwock, which lics aflame,
Came Goering down the corridor
And Goebbled as he came!

ANON.

Bart's student apathy struck another triumphant blow for democracy recently when it foiled an attempt by the Sudents' Union executive to steam-roller the new Constitution into acceptance. Although it is only necessary to call one meeting to pass a new Constitution, and although no provision need be made to allow people who cannot be present at the meeting to object in writing, there, is fortunately, a requirement that a quorum of students be present. On the occasion chosen by the Students' Union, there were at least two other meetings taking place, as well as a Hospital Cup cricket match (which was actually rained off). As a result, only fourteen students turned up. When I spoke to the Chairman of the Students' Union, he was preparing to leave the country, but he did say that the introduction of the new Constitution will now be delayed unil the Autumn. This will give some of us an opportunity to read and perhaps question the proposed changes.

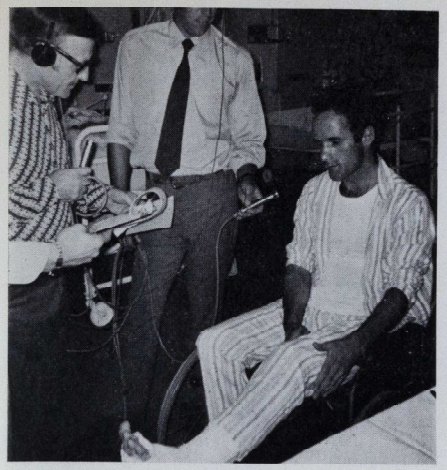
OXFAM'S CALL FOR HELPERS

Active members of the medical professions—doctors, nurses, dentists and hospital workers—are being sought by Oxfam's Central London Branch to join a voluntary group, designed to strengthen support for the agency's aid programme to the developing world.

Oxfam's Central London Organiser, Robin Sharp, hopes it will attract a strong membership. "There must be many people in the medical world who have had experience in the developing countries and who would like to help promote our ongoing work, either in the general development field or specifically on medical welfare projects."

The first Medical Group will be limited to people living or working in Central London and anyone interested in further information should contact Robin Sharp at 12 Crane Court, Fleet St, EC4, Tel: 01-353 5701.

BBC BROADCASTS FROM BARTS



What's your recipe for plaster, Jim?

What's Happening at Bart's today, Jim?

A warm July morning, July 18th to be more precise, and the outside broadcast vans from the Beeb were in the square and every nurse had a clean apron on and a special haircut hoping to be invited to appear in front of the cameras, but alas there were no cameras for it turned out that the show was being broadcast on the radio. In fact a few days before every ward sister was sent a letter asking her to check that all the radios were working so that every patient could, indeed they should, listen to this historic broadcast.

However on walking around the wards during the transmission I am in a position to reveal that 100 per cent. of the patients, and 100 per cent. of the staff were listening in to the JIMMY YOUNG SHOW.

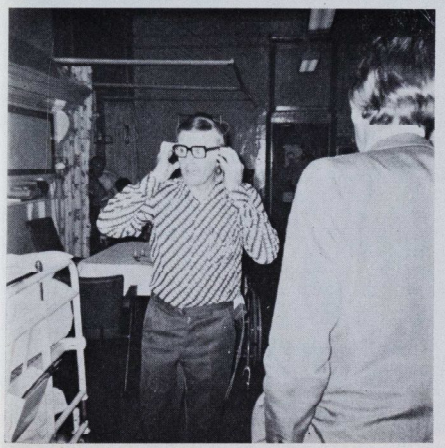
The Broadcast was going out to the nation live from our very own hospital, the reason why Bart's was chosen was that it is the hospital's 850th Anniversary and that "it's always popular to interview ill patients," added a spokesman from the Bee Beeb Cee.

The show began from Gloucester Hall with our hero Jim speaking to hospital staff in between playing records, and then into the wards we Jolly well went. First of all Henry and then the maternity wards.

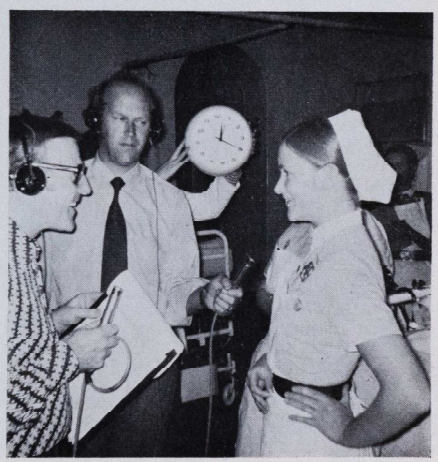
"It's even more popular to get pregnant mums on the air", said the same spokesman.

A good time was had by all, especially the gentleman on Henry who listened to himself on headphones while being interviewed by young Jim, and then as the crew from the Beeb left the ward, he turned round to his fellow patient and said, "Isn't Jimmy Young coming today?

THANK YOU, JIMMY!!



It's my ears, Doc.



Jim "sur la microphonio".

HOGARTH AND THE HOSPITAL STAIRCASE

The address given to the X/X1 Decennial Club by the Chairman, E. ap I. Rosser, M.B., F.R.C.O.G. at the 38th Annual Dinner Meeting 4th May, 1973.

About 1730, extensive rebuilding was due to start at Bart's, the quadrangular structure being the design of the architect James Gibbs. The building was to include the administrative or "ceremonial block", called the first wing, and this was to be more elaborately decorated than the rest of the hospital.

Jacopo Amigoni, a Venetian, was the first foreign artist of note to try his luck in England, arriving in 1729. He was reasonably successful and in ten years completed many commisions, including those in the New Covent Garden Opera House, Hampton Court, Moor Park and many stately homes. He became interested in the proposed new Hospital decorations, and there were some unofficial negotiations between the Governors and himself concerning the staircase.

William Hogarth, having been born almost within a stones throw of the hospital, regarded it as coming within his pad and resented the intrusion of a "foreigner". He himself by virtue of his engravings was fully established as a satirical and social commentator, but was feeling the need of fresh fields and also wanted to avoid "sinking into a portrait manufacturer". He had shown certain special talents from an early age, as evidence by sketches which adorned the margins of his school text books. He possessed a prodigious visual memory, never satisfactorily explained, and an uncanny skill of recording in "shorthand line" momentary action of expression. On one occasion, still an engraving apprentice, taking a country ramble to the little village of Highgate with others and stopping at a pub he witnessed a drunken brawl. One man, his scalp having been split open by a quart tankard, was lying on the floor, his head covered with blood and grimacing hideously. Instantly young Hogarth produced in pencil an exact likeness of the victim, his aggressor and of the principle persons gathered round. This sketch has vanished unfortunately. Hogarth, sometimes called the "five foot painter", was short and had square hands and often used his nails on which to record some expression. It was said that he could sketch Saint George killing the Dragon in three lines.

In 1734 William Hogarth and a Mr. Jolliff were nominated Governors of St. Bartholomew's Hospital by Sir Richard Brocass, President of the Governors and an ex Lord Mayor of London. A Presidential nomination was not contingent on any donation — the usual being £50 or £100 — and the "green staves were sent by ancient custom". By this time the foreign Amigoni has been subjected to some cavalier treatment and Hogarth was having the support of James Gibb, the architect, John Lloyd the Hospital "renter" or rent collector, and others. The upshot was that William Hogarth volunteered to decorate the new staircase as a present; his offer was accepted and an agreement reached.

"Without having done anything of the kind before, I entertained some notion of succeeding in the grand style of history painting, and painted the staircase of St. Bartholomew's Hospital gratis".

This was regarded by some as his donation. The subjects were the Miracle at the Pool of Bethesda and the Parable of the Good Samaritan.

Started in 1735, the work was carried out at the Hospital, but not in situ, in oils on an enormous canvas. Hogarth rightly did not venture into fresco. All the figures are larger than life, being 7 feet tall. Thanks to his inborn flair and to his acute observations at the Hospital, the crippled and diseased subjects are most accurately portrayed although the "heroic personages" appear rather lifeless. One of the female heads was recognised as being Nell Robinson, a celebrated courtesan residing at Chiswick, where Hogarth's country home was. To really appreciate this lady one should look at a sketch for the Pool (now in Manchester City Art Galleries) — she is much too healthy and good looking for the part allocated to her. Incidentally another Chiswick resident was inserted by Hogarth into one of his "groups" — namely John Ranby, a young sarjant-surgeon whose likeness was to be seen in Tom Rakewell, the anti-hero of A Rakes Progress.

Sadly this first mural did not fulfil all the artist's hopes and received criticism as well as praise. No immediate commissions followed either from the Protestant Church, the State or elsewhere. One malicious comment suggested that Hogarth had "one eye on the Church as well as the hospital". His own comment was that "the venture had failed".

The other wall remained unadorned for an interval while Hogarth returned to his engraving work, possibly to replenish his purse. One is of particular interest to us — the "group of heads" carried out in the style of heraldry and called the Consultation of Physicians or the Company of Undertakers. Et plurima mortis imago' — the general image of death.

The possible motivation for this work could be that Hogarth imagined that he had been snubbed by the Royal Family. The chief part of the shield is occupied by three well known quacks of the day, all having had close contact with Royalty. The centre of the shield is occupied by twelve figures portraying physicians, some identified as from Bart's. This offshoot of observation at the Hospital was concerned with physiogomy as well as other interests. The physicians were nuzzling the gold heads of their canes and one, holding a urine bottle, is dipping his finger into the contents prior to tasting the specimen. Far from annoying the profession this particular engraving seems to have made some contribution to Hogarth's popularity with us. The quacks are "Chevalier" Taylor, eye specialist, Crazy Sally Trapp, bone setter, and the most dangerous and successful "Spot" Ward, characterised by an extensive port wine stain on his face. The latter used antimony and arsenic in his practise, and had successfully reduced a dislocated thumb of George II receiving a sharp kick on the shins as an immediate reward. But following this episode he could do nothing wrong, was allowed to drive his carriage through St. James' Park and ultimately was interred in Westminster Abbey, but not within the alter rails as he had wished.

