TENNIS CLUB REPORT

At the Annual General Meeting of the Men's Tennis Club, held in the Hospital Abernethian Room in December, 1973, it was expressed how near the 1st VI came to repeating their record success of 1972 when they won the University Cup and Hospitals Cup and League Championship. Only a very strong St. Mary's side in the final of the Hospitals Cup prevented Bart's from retaining all three titles.

With another tennis season approaching, the 1st VI can look forward with encouragement. Only John Wellingham has been lost from last year's side; Nick Perry, Jim Smallwood, Peter Mortimer, David Stewart, Tony Dale and John Howell remain to form the 1st VI squad. Nevertheless, new blood is always welcome and so it is hoped that all Freshers interested in Tennis will come forward.

There are six excellent grass courts at the Athletic Ground, Chislehurst, available for play throughout the Summer months, so there is ample opportunity for students wishing to play social tennis as well as those interested in competitive play.

The Club intends to extend the tennis calendar, with the help of the Ladies' Tennis Club, to include more mixed and social tennis matches.

If any of the new intake, both pre-clinical and clinical, would like to play tennis this Summer would they please contact either: —

David Stewart (Captain) at College Hall or Male Students Cloakroom in the Hospital—or

John Howell at Male Students Cloakroom in the Hospital.

SAINT BARTHOLOMEW'S HOSPITAL JOURNAL

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QUESTION TIME

"Editorials", or "Leaders" as certain journals call them, are congenitally designed to be serious, relevant, and overweight. They are meant to be written in impeccable English, yet a leavening of facts must support any given statements; they should present the arguments for both sides of a case with equal force; they should synthesise all aspects of a problem into a coherent whole; and, finally, they should reach some measure and ponderous conclusion. In effect they should be the Heavy Artillery in a journal's armory of selected weapons, to be aimed only at the more obviously hittable targets, targets worthy of a first-page assault. Sadly, but unsurprisingly, they have a consistent tendency to go the way of all "big guns" in unsuitable conditions, they get stuck in the mud.

However, if such writings are seen as prefaces to the following pages, as mirrors into the attitudes of those putting a journal together, then their primary task becomes one of readability; they must provoke interest and amusement (whether scornful or approving), and try to appeal to something sprightlier than the dull "spirit platitudinous". It is so easy for a writer to seat himself at the sacred desk, sharpen his quill, see the word "Editorial" grinning up at him, and became transmuted by a sense of awesome responsibility into a pompous, jellified hack (e.g., see my opening sentences). Contrariwise, he may flee to the opposite extreme, to the shrill heights of the radical polemic, demanding all sorts of ideal situations and sudden changes despite being without the responsibility for or an understanding of the issues at hand. Speeding through lights is great fun, unless you are the driver who may have to carry the can. So, enough of statements, let us instead revert to the interrogative mood and try a few very simple questions.

1. Why was the "lay-staff" dining-room closed due to staff shortages? The closing of the smaller "consultants" one would have been much more efficient in terms of queue length and seating capacity per serving area. Come to that, why can't we all eat together as they do in many other hospitals and large companies?

2. Why are cars allowed to roam within the hospital, yet bicycles (which often clatter and carry distinctive, high-pitched bells on them) must be pushed? Bikes may bruise, but cars can kill. Does not logic demand that car drivers also should push their vehicles around when inside the ancient confines?

3. How far can patronage influence one's chances of a house job here? No system can hope to eliminate altogether some subjective element, but is it healthy to let individuals control the careers of other indivi

duals? The Sub-Dean has, quite rightly, laid down criteria based on exam and "student career" factors, and matters are much improved compared to previous times, but the role of patronage has never been fully elucidated.

4. To what extent can private patients receive treatment in Bart's, which unlike many hospitals has no "pay" beds. (Thanks to the wisdom of its statutes). The beds situation gets tighter all the time and surely therefore control of occupants should be equally tight.

These questions are aimed at anomalies in the status quo which in most respects is very reasonable. It is hoped they might elicit clear and fair answers, dealing as they do with subjects both general and particular. Left obscure they will only serve to worry one of the happiest communities in London.

THE PRICE OF EXPEDIENCY

Private Medicine has many supporters arguing vocally and financially on its behalf. It is said to be an extra source of income for the National Health Service; it is said to ensure that leading members of the profession are not drawn abroad by the lure of gold; it is said to "protect the doctor-patient relationship"; it is said to provide consultants with the chance to keep their hands in by the actual examination of patients; and so on. But all these are pleas of expediency, and the most specious of all is the one about "freedom to choose" one's own doctor. Because not only does the layman not know who is the best doctor for his condition (which could make his freedom a somewhat risky asset) but he forgets that his freedom is lessening someone else's. He is, to all intents and purposes, queue-jumping, using money to barge in ahead and that is nothing less than a bullying form of bribery.

But the classic weakness of the expediency argument, of doing something for the present which one may not like but which the circumstances demand, is that it is self-perpetuating. Thus the cheap housing put up to replace slums soon degenerates into a slum itself and the whole cycle of clearance and rebuilding has to begin again. If one has ideals they cannot just be for some unspecified time in the future, because action in the short-term interest merely worsens the chances of speeding up the deeper, long-term changes that may be necessary. The approaching centenary of the "Irish Question", as it is so euphemistically phrased, is the classic example of procrastination on the grand scale.

In the case at hand, the prevalence of two standards of health care in this country, it is exactly this unwillingness to see beyond the end of our own conveniently short noses that can only bring worse problems for the future. For the rich and influential in all walks of life, those most able to get things done by virtue of their positions and their intelligence and their knowledge of "the ways of things", are shielded by the trappings of private medicine from the appalling state of disrepair of the N.H.S. Put a few leading politicians and businessmen in the average ward or outpatient queue for a day or two, let them see the miles of knotted string and personal sacrifice that are holding the whole crumbling edifice together, and things would get done. Were pay and conditions made equal, for example, to those of a major oil company there would be no need to ban the practice of private medicine, it would just die a natural and timely death. But only when the decision-makers and policy-formulators (i.e., the ruling classes), those in positions of influence in the industrial, financial, political and communications fields, are prepared to demand these sorts of radical improvement will matters really change for the better.

There are other arguments also of weight; the extra burden placed on housemen and registrars (who have probably been up half the night) when the "big man" trots off to Harleystrasse; the extra politeness that misses out the uncomfortable, but sometimes crucial, rectal examination; the terrifying American example where lack of credit can get you turned off the stretcher. The creation of the N.H.S. was the single most civilized act of this century in Britain; if we are not prepared to maintain it to the full then we deserve all the horrors of "the law of the jungle" that its continued demise will inevitably bring.

OBITUARIES

SIR CHARLES (Felix) HARRIS

Sir Charles Harris died on March 9th, 1974, and with his passing there ended a remarkable era of service to St. Bartholomew's Hospital, its Medical College and the University of London.

Charles Harris was born in New York City, but spent most of his early childhood in Australia. He came to England in 1914 and entered Epsom College. In 1918 he entered St. Bartholomew's Hospital Medical College for his medical training. After qualification he became House Physician to Professor (later Sir Francis) Fraser. He became Second Assistant under Professor Fraser in the Medical Professorial Unit, working on the problems of calcium metabolism, which fitted in well with his early interest in the diseases of children, and acquired the MD (London) and the MRCP. He was awarded a Rockefeller Fellowship and proceeded to work in the Paediatrics Department of the John Hopkins University Medical School in Baltimore, returning the following year as a House Physician at Great Ormond Street Hospital. He returned to St. Bartholomew's Hospital as Chief Assistant and later Assistant Physician to Dr. Hugh Thursfield in the Children's Department which, at that time, was represented only in outpatients: the inpatient children being cared for by the general physicians.

In 1929, on the retirement of Dr. Thursfield, Charles Harris became the first Physician-in-Charge of a separate Children's Department with its own ward accommodation. This, the end of a prolonged struggle to obtain the recognition of a separate department for diseases of children, was a personal triumph.

He later held many appointments, becoming Physician to the Westminster Hospital for Children, Vincent Square, and Consultant Paediatrician to the London County Council. He was President of the British Paediatric Association in 1962/63.

In 1936 he became Warden of St. Bartholomew's Hospital Medical College in the new Pre-Clinical Medical School which had been created in Charterhouse Square, being the first Warden to be resident for many years. He worked closely with the then Dean, Sir Girling Ball, and these two men were largely responsible for the inauguration and development of the School on that site.

At the outbreak of hostilities in 1939, he took over the task of Medical Officer-in-Charge of St. Bartholomew's Hospital under the Emergency Medical Service and was able to show his remarkable administrative capacity. He organised the hospital for its wartime role, maintained the College activities and education on that site and, at the same time, continued his teaching in Paediatrics.

At the end of the war and following the death of Sir Girling Ball, he became Dean and was faced with the immense task of rehabilitating the College which had been devastated by enemy action. Only those who had the privilege of working with him knew the great ability and efforts which were required to face this problem. The rebuilding of the Pre-Clinical Medical School and the addition of a Hall of Residence were almost entirely due to the initiative and administrative skill which Charles Harris exercised both within the College and the University.

These qualities were recognised by the University. He was elected to the Senate in 1905 and to the Court in 1951. He was Dean of the Faculty of Medicine from 1952 to 1956 and, at the same time, Chairman of the Conference of Deans of the Metropolitan Medical Schools. He then became Chairman of the Academic Council, was Deputy Vice-Chancellor from 1955 to 1958 and Vice-Chancellor from 1958 to 1961.

At the end of this term he was elected Chairman of Convocation, at a time when all his powers were needed to steer this body into calmer waters. Concurrently, he was Chairman of the Joint Finance and General Purposes Committee.

During many busy years he found time to help in the governing bodies of the London School of Hygiene and Tropical Medicine and of the School of Pharmacy. The part he played in the establishment of the Institute of Basic Medical Sciences at the Royal College of Surgeons was recognised by the award of an Honorary FRCS. He continued in office in the University until the autumn of 1973 and his distinguished service was recognised by the conferment of an Honorary LL.D.

With the advent of the National Health Service, Charles Harris became a member of the first Board of Governors of St. Bartholomew's Hospital appointed by the Minister and he served as a medical member of the Executive Committee until his retirement from the active staff.

The Medical College was, indeed, fortunate to have Charles Harris to guide it through the vicissitudes of war and its rehabilitation in the aftermath of war. Not only did he guide and was the main instrument of reconstruction, but he established a policy, the impetus of which lasted long after his term of office as Dean and as Vice-President of the College. Even after this his wise counsel and kindly advice remained available as he was elected a Governor and served on the College Council.

His service to the Medical College was truly outstanding. The students and staff of both College and Hospital will have known how approachable he was and how kindly and wisely he would help with their problems, though at times exterior appearances may have seemed a little forbidding. To all those who worked with him in the Children's Department, his love of children and his kindness and gentleness with both child and parents were easily apparent and a great example.

He faced his final illness with the reserve and fortitude with which he had faced other problems in his life. He was able to meet his ultimate defeat with courage and dignity and with the quiet smile of recognition which we had known so well.

E.S.

PAUL LEECH

Paul came to Bart's in October 1970, joining a polyglot First M.B. group full of fellow-graduates. He had taken a History degree at Lancaster University and suffered cheerfully the mental re-adjustment to facts and formulae; despite a tight County Council he passed in June and went on to Second M.B., only to fall ill in the ensuing Christmas term. For the next two years and more, until his death in March, he worked long hours to overcome the delays and problems set by his illness, showing throughout a courage and perseverance which none who knew him will ever forget.

Two factors in particular set Paul apart. He was entirely honest, so unlike most of us he actively put his principles into practice, being a driving force in the old peoples' Sunday Club to which he devoted much of his spare time. At the same time he was always kind, with a respect for everyone whether friend, acquaintance, or stranger. In a sense this total sincerity and lack of malice provided something of a yardstick by which others unconsciously judged themselves. But Paul himself would simply have laughed uproariously at such things being said about himself, for he had a sparkling wit and a keen sense of the ridiculous behind a quiet and serious demeanour. Finally he was also an able athlete, playing squash and running for the college, so I will always think of him combining his humour and fitness back in the "1st M.B. class of '70"; at leap-frogging parking-meters Paul was the tops.

T.T. and G.B.

ANNOUNCEMENTS

Deaths

GODWIN—On March 2nd, David Godwin, M.B., B.Chir., M.R.C.S., L.R.C.P., D.Obst.R.C.O.G.

HARRIS—On March 10th, 1974, Sir Charles Felix Harris, K.B., M.D., M.B.B.S., F.R.C.P., F.R.C.S., M.R.C.S., L.R.C.P. Qualified 1923.

HUME—On March 2nd, 1974, John Basil Hume, M.S., F.R.C.S. Qualified 1916.

LORD UVEDALE OF NORTH END—On February 28th, F.R.C.S. Qualified 1911.
1974, Ambrose Edgar Woodall, M.Sc., M.D.,

WILLIAMS—On March 6th, 1974, Roger Lester Williams, M.A., M.B., B.Chir., F.R.C.S., L.R.C.P. Qualified 1919.

Engagement

PEACOCK—MARSDEN—The engagement is announced between Dr. Andrew Peacock and Miss Judith Marsden.

Appointments

Dr. R. E. Atkinson has been appointed to a Clinical and Research Fellowship in the McGill Department of Anaesthetics, Royal Victoria Hospital, Montreal.

Miss Patricia Gordon, at present Home Administrator of the Renal Unit at Bart's, has been awarded a 1974 Churchill Travelling Fellowship. She will study social and economic consequences of renal transplantations and dialysis for 2½ months in the USA and Canada.

Mr. M. H. Irving has been appointed Professor of Surgery at Manchester University.

N.B. The journal offers its especial congratulations to Mr. Irving on his appointment to the chair of Surgery at Manchester. He has devoted much time at our Publications Committee meetings and has given valuable help in many other ways. Our best wishes to him.

Changes of Address

Until March 1st, 1975, Dr. and Mrs. R. E. Atkinson will be living at Apartment 111, 511 Abelard, Nun's Island, Montreal, Province of Quebec, Canada.

Dr. J. Smart is now living at "Copplestone", Corfe Castle, Dorset, BH20 5HU. Telephone No.: Corfe Castle 253.

Experienced Medical Secretary (previously at Bart's) willing to undertake free-lance work—typing of research projects of theses, or other medical secretarial work. Own Grundig stenorette taperecorder. £1.25 per hour or £12.00-£15.00 per 100 quarto pages double spacing. (Susan Ramjohn, M. A. M. S.—tel. No. 01-366 2545 after 4.30 p.m.)

Nurses wishing to join the *Journal* staff should contact the Editors.

A NEW HISTORY OF THE HOSPITAL

The celebration of the 850th anniversary of the founding of the Hospital appeared to be an appropriate occasion to be marked by a book commemorating the event. Sir Norman Moore's *History* was published in two volumes in 1918, and Sir D'Arcy Power's *Short History* was issued in 1923 to celebrate the Hospital's octocentenary. It was decided to plan a volume intermediate in size between these two, and to serve a somewhat different purpose. The new History is planned for the general reader, and it is not documented for the professional historian, although some references for further reading are included. Emphasis in most of the chapters is on the contributions of physicians, surgeons and others to their respective professions. Furthermore, the close association of the Hospital and the Medical College is demonstrated in chapters detailing the development of the latter, originally on the Hospital site, but latterly with the growth of the pre-medical departments in Charterhouse.