Today a portentious statue of Joshua Ward is to be seen in the Hall of the Royal Society of Arts.

Although Hogarth could never resist a moral judgment he tempered his condemnation of quacks, regarding them as a natural consequence of man's folly. The two disputing quacks in at the death of Mollie Hackabout in A Harlot's Progress were well known. The meagre Jean Misabaun and the fleshy Richard Rock were both "specialists" in the treatment of syphilis—one by pills—one by the bottle. Rock resided in Ludgate Hill living in style with carriage, country house, but had no education, skill or knowledge of science. While sunning himself at hs front door, a real doctor of Physic with learning ability and modesty—possibly a Bart's type—approached and questioned him about the secret of his success. Rock smilingly made the point that of the hundred or so people who had just passed them, probably only one possessed common sense. "That one comes to you, and I take care of the other ninety-nine." As regards the staircase, Hogarth had been inactive for about one year and finally seems to have been invited by the Governors to answer "why he had not gotten on with the painting".

The Miracle at the Pool of Bethesda.

The Good Samaritan was commenced and carried out in situ in order to ensure colour toning with the Pool. But most of the artist's enthusiasm had gone into the Pool and work on the Good Samaritan was relatively perfunctory although the parable problem was introduced. It was July 1739 before the scaffolding before the painting was finally removed. Although immediate appraisal was guarded, at that period "any day on the Town" always included a visit to St. Bartholomew's Hospital staircase.

Hogarth requested that these canvasses never be varnished, apart from an application of his own glair. But after his death, they were repeatedly varnished until the mid-1930's when all varnish was removed. The paintings are now to be seen in their original state, well preserved and showing striking execution.

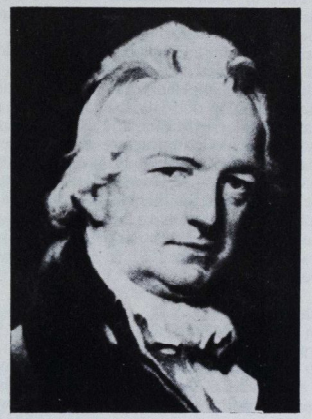
An inscription over one door leading into the Great Hall briefly reads "The Historical paintings of this staircase were painted and given by Mr. William Hogarth and the ornamental painting at his expence. A.D. 1736".

The Good Samaritan (detail)

THE ORIGIN OF WARD NAMES
part 2

COMPILED BY NELLIE J. M. KERLING

Abernethy Ward
John Abernethy was born in London in 1764. After he left school it was decided that he should be trained as a Surgeon. In those days the usual way to receive the necessary training was to be apprenticed to a well-known member of that profession. Abernethy's teacher was Charles Blicke, Assistant Surgeon of St. Bartholomew's Hospital, and when Blicke was appointed Surgeon to the Hospital in 1787, Abernethy was elected by the Governors to fill the vacancy of Assistant Surgeon.



He held this post until 1815, in which year he became Surgeon. He resigned in 1827 and died in 1831. Abernethy was an excellent teacher and will mainly be remembered for his lectures in anatomy. Through his influence the importance of the Medical School of this Hospital was greatly enhanced.

Bowlby Ward
Sir Anthony Alfred Bowlby was appointed Assistant Surgeon to this Hospital in 1891 and in 1903 the Governors appointed him to the post of Surgeon. He lectured to the students on surgery and took a great interest in the Hospital. During the first World War he was on active service in France. He was released in June 1919 and being near his retiring age he offered his resignation. He was appointed an Honorary Consultant and in December 1919 he was elected a Governor. He took an active part in the Hospital's administration and served on a number of sub-committees. He died on April 7th, 1929. His portrait by Sir William Llewellyn stands in the Great Hall showing him in uniform.

Henry Butlin Ward
Sir Henry Trentham Butlin was appointed Assistant Surgeon in 1880 and Surgeon in 1892. He resigned in 1902 and died in 1912. He was interested in diseases of the throat and tongue. As a Surgeon he was put in charge of what was then called the Throat Department. He carried out several operations on the larynx. His portrait by John Collier stands in the Great Hall.

Colston Ward
Towards the end of his reign Charles II (1660-1685), having no legitimate children, realised that his brother James would have to be his successor. To avoid any opposition in favour of the protestant William, Prince of Orange, James' son-in-law, Charles tried to put his own supporters in prominent places. Even the Governors of St. Bartholomew's Hospital and of St. Thomas' were scrutinised. Contrary to St. Thomas' the Governors of Bart's were great Royalists. No one was dismissed but in November 1683 a number of trustworthy people were added to the Board, among others Edward Colston, a mercer and the son of a Bristol Alderman. Colston, himself a wealthy business man, soon became interested in the Hospital and in 1684 he gave £500 to be used for buying houses or land to increase the revenue to the benefit of the poor patients. No suitable property was for sale at that time and the money was temporarily invested. In 1693 Colston gave £850 and in the same year the manor and advowson of Mayland in Essex were purchased for £1,350. In his Will—he died in 1721—he left £100 for the improvement of the Vicarage of Mayland and £500 to the Hospital for the buying of land or houses. In 1732 the Governors purchased a house in Giltspur Street, now demolished and replaced by the Medical College Library and the Museum. In 1920 Mayland Hall with the farm lands were sold to obtain ready money for the building of what would become the George V Block. In 1964 the Governors surrendered the advowson to the Bishop of Chelmsford. Colston's portrait hangs in the Clerk's room. It is dated 1693 and was painted by a pupil of Sir Godfrey Kneller.

Dalziel Ward
In 1932 Lady Dalziel of Wooler gave a donation of £1,000 towards the building of the later George V Block. In 1935 she added £100 and £2,439.02½ invested in 2½ per cent. consolidated stock on condition that the Governors would make themselves responsible for the upkeep of the Dalziel of Wooler mausoleum in Highgate. A Ward was named after her and until the present day the Hospital looks after the mausoleum in Highgate.

Elizabeth Ward
In 1681 Sir James Edwards, Alderman of the City of London, was elected President of this Hospital. Almost his first action was to promise sufficient money for the building of a new Ward. This generous offer was gladly accepted for in those days the Hospital Funds were

rather low. Much valuable property in the City had been lost in the Great Fire of London in 1666 and consequently the Hospital's income suffered heavily and new building schemes had to be postponed indefinitely. Now with Sir James' support at least one new Ward could be constructed. When it was finished in 1683 the Governors decided to call it "Elizabeth", presumably after the mother of John the Baptist. This name was maintained for one of the Wards in James Gibbs' new building in the 18th century. Since 1910 this Ward is for gynaecological cases only.

Fleet Street Ward
Fleet Street journalists were always greatly interested in Bart's. In 1921 they collected £7,021 8s. 1d. and in February 1924 they sent a cheque for £9,468 4s. 1d. In the Autumn of 1926 they organised a "Fleet Street Week for Bart's". They called this Hospital "the Mother Hospital of the Empire" and told the public that it needed £100 a day over and above its income from endowments. In order to collect money the journalists organised a number of fund-raising activities: an auction sale of household goods, jewellery, wines, books, etc., collected from shops and private people, a bazaar, a concert at the Kingsway Hall and Fleet Street rambles to visit with a guide "unknown London". A programme describing all these events was sold, the proceeds of which were paid into the Hospital's funds. In June 1927 the organisers handed to the Governors £3,100 for the General Hospital Funds and £25,000 for the Reconstruction Fund on condition that one of the Wards in the new Block (the George V Block) would be called Fleet Street.

Harley
The Rt. Hon. Thomas Harley, Alderman, M.P. (1730-1804) was a son of the Earl of Oxford. For many years he represented the City of London in Parliament and in 1767 he was Lord Mayor of the City. He was greatly interested in Hospitals and specially in St. Bartholomew's. In 1770 the Governors asked him to be their President, a function which he held until his death in 1804.

Harmsworth
When the Governors were planning the building of the George V Block after the first World War, they agreed that a gift of £10,000 would give the donor the right to name a Ward in the new building. In 1927 this sum was given to the Hospital by Lord Rothermere (Esmond Cecil Harmsworth), a well-known newspaper proprietor, who asked to have a Ward named in memory of his mother Geraldine Mary Harmsworth.

Heath Harrison Ward
This Ward, opened in 1930, carries the name of Sir Heath Harrison, Baronet, of Le Court, Greatham, Hampshire. He was born in 1857 and became a Justice of the Peace and County Councillor. In 1916 he was High Sheriff of his county. He must have given a generous donation to the Hospital for only a gift of at least £10,000 gave the donor the right to name one of the new Wards planned in the George V Block. Yet his name is never mentioned among the gifts to the Hospital between the years 1916 and 1930. It is possible that he gave the money anonymously but even then it is strange that his name does not appear in the Minutes of the Governors' meetings nor in the Clerk's correspondence.