The book contains lists of physicians and surgeons, and of heads of departments in the College. The 200 illustrations include portraits, title-pages, wards, theatres, seals and documents, silver, and many well-recognised architectural features, both ancient and modern.

Over 700 subscribers have already ordered the book, which is expected to be published in June. To enable all interested in the history of the Hospital to secure copies at the pre-publication price, a subscription form is included in this issue of the *Journal*. Save £2 per copy by ordering now, and if you have already subscribed, why not have a copy for your department, for a friend or a relative? The book will make a handsome present, and if you only have one for yourself, never lend it. It will not be returned! If you do not purchase one now, you will regret not having ordered it earlier, because you will be unable to resist acquiring a copy, even at the higher price.

J.L.T.

COURSES OF LECTURES

A short general course on aspects of teaching in Higher Education will be held at the University of London Institute of Education from September 16th-20th, 1974. Some of the topics included in the course are: techniques of lecturing, planning a course, choosing teaching methods, assessing students' work, responding to students' problems.

A course for teachers in Clinical Medicine, arranged in conjunction with the Middlesex Hospital Medical School, will be held on July 22nd-24th, 1974.

Other short courses during the year will include student selection, course planning, small group teaching, aspects of running an academic department.

For details of these and other short courses and conferences write to: University Teaching Methods Unit, 55 Gordon Square, London, WC1H 0NT.

LETTER TO THE EDITOR

Dear Editor,

Having just collected my copy of the March *Journal* it was with some trepidation that I turned the page, to read the first offering from our new editors. I was not to be disappointed. There was the by now standard, stimulating editorial still present, even under the new management.

I felt, however, that I must disagree with you about the ability of the student case, for increased grants, not to leak water. Having now been a student for 4½ years, I feel that I can quote from personal experience about the grant situation.

First of all let me agree with you entirely regarding the clinical student grant. Though where you get the figure of £14 a week from I do not know. I receive just under £13 a week and can assure you that the extra £1 would help immensely, so tell me where you get it from.

The preclinical student, and also other university students, however, are a completely different case. I feel that if an intelligent student is incapable of living on £17 a week, tax free, then he must be an appalling financier. Many less able people bring up families on that sum of money, and while this state of affairs exists I feel it grossly unreasonable for the student body to demand more money, for themselves.

I should add at this point that I am opposed to any idea of the grant sum being dependent on parental income. All students should receive the same amount, paid entirely by the government.

To return to the subject of whether £17 a week is adequate for a student. With regard to your expectation of support during the holiday—what right do students feel they have to 22 weeks paid holiday a year. Most students who claim they have to spend most of this time on extra course work are, in fact, merely catching-up on work they should have done during the term. As for the unavailability of holiday jobs, I have never found any difficulty in obtaining one, neither has anyone else that I have ever spoken to. Most seem to have earned enough money, or saved enough from their "poverty-line" grants, to be able to go on holidays abroad, even to exotic places like Turkey. Something which many working people could never afford, and can only dream about.

How you can say that flats are more expensive than £9 to £12 a week I do not know. If students were prepared to actually look around, and also live more than 10 minutes' walk from their college, they will find adequate accommodation at a cheaper rate.

Perhaps the answer to the problem would be to convert university courses into two-year ones. Each year consisting of four terms of 12 weeks each and four weeks paid holiday (still more than most people get a year). The student could continue to receive his £17 a week (£1 more than the current rate for married OAP's). A system could also be instigated to ensure that he actually attended college, i.e., he would have to be signed in for lectures and tutorials. He would then do some work, rather than the present round of coffee mornings and parties (and recovery from them the next day). Many students seem to expect to be supported in this life of luxury, in the belief that it is giving them a "broad general education" which they have a right to expect, whilst the less fortunate support them.

How many students, however, do you think would accept the idea of actually having to turn up to lectures? There would be howls of protest about the student's right to work in his own time without, in many cases, having to prove he is working until after three years of state support.

The sooner students start working for their living then the sooner they can start pressing for increased wages, commensurate with their abilities. They are not in comparison with many people, rather than their own well-off family background, on the poverty line. Students must realize that they have to prove themselves worthy of more money, which can only come by assessment of grant on the basis of academic standards or, as happens at the moment, higher wages for those with degrees, after three years of free support by others.

Yours faithfully,
J. H. HOUSE
(Final Year.)

Editor's Note

Mr. House's letter is in many ways entirely acceptable but he is writing under the assumption that the Bart's student body is representative of the average student. We are largely from better-off homes; we have an exceptionally good hall of residence; we have much less vacation work than any other course. The figure of £17 is for only 30 weeks of the year and jobs are not so readily available outside London, particularly in the depressed areas; in reality then £10 is a nearer figure.

As for his generalisations about parties, etc., this merely reflects the socialising minority who make the most noise and again is a phenomenon of the Bart's student rather than the norm.

The two-year course I would agree with entirely, but its main opponents happen to be the lecturers and university staff.

JOURNAL Mathematic Problem No. 5

By R. TREHARNE JONES

Imagine the Earth to be a perfect sphere, radius 4,000 miles, and devoid of all mountains and other irregular geographical features. Let a string be tied around the Equator such that the two ends of the string just meet at a certain point . . . the length of the string will now be equal to the circumference of Earth. An extra three feet of string is now tied into the main length by convenient knots that do not use any of the lengths of either string. The whole string (equal in length to the circumference of the Earth plus three feet) is now caused to be raised off the ground by exactly the same amount all around the circumference of Earth. By how much is the string able to be raised? I guarantee that if you succeed in extracting a value for this distance, you will repeat your calculation in order to obtain peace of mind; the answer is quite incredible!

Solution next month.

DR. C. S. NICOL - RETIREMENT

Dr. C. S. Nicol was appointed Consultant Venereologist at St. Bartholomew's Hospital in October, 1947, and he retired from this hospital in February of this year. He was born in 1914 in Dublin and educated at Harrow School. He qualified M.R.C.S., L.R.C.P. from St. Mary's Hospital in 1936 and graduated M.B.B.S. two years later. He obtained the M.R.C.P. in 1946 and proceeded M.D. in the same year. He was elected F.R.C.P. in 1962.

For two years after qualification Claude Nicol worked in various departments at St. Mary's, including the venereology and dermatology clinics. Early in 1939 he moved to Oxford to work under Sir Howard Florey, but he was a keen Territorial so was called up at the beginning of World War II. He soon became a Specialist in Venereology and was posted to the Royal Victoria Hospital, Netley, near Winchester. At that time most patients had to be admitted to hospital and when Captain Nicol arrived the venereology department had increased from one ward to fill most of the hospital. He took part in important research on fever therapy there. Later he was posted to the Middle East and became Adviser in Venereology to the 9th Army. After the war he remained in the Territorial Army rising to the rank of full Colonel and commanded 217 (London) General Hospital (T and AVR). While commanding this unit he was appointed a Queen's Honorary Physician, one of the few venereologists to hold this distinction. He retains a great interest in the R.A.M.C.; since 1967 he has been Honorary Consultant Venereologist to the Army, he still gives venereology lectures to young R.A.M.C. officers, and provides post-graduate training for specialist medical officers.

After the war Dr. Nicol went to the London Hospital where he became consultant venereologist. Later he left the London when he became consultant in charge of the department at St. Thomas' Hospital. Few, if any, other venereologists have been on the staff of three London teaching hospitals.

Despite these others commitment Dr. Nicol built up the Special Treatment Centre at Bart's from a very small clinic to one of the busiest outpatient departments in the hospital. He is a excellent venereologist who takes great pains in the care of his patients. He is a sound teacher and during formal and informal teaching frequently demonstrates his wide knowledge and experience. Shortly after taking up his appointment here he spent a year as Fellow in Medicine working with the late Dr. Earle Moore at Johns Hopkins Hospital, Baltimore, USA, where he took part in an important study on cardiovascular syphilis. Throughout his career he maintained a great interest in research projects and when he retired from the STC at Bart's, two major research projects he had started were in progress. He has published many papers and contributed to a number of books, including Price's Textbook of Medicine edited by Sir Ronald Bodley Scott, and Roxburgh's Common Skin Diseases by Dr. Peter Borrie. He is co-author of a standard textbook on Venereal Diseases.

Dr. Nicol has done much for the specialty of venereology. He has been Secretary and President of the Medical Society for the Study of Venereal Diseases. He has been Secretary General of the International Union against Venereal Diseases and Treponematoses and is currently Vice-President of this body. In 1968 he became Consultant Adviser in Venereology to the Department of Health and Social Security. In this role he has played a most important part in improving the Venereal Disease Service and so helping to combat the increase in the number of infections which has occurred in recent years. Through his efforts additional funds have become available for new and improved clinic premises, for new posts, and for research.

Though Claude Nicol has left Bart's he is still working at St. Thomas' and we wish him continued success in this and his many other interests in venereology. We hope that in due course when he leaves his departments south of the river, he and his wife will enjoy a well earned retirement.

THE N.H.S. REORGANISATION

D. F. ELLISON NASH, FRCS.

In 1958, under the Chairmanship of Sir Arthur Porritt (now Lord Porritt) there was established the Medical Services Review Committee. There were 43 members drawn from the Royal Colleges, Faculties and the British Medical Association. The terms of reference of this committee were, "to review the provision of medical services to the public, and their organisation, in the light of 10 years' experience of the National Health Service, and to make recommendations". Among the representatives were the Presidents of the Royal Colleges but this was a non-political committee, and it was made clear to representatives that they were there in their own right so to speak. The review turned out to be a much greater task than was expected and it was not completed and the findings were not published until 1962. Dr. Derek Stevenson, the Secretary of the BMA was Secretary to the Committee and an enormous amount of work went in to its proceedings in an endeavour to pinpoint the weaknesses of the NHS and other medical services. I had the privilege of being one of the RCS nominees and I recall at one of the early meetings there was a fairly vigorous discussion on abuses of the NHS facilities by the public. The interesting thing was that ultimately the Committee came to the conclusion that although the vast resources of the NHS were free to the public, there was very little abuse—a significant finding.

Perhaps the most outstanding deficiency was the fact that the country's services were divided into separate systems with very little liaison. There was the general practice service in which the individual practitioners had their contracts with the Ministry of Health (as it then was); there was the hospital service with its gross deficiency in building and equipment and ever rising expenditure, and there was the conglomeration of local authority medical services and the medical arms of the various Ministries. The report still makes interesting and instructive reading and 14 years later various recommendations are cropping up in multitudinous papers on hospital problems and postgraduate education which were dealt with very adequately and in similar terms in the MSR report. The principal recommendation of the Committee was that there should be established Area Health Boards to oversee and combine all 3 arms of the medical services. Since the publication of this report there has been a great deal of cross representation on committees, liaison and co-operation in all fields. Many of the advantages which we saw as arising from the establishment of Area Health Boards, have in fact been achieved in the intervening years. The proposed scheme of administration is shown in the chart, and it will be noted that the outstanding differences between this suggestion and the forthcoming re-organisation scheme is that the general medical practitioner services after April 1st will not in fact be under the control of the Area Health Board as the practitioners have their contracts direct through their Executive Councils (with a new name) to the Department. Similarly, the Board of Governors will no longer be funded direct from the Department of Health, but will have their financial provision allocated by the Regional Authority through the Area Health Board. For the first time for 850 years, our great teaching hospital will no longer have a controlling authority on the site. Although we are assured that the available funds for the first two or three years will be based on past requirements, it is a very clear principle of the new system that the finance provided by the Department of Health will be related strictly to the population of the hospitals' catchment area. Although a certain amount is allowed for what is known as the "import" work load from other areas, one of the disadvantages which we have suffered in all discussions about the hospital's future, is that the Department of Health steadfastly refuses to acknowledge the work load that comes from the vast commuted population of the City of London. It is not simply that people go sick when they are in London, but many of those who work in the City have come to regard Bart's as the City's hospital, and because of the ease of transport into the City under normal conditions from the suburbs, they still prefer to come to the City hospital.

In January, 1962, 10 months before the Porritt Report was issued, "A Hospital Plan for England and Wales" was published by the Ministry of Health. This was described as "a long term plan" for hospital development. Mr. Enoch Powell was Minister of Health at the time. Consultants all over the country spent many hours in discussion and planning committees producing the evidence on which this report was based. Two major schemes foreshadowed to start sometime after 1970, were a new out-patient department and a psychiatric day hospital at Bart's. Moorfields was to be rebuilt on the site of the Royal Free and a new hospital was to replace the present St. Leonard's Hospital and the Metropolitan.

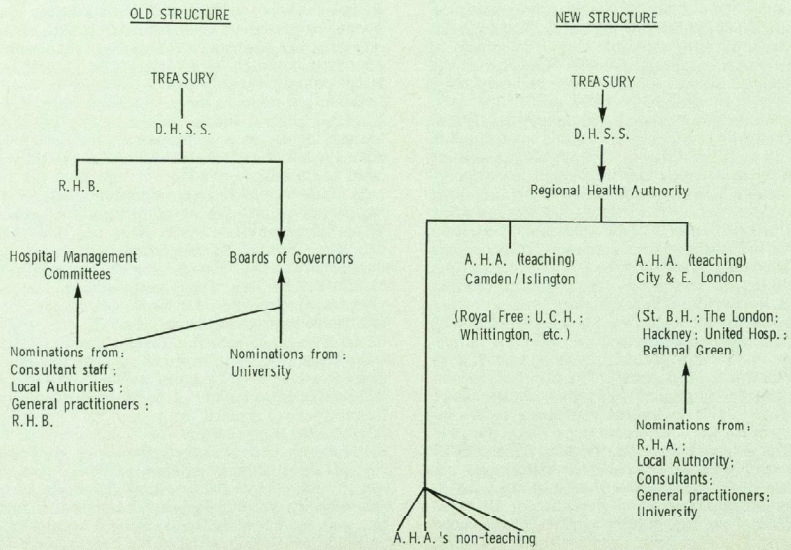
Population changes have led to a very marked reduction of the resident population of London and consequently there have been several reassessments of the needs for the hospital service. The present re-organisation was conceived by the Socialist Government and a consultative document (Green Paper) was debated

widely all over the country. When Mr. Heath's Government came into power another Green Paper was issued in which the principal changes were in the structure of the Area Health Boards. It was decided to "twin" the NHS re-organisaiton with that of the change in local government boundaries. The doctrine of "co-terminosity" grew up. It is because of this obsession with the doctrine that many hospitals which have been working very well together in co-ordinated groups, and with organised junior staff training programmes are now being split: it will be several years before the disadvantages inherent in this dehiscence have been overcome.

As far as our own hospital is concerned, there will clearly be many advantages. For 10 years the Medical College has not been provided with the facilities that it requires for teaching the number of students committed to its care. Repeated efforts on behalf of the Board of Governors to obtain teaching facilities in associated hospitals have been frustrated by lack of finance, or lack of accommodation and in the intervening years the number of students in clinical years has increased by 30-40 per cent. Joint staff appointments with the hospitals of the East London Group and the Hackney Group have improved the situation considerably, but some of us at any rate now look forward to a much closer association with the staffs of these hospitals and an opportunity to develop a co-ordinated policy both in the provision of medical services and in the teaching of students. In hospital planning the Department of Health works on what are known as "norms"—that is they determine what is considered to be the correct number of beds per 1,000 population. For acute conditions—that is everything except the long stay states—the national norm seems to be taken as 2.9 beds per 1,000. The actual requirement at present in the East End of London is nearer 5 per 1,000, and in some months of the year it is much higher. This is largely on account of the housing conditions and the fact that the general practitioner services historically have only been used by the population during the normal working day: there has been for many decades an ever open door for casual patients at St. Leonard's, the Metropolitan Hospital, Hackney Hospital, Bethnal Green, Mile End, Mildmay Mission and the two teaching hospitals in the Boroughs of Hackney and Tower Hamlets. To the west the Royal Free has served the population of Bloomsbury and to some extent overlapped with the services provided by Bart's for south Islington. With the recent move of the Royal Free to the north and with the closure of Charing Cross Hospital's Casualty Department, there has been an enormous increase in the work load here at Bart's. One of our main problems remains that of home conditions for many of the elderly patients living alone and with the re-arrangement of local authority medical and social services it should be possible to effect an earlier discharge for some of these patients.

The New Authorities

The Board of Governors in the past has had two functions—that of managing the hospital's affairs with its financial allocation coming direct from the Department of Health and that of managing the hospital's endowment funds as Trustees. This hospital has the reputation of being very wealthy, but its wealth lies in property and investments, the income from which can only be spent in accordance with certain provisions. For instance, endowment funds cannot be used for capital projects which would involve running expenses



unless these could be retained within existing NHS budget. Nevertheless, over the years by dint of good stewardship the Board of Governors has managed to underwrite a good many projects from the endowment funds in the hope that towards the end of the financial year the Department of Health would come up with a bonus from monies which they themselves have unexpended. The Board's faith and confidence in its own projects have been fully justified.

The endowment fund function of the new Board is vested in special trustees appointed by the Secretary of State and they will be responsible for the administration of the endowment funds. Nevertheless, there are restrictions on how the money can be spent and the representatives of the new Area Health Board acting as Trustees will ensure that the money is only spent in accordance with the overall plans of the Area in providing services. The massive contribution which the endowment funds have made to research will almost certainly continue.

The new Regional Health Authority—North East Thames Regional Hospital Authority—takes on the Board's function in relation to long term planning and overall strategic policy, whilst the Area Authority—the City and East London Area Health Board— takes over the management role. The same Area Board is responsible for The London Hospital and all hospitals within the Boroughs of Hackney, Tower Hamlets and Newham. This Area is divided into 3 Districts each with its own District Management Team. In each District there will be a District Medical Committee whose duty it will be to advise the District Management Team on the overall health services of the District. The functions previously carried out by the local Health Authority, the Port of London Authority and the School Medical Service are now included with the hospital services. The day-to-day operation of the hospital will be in the hands of a Hospital Administrator under the direction of the District Management Team.

The complexities of the Medical Advisory machinery at Regional, Area and District level are at present quite unfathomable and discussions are taking place all over the country as to how best these can be arranged. In the past at St. Bartholomew's, the Medical Council has been the formal Medical Advisory Body to the Board. There have always been consultant members on the Board appointed by the Secretary of State, but strictly their function on the Board has been to advise their lay colleagues in the decision making function of the Board, rather than putting forward staff policies. Now the Medical Advisory machinery has to embrace the District Medical Services and it is intended to set up a "Cog-wheel" medical staff structure right across the District so that there is unification of the specialists working in the various fields in all the hospitals of the former Hackney Group and the "United Hospitals" section of the old East London Group.

During the last 3 years there has been a joint working part studying the long term needs of the hospitals in this new District and we look forward to a very much easier system of co-ordination of our efforts to secure the mutual advantage of consultants, patients, and by no means least, of the students.

The recent cut-back in Government expenditure may well put paid to a good deal of our planning, but at least all the negotiations that have taken place have enabled the staffs of the various hospitals to understand one another's problems. One of the greatest dangers is that the establishment of so many new committees inevitably makes heavy demands on the time of the consultants involved and without increases in staff this in turn throws a bigger burden on the intermediate levels of staff, quite apart from the fact that a number of the junior members of the staff also have to act now in an administrative capacity on committees.

Membership of the New Authorities

It is at least some consolation for us to know that Mr. Louis Freedman who has been Chairman of the Development Committee at this hospital is a member of the new Regional Authority. We have, however, no medical representative at that level. (The author has been a member of the old Regional Hospital Board for 15 years). At Area level, there are 4 members of the old Board of Governors, Sir Robin Brook, the Hon. Mr. Peter Vanneck, Alderman Mrs. Sherman and the Dean. They will be in a position to advise their respective Authorities on the role which Bart's is able to play in the new co-ordinated service. The officers of the Area Health Authority are Dr. N. S. Galbraith, formally Medical Officer of Health for Newham, Miss A. P. Little (formally Sister Fleet Street) and Mr. Sotiris Argyrou who has worked closely with us as one of the administrative staff here and at The London.

The District Administrator is Mr. Dennis Jones, previously deputy secretary of the NE Metropolitan Regional Hospital Board, and we are very fortunate in having someone with such wide experience of planning and the machinery of central administration with which he will have to work. Mr. A. D. Stockmarr is the District Finance Officer and Dr. Lora Fry, formerly assistant MOH Hackney is the District Community physician.

In this topsy-turvy confusion, we have lost many colleagues whose services will be greatly missed. Some of our most senior staff have accepted "early retirement", and others have moved to new posts. St. Bartholomew's Hospital ceased to exist as a corporate body on April 1st, but as a reality in history, past and future, its "spiritual" body will be unsullied by the passage of time. Its staff and students will undoubtedly continue to replenish the credit balance in the bank of tradition and achievement in the care of the sick.

Mr. Ian P. Todd, M.S., M.D., F.R.C.S., will be the candidate from St. Bartholomew's at the forthcoming election to the Council of the Royal College of Surgeons of England. He is also on the staff of St. Mark's Hospital for Diseases of the Colon and Rectum, the King Edward VII Hospital for Officers and is Civilian Consultant Surgeon (Proctology) to the Royal Navy. He is at present an examiner in Surgery for the University of London.

No member of the staff of the hospital is at present on the Council and it is felt that this deficiency should be rectified as soon as possible. We sincerely hope, therefore, that Mr. Todd is elected on this occasion.

ARE YOU BEING FOXED?

I have lost count of the number of people who have said to me, "Oh yes, I'm opposed to stag hunting, otter hunting, badger digging and hare coursing but these thieving foxes have got to be kept down, haven't they?"

The image of the fox as a devilish, marauding killer of poultry and lambs, is so deeply ingrained in the minds of the public, that the fox will probably be the last British wild animal to be granted legal protection from the cruelties of the snare, the gun, poison and the "chase". And yet, if the fox does eventually gain the status of a "protected animal" it will be due to Man's insatiable appetite for scientific knowledge—ironic when one considers the number of animals which have suffered satisfying that same appetite.

Unfortunately, the fox's image is not only ingrained in the minds of the disinterested general public, but also in the minds of many of those who are loud in their opposition to traditional fox hunting. The result is a continual argument between hunt supporters and "antis" as to which is the best method of killing foxes. Not surprisingly, hunt supporters often come off better in these arguments, simply by pointing out the cruelties of snares, traps, poisoning and indiscriminate shooting, etc. "But then," say the antis, "fox hunting actually keeps the numbers of foxes up. Artificial earths, preserved coverts and the transportation of cubs, are all methods designed to keep the number of foxes up. Therefore hunting cannot be accepted as a method of keeping foxes down." All very logical stuff! "Ahha," retort the hunters, "if it wasn't for fox hunting, the fox would be ruthlessly exterminated by farming and shooting interests. Is that what you want?" "Don't try and tell us you are concerned for the fox," counter the antis, "you spend four days a week trying to kill them!" And so on and so on.

One can well imagine a fantasy situation of a portly, red-coated, and red-faced huntsman arguing, whip in hand, with be-spectacled, bearded anti, complete with banner. Backwards and forwards fly the arguments—scathing insults interjecting each point scored, "Upper class twit", from one, "Communist layabout", from the other, "Sadistic moron", returned by "Ignorant towny". While the dispute blazes, between them sits a curious fox, its baffled face turning first to one and then the other, like a spectator at Wimbledon. The fox, baffled, tries to interrupt, "Excuse me," the row continues, "Excuse me." The fuming adversaries are oblivious to all but each other. "EXCUSE ME!" explodes the fox. At last pro and anti hesitate and glare down angrily at the little animal. "What do *you* want?" they chorus. "Well, I just thought I would ask . . . I mean, just wondered . . . " and then seeing the impatience growing in the faces of the adversaries, "Well, what have I done, anyway?" Pro and anti, momentarily silenced, look into each others eyes. So far apart but still close enough to suddenly blast the fox with a chorus of "Don't ask silly questions!" And while the abashed and bewildered animal slowly wanders off towards his home in the woods, the hunter and the anti resume their hostile and irreconcilable argument as to which is the best method of killing foxes.

If their minds had been more open and their interests less narrow, they may well have recognised in the appeal of the fox, an old and simple adage. "Out of the mouths of . . . foxes?"

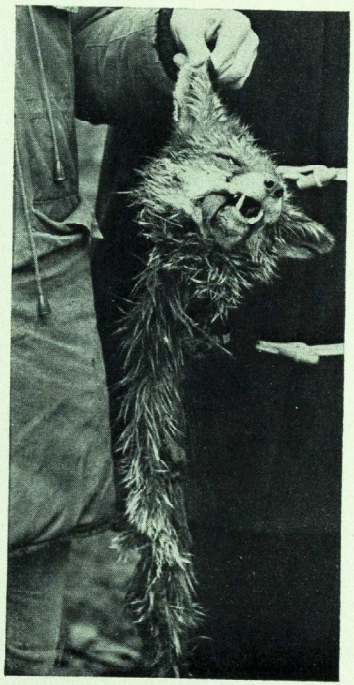
To control or not to control, that is the question—the question which only the human animal is capable of asking but which is asked by far too few. I believe that the "antis" spend far too much time and effort arguing the question of whether it is morally right for human beings to use the animal kindom for pleasure, profit or so-called advancement. The anti-vivisection movement has at last recognised this and are having considerable success by using scientific argument against the scientists. After all, sentiment and moral argument are unlikely to impress people who believe that to inflict venereal disease on to a chimpanzee is worth the Nobel prize!

So it must be with the anti-blood sport movement. Scientific research into the fox is not extensive and is somewhat fragmented, but there has been enough documented to give the anti movement a more impressive argument than any they could present on moral grounds—no matter how important that argument may be. The question of whether foxes actually need controlling seldom occurs to the man in the street. This is because he has been conditioned to believe that foxes are vicious creatures of the night which will kill poultry and lambs purely for fun. Take a look at a few children's comics, children's books and even television cartoons. The fox is always portrayed as the "baddy"—as of course, is the much maligned wolf. The "cunning" image is so popular that the fox has even been given a special place in the English language. If one has been "foxed" then one has been out-witted by some sort of superior cunning, and many a clever criminal has been endowed with the nickname of "foxy".

If one asks the average person whether the fox population must be kept down, he is likely to answer in the affirmative and if asked to explain why, he is likely to explain that foxes live off hens and lambs. In fact, the British public can be excused for believing this, considering for instance, that in the usual reputable Daily Telegraph of 17th July, 1973, an article on pests included the statement, "Foxes have been known to carry off pet cats, but generally their prey consists of chicken or lambs."

The tragedy is that such statements provide invaluable propaganda to those who kill foxes, either for sport or profit and any moves to protect the fox are doomed to failure while the great majority of the public remain so mis-informed. So how do we find the truth about the fox?

Obviously those who know most about foxes are naturalists, biologists and of course, "professional" huntsmen. Strangely, if one cares to look deep enough, it becomes apparent that many huntsmen are prepared to defend the fox in hunting literature. For instance, a British Field Sports Society fox hunting leaflet written by a Master of Fox Hounds, ventures the opinion that less than five per cent. of all foxes ever taste domestic poultry and that they live largely on beetles, frogs, rabbits, wild birds, carrion, rats and mice. In fact the author of the leaflet credits the fox with being the "biggest destroyer of rats and mice in the world". If that Master of Hounds is correct, then 95 out of every 100 foxes which he hunted to death, had never been guilty of killing even one chicken. Perhaps it should also be remembered that when that leaflet was first published, free range chickens were very much more in evidence than they are today and therefore the figure of five per cent. is probably much higher than would be a present day estimate of "poultry killers". As Doctor A. D. Scott, zoologist and writer, wrote in a recent letter to me, "How many people have experienced foxes raiding chicken houses? Only those who were either too lazy to lock up their hens for the night, or too careless. No-one can expect a fox to walk



After the Hunt was over . . .

The author, T. M. Bryant, is a member of the Council of the RSPCA and of the League Against Cruel Sports.

through a pen of unshut-up hens singing yield not to temptation. And foxes don't go around carrying screwdrivers with which to open locked hen houses. Anyway, the way the majority of hens are kept nowadays, most foxes don't even know what a hen looks like. So that lets the fox out as a poultry killer."

Naturalist David Stephen expressed the same opinion in his book "Watching Wild Life", as did another naturalist, Roger Burrows in his book "Wild Fox". Their informed views were supported by another Master of Fox Hounds, Lt. Col. E. F. S. Morrison, who pointed out in his book "Fox and Hare in Leicestershire", that when one compares the number of reported farmyard raids, with an estimate of the fox population, it becomes obvious that the regular diet of the fox is not poultry.

It appears then that the naturalists and the professional huntsmen agree that the fox's reputation as a poultry killer is largely unjustified. What then of lamb killing? The fox has a terrible reputation among sheep farmers, of that there is no doubt. In parts of Scotland especially, many think that no form of death is bad enough for the fox, and it is therefore ruthlessly exterminated with snares, guns, terriers, gas, poison and up to April, 1973, with gin traps. Popular opinion amongst highland sheep farmers is that any form of death is well deserved by the fox. But is such vehement persecution really justified?

That foxes eat lambs cannot be denied, but the important questions are whether foxes actually kill lambs and if so, how many? Once again one must turn to those who know foxes best—the naturalist, the biologist and, of course, the professional huntsman. And not just any huntsman! Take the words of the Duke of Beaufort, President of the British Field Sports Society and *the* Master of Fox Hounds, written in the Sunday Times, March 13th, 1955. "My ewes are lambing in a field bordering one of my own coverts where foxes abound, and so far I have not lost a single lamb, although owing to bad weather some are weak."

Another Master of Hounds, Frances Pitt, who is also a naturalist, was a contributor to the book "In Praise of Hunting". She also defended the fox, saying that although foxes will occasionally take small lambs, they are in her opinion, usually dead before they are carried off. Miss Pitt explained that foxes do quite a bit of scavenging for afterbirth and dead or dying lambs during lambing time.

Brian Vesey-Fitzgerald, author of "Town Fox, Country Fox", also pointed out in his book that finding lambs at foxes' earths does not indicate that they were in fact killed by the fox. Doctor A. D. Scott has analysed countless numbers of fox droppings as well as the stomach contents of many animals. He found that game birds and poultry were insignificant in the fox's diet and that the only two lambs he ever found at foxes' earths, were in fact dead before they were brought in.