Henry Ward
In 1536 Parliament passed an Act ordering the dissolution of all Monasteries and Priories in England. Consequently the Priory of St. Bartholomew in Smithfield was closed down in 1539. The Hospital's gates, however, remained open as by that time the Hospital was no longer a monastic institution. Yet its existence was very precarious and in order to avoid the loss of this useful organisation, the City of London sent a petition to the King asking him to grant the Hospital with its endowments to the Mayor; Aldermen and Commonalty of the City. For some years diplomatic manoeuvring went on behind the scenes but at last King Henry agreed and on December 27th, 1546, he signed Letters Patent granting to the City the Hospital formerly called the Hospital of St. Bartholomew and now to be known as "The House of the Poor in West Smithfield near London of the Foundation of King Henry VIII". On January 13th, 1547, he signed an agreement confirming to the City authorities most of the Hospital's medieval endowments. Though the Hospital was never considered to be a "Foundation" of King Henry VIII, one generally speaks of the re-foundation of 1546. It abolished the medieval organisation under a Master and Brethren and paved the way for the modern structure much as we know it today. In memory of this important development one of the Wards is called after Henry VIII. His statue stands over the main gate in Smithfield which was built in 1702 and in the Great Hall we have the King's portrait, a copy by an unknown painter, of a larger painting by Holbein which was destroyed in 1698 in a fire in the former palace of Whitehall.

Hogarth Ward
William Hogarth (1697-1764) was well known by James Gibbs who rebuilt this Hospital in the 18th century. Though in 1732 Hogarth was still comparatively little known as an artist, Gibbs introduced him to the Governors and they decided to allow him to paint two murals on the walls of the grand staircase newly built by James Gibbs. Hogarth did not charge anything for this work and by way of appreciation the Governors elected him a member of the Board. The paintings—well known to every member of the staff—were finished in 1737 and Hogarth was officially thanked "for his generous and free gift of the painting of the great staircase, performed by his own skilful hand in characters—taken from Sacred History—which illustrate the charity extended to the poor, sick and lame of this Hospital". The next year Gibbs and Hogarth were asked to frame the large picture of Henry VIII, now in the Great Hall over the fireplace opposite the entrance, and to fix it "with decent and respectful ornaments". Hogarth was never an active Governor but his paintings are a great asset to the Hospital. Fortunately they suffered no damage during the bombing of the last war. They were cleaned in 1960 shortly before the visit of the Queen in May 1961.

James Gibbs Ward
In the beginning of the 18th century it became apparent to the Governors that the Hospital accommodation was insufficient to meet the needs of the growing population in the surrounding area. In 1723 James Gibbs, already a well-known designer of new buildings, was elected a Governor and put on a Planning Committee. In the next few years he designed a square consisting of a North Wing to be used for administrative purposes, and an East, a West and a South Wing for patients, each block containing 12 Wards with 14 beds, making a total of 504 beds. The new building was finished in 1769. Though Gibbs built a Hospital which was very modern in his time, 18th century conditions can no longer be accepted in the 20th century. In 1937 the George V Block with 250 medical beds replaced Gibbs' South Wing and internal alterations have improved the East and West Wing. The Great Hall and the staircase in the North Wing show the original design. They are now scheduled as a National Monument and must not be demolished. The former Clerk's House, which belongs to the North Wing but received extensive damage in the second World War, has been rebuilt as much as possible in the 18th century style and now that it is no longer exclusively used by the Clerk and his family, it seems right that it should be known as the James Gibbs House.

Kenton
Benjamin Kenton, born in the first half of the 18th century, began his working life by being a waiter at the Crown and Magpie Tavern, a pub which may have been in the vicinity of the Hospital. After some time he managed to buy the business and eventually he became a very rich man. Most of his fortune he seems to have earned by his invention how to bottle beer for tropical countries. With the growing interest of the English in India he soon handled a very lucrative trade in this drink. After having given £50 to the Hospital in 1770 he was elected a Governor in June of that year. At his death in 1800 he left £5,000 to Bart's in his Will.

Lawrence Ward
Sir William Lawrence (1783-1867) was the son of a Surgeon who practised at Cirencester. In 1799 at the age of 16 he became a pupil of John Abernethy at that time Assistant Surgeon at this Hospital. Abernethy was an extremely efficient teacher and the young Lawrence soon became one of his most successful pupils. In 1813 he was appointed to the post of Assistant Surgeon and in 1824 he became a Surgeon. In 1829 he succeeded his teacher as a lecturer on surgery. He resigned from the Hospital in 1865 and two years later, only a few months before his death, he was created a baronet. His son was afterwards Treasurer of Bart's from 1892 to 1905 and he and his sisters founded a scholarship, worth about £200 in their father's memory, for those interested in research in pathology.

Luke Ward
In the 19th century when almost everyone was a regular churchgoer and was familiar with the Bible, it was usual to find Wards being called after Biblical figures. In the West Wing built by James Gibbs four of the Wards were called after the four Evangelists: John, Luke, Mark and Matthew. It is perhaps typical of the 20th century that these four names were all discontinued when this Wing was re-arranged. The name of Luke was again used for a medical Ward after the first World War and when the George V Block was opened one of the new medical Wards was given the name of Luke, the physician and evangelist.

Lucas Ward
Matthew Prime Lucas, Alderman, was elected President of the Hospital in 1831. He served the Hospital until his death in 1848. His full-length portrait, painted by Sir David Wilkie in 1838, is at present on permanent loan to the Museum of Guildhall, London. A Ward was named after him but when the George V Block was opened, the name disappeared to make place for Rees Mogg. In 1954 it was given to a new Children's Ward in the Lucas Block, built by the Hospital's Surveyor, Hardwick, in 1842.

Martha, Mary Ward
As far back as the 17th century it was thought appropriate to use for the Wards the names of the two sisters who received Jesus in their home, Martha the active housewife—perhaps to be compared with a Ward Sister concentrating on her patients' welfare—and Mary who listened to the words of the Master, symbolising the importance of obtaining spiritual guidance. Rather strangely the name Mary was first used for a new Ward arranged in 1648 for the often rough and undisciplined soldiers wounded in the Civil War. Martha Ward was opened some years later in 1664 for wounded sailors and soldiers during the second Anglo-Dutch naval war. In the new building of James Gibbs' Mary Ward was arranged for women. Martha was again used in the 19th century for a Ward in the South Wing, also for women this time. When this was demolished after the first World War, the name was not used for the new Wards in the George V Block but for a gynaecological one in the East Wing.

Paget Ward
Sir James Paget was born in Great Yarmouth on January 11th, 1814. He was much interested in botany and in 1834 he published together with one of his brothers: *The natural history of Yarmouth and its neighbourhood*. In the same year he came to Bart's as a medical student and it is interesting to note that in 1852 he presented the Hospital with about 1,000 specimens of dried plants collected during his school days. One wonders what happened to this collection which now may be of great value to botanists. In 1836 Paget became curator of the Hospital's museum in which he showed a life long interest, writing its first detailed catalogue. In 1843 he became the first Warden of the new Hospital hostel for medical students. By that time he had already a great name as a lecturer in Anatomy and Surgical Pathology. He published many articles on his discoveries and played an important part as a teacher and Surgeon. In 1847 he was elected Assistant Surgeon and in 1861 appointed Surgeon. He was a great friend of Florence Nightingale who gave him a silver inkstand which is still in the Hospital's possession. Perhaps because he saw the good points of Miss Nightingale he had no objection to grant permission to another woman, Miss Elizabeth Blackwell, an American medical student, to follow his lectures and attend his demonstrations, quite a sensational decision in those days.

In 1858 he was appointed Surgeon Extraordinary to Queen Victoria and in 1877 he became Sergeant Surgeon. He received a baronetcy in 1871, the year he resigned from Bart's. He died in 1899. A very good portrait of Sir James, painted by Sir John Millais, is in the Great Hall.

A CASE OF REYE'S SYNDROME

By J. M. G. FOSTER and D. B. ROWLANDS

Summary
A six-months-old white male developed the clinical and biochemical features of Reye's syndrome, following a typical chickenpox infection. This case was complicated as, the patient had, prior to admission, received high doses of various medications, notably salicylates, in an attempt to alleviate his symptoms.

Introduction
In 1963, Reye et al. in Australia, characterised twenty-one cases of acute encephalopathy with fatty degeneration of the viscera, as a distinct clinico-pathological entity, of unknown aetiology, in childhood.

Case Report
History
A six-months-old white male was admitted to the Tucson Medical Centre. The history of the admitting complaint started three days prior to admission and comprised of a fever of 103°F, vomiting of all his feeds, a cough and rhinorhoea. The patient had contracted chickenpox two weeks prior to admission, which was resolving satisfactorily.

During the three days prior to admission, the patient had been given a variety of medications by his mother in an attempt to alleviate his symptoms. These medications included analgesics and anti-pyretics (Aspirin and Tylenol), anti-emetics (Tigan and Phenergan) and a cough medicine which contained a Codeine preparation.

At admission the patient had not kept down any solids or liquids for two days and the last urine output was on the day before admission.

The patient was the first born of twins who otherwise had had an uneventful first six months of life.

Physical Examination
On examination the patient had a temperature of 100.4°F, a pulse of 126 per min. and laboured respirations of 46 per min. The eye examinations revealed the pupils to be equal and sluggishly reactive to light. The fundi were normal. The right tympanic membrane and throat were both slightly inflamed.

There was an holosystolic murmur at the left lower sternal border, with radiation into the left upper sternal border and into the back.

No abnormalities were found on initial examination of the abdomen.

On neurological examination, the patient was found to be obtunded, in coma, and unresponsive to pain or verbal stimuli.

The skin revealed healing chickenpox lesions on the extremities and the patient was estimated to be 10 per cent. dehydrated.

No other abnormalities were noted on physical examination.