The last word on lamb killing should surely go to a sheep farmer. Brian Hamilton and his shepherd were doubtful whether the fox's reputation was justified and so they arranged to collect from ten other farms, all lambs which had been allegedly mutilated by foxes. They carried out post-mortems on two hundred lambs and found that in every case, the lambs had been dead before mauling. Mr. Hamilton said that he had twice seen foxes leaving his lambing fields with lambs in their mouths and had he not frightened them into dropping the lambs, he would have been certain that the foxes had killed them. In fact, post-mortems revealed that the lambs were dead before being carried away, and therefore in 1962 when Mr. Hamilton found four foxes prowling around his flock, he was not concerned because he knew they were waiting for afterbirth or dead lambs.

Australian research has also shown that the fox's significance as a lamb killer is nullified by post-mortem evidence, revealing that of every hundred infant deaths only a maximum of two could be attributed to fox and crow predation. There are many such snippets of documented evidence which seem to prove that the persecuted fox badly needs a massive "public relations" job—a thought perhaps shared by Roger Burrows, who in his book "Wild Fox", wrote, "unfortunately, the fox suffers probably more than any other British mammal through a misunderstanding of its way of life. Popular misconceptions about the fox are so deeply ingrained that people find it difficult to be objective when talking or writing about them."

So there it is. With nothing but a slightly sympathetic shrug of the shoulders from the supposedly animal loving British public, fifty thousand foxes—a quarter of the fox population—are slaughtered every year by Man, either in the person of the hunter, the game keeper, the farmer or the pest control officer.

Fortunately, Mother Nature in her usual miraculous fashion, adequately rebuilds her fox population to around the 200,000 mark each year and perhaps here we could learn our greatest lesson. Controlling so-called pest populations by killing is proving to be an expensive waste of time. Nature dictates the populations of her animals by the availability of food supplies and there seems to be evidence to prove that the killing of a species actually stimulates greater breeding in order to restore the numbers to fit the food supply.

In Northern Ireland for instance, there has been a bounty scheme for fox kills since 1943. Up until 1954 the bounty was ten shillings per fox, and has been one pound since. About seven thousand bounties are paid each year but there is little evidence that there has been any change in the overall density of the fox population since the scheme started. The story has been the same with rats, mice and squirrels. The bounty scheme introduced twenty years ago in an attempt to exterminate the grey squirrel, cost £100,000 and had no apparent effect on the size and distribution of the squirrel population. Like-wise, the recent decision to approve the use of Warfarin poison in yet another attempt to reduce squirrel population, will probably prove to be costly and except for some temporary effect, insignificant in terms of population reduction.

This is not mere conjecture. When Warfarin was introduced for the control of rats and mice, it was hailed as the ultimate weapon, and yet we hear increasingly of "super-rats" and "super-mice", which have not only become immune to the poison, but which actually thrive on it. Nature has taught her animals that Vitamin K is a natural antidote to the Wafarin, which kills by causing internal haemorrhage. The more Warfarin is used to kill susceptible rats and mice, the more the resistant animals breed and therefore the resistance spreads.

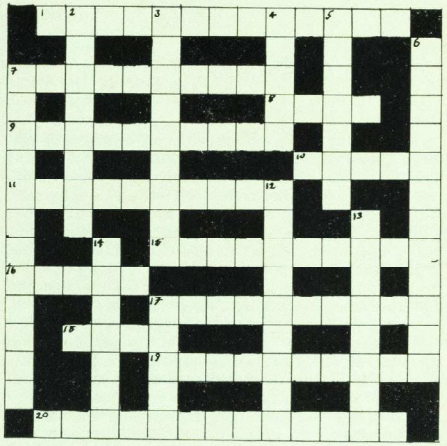
Similarly with rabbits upon which Man inflicted the horrific disease of myxamatosis. Despite the devastating effect on both the rabbit and our sensitivities, the rabbit population is now rapidly recovering, having been endowed with increasing immunity to the disease by wise, Old Mother Nature. Having "learnt" that myxamatosis is transmitted by fleas in the warrens, more and more rabbits are living above the ground. The more "warren rabbits" which die from the disease the more the resistant rabbits breed, and therefore the resistance spreads.

So it can be seen that the more so-called pests we kill, the more pressure there is on the species to breed replacements and the evidence appears to indicate that with or without killing, the population always returns to a figure equatable with the suitable environment and food supply. Surely that is a far more effective argument against hunting (or any other form of so called control) than a mere moral or sentimental opinion.

The art of compassion is in assuming the identity of the sufferer, whether human or animal, but once we have attained it, we must reinforce that compassion with strong logical, scientific and even economic arguments for the humane treatment of living creatures. Each unsubstantiated argument, every false motive, and all prejudice, utilized to promote and preserve cruelty, must be clinically dissected with the knife of truth.

No knife was ever as sharp!

CROSSWORD — RONTY No. 1



ACROSS

1. Star player Stan, losing articles, for new dance (6, 7)
7. Bouncer tore Maplin (10)
8. Risk rising just for a knife? (4)
9. A wrong maths credit endlessly gets direction. They are troubled by diminutive Royal Society (10)
10. About the way to commit ravages? (5)
11. Sounds knowledgeable, almost blind. Ug! Muddled? That isn't being helpful! (10)
15. Possible reaction to cute ration. Pardon? (10)
16. Illegal extension of 13 down? (5)
17. Neat topknot? No, more like a tree and sounds like an animal (6, 4)
18. No chess piece about this twisted rope (4)
19. Do people die of this in 6 down? (10)
20. Rules of the meeting? No, construction channels (8, 5)

DOWN

2. Former deed? No, it's extortion (8)
3. A company zither? That's a funny way of saying it! (9)
4. House emits smoke (5)
5. Possibly took advantage of a vile ad? (7)
6. Finally inn rule, not you, comes to nought? (2, 3, 4, 3)
7. Aid I can trust, possibly has an inherited soul? (12)
12. Obtains about a hundred rules? No point. That's a vicious turn (4, 5)
13. Tail about on a tree. Note, and struck a match (3, 1, 4)
14. Smells about a French church, caused by 7 across? (7)
17. Waste a minute inside the mist (5)

Solution next month.

THE TEACHING HOSPITALS OF IRAN

A Visit to Shiraz

By DAVID COOKE

In Fars, in the south-west province of Iran, nearly 600 miles from the present capital, Tehran, lies the city of Shiraz, itself a capital of the Persian Empire in the tenth and later in the eighteenth centuries. The city, with its roots going back as far as the Achaemenian period (550BC-530BC) is surrounded by mountains, but is itself on a plain at an altitude of 5250 feet. The population of 300,000 forms about a tenth of the people in the province of Fars, both the ethnography and the climate of which vary markedly within its boundaries. In the south temperatures of up to 130F (55C) were measured, whereas in the north of the province winter brings with it reports of 50 foot drifts of snow. Similarly the nomadic tribesmen of the north, as rugged as the hills in which they live, contrast with the people of the south who sit, drinking tea, waiting for something to turn up; admittedly an attitude towards which one rapidly develops an understanding, even an empathy, in the summer temperatures.

The Hospital and University of Shiraz enjoy a reputation which extends far beyond the provincial boundaries and attracts students from many overseas countries.

Six hospitals form the group at which students may study, the Saadi being the major teaching hospital and at the present time the largest in the group. The size and type of other hospitals in the group are shown below (Table 1).

The Saadi and the Nemazi are the hospitals at which students would spend most of their time, should they elect to travel there. Naturally in a country with an expanding population, paediatrics feature strongly throughout the hospital group, with 80 beds in the Gotbedin Hospital, 76 in the Nemazi, 50 in the Saadi and a further unit of 42 beds (which opened in November) in the Saadi which is devoted to paediatric surgery. Cases most frequently seen are gastro-intestinal disorders but also seen are pneumonia, meningitis, tuberculosis, leukaemia and Hodgkin's disease, in addition to the many other commoner childhood ailments seen in English hospitals.

Nemazi

Although it only has 272 beds at present, the Nemazi hospital is undergoing a large expansion scheme to reach a target of 500 beds over the next two years. At present a three-storey building set in a spacious park at the foot of the mountainside, on which the University is perched, forms the hospital and is comprised of the wards shown in table 2 overleaf.

The Outpatients Department at the Nemazi is kept fairly busy, on average 400 patients being seen each day at the four clinics (Medical, Surgical, Obstetric and Paediatric). Normally there are 16 operations performed each day in the operating suite which is made up of 4 operating theatres, 2 cystoscopy theatres and two cast rooms. About 200 per day are seen in the Emergency Department and usually the 8 beds in the Emergency ward are filled. For those patients admitted the average stay is of 8-10 days.

Saadi

The Saadi hospital is the main teaching hospital whose 384 beds are distributed amongst a wide range of facilities.

- A paediatric unit of 50 beds
- A paediatric surgical unit of 42 beds
- An obstetrics and gynaecological unit with a special unit devoted to abnormal obstetrics. Ninety surgical beds filled by patients undergoing all types of modern surgery, with two or three open heart operations each week, in addition to routine cardiac catheterisation. Also a renal transplant unit is kept fully occupied.
- A Radiology Department, working in close conjunction with the expanding Department of Nuclear Medicine at the Nemazi Hospital.
- The largest Accident and Emergency Department in Iran serving the 3 million people of the province.

In addition many smaller departments have been formed, such as the Department of Social Medicine and the Department of Rural Medicine. An up-to-date Post-Graduate Education Department has also been formed and is very active. Naturally all the essential departments found in a large modern hospital are also found such as blood banks, pathology departments and modern research laboratories.

TABLE 1. HOSPITALS IN THE GROUP AT SHIRAZ

Hospital	Beds	Classification	Function
Saadi	372*	free	Main teaching hospital
Gotbedin	80		General paediatrics
Nemazi	272**	private/insurance/free	Paediatrics/Medical/Surgical/Obstetrics/Metabolic and Outpatients Departments
Khalili	100	mixed	Eyes/ears/nose/throat
Hafez	100	private/insurance	Psychiatry
Pousti	100	private/insurance	Psychiatry

**expanding to 500 beds over the next two years.
*plus 12 intensive care beds.

TABLE 2. BED DISTRIBUTION PLAN AT NEMAZI HOSPITAL

Location	Function	Classification	Capacity	Average daily occupancy
Ground floor East	Medical/Surgical	insurance/free	45	45
Ground floor West	Paediatrics	insurance/private/semi-private	35	35
First floor East	Medical/Surgical	insurance/semi-private	36	36
First floor West	Paediatrics	insurance/semi-private/private	41	41
Second floor East	Surgical	private/semi-private	26	26
Second floor West	Medical	private/semi-private	23	23
Second floor North	Obstetrics	private	28	20
	Metabolic	free	10	10
			244	236

The remaining 28 beds are composed of the operations recovery room, the emergency department and the Out-patient Dept.

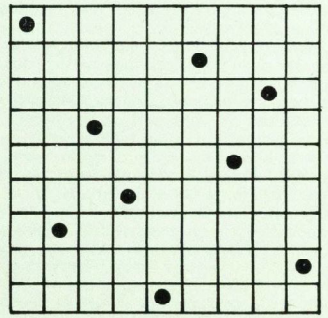
Despite the wide spectrum and the large quantity of clinical material available, the School restricts itself to 400 students (excluding pre-medical) of whom 280 are clinical. This clearly confers upon the school the advantage of more personalised tuition than is available, for example, in Bart's. Often a firm will have only 3 or 4 students, the largest being of 7 students. The American style of medical education is favoured, the students spending two years undertaking pre-medical studies in both the Arts and the Sciences before starting 2 years of pre-clinical studies (including anatomy, physiology, biochemistry, pharmacology and pathology). There then follows a four-year course of clinical studies during which the students enjoy a total of 75 days holiday (15 days in the 5th, 6th and 8th years and 1 month in the 7th year). Post-graduate education is expanding and recently the two-year orthopaedic and general surgical appointments were acknowledged by the Royal College of Surgeons as suitable training for Fellowship.

Making the Hospital particularly suitable for an elective period (even for those amongst us who have not yet mastered Farsi) is the fact that all the teaching, all charts, medical histories, drug notes, and records are in English. The Faculty at Shiraz is the only one to do this in Iran and consequently attracts a number of English and American students each year. Those interested in spending some time at the Medical College in Shiraz should address themselves to the Dean, Dr. Fahrpour, or the Assistant Dean, Dr. Haghighi. Dr. Houssaini in the Department of Admissions also deals with enquiries from those who wish to undertake all their medical training at Shiraz. At the Saadi, Dr. Zabihi, the medical administrator of the hospital, although extremely busy, is always ready to help and is prepared to refer letters to the appropriate Heads of Departments for those wishing to work in some special field during their stay.

Apart from the interesting clinical opportunities that Shiraz has to offer, there is much to see and do in the way of extra-mural activity, both within the boundaries of the city and within the province. Shiraz is known as the city of roses and nightingales, of wine and poetry (we couldn't find the nightingales however) and appropriately each summer a Music Festival takes place in the city, with items ranging from Maurice Bejart ballet and recitals by Claudio Arrau to Traditional Persian music and Indian folk dance.

Throughout the year visits can be paid to the nearby sites of Persepolis, Pasagardae and Naqsh-e-Rustam, in the surrounding province. Within the city are many finely decorated mosques and tombs to be wondered at and an interesting old bazaar under whose roof bargaining for items can be prolonged over two or three days. Visits to Iran have been simplified by the abolition of visa requirements for British citizens travelling to Iran. Help, advice and information is willingly offered by the Iran National Tourist Organisation in London and at the many INTO branches throughout Iran.

SOLUTION TO LAST MONTH'S MATHEMATICAL PROBLEM by R.T.J.



I would be interested to hear of any more symmetrical solutions.

NEWS AND VIEWS

A LOAD OF RUBBISH?

By ADDIS POSABLE

It is now very fashionable to talk about "preserving the ecology", conservation, and re-cycling waste. Of course nobody really cares about all these things, they are the latest fashionable gimmick that the media is putting across to us. Or are they? At least one large group of people appear quite capable of ignoring the writing on the wall, a group of people who, in the eyes of many, should care most about the environment. This group is of course our good selves, the medical profession.

One aspect of medical waste is the number of disposable goods used around the hospital. Is it really cheaper in the long term to use paper theatre hats and masks rather than wash cloth ones? In terms of the trees required to make them the answer is no. Are the number of disposable syringes used absolutely essential?—in my own experience I know the answer is no.

When we have used all these materials what do we do with them? Throw them away of course, like everyone else does—but is it really necessary? Two enterprising students recently tried to collect together a small proportion of the vast amount of paper that passes through the hospital. They failed because they could not find anywhere to store it, a ridiculous reason in a place as large as Bart's. They really failed from a lack of support and co-operation. It would be a simple procedure to collect all the patients' newspapers in a ward together and have them transported to a storage space to await collection, not to mention all the other paper rubbish that passes through the hospital. This could be profitable; two London Boroughs make a large sum of money every year in scrap paper and they have had to build special plants to sort it out. Any profit could be used to pay for any non-disposable theatre hats and masks.