Laboratory Findings
Blood Analysis: Haemoglobin 11.7 gm./100 ml., Haematocrit 35%, White Cells 29,300 per mm.^{3} (60% neutrophils, 1% eosinophils, 34% lymphocytes, 3% monocytes). Platelets 272,000 per mm.^{3}. Electrolytes: all within normal limits. Blood sugar 10 mg. per 100 ml. Blood Urea Nitrogen 24 mg./100 ml., Blood Ammonia 250 μg./100 ml. (Normal less than 80 μg./100 ml.). S.G.O.T. 1036 I.U.

Lumbar Puncture: 2 white cells (100% lymphocytes) Protein 11, Glucose 9 mg./100 ml. culture was negative.

Urine Analysis: pH 5.5, S.G. 1.023, 0-3 red blood cells per high power field, 20-25 white blood cells, 0-2 hyaline casts.

Hospital Management
During the patient's stay in hospital the following problems were encountered:

Hypoglycaemia: This was treated with intravenous dextrose solution and small doses of Insulin. However, it was very difficult to maintain the patient's blood sugar at a steady level.

Liver Failure: The liver gradually enlarged in size to 2 cm. below the right costal margin. Neomycin was administered by mouth to reduce the number of ammonia-forming bacteria in the gut. The blood ammonia and transaminases returned within normal limits. On one occasion there was an episode of gastro-intestinal bleeding, which resolved after an I.M. injection of Vitamin K.

Metabolic Seizures: The seizures were of the grand mal type and later developed into status epilepticus. The seizures were gradually controlled by the use of high doses of Dilantin, Phenobarbitone and Paraldehyde.

Metabolic Acidosis: This was initially present and managed with bicarbonate therapy. The condition improved as the hepatic function improved.

Encephalopathy and Severe Neurological Deficit: The patient had evidence of a diffuse encephalopathy, which was treated with high doses of Decadron. At discharge, the child was alert, out of coma and responsive to painful stimuli. However, there was hypertonus of all the extremities, increased deep tendon reflexes and a bilateral Babinski response. There was no clinical evidence that the child could see or hear and examination revealed the patient to have developed optic atrophy. The E.E.G. record was consistent with that of a diffuse encephalopathy.

Discussion
Possible Aetiology
The relationship of Reye's syndrome to a variety of viral illnesses has been well documented, but the exact cause of the hepatic and cerebral dysfunction remains obscure. At the moment, it would be reasonable to classify Reye's syndrome as another post-viral illness. A toxin released during the viral infection or an abnormal immune response may both have to be considered as possible causes of Reye's syndrome. The aetiology of the cerebral disturbances described in Reye's syndrome may be due to the high levels of blood ammonia found in all cases; i.e. a metabolic encephalopathy secondary to hepatic failure. Indeed, blood ammonia levels far lower than those encountered in Reye's syndrome can cause coma. Another cause of the cerebral disturbances may be the hypoglycaemia which is present in most cases. Some workers have even suggested that the initial step in the pathogenesis of this disease involves complete depletion of glucose and glycogen stores by some unknown initial infection.

Epidemiological studies have provided further speculation as to the possible aetiology of Reye's syndrome. In the U.S.A. and Puerto Rico a close association was found between an outbreak of influenza B virus infection and an increase in the incidence of Reye's syndrome. In Thailand, a geographic and seasonal relationship was described between encephalopathy and fatty degeneration of the viscera and the distribution of Aflatoxin, a toxin produced by the fungus, *Aspergillus flavus*. Salicylate intoxication has also been described as a possible cause of Reye's syndrome. Although epidemiological data would appear to dispute this, many patients with Reye's syndrome have also received salicylates for their fever.

The exact cause of the disease in the above case report is unknown. However, it is worthy of note that the patient had a preceding chickenpox infection and had received a very high dose of salicylates.

Clinical Picture
The clinical picture of Reye's syndrome is by now fairly well defined. In many reported cases there has been a history of a preceding viral illness, accompanied by fever, coryza, or cough. Typically, the child appears to be recovering when protracted vomiting occurs. Vomiting is so consistent a finding that the diagnosis of Reye's syndrome is unlikely in its absence. Within 2-3 days of the onset of vomiting, symptoms and signs of C.N.S. dysfunction usually appear. At first there is evidence of excessive C.N.S. stimulation with hyperactivity, seizures, increased tendon reflexes and often marked hyperpnoea. In the more severe cases, the initial stage of excitement is followed by a marked depression of cerebral and brain-stem functions with absence of extra-ocular movements, decerebrate posturing on painful stimuli and decreased respirations.

The clinical evidence of liver disease is minimal and overshadowed by the cerebral symptoms. Jaundice is rarely clinically evident, and the liver is mildly to moderately enlarged in a majority of cases. A bleeding tendency has been noted in some cases and G.I. haemorrhage has complicated the course of some patients.

The above case report demonstrates a reasonably typical clinical picture of Reye's syndrome. The child had a prodromal chickenpox infection with fever, coryza and cough. Vomiting occurred three days prior to admission and, on admission, the patient was lethargic, unresponsive to pain, had depressed tendon reflexes responses and a decreased respiratory rate, i.e. demonstrated evidence of depression of cerebral and brain-stem functions. There was also little clinical evidence of hepatic disease; the liver was moderately palpable and the child was not icteric; however, there was one episode of G.I. bleeding.

Therapy
The major problem in administering successful therapy to cases of Reye's syndrome is the lapse in time before the diagnosis is made. The therapy is related to correcting the imbalance caused by hepatic dysfunction, this leading to many of the neurological symptoms. The most recent approach to the problem has been peritoneal dialysis, which might result in a removal of the toxin, or toxins, responsible for the hepatic dysfunction. At present, however, therapy is directed at limiting cerebral damage.

Neomycin: this limits the activity of ammonia-producing bacteria in the G.I. tract and thus causes the blood to be presented with a lower level of ammonia.

Insulin and Glucose Therapy: given together, these combine to inhibit the degree of lipolysis occurring in the body. Excessive lipolysis and mobilisation of fat from adipose tissue induced by vomiting, fasting and hypoglycaemia occur in Reye's syndrome. Consequent metabolism of the fatty acids presents the cells of the body with large amounts of triglycerides to be oxidised. In addition to being metabolites, fatty acids are potential endogenous toxins, capable of uncoupling oxidative phosphorylation and inhibiting glycolysis—thus being capable of causing degeneration and malfunction of cells, particularly those of nervous tissue, which are less capable of handling fatty acids than other tissues.

With this in mind, it should be remembered that salicylates, which tend to increase mobilisation of lipids by aggravating the hypoglycaemia and increasing the diffusion of fatty acids into body tissues by binding to albumin, will have a deleterious effect on the tissues in such conditions.

Glucocorticoids and I.V. Mannitol: are given to relieve the cerebral oedema. Glucocorticoids may also increase lipolysis, but this effect is far outweighed by the beneficial effect of combating cerebral oedema.

Exchange Transfusion: with fresh, heparinised blood is carried out when the blood ammonia levels are above 300 μg./100 ml. At this level of ammonia intoxication, the clinical picture is the guide-line for transfuson, the exchange beng carried out before decerebrate posturing occurs. The exchange transfusion is repeated every twelve hours until there is evidence of improvement in the state of consciousness.

The widely used general forms of treatment have been briefly described, but it now seems that peritoneal dialysis will provide a more complete treatment, with less need for supplementation with other drugs to combat the patient's problems.

Conclusion
The case described demonstrates the main criteria of Reye's syndrome. Unfortunately, in this particular case, there was a lapse in time before adequate treatment was commenced and this may have predisposed to the gross neurological deficits seen in this patient at the time of discharge from hospital.

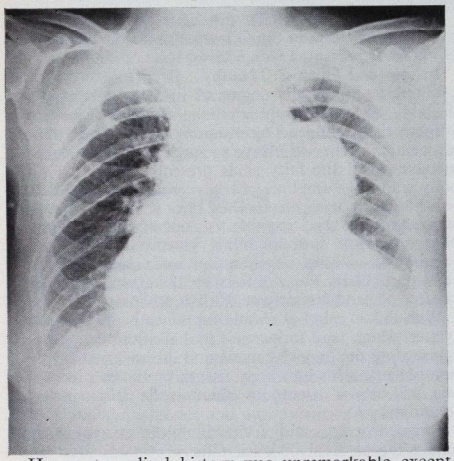
We should like to express our thanks to the staff of the Paediatrics Dept., Tucson Medical Centre, for their help in preparing this article.

PULMONARY ARTERY ANEURYSM-Case report

N. J. C. SNELL, M.B., B.S., M.R.C.S., L.R.C.P.,

Case Report

The patient, a 67-year-old housewife, was referred to our Out-Patient Department by her own doctor, with severe oedema of the lower body extending to the subcutaneous tissues of the left breast and lower abdomen. She also gave a history of exertional dyspnoea and ankle swelling of 3 years' duration. A chest X-ray (fig. 1) showed a large rounded opacity overlying the aortic shadow and, in view of this and her physical findings, she was admitted to hospital for further investigation.



Her past medical history was unremarkable except for a mild attack of diphtheria at age 7. She had been told 32 years previously that she had a "bad heart" but had been asymptomatic until recently, and had successfully given birth to 3 healthy children. She had been on Digoxin 0.25 mg. daily; from her own doctor, for 10 months prior to attendance. She was a life-long non-smoker.

Examination on admission revealed a cheerful, well-built old lady. She was not obviously anaemic, and had no finger or toe clubbing. She was centrally cyanotic. The J.V.P. was elevated 3 c.m. The pulse was chaotically irregular with coupling. A harsh ejection systolic murmur was present, maximal over the left sternal edge; there was no thrill. The B.P. was 130/90. The fundi were normal. The femoral pulses were present and not delayed. There were basal crepitations and scattered rhonchi present in the lungs. There was no palpable hepatosplenomegaly. Gross pitting oedema of the lower limbs was present. She was dyspnoeic on minimal exertion, but had no cough.

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Present Address—N. MIDDX. HOSPITAL, N.18

The chest X-ray showed an enlarged heart with congestive changes in the lungs and a small effusion at the left base. A large, smooth opacity was again noted in the P.A. film. E.C.G. confirmed the presence of atrial fibrillation at an average rate of 80 beats per minute, with multiple multifocal ventricular ectopic beats. Hb. was 12.7 G.%, E.S.R. 13 m.m./hr., W.B.C. 4000 per c.m.m. Serum electrolytes and proteins were within the normal range.

The congestive failure and consequent oedema were thought to be due primarily to Digoxin intoxication, and this medication was withdrawn and potassium supplements given, with a mild diuretic. This resulted in rapid improvement in her clinical condition, with a loss of 9 lb. in weight, accompanied by disappearance of her subcutaneous oedema.

At this stage screening and tomography of the opacity in the chest were undertaken. The diaphragms moved normally. Pulsation was not a prominent feature of the mass. Lateral tomography showed the mass to be almost certainly an aneurysm of the main pulmonary artery.

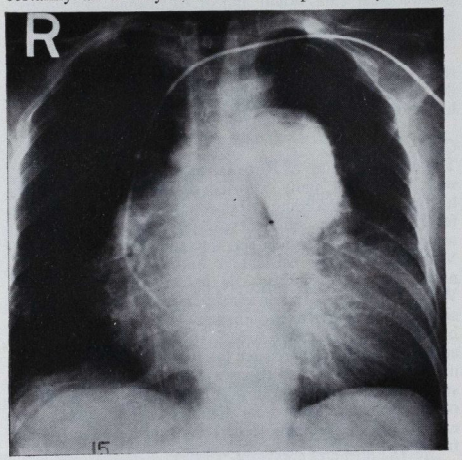

Fig. 2. Pulmonary angiography (see text).

This finding was confirmed by pulmonary angiography, which showed a grossly enlarged, tortuous, primarily fusiform aneurysm of the pulmonary conus and left main pulmonary artery (fig. 2). The right pulmonary artery was normal in size. There was almost complete absence of contrast filled vessels in the upper zone of the left lung. No intra-cardiac shunt was demonstrated.

In view of the fact that she was now feeling very well in herself, it was decided that no further action in respect of her aneurysm was justified, and she was discharged to her home. When seen again in the Out-Patient Department, she had maintained her improvement and was stabilised on a mild diuretic with potassium supplement. A W.R., V.D.R.L. and Reiter complement fixation test done at this attendance were all negative.

Comment

Aneurysm of the pulmonary artery is a rare condition, presumably because of the low intra-luminal pressures normally developed in this system. It is found in less than 0.01 per cent. of all post mortems, comprising less than 0.5 per cent. of all aneurysms.[5] In the most comprehensive review of the literature,[2] 8 cases only were reported in a series of 109,571 routine autopsies. The sex incidence, in contrast to aortic aneurysms, appears to be equal.[1 2] The main trunk is affected in 85 per cent. of cases;[3] where the main branches are predominantly involved the left P.A. is much more commonly affected than the right main branch. Deterling and Clagett[2] in their series, found that fusiform aneurysms were twice as common as those of saccular type; though Boyd and McGovack stated that both types occur in roughly equal proportions.[1]

Aetiology

Pulmonary artery aneurysm is commonly associated with congenital cardiovascular disorders, notably patent ductus arteriosus, which may be present in up to 20 per cent of cases.[2 6] Several of these cases have been fully reported in the literature.[6 7] Less commonly they are associated with atrial septal defect, usually of the ostium secundum type,[7] ventricular septal defect,[6] and Marfan's syndrome.[8 9] Post-stenotic dilatation of the pulmonary artery is common in pulmonary stenosis and may attain aneurysmal proportions.[17] Paul Wood[5] considered that 40 per cent. of all cases were due to congenital anomalies of the pulmonary artery or associated cardiovascular abnormalities. Thirty per cent. of all cases were seropositive for syphilis.[5 1] The remaining 30 per cent. are said to follow chronic pulmonary hypertension due to various causes.[10 11] Rare reported causes are ligation of a patent ductus arteriosus,[12] and recurrent septic thrombophlebitis (Hughes-Stovin syndrome).[13 14]

Clinical features

The condition may, as in this case, present late in life, but 30 per cent. of cases are 30 years of age or under at diagnosis.[2] Exertional dyspnoea is the commonest symptom, frequently associated with a cough and sometimes haemoptysis. A vague feeling of suffocation is common. In about one-third of cases precordial pain is complained of. Central cyanosis is very common, but is usually a late development in the absence of associated congenital syanotic heart lesions. Oedema is always a late symptom.[1] The most constantly detected sign is a harsh systolic murmur at the left sternal edge. A diastolic murmur due to dilatation of the pulmonary valve ring has been noted.[4] Right ventricular hypertrophy with accompanying signs and E.C.G. appearances is common.

Prognosis

Early reports[2] of this condition stated that rupture of the aneurysm was common; there are 2 cases in the recent literature[6 7] where death was due to this cause.

Rupture may occur into the lung with fatal haemoptysis, or into the pericardium causing tamponade and sudden death. More recent reports have cast doubt on the frequency with which rupture occurs; Shull et al.[7] reviewed 68 cases confirmed at autopsy, in which death was due to rupture of the aneurysm in only 13. Evans[16] states that rupture is a rare complication unless infective endocarditis occurs. The management of these cases is usually symptomatic, but there is a reported case from Prague[19] of resection of the aneurysm in a 15-year-old boy, who survived and has done well.

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My thanks are due to Mr. D. Farley, Consultant Surgeon, for permission to publish his case, and to Dr. Lawton, Consultant Radiologist, who performed the radiographic investigation.

TESTS OF EIGHTH NERVE FUNCTION

By THOMAS C. KENEFICK, F.R.C.S.

In the following paper I intend to briefly set down in a simple and readable fashion the commonly used tests, their indications and interpretations.

I will begin with tuning fork tests.

Webers Test

Use a tuning fork of 512 cycles per second. Place it on the forehead and ask the patient in which ear it appears loudest. It is indicated in unilateral deafness and unequal deafness in both ears. In conductive deafness it is referred to the deafer ear. One can remember this by thinking of the mechanism of conductive deafness. The conducting mechanism, outer or middle ear mechanism, is not functioning fully; therefore, there is less extraneous noise reaching the inner ear on this side—so it is less disturbed and more sensitive to bone-conducted sound—thus the vibrations appear louder in the deafer ear in conductive deafness. In perceptive deafness it is referred to the better hearing ear. When one remembers the mechanism of perceptive deafness and realises that it is the inner ear that is damaged, and the Weber test is received by the inner ear, it stands to reason that the less damaged or normal inner ear will hear more clearly than the other.

Rinnes Test

Using the same tuning fork test, it is placed next to the ear being tested and the patient is asked to indicate when the sound stops being heard. It is then placed on the mastoid process. A common, shorter method is to sound the tuning fork in front of and over the mastoid process, and to ask the patient which of the two positions is louder. In unilateral perceptive loss, the bone-conducted sound may pass through the skull to the normally-functioning cochlea, giving the impression that the sound is heard better behind than opposite the ear and so indicating a conductive loss (see below). In all cases of this type, the good ear should be masked by extraneous sounds from a Baranys noise box to occupy its inner ear and so prevent the false interpretation (false negative Rinne). In conductive deafness, the Rinne test is negative, i.e., bone-conducted sound is louder than air-conducted sound. BC > AC. Bone conducts sound to the inner ear better than a damaged conducting mechanism. In perceptive deafness, the sound conducted, whether by air or bone, is diminished to an equal extent; so that the result will be the same as in a normal ear where the sound is heard louder by air-conduction than by bone-conduction and so will be AC > BC, i.e., a + Rinne test.

Absolute Bone Conduction Test

This is indicated in perceptive deafness where the patient's hearing by bone-conduction is compared with that of the examiner who assumes normal hearing. The tragus of the patient is pushed into the meatus to exclude extraneous sound and when he ceases to hear the sound by bone-conduction, it is placed on the examiner's mastoid with his tragus blocked. In perceptive deafness, the bone-conducted sound is heard longer in a normal ear than in a damaged inner ear.

Pure Tone Audiogram

The standard audiogram is made by plotting frequency against intensity.

In conductive deafness, the air-conduction falls below bone-conduction, i.e. there is an air-bone gap, e.g. in the common glue ear condition in children.

This effects mainly low tones and the air-bone gap usually is not very large—30-40 DB maximum.

Another common cause of conductive deafness is otosclerosis. In this condition, the loss is uniform throughout and may be more severe, i.e. A-B of 50-60 DB.

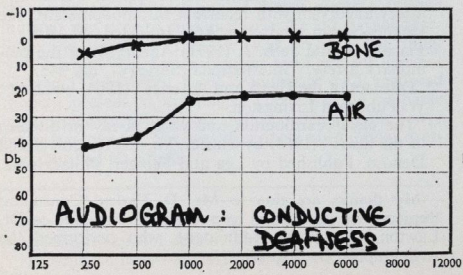
Another useful thing to remember is that in conductive deafness due to CSOM if the A-B gap is larger than the 40 DB, one should suspect the presence of ossicular destruction or discontinuity.