To complete the cycle the hospital should insist that all stationery that is ordered is re-cycled paper; high grade paper is not necessary for writing notes on. Already there are companies selling fashionable writing paper made out of totally re-cycled paper. To be fashionable may well turn out to be cheaper.

The most blatant example of neglect lies in the centre of the hospital. Is it reasonable to take patients out in the sunshine amongst all those large cars? Is it reasonable to tell cyclists to walk in the square when sports cars can nip in and out at will? These vehicles pollute our lungs, our eyes, our cars, and since most take high octane fuels, our brains. Furthermore, how many hospital doctors carry large signs on their windscreens in the hope that they can park illegally and congest other parts of the City? Students are not completely blameless; how many can truthfully say they live in an area where public transport is so deficient that they have to drive into college every day? I can think of better uses for the college hall car parks.

These are just a few points, illustrations of the wide range of areas where as a profession we are doing damage or could be doing less damage. It needs little thought to expand the possibilities infinitely. Perhaps it is about time we came down from our collective pedestals and started worrying about the things that really matter instead of academic niceties.

A BIRRA YAR REEEEAL FING

Cheezizkrize, wozyacuntrycummintooay? Doanarstmee. Meenyacarn purrallyablaimon purolEefcanya? Lezzacors yorraredd (unnerabeddhah!). Meeneedinwonorl yariseinprizes diddeenah? Bleencorznot. Ieshasaysoe. Meenasae, wernizfall ifyerayrabsjakkedup yeroylprizeswurit? Corznott. Dinnarsya bleenmienersagornstryke diddee? Corznott. Dunnworreecood fyoreeconnmee dinnee? Ieshasaysoe. Dinneeven givya fazefreeacharnz yamienersdinn. Nobbleenlyekli. Wonnadooa deezndayzwere thaydoo. Norarf. Sposeyer-Arroldsgonnafixitall! Ieshasaysoe. Wunnlookatiman yermundaeclubll cumahtonstryke. Hoeyez! Thenwollappenay? YurEenokllaykover yorWolverammpen anchukorlya wogsaht. Bleengoojobieshasay. Norarf. Wunzallyawogsgorn beenuffjobs orlranneshafink. Corz, weewoanavnoe nashnllelfsurviz. Norpoe bussezantoobtrainz. Buwossimarray? Woanavnoe pakkiznyver. Ieshasaysoe.

SPORTING NOTE

Not content with the quaintly-sized 'rugby team style' firms that have come into fashion in recent times (i.e. 15-a-side with the consultant and henchmen acting as officials), there has now been a new departure of a somewhat Antipodean nature. Yes, 18-man firms have arrived, the same number as they have in Australian Rules football. Sadly, whereas the 'Rules' players have the Melbourne Oval to cavort around in, we only have the much-bedded area of two wards. Perhaps they will soon be handing round periscopes and oxygen masks (plus a speaking-trumpet for the consultant)!

ERRATUM

I have recently heard that, contrary to the sweeping generalisation made in my article in the April *Journal* on the hospital square, not *all* nurses receive subsidies for parking in the Aldersgate NCP car park. In fact, subsidies are restricted to those nurses resident in Gloucester House, and to non-resident Sisters. Apologies are therefore due to those who may have felt they were getting an unfair deal.

R.T.J.

MORE DOORS BORE

Around the latter days of March a strange new growth appeared in the casualty entrance hall, characterised by its metallo-glassy resemblance to a modern, undifferentiated double-door. "What is it?" cried everyone with puzzled admiration at its speedy rate of growth. Answers were many and various, the wisest suggestion being that the Works Dept. were preparing some elaborate joke for April Fool's Day. On hearing of its more permanent nature jaws dropped, ears popped, brows were mopped, etc., but all to no avail. There it stays, a useless space-occupying piece of modern bric-a-brac, providing nothing more than an extra obstacle for ambulance-men, porters, nurses, doctors and the occasional student as they struggle nobly to manoeuvre beds, patients, assorted trolleys, stretchers and the odd girlfriend through that particular zone. It is rumoured to be a device for preventing the continuous passage of unauthorised persons through casualty, but its modus operandi (can it recognise bona fide passers by some arcane photo-cell technique?) is yet to be elucidated.

LACK OF SUPPORT—ONE

At a General meeting of the Students' Union held earlier in the year, apathy that old friend of Bart's students raised its ugly head when a grand total of 19 persons turned up.

The chairman of the meeting while lamenting the lack of support resulting in an attendance of less than 40 per cent needed for a quorum for a meeting of this type, did point out that only five council members were present, being insufficient even for a council meeting.

Moral: If the Students' Union won't support the Students' Union who will?

LACK OF SUPPORT—TWO

The American craze of Streaking has finally reached the hallowed though drafty confines of the Medical College of the Royal and Ancient.

The viewing public of the "Wrong Box", a film shown by the Bart's film society, were treated to an added attraction of a Streaker. Not to be out-done three persons known to your reporter went on a midnight Streak around the Smithfield Meat Market. However, this time it was more a case of streakers being hit by a Londoner than London being hit by streakers. I have it on reliable information that a jovial market porter caught one of the streakers a hefty blow in the area of his gluteus maximi.

OVERHEARD

"Good morning Mrs. Jones, I'm a student."
"Yes, doctor."

BARTSFILM PREVIEW

By FILMFREEK

May 14—Fiddler on the Roof

The much-loved musical, starring Topol, directed by Norman Jewison, the maker of "In the Heat of the Night". Songs, dancing, tears, joy, smaltz, as the Jews wend their way to the long-lost homeland.

May 21—Snoopy Come Home

Avid readers of the back page of the *Daily Mail* and the inside back cover of the *Observer* Colour Magazine will delight in this, the cartoon film of the strip cartoon. The nasal whining of American kids' voices may prove disconcerting, and you have to be au-fait with American slang and customs, but Snoopy and his dream-world are all there. Seeing that beagle-philosopher, with his silly little suitcase, trotting along the bleak streets of the urban jungle is a most heart-rending experience—but all ends happily ever after.

May 28—Midnight Cowboy

"I'm going where the sun keeps shining,
through the pouring rain,
I'm going where the weather suits my clothes;"

Thus accompanied, soundtrack-wise, blond Jon Voight sets off by bus for the magic of New York. All he meets is disillusion, partly in the form of Dustin Hoffman, but the pair of them make for good watching as they struggle against the neutral wasteland of the big city. As the straightforward countryman and the little half-slick Ratso, Voight and Hoffman turn in some superb acting which is well-directed, sharp, funny and sad. Again, Americanism may spoil it for some.

June 4—The French Connection

Here it is, the seminal 70's cop movie, the basis of Gene Hackman's elevation to stardom, temporarily. Previous detective movies generally suffered from "glamourisation", and tended to look like nothing more than the fantasised wish-fulfilment of some super Hollywood hunk (which is exactly what they were). But here the director used non-handsome actors, put them in ugly, ambiguous situations and let them make plenty of mistakes. You see them running in fruitless chases, freezing to death on long, boring vigils, roughing up suspects with minimal results, and altogether making a right hash of the whole business. In fact the routine duties and slog of being a policeman get shown for what they are, nasty, brutish and short-haired. Yet it is a tense, exciting film—with Fernando Rey slipping around in the background as the cultured and slimy Frenchman who's cool never cracks. The chase is a real seat-gripper (or thigh-gripper if that is your wont) and the ending as bleak and cruel as can be. So its what we in the trade call a two-level movie, an all-embracing thriller while you watch yet a thought-provoking analysis of corruption when you brood over your midnight beers. Goodies and baddies aren't in it at all; people are just working away, without their own limitations, at what they think they ought to be doing.

FLUORIDATION

Tooth decay is mainly due to an excessive consumption of refined carbohydrates, the long-term effects of which may be more harmful to human health and general well-being than those caused by cigarette smoking. Fluoridation represents an attempt to protect man from the consequences of human folly without regard to the folly and its causes.

Since it has not yet found its way into every dictionary, let us first define the word fluoridation in the sense of *artificial* as distinct from *natural* fluoridation. It means deliberately adding fluorine in the form of one of its more soluble compounds to public water supplies in order to give the water a property it did not previously have and so to create a mixture capable of influencing the development of a part of the human body (the teeth); it means forcing people to consume something, in uncontrolled and uncontrollable quantities, that is known to influence bodily development and doing so without consumer-consent and even against the will of some consumers; it means trying to prevent a disease without regard to its causes; it means establishing a precedent for other forms of compulsory treatment of the human body, nervous system or mind.

Proponents of artificial fluoridation (hereinafter referred to simply as fluoridation) say it is one of the greatest discoveries in the field of medicine and dentistry of the present century. A medical officer of health once said it was comparable in its own field to the genius of space travel. Its opponents say it is little other than a commercially-inspired, government-sponsored hoax. Both groups cannot be right. Which is wrong?

The case in favour of fluoridation is based on the claim that drinking fluoridated water from birth will mean an average reduction of at least 50% in tooth decay. Carried to its logical conclusion, this unqualified claim means that whereas a person living in a non-fluoridated area may have lost all his teeth by the age of, say, 50, he would still have at least 16 sound teeth at that age if his water had been fluoridated before he had been born—a truly attractive prospect which has gained for fluoridation most of the support it has had from the public.

What grounds exist for the sweeping claims made for fluoridation? How did these claims first arise? They arose from observations during the first part of this century that in areas where the natural content of fluorine in the form of the fluoride ion in drinking water was relatively high, the incidence of caries in young children's teeth was remarkably low. In 1939 a chemist named G. J. Cox, then a research fellow at the Mellon Institute in Pittsburgh, USA, published a paper in which he suggested that the fluoride level of all public water supplies should be raised to 1 part per million (ppm). This level, which provides 1 milligram of fluorine per litre of water, has since been called "the optimum level" by the proponents of fluoridation —a purely arbitrary definition.

A few years after Dr. Cox had made his suggestion it received a tremendous boost from an article in *The Reader's Digest* of February, 1943, entitled "The Town without a Toothache"—and the writer would not be in the slightest surprised to learn that this article had been inspired by those who were promoting fluoridation in the background. On the contrary, he *would* be surprised if it were proved that this had not been the case.

The town said to be "without a toothache" was Hereford in Texas, USA, where the water contained from 1.5 to 2.5 ppm of fluorine. It also contained unusually high amounts of calcium and other minerals, but the effects of these on the people's teeth was entirely ignored, all credit for the absence of decay being given to fluorine. In fact, fluorine is by no means the only water-borne substance that affects tooth development and it is important to note that when the fluoride ion is present in water due to the environment and terrain through which the water has passed before reaching the water works, it generally has a relatively high content of other substances as well. Bore hole water nearly always has a higher concentration of these substances than surface waters. But as was the case in Hereford, the presence or absence of these other substances, and their effects on the human body, are generally ignored by the proponents of fluoridation.

Referring back to the research done by Dr. Cox— it must be noted that this was not pure medical research or research of an altruistic nature. It was *industrial* research, the ultimate purpose of which is always the making of money either directly, as by the sale or increased sale of products, or indirectly, as by finding uses for waste products. Dr. Cox had been commissioned to solve two problems (1) how to reduce tooth decay without reducing the consumption of sugar products (a sugar combines assignment) and (2) how to get rid of mounting stocks of waste products containing fluorine which were both expensive and difficult to get rid of due to their highly toxic and corrosive nature and which were leading to claims against industry for environmental pollution (an assignment from the aluminium industry).

		Average per child		Percentage reduction or increase(+)
		Baseline	Latest year	%
Full temporary dentition				
Age 3	Study areas	3·5	1·1	67
	Control areas	2·7	2·3	16
Age 4	Study areas	4·9	2·1	57
	Control areas	4·2	3·3	21
Temporary canines and molars only				
Age 5	Study areas	5·5	2·4	55
	Control areas	5·2	3·8	27
Age 6	Study areas	6·1	2·9	53
	Control areas	5·8	5·0	14
Age 7	Study areas	6·7	3·4	50
	Control areas	6·6	5·6	16
Ages 3–7	Study areas	5·3	2·4	55
	Control areas	4·9	4·0	19
Permanent dentition				
Age 8	Study areas	2·1	1·2	43
	Control areas	2·2	2·0	8
Age 9	Study areas	2·8	1·8	36
	Control areas	2·8	2·7	3
Age 10	Study areas	3·4	2·4	31
	Control areas	3·5	3·3	5
Ages 8–10	Study areas	2·8	1·8	36
	Control areas	2·8	2·7	5
Age 11	Study areas	4·0	3·0	26
	Control areas	4·0	4·0	+ 1
Age 12	Study areas	5·1	4·0	23
	Control areas	5·0	5·6	+11
Age 13	Study areas	6·6	5·4	18
	Control areas	5·9	6·9	+17
Age 14	Study areas	7·7	6·3	19
	Control areas	6·8	7·2	+ 7
Ages 11–14	Study areas	5·9	4·7	21
	Control areas	5·4	5·9	+ 9

FIG. A: from Department of Health figures. (See text)

Dr. Cox's solution to both problems was the novel and ingenious idea of extracting the harmful element fluorine from these waste products and its addition in the form of one of its compounds (sodium fluoride, sodium silicofluoride or hydrofluosilicic acid) to public water supplies in the proportion of 1 part of fluorine by weight to 1 million parts of water. Superficially, this suggestion appeared to be an excellent one. The constructive use of waste products is obviously a good thing, as is the prevention of tooth decay in children. These two facts quite obscured for the vast majority of people the question of the morality of forcing people to accept a prophylactic treatment whether they needed it or not, whether they wanted it or not, whether they might be allergic to it or not. Moreover, such was the urgency of finding ways to get rid of these waste products, and such were the advantages to be gained from Dr. Cox's suggestion, that those who stood to gain financially may have been less disposed than they might otherwise have been to question the morality, the effectiveness and the safety of the proposal.

So fluoridation was launched in the early 1940s, and following generally accepted sales techniques the shrewd businessmen behind the idea set out to persuade those whose support for fluoridation would most impress the general public, to jump on to the band wagon which they had built with the expertise gained from long experience in the marketing of new products. Their natural choice was dentists, most of whom were only too glad to support fluoridation if only for the reason that by reducing considerably the incidence of decay in the *first* teeth of children, what can be a most unpleasant experience for dentists can be considerably reduced—namely, the treatment of caries in children below the age of six. By persuading dentists that fluoridation was a good thing, and that by its public promotion they (the dentists) would be performing a service of great value, these businessmen soon built up a veritable army of unpaid agents who are now promoting their (the businessmen's) interests all over the world. This is an excellent example of that enterprise which has led to the saying *caveat emptor!*

Does fluoridation really reduce decay in the sense of preventing its occurrence or does it, as suggested by Weaver as long ago as 1944, merely postpone its commencement for a year or two? This question can best be answered by referring to a booklet entitled "The Fluoridation Studies in the United Kingdom and the Results Achieved after Eleven Years" published in July, 1969, by the Department of Health and Social Security. Reproduced above is a table marked A which appears on page 29 of this booklet which is the most up-to-date statement of the results of fluoridation. As will be seen, while the figures show that fluoridation had caused an average reduction of 2.4 decayed, missing or filled (DMF) teeth at age 3, amounting to a reduction of 67% (51% nett) this reduction had fallen to 1 DMF tooth at age 10, amounting to a reduction of only 31% (26% nett). The fact that fluoridation only delays decay is illustrated by the accompanying chart marked B compiled by the writer some years ago from the figures given in the Department of Health's table. The lines on this chart show that after a postponement of decay for a short period, the *rate of increase in decay* in fluoridated areas is almost identical to that in non-fluoridated areas. Those who are opposed to fluoridation do not accept that the official results published by the Department of Health justify its introduction even if the policy of using public water supplies as a means of administering a compulsory treatment were accepted as ethical.

In their efforts to provide evidence of benefits to be gained from artificial fluoridation in addition to the doubtful evidence provided by the Department of Health, the proponents of fluoridation often refer to areas where water supplies have an unusually high (i.e. up to 2 ppm) *natural* concentration of fluoride and argue that because teeth in these areas have less decay than those in non-fluoridated areas, the *artificial* fluoridation of water must be a good thing. They also argue that because people in these *naturally* fluoridated areas appear to be just as healthy as those in non-fluoridated areas, *artificial* fluoridation cannot have any harmful effects. These arguments are altogether specious and unscientific and one cannot help being alarmed at their use by people in the field of professional as well as general education.

Of course water influences bodily development and if it contains fluorides, teeth will be affected. But many other things in water affect teeth as well. Calcium, for example, not only affects teeth but also, in certain circumstances, helps to offset harm which might otherwise be caused by fluoride. But to equate *naturally* and *artificially* fluoridated water and to compare their effects without taking *all* other constituents of the two kinds of water into consideration, is not permissible. The only occasion when it might be both morally and

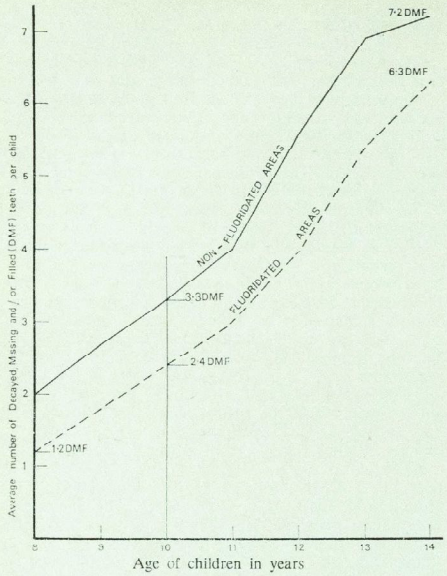


FIG. B: D.H.S.S. figures. (See text)

scientifically right to compare the effects of such waters on the human body, nervous system or mind, or on animal and plant life, would be when *all* the constituents of the two kinds of water were identical and in the same concentration. To compare the effects of these two kinds of water without regard to all other relevant factors might be regarded as a sort of "scientific dishonesty".

From the way they talk, some proponents of fluoridation seem to think that water is $H_2O + F$ and that if the F is missing, or in a concentration of less than 1 ppm, the liquid must be classified as "deficient water"—which is palpable nonsense. Chemically speaking, water is H_2O and nothing else, but by the time it has reached the water works it contains a large variety of substances which have been picked up from the environment, and by the time it has reached the ultimate consumer, even more substances may have been added, not excluding lead from the water system. In fact it is possible that some water may contain at least a trace of every known element, but such a possibility cannot be used as an excuse for adding more of any of them to suit the private interests of industrialists or for any other reason. The only justification for adding anything to public water or for treating it in any way before it reaches its ultimate consumer is in order to make the water safe, potable and fit for domestic use which principle had been meticulously adhered to right up to the time of Dr. Cox's odd suggestion. A policy which allows the authorities to give properties to water supplies which they did not have in their natural state in order to make them capable of influencing the development or functioning of the human body, nervous system or mind, would be most unwise politically and of great potential danger.

Having established from the evidence contained in the Department of Health's Eleven Year Report that artificial fluoridation merely delays the commencement of tooth decay, it is pertinent to ask—why does fluoridation reduce or postpone the incidence of dental caries in children? There seem to be two main reasons for this. The first is that the fluoride ion gives an abnormal hardness to the enamel of developing teeth, causing them to be resistant to decay for a longer period than they would otherwise have been. Some dentists are of the opinion that while this unnatural hardness may seem to be a good thing in that it delays the onset of decay, it is a really bad thing because if decay does start, as it is almost bound to do, sooner or later, if its causes are not removed, the teeth will be more difficult to deal with than they would otherwise have been, due to the brittleness of the enamel.

The second reason for the delay is that the fluoride ion appears to retard the development and eruption of first teeth. When this occurs, these fluoridated teeth become exposed to the risk of decay later than would have been the case without fluoridation. Since it is self-evident that the incidence of decay depends largely upon the length of time that teeth are exposed to the risk of decay, anything which delays eruption must delay exposure and the onset of decay. Therefore, if the *first* teeth of children of any age in fluoridated areas are compared with the *first* teeth of comparable children *of the same age* in comparable non-fluoridated areas, it will be found that the former will have less decay than the latter provided that all other relevant factors have been the same.

We now need to consider why fluoridation delays the eruption of children's first teeth. It has been suggested that this delay is attributable to inhibition of the normal process of tooth development resulting from the toxic effect of the fluoride ion on the action of enzyme systems which control, directly or indirectly, practically all the chemical reactions in the human body and thus the development of its separate organs. This leads one to wonder where else in the body or in the brain development is being retarded, *unseen and unsuspected*. Is it possible that a gradual, almost imperceptible poisoning of every man, woman and child in the country, which in time may affect their progeny, is the price we must pay to have this tap-dispensed "medicine" whose only "benefit" is to delay for a short period the incidence of tooth decay in children?

It is up to the proponents of fluoridation to prove that what is postulated in the previous paragraph does not happen, rather than for its opponents to prove that it does, as on general grounds any toxic agent taken over a long period always has an accumulative effect provided it is not excreted as fast as it is taken—and it is generally accepted that fluorides are not excreted as fast as they are taken into the body.

P. CLAVELL BLOUNT,
Chairman, National Anti-Fluoridation Campaign.

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

SMOKE GETS IN YOUR EYES

The 1974 Smoker entitled "Wine Committee Gymslip & Salivate Society production of Robigorelli" played to a packed house on its three nights of performance. For size its audience could not compare with that achieved by the other "G & S" society, this I feel due to limitations of space rather than merit. The performances were very amusing and smoothly executed in the true tradition of Bart's Smokers.

Rob Robertson, Martin Gore and their team managed to deal with a large range of subjects, most of which were topical. These included a sketch on the late, if I can dare say so, Energy Crisis, a cynical song in the style of the Everly Brothers sung in a fine tenor by Bill Gutteridge, and the Bart's version of the Galloping Gourmet. The first half was capped by the fairy tale of Peter PanZi. However this version, although performed in rhyme, could not be recommended for children's entertainment. Peter was played by Paul Cooper who gave a new image to the part, with Sue Boddy as the sexy Wendy and Rob Robertson as Tinkerbelle.

The majority of the material flowed effortlessly, but one felt that the laughs tended to be a little far apart to have their full impact. Last year's reviewer and I decided that while nostril jokes, and the large numbers of jokes about spheres of various dimensions could be considered to be "in", jokes about **** and **** were of doubtful if not questionable taste. The ladies concerned in the production attired in black evening apparel added considerably to the visual entertainment. Miss Davies even had me yearning to return to life in Charterhouse Square.

In the second half the suggestion of "bittyness" was stronger, but the American 20's sketch with Martin Gore as the detective Spirograph, whose first name I can't remember, did a lot to remedy this. I don't want to single out any one actor but Cooper was excellent. One felt that as soon as he appeared a laugh was imminent and this was so even when he forgot the lines of one of his songs.

The music in this production was partly made and partly accompanied by the group "Donkey". These four musicians were polished in their performance and I was pleased to note that music played a strong part, from Bach's Jesu Joy sung to four part male harmony in a public lavatory, to Rossini's William Tell Overture with a libretto of a General Election Campaign.

My congratulations to all concerned, for this was a well - produced performance which got audience response to every nuance and was given the applause it so rightly deserved.

CYFARTHA.

Your girdle's killing us . . .

BARTS DRAMA

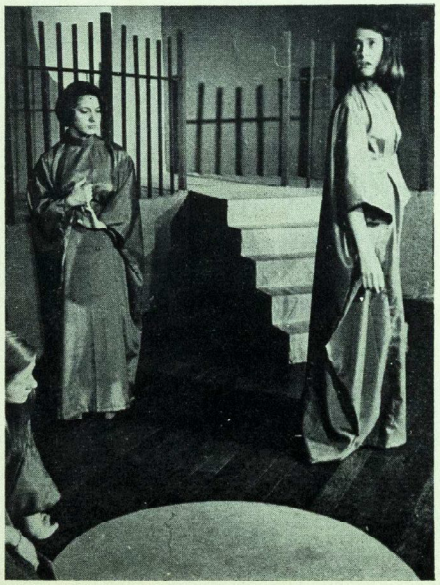
Sylvia Plath's "Three Women", a Poem for Three Voices, was originally written as a radio play and as such immediately presents problems for an aspiring production on stage. The setting is "A Maternity Ward and round about", but short of filling the stage with all the paraphernalia of beds, babies, nurses, etc., a symbolic set design is clearly required. Secondly a script meant to be heard must be used as the basis for something that is also worth watching. And having carefully mixed the visual and social elements, the cruellest trap of all, the trap of clarity, of clearly expressing written verse without descending into the realms of disjointed obviousness, has to be delicately circumvented. Furthermore this short one-theme, one-act play (one might call it a Meditation on Pregnancy) is even more of a self-contained entity than most of its ilk and requires a degree of concentration which a weak production could not justifiably demand.

I am glad to say that Olivia Hudis' presentation skilfully avoided the worst of these pitfalls, partly by a tight control of movement and colour on stage, partly by the use of a very well-chosen cast. For each actress at once succeeded in establishing a distinctive identity within the common ground of pregnancy and went on to develop it with little hesitancy and some fine, elegant diction. Rissa Chapman opened the vocal proceedings. "I am slow as the world. I am very patient," and her portrayal of the contented, calm matron set the norm against which the other two played less tranquil variations. She was very strong and a delight to listen to, the lynchpin of the evening.

Sarah Robertson, as the embittered sufferer of miscarriages, was a disturbing contrast to this background of acceptance. Despite the problem of having to start "cold" with no time to build up her anger (the play lasting in all some 40 minutes), she turned herself bravely into a stark, proud woman, facing "the incalculable malice of the everyday". Hers was the toughest part of the three and once in her stride she was an excellent display of sympathetic angularity. More ambiguous than either of these two, the third voice played by Louise Newbold was the most difficult yet the most fascinating to assess. For somehow she contrived to portray the calm, cold ability to dismiss her baby (it was a dream and did not mean a thing), while at the same time maintaining throughout a warm, questioning presence that finishes with the words, "What is it I miss?" To combine with such poise these variant attitudes of sureness and uncertainty was an extraordinary feat even though the role was of her age and situation.

With these three strong performances and a sympathetic, controlled direction there was a fine tension, a high level of interest, permeating the room. What could so easily have been a pretentious bore, especially since Plath's introverted, omni-feminine world makes no allowance for any watching males, in fact turned out to be a really engrossing 40 minutes. Having conquered this demanding yet ultimately rather precious little work, such a strong team should try a good, meaty piece; I'd love to see them, for example, take on King Lear's three daughters (hint).

T.T.



BARTS MUSIC

—A Concert in Bart's Great Hall on March 21st —

The Bart's Great Hall is an ideal setting in which to appreciate a Bach string concerto, but before the concert I was not so sure about its suitability for a full scale choral work. However, having heard the Choir and Orchestra of Christ Church, Woburn Square, under the direction of John Lumley, perform Ein Deutches Requiem by Brahms, my doubts were allayed; the sound of full choir and orchestra proved to be impressive.

Although there is some controversy as to whether it was Schumann's death or that of the composer's mother that inspired this Requiem, there can be no doubt that it is a masterpiece of balanced writing. From his deep knowledge of the Bible (even though he was not a religious man) Brahms himself was able to choose the text which he set to music.

For a choir of this small size (it numbered no more than 40) to tackle so demanding a score is indeed pleasing; however, one expects a greater degree of precision from a small group than from the large, unwieldy choirs of 200 or more, and in this respect it is a pity that the singers did not watch the conductor's beat more assiduously, as in several places (notably the fugue in the 3rd movement) their timing was somewhat wayward; nevertheless their singing was expressive, and though the orchestra played well throughout, at times they could not produce a sufficiently mellow tone to match that of the choir.

The 5th movement was most moving, thanks both to the perfect phrasing and wonderfully sustained tone of Joyce Collinson, the soprano soloist, and the sensitive accompaniment provided for her by the choir and orchestra together. The baritone solo passages were sung with great feeling by John Gamble, who extracted every ounce of drama from the music.

I was slightly saddened that it was chosen to perform the work in an English translation rather than in the original German, but this is a small reservation when considered beside the high standard of the performance as a whole.

Before the Requiem, we heard a lively account of the Bach double violin concerto in D minor; Valerie Palmer and David Hadwin played the solo parts, and despite some slight hesitancy in the flow of the concertante passages between the soloists, the performance was enjoyable.

The considerable applause given by the audience at the end of the concert was richly deserved by all the singers and instrumentalists, but most especially by John Lumley who ensured the evening was a success by his thoughtful and imaginative conducting and careful preparation.

ALLEGRO MA NON TROPPO.

CHORAL SOCIETY

The Choral Society will be performing The Seasons, by Haydn, on Thursday, May 9th, at 7.30 p.m. in the Central Hall, Westminster. Tickets priced 50p can be obtained by post from Box 16, Nurses Home, St. Bartholomew's Hospital, EC1.

The choir and orchestra of Christ Church, Woburn Square, will perform the Verdi Requiem on June 20th. The concert will be conducted by Mr. John Lumley and will take place at 8 p.m. in the Great Hall.

MAHLER AND CHORDS

Each of Ken Russell's films about the life of a composer has been followed by considerable comment, both verbal and written. To begin with there was nothing but praise, but more recently Russell has had to face much adverse criticism.

His television documentaries about the lives of Elgar and then Delius were both justly hailed as brilliant; his sensitive portrayals of these two composers have understandably received repeat screenings on several occasions. Later, also for television, came his impressions of Debussy and Richard Strauss; the former passed with scarcely a word from the critics, but the latter resulted in outpourings of abuse from stunned Strauss admirers, complaining at the incredibly biased and in some places frankly surrealistic treatment of this great composer.

Not long after this storm had blown over, Russell's full-length feature film "The Music Lovers" (ostensibly about Tchaikovsky's Life) started an even more heated and passionate argument. The lovers of Tchaikovsky's music are far more numerous than those dedicated to Strauss, and so not surprisingly there was a much louder voice raised in the defence of Tchaikovsky at so harsh a biography.

As "The Music Lovers" was very inaccurate in minor details, Russell's rather warped thesis held little credence for me; though I was angered that the director should present a superficial sensationalised portrait of the life of this tragic man.