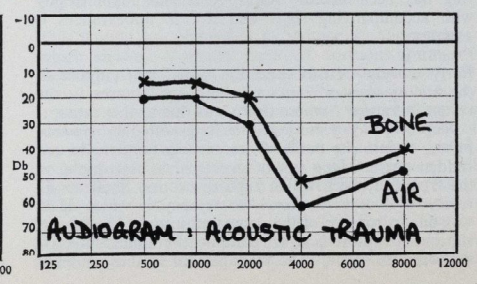
In perceptive deafness, the air and bone-conduction curves are affected to the same extent and here again you can get fairly typical types in different common causes of perceptive deafness.

In mixed deafness, there is an air-bone gap with a lowered threshold for bone-conduction. This occurs in conditions which can affect the cochlea and the middle ear, e.g. otosclerosis.

Impedance Audiometry

This test is performed by measuring the compliance or elasticity of the tympanic membrane and middle ear mechanism by plotting a graph which is arranged so that a high peak indicates a high elasticity, i.e. a diminished impedance which occurs in ossicular discontinuity. Various graphs are obtained depending on elasticity of the mechanism, e.g. in glue ears and Eustachian tube obstruction, the peak will be lower than in ossicular discontinuity for obvious reasons, and in otosclerosis, it will be very low indeed.





This can also be used to test the stapedial reflex, e.g. in facial palsy, in malingering and in tests for recruitment.

Speech Audiometry

This test is used when one wants to ascertain a person's ability to understand the spoken word in different types of deafness.

The fact that a sound is louder does not necessarily mean that it will be heard and understood more clearly—it usually is in conductive deafness which has a high speech discrimination score. But in sensory neural deafness speech discrimination is low. Hence hearing aids are more useful in conductive than perceptive deafness, but conductive deafness obviously is more amenable to surgical treatment.

With the advance of audiometry, specialised tests are becoming more common and they can be used to help the otologist in localising the site of the lesion in perceptive deafness. I now intend to discuss these briefly, but before this, one must explain that in cochlear deafness you get the phenomena of recruitment and in retrocochlear deafness recruitment is absent.

Tone Decay

In normal ears, if we feed in a sound at threshold or 5 DB above at the frequency of 1000 HZ it can be heard indefinitely. In cochlear deafness, this is not found to be so and it is necessary to continue increasing the increments, as at the lower intensity there is not enough nerve endings to produce a constant stimulus lasting 60 seconds. The louder sound reinforces the stimulus, i.e. causes recruitment, and then the sound is heard for the period of 60 seconds—it is usually not necessary to go above 20 DB above threshold to get this phenomena in cochlear deafness. In retrocochlear deafness, however, an increase of 25 DB or more is required.

Loudness Discomfort Level

Not effective if patient has learned adaptation through working in noisy surroundings.

Commencing at threshold and through all the frequencies, increasing sound intensity is applied until the patient notices discomfort. In a normal person, discomfort is noticed at 80 DB above threshold. It is much lower in cochlear deafness due to recruitment and in retrocochlear deafness discomfort is absent.

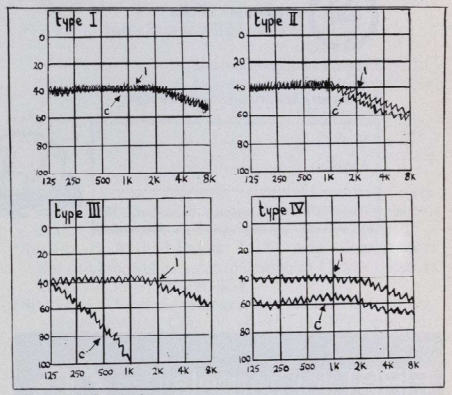
Fowlers (Binaural loudness balance) test—used in unilateral perceptive deafness or in bilateral perceptive deafness if the differences between the two ears is more than 20DB, but less than 60 DB, as air-conduction from the bad ear occurs to good ear at difference of 40 DB. (False Rinne again.) The test is plotted as a laddergram.

In cochlear deafness, as the intensity is increased, the sound is heard to the same degree in either ear due to recruitment. In retrocochlear deafness, the lines just stay parallel.

Short increment sensitivity index (SISI) test—used when the previous test is not applicable. Using a tone of 1000 HZ a sound 20 DB above threshold is applied to the ear being tested. This is increased by 1 DB every 5 seconds on 5 occasions. This cycle is repeated 4 times. The number of 1 DB increments is measured and expressed as a percentage. If the score is 80 per cent. or more, recruitment is present. The non-recruiting ear, i.e. a normal ear or one with retrocochlear deafness scores 0-20 per cent. Very few results between these two, i.e. 20 per cent. and 80 per cent. are obtained, so it is quite a good test.

Bekesy Audiometry

This is a complicated test used in perceptive deafness and using continuous and pulsed tones. A series of four graphs can be obtained as follows:



Type I: Normal ears.
Type II: Cochlear deafness, e.g. Menière's disease.
Type III & IV: Retrocochlear deafness.

Various tests which use masking, etc., are used to uncover the malingerer in certain special centres; but, in a paper of this sort, will not be entered into.

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To summarise the above tests, the following chart is useful.

	Pure-tone audiogram	Békésy	Short-increment sensitivity index	Tone decay	Recruitment	Discrimination	Loudness discomfort	Stapedial reflex
Cochlear (sensory)	Gradual downward sloping graph	Type II (or type I)	High score	Not significant (less than 20 dB)	Present if enough residual hearing	Measurable	Present	Present if sufficient residual hearing
Retrocochlear (neural)	Flat or trough-shaped graph	Type III (or type IV fixed frequency)	Low score	Abnormal adaptation (more than 25dB)	Minimal or absent (at times reversed)	Not measurable	Absent	Absent

RECENT PAPERS BY BART'S ALUMNI

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BOOK REVIEWS

OCULAR PATHOLOGY, by C. H. Greer, 2nd Edition. Published by Blackwell Scientific Publications. Price £5.

This book is designed for post-graduates who are training to be ophthalmologists but undergraduate students could, with great profit, read at least the first few chapters on inflammation and repair. The descriptions are almost cryptic, yet are full of interest and very informative for the general student. Moreover, for someone first attending in the Eye department, it would be of great value to have learnt so painlessly about hordoleum, chalazion, hypopyon and numerous other ophthalmological terms which are mystifying the beginner. At the end of each section are just one or two well chosen references.

For the embryo ophthalmologist this book needs no introduction. There is as much important information crammed into this 260-page book as exists in many larger tomes.

I am rather disappointed, however, in many of the illustrations which are often dark, and ill-defined, making it difficult even for a trained histologist to identify the details recorded in the captions. The paper is of good quality and one or two very good illustrations indicate that a general improvement could have been made in this respect.

Apart from this criticism, I can thoroughly recommend this book which incorporates many improvements and additions to the 1st Edition, which itself proved to be a popular and successful textbook.

R. J. R. CURETON.

"STUDENT CASUALTIES", by A. Ryle. Pelican Books. Pp. 152. Price 35p.

No, this isn't an ideal book for the last minute pre Finals spurt—but I am sure that at any other time you will find it interesting and rewarding reading. (I certainly did, but then it is written by a friend about my own line of business!) It is a smallish paperback, easy to read, of quite wide general interest—it would even make reasonable railway bookstall fodder. It has much of personal application to anyone in Higher Education, teacher or taught. Freshers could find it really useful for avoiding some of the common pitfalls (supposing anyone ever took any notice of helpful warnings). Many a tutor could gain deeper understanding of his students' problems from it—indeed several courses now exist for pastorally minded university staff, offering just this kind of material.

For the medical student there is the additional special interest of all the clinical aspects of a whole range of medical and psychosocial topics. There are three common responses people make when I tell them I work in Student Health: "I should think they're a healthy lot" (polite way of saying "That must be a pretty cushy job"); "Really? Are you a psychiatrist then?"; and "Oh, but that's just General Practice in a rather narrow selected group". This book will give you a balanced picture of what Student Health practice is really like.

I would be surprised if you didn't consider it well worth having read—and you might even get an idea of a new field, perhaps one you hadn't considered yet, which you might like to work in when you qualify. I have been very encouraged and delighted by the high proportion of Bart's men and women I am beginning to meet at Student Health conferences these days.

J.H.C.

ANATOMY, 1600 MULTIPLE CHOICE QUESTIONS. Butterworth Group. Price 95p.

For better or for worse the Multiple Choice Question paper is increasingly becoming the most searching and significant assessment in both graduate and undergraduate examinations.

The emergence of the MCQ paper has not been accepted without some opposition, presumably from those who believe that the merits of a would-be doctor or surgeon should not be assessed on his ability to unravel double negatives and draw straight lines, but rather on his ability to express himself in a cogently worded essay which allows the examiner to judge if a complete knowledge of the subject has been acquired.

The value of the MCQ papers are that they can cover so much of a subject in relatively few questions. Of the three basic sciences studied at 2nd M.B. and Primary F.R.C.S. level (to both of which this book is directed), Anatomy lends itself best to this form of assessment. It is a concise, exact science, and except in a few cases the answers to questions cannot be disputed. However, a precise knowledge of detail does not reveal an understanding of the local or general significance of many tissues, and thus I fear the day when MCQ papers will be the sole means of assessing one's all round knowledge.

A book of this type, while having little extra to recommend it apart from other similar books available, is helpful for two reasons: firstly, to acquaint the student with the kind of approach required for an MCQ paper, and secondly as a rapid means of last minute revision.