After the premiere of "The Music Lovers", the music critic of the *Daily Telegraph* said "God forbid that he ever makes a film about Mahler"; well, whether to spite this critic or not I don't know, Russell *has* made a film about Mahler, which is due to open in the West End in April. No doubt there will again be much comment following the showing of the film (which, incidentally, has the simple unobtrusive title "Mahler"), but I for one hope it is once more congratulatory, indicating the return of Russell to his former compassionate self.

ALLEGRO MA NON TROPPO.

BARTS SPORT

HOCKEY CLUB REPORT—SEASON 1973/74

FIRST XI RESULTS:

Opponents		Score
GWR	L	0—1
UCH (league)	L	0—1
QE College (ULU Cup)	W	3—0
Caius	W	4—3
Trinity	W	2—0
St. Catherines	L	2—4
Selwyn	D	3—3
Kodak (league)	W	4—3
Kingston G S	L	0—8
Meadhurst (league)	L	0—2
Royal Naval College	W	8—0
Harrow HC	D	1—1
Imperial College (ULU Cup)	L	1—3
Imperial College (league)	W	3—0
UCH (UH Cup)	L	0—1
Sanderstead HC	L	1—2
HAC	L	1—3
ISH	W	16—1
St. Mary's College	W	4—2
Lloyd's Bank II	L	1—3
City University	L	1—3
Rolenmill HC (league)	D	2—2
Southgate IIa	L	0—3
Bart's H.C. Past XI (C. Reid, etc.)	W	3—2
East Grinstead HC	W	3—0

Record: P—25, W—10, D—3, L—12, GF—59, GA—45.

What a season it has been! Bar seven strokes of bad luck we would have won the Hospitals Cup! Our record speaks for itself; we were knocked out of the UH Cup in the first round, ULU Cup in the second, the league was a flop, and we failed to turn up to the ULU Sixes. However, we had some very good moments, notably an enjoyable Cambridge tour—with some very good hockey—, a very spirited win against St. Mary's College in the league, a superb Sunday at East Grinstead, an enjoyable game against Colin Reid's XI, and I am sure UCH will agree that both of us should have got into the next round of the Hospitals Cup!

John "Trifleman Billy" Linsell, Chris Hands (congrats on getting married) and myself continued to swell bar takings up and down the country, and Bruce Ferguson shaved his beard off. ANTONIA Scott won the club driving award, and I think it is safe to say that skiing and golf were once again the club's favourite pastimes.

For the devotees of hockey, here are some details about the players. Our back three, Ferguson, Linsell and Scott were the best players in the club, because they always played and developed themselves into a team within a team. Ali Alibhai and his goals brought a touch of class to the side, Tim Dudgeon some "over the ball" stuff, Martyn Procter a few goals and Martin Gillings a steadiness in defence which we will sorely miss next season; his international experience made him indispensible for U.H. and Bart's. Chris Hands, our famous inside right, showed for the second season running that he is no fool on the right wing, and Mike Lean was transferred to Stirling Albion for 50p, but we hope he will return soon, when Dave Sexton gets the sack.

The 2nd XI deserve a lion's share of the credit for keeping going under Steve Miller against all the odds, which usually included avalanches, earthquakes and not enough players. My thanks to the first year clinical for providing the entire team (whatever will happen in two years' time?). So on a closing note, I would like to say that it is not the fault of the players at Bart's that we could not mould the excellent nuclei in both XI's into winning combinations, it is the fault of the senior ex-members still at Bart's, who have taken the ball away and won't play with us anymore—but of paramount importance is that we have more hockey playing admissions into the college.

Finally my thanks to our long suffering captain Peter Donaldson, to the other officers, the regular members of the First and 2nd XI's who made it possible, the guest players, our hospitable and ever helpful President Mr. Jayes, and Professor Lawther.

Chislehurst Report

1. The pitches are very well maintained and frequently used by both male and female clubs.
2. We are indifferent to hot meals, we do not mind if they are implemented.
3. The idea of putting the equipment where the bar-billiards table is at present is a bad one.
   Most of our members and our visiting opposition disapprove of the television. Removal is recommended, or at least ex-communication from the main area within the pavilion (e.g., to the recess that now houses the B-B table).
4. The changing rooms are perfectly adequate, though they could be warmer, and some form of matting 'twixt changing rooms and bathroom would help to maintain the circulation in the soles of one's feet.
5. The swimming pool project is thoroughly approved of—without delay!
6. We support the ladies in their fight for respectable facilities.

MICHAEL ASHBY
Retiring Secretary of Bart's Hockey Club.

THE BADMINTON CLUB REPORT

The badminton club has been revived once again and currently comprises a nucleus of some eight aficionados. Mainly through a grant from the Student Union, the club was able to purchase several rackets and shuttlecocks; games and practising sessions are held in the gym fairly frequently and it is proposed to make Wednesday afternoon a regular meeting time.

January 31st saw the first away fixture against a similar standing club at the Middlesex Hospital. Although a friendly, the games were staged in a serious vein with Bart's going down 4—5 to what was in fact a mediocre farrago of Middlesex players; and this result expatiates the need for long sessions of serious practice. I feel there is sufficient enthusiasm in the club currently to make this venture worthwhile and I sincerely hope that hidden talent will reveal itself on future Wednesday afternoons when we invite all those who are interested in playing to attend.

One reason why a badminton club has not been successfully got off the ground in the past is I believe due to the despicable condition of the gym, probably at its nadir at the moment. Quite apart from the condition of the floor, it is always clogged up with debris from the drama club, rugby ball scenery, G. & S. scenery and even houses a boat at the present time. In such a condition the gym cannot be used for home venues, and this is a sad state of affairs. Surely it is about time the aforementioned clubs made a concerted effort to leave the gym clear except when they absolutely need to use it. I think that such an effort would not only encourage the badminton club but allow other sports, e.g., volleyball, basketball, etc., sufficient room for play.

A fixture list is being prepared for the future and it is hoped that new members will come to reinforce the present squad and inject life into the club; this will ensure that the venture will not be ephemeral.

PIERRE BOULOUX.

SQUASH CLUB REPORT

The club has had an enjoyable season despite only winning a few of its matches, for since we do not play in a London league most of our fixtures are friendlies of one sort or another against teams from the City. However, although not having a core of good players wishing to play regularly twice a week, we have been able to draw on some 20 players to fill the team places. This has meant a lowering of standards, but at the same time more people have been able to take advantage of the club's union grant.

The most successful evening was that occasioned by the re-institution of the staff match, on March 11th. Professors Shooter, Landon, and Fairley, Dr. Beard and Mr. White all seemed fair game, even with the agreed handicap. But they craftily re-inforced their side with two ex-stars of younger vintage, Drs. Burke and Firmin, so Alan Colver and Donald Bain had to be written off in the top two matches. However, Donald pulled off a great win and John Howell, David Dosseter and Trevor Turner were all prepared to put victory above career prospects, so we emerged com-

fortable winners at 4—3 (gulp). There were a few tight moments, but in general they managed to prolong things to the fifth game where superior fitness (mildly assisted by the odd decade or two in age) decided the outcome. Only Tim Dudgeon and Mike Lean failed us, the former being accused of "darker" motives, which he blusteringly denied, and the latter being well-known for his mercurial ineptness; but all was happily blurred in the Sutton Arms "apres-squash" where the staff entertained us handsomely. Our thanks to them for a most enjoyable and competitive evening.

N.B. The courts are badly in need of repair as this goes to press; hopefully April will have seen this task accomplished.

A. COLVER.

CRICKET CLUB REPORT

Preseasonal Summary of Fixtures and Prospects

With the large fixture list that the hospital cricket team has this year the members of the club are hoping for a good season both socially and in the UH Cup.

The officers of the club elected at the year's A.G.M. held on March 19th are as follows:

President:	Professor P. Lawther
Captain:	Tim Dudgeon (1st year Clinical)
Vice-Captain:	Alun Davies (2nd year Clinical)
Treasurer:	Ian Barrison (3rd year Clinical)
Preclinical Representative and Social Secretary:	David Cunnah (B.Sc. year Charterhouse)
Secretary:	Roger Bulley

This summer's fixture list includes a large range of matches, including those for the serious as well as the not so serious player. The provisional list is given below and includes a tour to be held at the end of the season in Sussex, which promises to be a very interesting week.

The prospects for the season are very good with many of last year's team still playing. However, as there is such a large list of matches this year any old or new cricketers interested in playing at least one game a week are welcome, and are urged to contact one of the above officers.

Saturday, April 27 ...	... UCH
Sunday, April 28 ...	... Carnegie
Wednesday, May 1	... Sussex University
Sunday, May 5 ...	... London House
Wednesday, May 8	... Royal Vets
Sunday, May 12 ...	... Gaities
Wednesday, May 15	... Medical Sickness Society
Saturday, May 18 ...	... Old Erithians
Sunday, May 19 ...	... Southend
Tuesday, May 21 ...	... UH Cup round one v. Kings
Saturday, May 25 ...	... St. George's Hospital
Sunday, May 26 ...	... Woodpeckers
Saturday, June 1 ...	... Hampstead
Sunday, June 2 ...	... Blackheath
Tuesday, June 4 ...	... 2nd round UH Cup
Wednesday, June 5 ...	... Trinity College
Saturday, June 8 ...	... Incogniti
Sunday, June 9 ...	... Loughborough Park
Saturday, June 15 ...	... Jesters
Sunday, June 16 ...	... Guys
Tuesday, June 18 ...	... UH Cup semi-finals
Saturday, June 22 ...	... Temple Sheen
Sunday, June 23 ...	... UCS Old Boys
Wednesday, June 26	... City Police
Saturday, July 6 ...	... Nomads
Sunday, July 7 ...	... London Hospital
Tuesday, July 9 / Wednesday, July 10 / Thursday, July 11	... UH Cup Final
Saturday, July 27 ...	... RNVR

The Cross-Country Team after a recent fixture.

1974 TABLE FOOTBALL CHAMPIONSHIPS

March 19th, 1974, saw the final of the Bart's Table Football Championship being played in the bar amidst much revelry, none of which was due to the football, but more due to the smoker, which was taking place at approximately the same moment in time. This final was, in fact, the climax of weeks of concentration, effort, and sweat loss, resulting in severely disturbed mentalities, physiques, and body electrolyte statuses.

All credit to Pete Farrow for organising the event, but though well publicised, entry for the event was poor. Admittedly, the real afficianados of the sport were the first to enter, but many other pairs could have entered, and done quite well, had there been a greater time interval between notice of the event, and last date of entry. This factor, coupled with saturation publicity, would probably have made a great difference to the size of the entry.

The tournament was for doubles only, and 16 pairs entered. The draw included four seeded pairs which comprised the following: Pete Kaplan and Pete Franklin, the previous winners of the Championship, had formed new partnerships with John Cooper and Pete Farrow respectively. The other seeds were two promising pairs—Dave Ryan and Roger Tackley, also Big Jim House and Boy Wonder.

The first round saw no serious upsets in the draw; suffice it to say that Frisch and Liz Anne were a bit out of their class against two semi-professionals like Dave Simpson and Eugene Yeung. Neither the hands of Safe Hands, nor the play of Killer, proved to be either as secure or as lethal as they might have wished. Big Jim and Boy Wonder counted themselves lucky to get through by default, as Colin Ferguson was away for the duration of the tournament, so that he and Tony Randall, who were regarded very much as dark horses, were unable to play.

In the quarter finals, Farrow and Franklin won their match by two games to one against Thomas and Patel, but Ryan and Tackley had little difficulty in holding off Blakeney and Chapman, whom they beat in straight games. Big Jim and Boy Wonder again won by default, since Messrs Capper and Renouf obviously thought it useless to fight against such opposition. The three seeded couples were joined in the semi-finals by Simpson and Yeung, who knocked out the seeded Cooper and Kaplan.

All matches played so far had been the best of three games, but for the semi-finals and final, the best of five games were played. Ryan and Tackley again won their match, but they were held to the full five games by Simpson and Yeung. The rate of ball play was quite fast in this game compared with the other semi-final in which Farrow and Franklin lost to Big Jim and Boy Wonder by 3—1.

The final was between the favourites for the championship, Ryan and Tackley, against Big Jim and Boy Wonder, who had only played one match in the whole tournament, so far. The match took 1½ hours to play, and went to the full five games. The first of these went to the favourites by 8—6, but they lost the next two games 6—8. The fourth game went well for Big Jim and Boy Wonder, who were 6—3 up at one point, but Ryan and Tackley managed to clinch it by 8—6. The fifth and final game also went to Big Jim and partner to give them the match and championship title.

Looking back on the game, it was interesting to note how new moves had to be evolved by both sides, as the well-practiced manoeuvres of each team were spotted and blocked by their opponents. This led to a very static rate of play, as more and more shots became designed as purely goal-scorers rather than one shot in a sequence that might have led to a goal.

R.T.J.

Editor's note:
For Boy Wonder, read Robert Treharne Jones.

BOOK REVIEWS

Nursing Books

GERIATRICS FOR PHYSIOTHERAPISTS AND THE ALLIED PROFESSIONS by Margaret Hawker.

Published by Faber & Faber Ltd. Price £1.25.

Miss Hawker has written this book with Physiotherapists in mind, but it would equally suit student or pupil nurses undergoing a course leading to State Registration. Presentation of the material is in a simple, logical fashion. The inclusion of the normal ageing process is most helpful. It allows the reader to appreciate the subsequent chapters. Aspects of geriatric care are considered under headings such as "the old person in illness", "hazards of hospital", "old people in the community" and "rehabilitation". The author has related aspects of rehabilitation to actual patient situations and this adds to the understanding enormously. Perhaps the inclusion of a few illustrations may have clarified some of the text. This, of course, would have added to the cost of the book. Without doubt this would prove a useful inclusion in all Nursing Schools' libraries.

PAEDIATRIC NURSING—Nurses' Aids Series by Margaret Duncombe & Barbara Weller.

Published by Balliere Tindall. Price 90p.

This is a new up-dated revised edition of the Nurses' Aid Series covering the treatment of sick children in hospital. New material is included on infant feeding, treatment of the sick neonate and advances in cardio-thoracic care, as well as a separate section dealing with handicapped children. This is an established text book on paediatric nursing suitable for students following courses leading to State Registration and Registration for Sick Children Certificates. It is within the price range of most students and is a "must" for inclusion in all Schools of Nursing libraries.

A. P. SMITH,
Nursing School.

ACUPUNCTURE—Cure of many diseases by Dr. Felix Mann.

Published by Pan. Price 50p.

Of the many ancient and empirical crafts long rejected by western science, acupuncture is at present attaining a position of some respectability, but only when used as an adjunct to standard medical practice. This is stressed from the start of Dr. Mann's new paperback, and all in all it makes for considerable credibility despite a certain lack of clarity. We are taken through the "Meridians", the "Twelve Spheres of Influence of the Body", the "Five Elements", the "Energy of Life—Qi', the "Principle of Opposites", and "Pulse Diagnosis", all of which can be vaguely related to physiological mechanisms. Plenty of clear, clean diagrams assist in some areas, and a final list of treated cases helps to strengthen the factual basis; sadly there are also some worrying anomalies.