An attempt has been made by the authors to relate the questions to clinical work, and by avoiding irrelevant detail they have succeeded in this book. It is laid out with sections on all the main anatomical areas with additional sections on the nervous system, histology and embryology. These three latter sections are most welcome as they contain material that is more pertinent to the clinician.

At 95p this book—with the present trend of examinations—must be worthwhile, but has to be viewed as a confidence booster in the weeks before the examinations rather than an easy way to pass the exam itself.

MEDICAL MICROBIOLOGY
By C. A. THOMAS

Students will take notes even if they own a concise or a voluminous text book. This book claims no more for itself than that it saves students the task of scribbling notes. Notes are however used for going quickly over the main points just before the examination, and their usefulness cannot be denied. This applies also to the present volume which is admirable in the way it compresses the most important features of medically important bacteria into 370 pages. The print is clear and does not overstrain the eyes of medical students. On the other hand the few illustrations and drawing although clear are not very impressive. The book is up-to-date and some suggestions for further reading have been added.

There would certainly be difference of opinion when one comes across statements like 'Lactobacilli, diphtheroids may assume a pathogenic role in some circumstances when isolated from the female genital tract". This is not based on any firm evidence and it would be difficult if not impossible to substantiate such a claim.

Although it appears to be rather long it can no doubt be recommended to medical students.

B. CHATTOPADHYAY,
M.B., B.S., D.C.P., M.R.C. Path.,
Senior Registrar in Bacteriology.

PATIENT CARE — CARDIOVASCULAR DISORDERS, by Pat Ashworth and Harry Rose.

This is the first really helpful Cardio-vascular nursing book that I have ever read.

The techniques and post-operative patient care described are very similar to our own, and this book will be very useful to new nurses who come to work in the Vicary Recovery Room.

The first chapter "Impact of Heart Disease" is a very necessary but often overlooked subject for discussion. One has to be able to know and help the families of these patients and over many years you get to know them very well indeed.

The section on Chemistry and Haemodynamics in cardiac conditions is very good and will help the nurses to understand this very complex subject.

All the diagrams, charts and illustrations are easy to follow and this book will be of great value for teaching purposes.

SISTER VICARY.

SPORT REPORTS

Sports Reports must be typed and submitted to the Clubs Editor before the 24th of each month.

SAILING CLUB REPORT

The recent good weather since the Harvey-Wright Gold Bowl, reported in the July issue, has given the season a good start with members sailing at Burnham most weekends. The club now has both Enterprises in good sailing condition, including a new suit of sails for "Percival Pott", and members also have access to several more Enterprises in the UHSC boat pool.

The recent refit of both Enterprises and some attempts to tune them have enabled those crews entering the Sunday a.m. points races to keep up with the rest of the fleet and have had several 2nd and 3rd places to their credit.

The Annual Regatta was held at the Welsh Harp on Wednesday, July 28th. Rain and thundery squalls, accompanied by an erratic wind did not deter about 25 students, nurses and physios turning up and racing.

The main series of races for fully crewed Fireflies was won, on points, by A. Blunt. The Ladies' race was easily won by Sue Latham, while R. Wells and A. Blunt still have to decide the single handed races.

Owing to the unpredictable conditions the proposed race with no rudders or tillers was postponed. The weather did not, however, deter C. Waite from sailing his Broads yacht around the inner distance mark by radio control!

Sailing will continue throughout the summer, and anyone who is not already afloat and is interested should see Richard Wells or David Patuck.

THE THREE RIVERS RACE, JUNE 1973

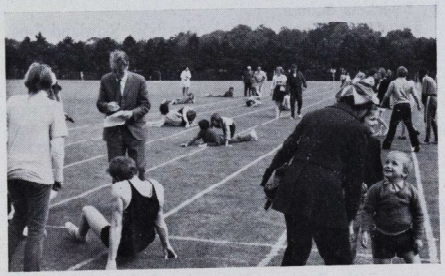
Two Bart's Enterprises competed in the Three Rivers Race in Norfolk. This 50-mile race started at 15.00 hours on Saturday, June 2nd, with nearly 100 boats of various sizes and shapes amassing at the starting line. The course involved calling at four different points on the Norfolk Broads, and passing under six bridges requiring the masts to be lowered.

First boat home, and sixth after handicap adjustments, was a Norfolk punt, Swallow II, privately owned by Tom Moore, with Chris Waite crewing. The Bart's boats finished halfway down the fleet: that known affectionately as 'Private Enterprise', sailed by Ian Jack and Chris Dawe, came in 48th. David Patuck and Richard Wells sailed "Percival Pott", coming in 52nd at 06.45 hours on the Sunday morning.

PHOTO FINISHES

An easy victory for R. Thomas and D. Cowling.

A close finish.



Dr. Malpas organises(!) the proceedings.

Photos by G. N. Fuller

SPORTS DAY, JUNE 2nd

This season's annual Sports Day was held at Chislehurst in—oddly enough—brilliant sunshine. The multitudes expected may not quite have materialised, but the number of competitors was a great improvement on latter years.

This was especially noticeable in such specialities as the three-legged, wheelbarrow and egg-and-spoon races. Perhaps it was the fresh farm eggs that inspired Richard Windgate to poach such an incredible lead in the last-named scramble.

Condolences to Dr. Malpas who did not quite get up to beat Dr. Bowen in the "Consultants" 100 yds.

The best race of the day came in the 440 yds. when Alvin Corbin just caught John Goddard over the last few feet. Unfortunately for Alvin, who also won the 220 yds., it was felt that Bruce Campbell's amazing efforts in the 880 yds., 1 mile and 3 miles merited him the Victor Ludorum award. All credit to the persistence of Steve Mann, who I am sure will be back in winning form next year, for being the runner-up in each of these three events.

The climax of the afternoon came in the Tug of War where the herculean exertions of the children(?) overcame the straining Wine Committee in the final.

It was a great pity that more were not down at Chislehurst to enjoy these gory spectacles, but I am sure those that were, will wish to come again.

My thanks to Dr. Francis and his helpers, the groundsmen, and Dr. and Mrs. Malpas for all their hard work.

Full Results:

110 Hurdles	G. Howell	15.8s.
100 yds.	C. Noon	10.1s.
220 yds.	A. Corbin	23.7s.
440 yds.	A. Corbin	54.4s.
880 yds.	B. Campbell	2m. 10.4s.
1 mile	B. Campbell	4m. 55.3s.
3 mile	B. Campbell	
Long Jump	G. Howell	18ft. 6in.
High Jump	G. Bath	5ft. 2½in.
Shot	G. Aitken	
Discus	G. Aitken	
Javelin	G. Howell	120ft. 9in.
Ladies' 100 yds. ...	Anne Cockcroft	
Wheelbarrow	Ric Thompson & Diane Cowling	
Three-legged	Roddy Barclay & Louise Davidson	
Egg & Spoon	Richard Windgate (14.8s.!)	
Consultants' 100 yds. ...	Dr. Bowen	
Inter-firm Relay ...	Veterans	

TENNIS CLUB REPORT

At the time of writing the 1st VI remained unbeaten in all League and Cup matches so far this season. Wins against Queen Mary College and London Business Schools in the University of London Cup saw the 1st VI reach the final for the second year running. In the Inter-Hospital Cup victories over St. Thomas' and the Royal Free meant that Bart's have reached the final for the fourth successive year. In both finals, Bart's will play St. Mary's Hospital, our old adversaries, and with John Williams still available for them tough opposition is expected.

For various reasons, beyond Bart's control, not one Inter-Hospital League match was played during June. Both St. Thomas' and UCH failed to raise a side, while matches against Royal Free and St. George's were rained off. These matches will be re-arranged to be played at the end of the season.

Staff Match

One of the most enjoyable occasions on the tennis calendar is the annual staff match. This year was no exception and on a near perfect day at Chislehurst on Sunday June 24th, the 1st VI took on a staff side comprised of Mr. Dowie, the President; Mr. Lettin, Mr. MacNab-Jones, Dr. Kelsey-Fry, Dr. Galton and Dr. Garrard. The 1st VI proved to be too strong for the senior but experienced staff side and won by seven matches to two—the match might well have been won more decisively had not J. B. Howell arrived two and a quarter hours late! Considering it was the first match of the season for many of the staff side they did produce a very creditable performance.

Following the match all the players were lavishly entertained at the home of Dr. and Mrs. Kelsey Fry in Chislehurst. This provided a most suitable climax to an enjoyable afternoon's tennis.

Representing the 1st VI were:— N. Perry P. Mortimer, J. Wellingham, J. Cooper, J. Howell, A. Colver.

RESULTS:

V. H. League

Wed. 23rd May: St. MARY'S 2 : 7 BART'S I. at Teddington.
TEAM: N. Perry, J. Smallwood, P. Mortimer, D. Stewart, T. Dale, J. Wellingham.

U. L. Cup 3rd Round

Wed. 30th May: BART'S 5 : 1 QUEEN MARY COLLEGE at Chislehurst.
TEAM: N. Perry, J. Smallwood, P. Mortimer, D. Stewart, T. Dale, J. Wellingham.

U. H. Cup 2nd Round

Sat. 2nd June: BART'S 6 : 0 St. THOMAS
TEAM: N. Perry, J. Smallwood, P. Mortimer, D. Stewart, T. Dale, J. Wellingham.

U. H. Cup 3rd Round

Sat. 16th June: BART'S 5 : 1 ROYAL FREE
TEAM: P. Mortimer, J. Smallwood, D. Stewart, J. Howell, T. Dale, J. Wellingham.

Friendly

Sat. 9th June: BART'S 5 : 4 LONDON HOUSE
TEAM: P. Mortimer, J. Wellingham, J. Smallwood, H. Simpson.

CRICKET CLUB REPORT

The outstanding features of play during June were the batting of Cooper and the bowling of Husbands. With one match still to be played before the end of the month, Cooper had scored 366 runs for an average of 61 and Husbands had taken 22 wickets at a cost of 9.2 runs each.

The best team performance to date was that at Hampstead, whilst the most exciting finish was against Trinity where Bart's lost by only three runs after the failure of the early batsmen had seemed to have put the match well out of reach.

Results

May 27th. Bart's v. Woodpeckers at Chislehurst. Bart's won by 7 wickets. Scores:
WOODPECKERS 109 (Brann 5-44, Flather 2-7, Husbands 2-6, Munro 1-19).
BART'S 110 for 3 (Rowland 53 not out, Husbands 23 not out).

May 28th. Bart's v. Chrishall at Chrishall. Match drawn. Scores:
CHRISHALL 221 for 9 dec. (Husbands 5-64, Anderson 2-28, Cooper 1-17, Brann 1-35).
BART'S 165 for 3 (A. Davies 82 not out, Joshi 37 not out).

May 30th. Bart's v. The Royal Dental Hospital at Cobham. UH Cup 1st Round Replay. Bart's won by 8 wickets. Scores:
RDH 55 (Martin 4-19, Joshi 2-11, Dudgeon 2-7).
BART'S 56 for 2 (Cooper 27).
BART'S TEAM: P. Cooper, J. Capper, R. Firmin, E. Rowland, A. Davies (capt.), J. Flather, T. Dudgeon, I. Barrison, M. Martin, B. Joshi, A. Munro.

June 2nd. Bart's v. Hampstead at Hampstead. Match Drawn. Scores:
BART'S 260 for 5 dec. (Cooper 39, Firmin 75, Rowland 52, Capper 53, Husbands 22 not out).
HAMPSTEAD 241 for 7 (Rowland 2-72, Husbands 5-99).

June 3rd. Bart's v. The Royal Free Hospital at Enfield. Bart's won by 9 wickets. Scores:
ROYAL FREE 84 (Barrison 3-15, Munro 2-22, Anderson 1-17).
BART'S 88 for 1 (Cooper 67 not out).

June 9th. Bart's v. Incogniti at Chislehurst. Incogniti won by 95 runs. Scores:
INCOGNITI 173 (Husbands 7-37, Flather 2-44, Munro 1-19).
BART'S 78.

June 10th. Bart's v. Loughborough Park at Chislehurst. Match drawn. Scores:
LOUGHBOROUGH PARK 164 for 7 dec. (Munro 3-28, Barrison 2-8, Brann 2-45).
BART'S 98 for 8 (Cooper 37, Joshi 23).

June 13th. Bart's v. Trinity College at Cambridge. Trinity won by 3 runs. Scores:
TRINITY 207 (Munro 5-63).
BART'S 204 (Muir 43, N. Davies 41, Fenn 43).

June 16th. Bart's v. Jesters at Chislehurst. Bart's won by 7 wickets. Scores:
JESTERS 233 for 7 dec. (Cooper 3-50, Rowland 2-64, Munro 2-45).
BART'S 239 for 3 (Cooper 79, Rowland 65, Reid 25, Capper 57 not out).

June 17th. Bart's v. Guy's at Chislehurst. Guy's won by 32 runs. Scores:
GUY'S 135 (Husbands 3-14, Nayak 3-30, Anderson 2-30, Barrison 1-20).
BART'S 103 (Cooper 35).

June 23rd. Bart's v. Temple Sheen Eccentrics. Match Drawn. Scores:
TEMPLE SHEEN 141 (Husbands 7-53), Dudgeon 2-58).
BART'S 106 for 5 (Cooper 70 not out).

June 24th. Bart's v. University College School Old Boys at Chislehurst. Match drawn. Scores:
UCSOB 198 for 7 dec. (Joshi 5-40, Dudgeon 1-64).
BART'S 119 for 6 (Cooper 34, Muir 22, Firmin 47).

WHAT ARE DOCTORS

As a naval doctor, you'll normally serve for five years on a Short Career Commission, some of the time at sea and some on land.

Naturally, you'll travel.

And you'll also be a naval officer.

AT SEA.

You can expect to get to sea as a Surgeon Lieutenant within six months after registration. Probably, you'll be the only doctor in your ship. In a frigate, for example, you'll have some 300 men to take care of. And you'll be responsible for all their medical needs, from a cold in the nose to tropical illnesses.

To help you, there will be a qualified staff on board. And your medical quarters will be small but modern and well equipped. (In some cases, including an operating theatre).

Your practice, however, won't be confined to your ship. If there's a natural disaster anywhere within a thousand miles, you could get involved in relief work. If there's an accident at sea, you could be taken to it by helicopter.

Often, you'll have to rely entirely on your own resources. So the work can be difficult. But it will certainly be varied.

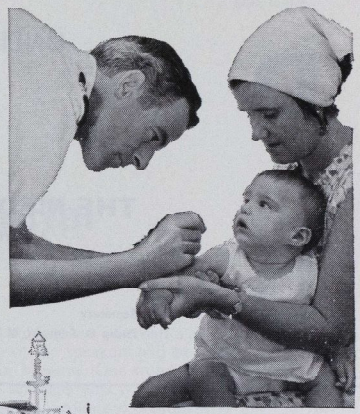
ON LAND.

Usually, you'll spend more than half your time with us on land. Either at home or overseas — in Europe, the Mediterranean and even as far afield as Mauritius or Hong Kong.

You'll be doctor not only to the naval personnel, but when abroad to their families as well. General practice, in fact, with the advantages of naval pay and a ready made naval social life.

If you're sent abroad, and you have a family of your own, you can take them with you at our expense. We'll help with accommodation (at very reasonable rents), and we can give you educational allowances for your children.

DOING IN THE NAVY?



SPECIALISATION.

When your 5 years with us are up, you can leave with a tax-free gratuity of around £1,200. Or you can stay with us, either for a full career or for a 16-year pensionable commission. You would then have the opportunity to specialise and to do post-graduate studies on paid leave.

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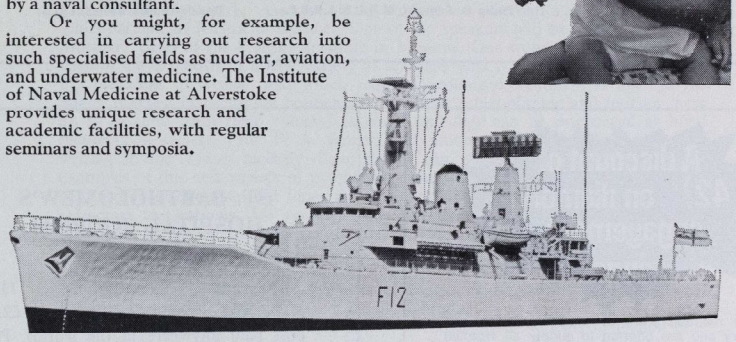

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Editorial

The World Psychiatric Association is holding an international symposium on schizophrenia in Russia in October. One of the speakers will be Professor Georgy Morozov, head of the Serbsky Institute in Moscow. One wonders if he will be discussing the diagnosis of a new variety of schizophrenia which is apparently becoming prevalent in Russia, and which requires prolonged treatment. I refer to the Soviet practice of certifying political dissenters as schizophrenic and locking them up in asylums until their "illness" is cured and they can be discharged as loyal members of society. Prof. F. A. Jenner, and, among others, Mr. Bernard Levin, writing in the *Times* recently, have drawn our attention to several horrifying examples of this new variety of psychiatric treatment. Vladimir Bukovsky has been confined in asylums several times for dissident opinions which have proved very refractory to treatment. He has managed to speak to Western journalists and has described the Soviet treatment for dissidence. He claims that methods used include continuous sedation, unethical administration of drugs, interrogations, and even physical torture. Daniil Lunts, who also works at the notorious Serbsky Institute, is quoted as saying, "When I say a man is schizophrenic, he is schizophrenic, just as, if I say an ashtray is schizophrenic, it is schizophrenic."

It is not difficult to see that a policy of consigning dissidents to mental hospitals would be much more acceptable to Soviet leaders today than the old show trials, which only attracted adverse publicity. The new policy does, of course, require the co-operation of psychiatrists. It follows that many of the appeals of friends of these dissidents have been directed to Western psychiatrists. Their reaction for the most part does not do them much credit. In 1971, forty-four British psychiatrists signed a letter of protest. Eighty psychiatrists have signed telegrams supporting the defence of Kiev psychiatrist Gluzman, and the National Association for Mental Health in Britain has also protested. But the American and German Psychiatric Associations have failed to respond to these appeals. Mr. Levin particularly criticised the World Psychiatric Association for failing to publicise this abuse of medicine. Dr. Denis Leigh, the secretary of the W.P.A., has apparently refused to meet a group in this country concerned about such abuses, and he has directed complaints about specific cases to the Soviet Society of Psychiatrists. Dr. Leigh has said that no member association has formally raised the matter with the W.P.A., and that even if they did, the W.P.A. would probably not be able to discuss such matters. Although the matter may not have been formally raised at W.P.A. meetings, it is not for want of trying. Russian psychiatric reports making the diagnosis of schizophrenia on the basis of dissenting opinions have been sent to Dr. Leigh for distribution to the W.P.A. Congress, but were ignored. Attempts to distribute