For example, the opening storytelling of a "cured" acute appendicitis is most impressive to the layman (for whom this book obviously is written), but one hopes that no logical doctor would dare describe any acute abdomen as being automatically an appendicitis without having actually taken an inflamed appendix out of the offending abdomen. Secondly, the liver is claimed as the "most important organ in the body", yet the title of chatper 8 is "The Living Interdependent Dynamism of the Body"; is there not a touch of contradiction here? Finally, the underlying belief of the author, that acupuncture works somehow via the "referred pain" system, receives little support from the statistics of neurology cases where one cure is claimed out of 19 attempted.

I came to this book with a real anticipation, but by the end was bored and glad to have it off my plate, something which has never happened before in my reading of any clinically related subject. It is a praiseworthy attempt to popularise the ancient Chinese art, but over-condensation has produced a largely colourless and annoyingly disjointed volume.

T.T.

GOALKEEPERS ARE DIFFERENT by Brian Glanville.

Published by Puffin. Price 25p.

The author is a regular reporter for a Sunday paper and he uses this experience in a well-pitched tale about the rise of a young goalie through the mire of reserve football to the early heights of an F.A. cup final. In the main it is standard Boys' Own stuff; early promise; amazing saves; a bad period; carrying on despite an injury in the "Final" finale. Several sharp scenes stand out, in particular an hilariously banal after-match T.V. interview, but the hero has no truck with birds, problems, philosophies, etc. "They get a lot of time to think, goalkeepers. Too much if you ask me," is just about representative of young Ronnie's approach. But the use all through of real teams and real footballers (excepting the hero's own club) and some good financial detail gives the book quite a realistic air. Any soccer fan will therefore find it very easy reading if overall a little predictable.

T.T.

Hypersensitivity always gives itself away under pressure.

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So when you recommend Sensodyne remember the Softex brush. Together they provide the complete home treatment for hypersensitivity (12).

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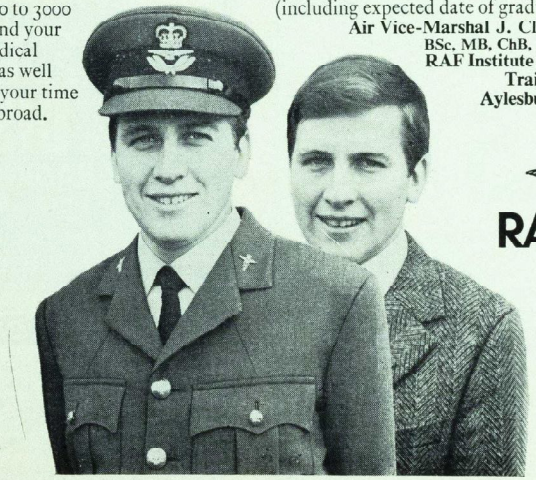

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RAF Institute of Health and Medical Training (26KR1), Halton, Aylesbury, Bucks, HP22 5PG

RAF officer
DOCTOR

SAINT BARTHOLOMEW'S HOSPITAL JOURNAL

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Vol. LXXVIII No. 6

Journal Staff

A PLEA FOR RESPONSIBLE PILL-PUSHING

Much of this month's issue is concerned with responsibility: in planning families, in educating and helping young people; in the moral uses of medical research. These are all areas where the medical profession is intimately involved—and yet slow the take a firm lead in advising and pressurising Government to formulate forward-looking policies. Obviously this raises the important question: should the professions (especially ethically-bound professions such as Medicine) involve themselves in politics? And the short answer to that question is: yes, at least, when problems on which they may have informed opinions are in debate. For example, in population planning the doctor's knowledge and experience is immensely valuable since he will ultimately be the means of implementation of the policy (though Professor Caspar Brook would disagree!). His views will affect the way in which the policy is implemented—and so affect the future of several of his patients.

Medicine is one industry which continually creates problems for itself just by its normal functioning. Witness not only the boom in population, but also the shifting patterns of disease and especially the increase in geriatric disease. It has been estimated that soon virtually all general medicine and surgery will be concerned with geriatric problems—and more and more acute general beds will become chronic geriatric ones. This is obviously an area where the medical profession has, yes, a responsibility to speak out and press for improved quality *and* quantity of geriatric facilities. There is of course a movement in this direction, but it is small and late in materialising.

At the other end of the age spectrum, family planning has recently become the doctor's domain with the Government's proposal to provide free contraceptives on request. This again appears to be a well-counselled move, and not solely so that zero population growth may be obtained. For, if Professor Campbell's frequent letters to *The Times* are to be believed, that situation has already been achieved, though unintentionally. Here the responsibility is the maintenance and improvement of that indefinable principle the Quality of Life. Thus the doctor's responsibility is to both the young child and the family, and to the unwanted foetus which might end up battered or neglected. And this responsibility extends to recommending that the latter should never be born—for the good of all. By further extension this responsibility applies also to the unmarried adolescent who may or may not have received previous health education. After all, to wish an unwanted child on a young unmarried girl (or on a loaded-down mother of six) by way of punishment for sexual misdemeanours is morally naive in the extreme.

The exhortation then is to stand up to our responsibilities at all levels of planning: family, government and society as a whole.

DR. WHO, HEAL THYSELF
(with apologies to St. Luke)

After a pleasant evening at "Three Women" in the Rec. Room at College Hall we repaired to the bar, for the proverbial swift half which lays the intellectual dust on such occasions, and found there another disturbing example of our fellows' irresponsibility. The trophy I am talking about was not the common road sign from "Ugley", or the naïve policeman's helmet, but instead an altar in perpendicular-style and Oxbridge Blue—an uprooted Police Box.

I had noticed the Box in question upturned and lying on its side in Smithfield—presumably due to some pointless collision on a sharp corner. I did not expect to see it again some days later in any civilised corner of middle-class reality, and especially not in that haven of respectability the Medical College. It is just another symptom (in the sense of something complained about) of an overt lack of responsibility shown by many groups of young adult males when confronted with symbols of authority. Elephants behave like it, as do young lions so I believe, and young East End kids do it. But animals are forced out of the herd and the kids end up with police records as long as Justice's sword. Only medics remain immune. And the result of this immunity is the continued irresponsibility of the minority.

There are other signs (in the sense of something elicited, usually by alcohol) of this malaise: smashed doors, and windows; vomitus on the stairs; milk going green on car roofs; and, on two occasions, dustbins through car windows. It seems that even this irreverence for man's most sacred possession does not stem the tide of childishness and damage. Frequently the perpetrators are outsiders, not students, people who have qualified but who have not severed the umbilical link with the sordid side of medical student tradition. Perhaps the link should be cut for them.

The points arising from this are, I hope, obvious. Drunkenness, theft and vandalism are stupid and childish in themselves and are poor substitutes for responsibility. But more important is the heinous lack of morality which allows these common criminals to condemn other young male offenders for the same crimes. There is no logic in the proposition that the former are just letting off steam while the latter are hardened thugs and of no value to society: there is no justification for violence on anyone's part. But a belief in middle-class morals and law cannot withstand being undermined by the activities of its own supporters. At least, not if you think about it.

ERRATUM

Last month we reported the engagement of Dr. Andrew Peacock and Miss Judith Marsden; this now seems to have been an elaborate joke brought on as the result of an excess of Firm Party punch. We apologise to all concerned.

SMALL AD RATES: 25 pence per column line. Contact Bruce Finlayson via M.S.C.R.

ANNOUNCEMENTS

Birth

ROSSER—On May 10th, at St. George's Hospital, to Hilary (née Courtney) and Mervyn, a daughter, Alice Hilary Jane.

Death

LOXTON—On March 25th, 1974, Geoffrey Ernest Loxton, M.B., B.Chir., M.R.C.P. Qualified 1936.

Appointments

Mr. M. H. Irving has been appointed to the new Chair of Surgery at the University of Manchester tenable at Hope Hospital.

Dr. A. Richens has been appointed Senior Lecturer in Clinical Pharmacology as from May 1st, 1974.

Dr. P. F. M. Wrigley has been appointed Senior Lecturer in Medical Oncology as from May 1st, 1974.

Dr. E. M. Rosser has been appointed G.P. Member of the Guy's Health District Management Team.

ADVERTISMENTS

Flat to Let: 6-18 months from July 1st, Swiss Cottage. Two bedrooms (sleeps 3), £10 per person p.w. Contact extension 383, or 328 1010 (evenings).

For Sale: Renault 12 TL, "J"-regd., 28,000 miles. Taxed, MOT, excellent order throughout. £725. Contact P. F. Meade via M.S.C.R.

HOP PICKING 1974
Applications are now invited for students to work the month of September, at very lucrative rates.
Hear what others have had to say:
"A third helping of blackcurrant and apple pie, please."
"Would definitely not make Jack a dull boy."
"More of a holiday than a job."
"Never before have so many done so little for so much."
For more information, contact:
ROBERT TREHARNE JONES
via the M.S.C.R.

NURSES QUESTIONNAIRE
A questionnaire was recently distributed to most of the hospital's nurses, and these are being returned at the moment. The results are proving most helpful, and in some cases, very interesting. The latest fact to struggle forth from our third-generation IBM computer, is that the fifth most popular topic in the *Journal*, from the nurses' point of view, is Case Histories! A full analysis and report, together with the first of the articles that we are commissioning especially for the nurses, will appear in the July issue of the *Journal*.

LETTERS

51, Sloane Street,
London SW1X 9SW.
April 30th, 1974.

Dear Editor,

Many thanks for printing my letter in the last edition of the journal, but judging from your own comment it was obviously open to misinterpretation. My chief object in writing was to express my appreciation of the unselfish services which the wine committee provides. I contrasted this with the behaviour of a small number of students involved in a particular demonstration; they were using it as a platform for highly irrelevant political ends.

Personally, I strongly support the need for higher student grants. I think it is more important for a student to have sufficient funds than a newly qualified doctor. The young doctor has ahead of him a high potential earning power and the knowledge that after a year or so of hard work he will earn relative financial comfort. For the student there is always the question mark of the qualifying examinations ahead. He needs to be able to enjoy his recreation time as much as his work time and the essential ingredient is money.

Following my letter printed in the April edition your letter addressed to yourself betrays in you the faults you seek to find in me, namely a lack of logic and the existence of prejudice. Surely to express one's views freely does not imply prejudice? As to the last paragraph, an extraordinary outburst from someone who has never met me, let alone seen my practice. You might do well to come and have a chat with some of our pensioners. I should be very happy to meet you here and show you around to give you some idea of what general practice means. Then you will be in a position to judge, but not before.

Your sincerely,

JOHN IND.

Dear Editor,

May I draw the attention of your readers to the fact that there is now a Social Club at Barts. Most people seem to ignore it completely—or perhaps, they do not know that it exists?

The club was started so that people from all parts of the hospital could meet informally in all kinds of activities. Probably the most important part, though, is the club room, which has a licensed bar where many people go to get a drink after work, at very low prices. Usually most of the people in the bar are lay-staff, although not all, but it would be nice to see more nurses, doctors, medical students, and others.

We have been trying out various activities such as: Folk-Nights, Discos, Table Tennis, Darts, Football, Guitar and Wine-making Classes. Some of these, and a few more, due to the lack of support, have fallen by the wayside, but most are thriving quite well.

At the moment, there seems to be a great deal of apathy in the hospital, and we too have had problems with bar staff, etc., but we are trying hard to overcome them and we really need your support.

Why not come and have a look at the club one evening? It's in the basement. In what used to be known as the "Red Room" next to the Consultants' and Registrars' dining room.

Yours sincerely,

JOHN WATSON,
Sports Chairman, Bart's Social Club

152 Harley Street,
London, W.1.
April 28th, 1974.

Dear Mr. Editor,

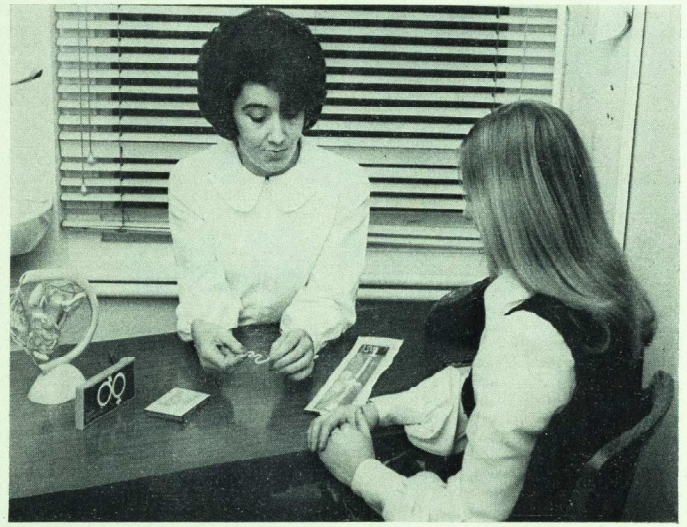
I was appalled by the photograph in your April number, showing how the hospital square has now become converted into a congested car park. I enclose some photographs taken in the period 1937-1941, showing firstly, how the square looked in the more peaceful days, before cars were admitted, and when it could be used more freely by bed-patients and others on foot; secondly, some effects of the blitz.

Yours sincerely,

ERIC C. O. JEWESBURY.

THE NEED FOR FAMILY PLANNING

By MARGARET POLLOCK



The Author explaining the use of an I.U.D.

Family planning is now an important element in preventive medicine and doctors, nurses, midwives and health visitors have been partly responsible for this major achievement. Voluntary organisations have been responsible for birth control clinics throughout the country since 1921. Their aims were the improvement of maternal and child health and the increase in marital harmony.

In the United States of America the nurse Margaret Sanger opened, in 1916, the first birth control clinic in Brooklyn and for this action she was promptly imprisoned. In England Dr. Marie Stopes, a geologist, opened the first British birth control clinic at Holloway in 1921. The birth control clinics had come to stay and the birth control movement slowly progressed.

By 1930 a number of societies were providing birth control services. To strengthen the movement the various organisations formed the co-ordinating "National Birth Control Council", which rapidly built up an impressive network of voluntary clinics and in 1938, with the exception of the Marie Stopes Clinic became a united body, The Family Planning Association, which now administers nearly 1,000 clinics and 80 domiciliary services.

Margaret Pollock, R.G.N., S.C.M., H.V., M.T.D., is Chief Nursing Officer of The Family Planning Association.

The programme for integrating the FPA's clinic and domiciliary services within Area Health Authorities has been agreed in discussion by the Joint DHSS/FPA Working Party and stated in the DHSS's draft Circular and Memorandum of Guidance on a Family Planning Service within the National Health Service (January 1974).

Domiciliary services: from April 1974 to March 1975.

Clinics: from April 1975 to September 1976.

It is however possible that some AHA's will not wish to integrate the FPA clinics in the foreseeable future.

The need to control fertility exists for the individual, the family and society. For the individual couple a successful method of contraception prevents unwanted pregnancies and the potential unhappiness which may result from the birth of an unwanted child. It is the way in which individuals can plan and space their families by giving them the freedom to choose how many children they wish to have and when they wish to have them. Family planning provides emotional and financial stability to those who have planned families of a size that they can cope with but more positively it is the means whereby society can work to conserve its resources and establish a better quality of life for the new generation.

Despite the fact that the maternal and infant mortality rates have declined phenomenally during the past two or three decades, even lower rates could be

achieved by encouraging family limitation, family spacing, and preventing unwanted pregnancies. Doctors and nurses are aware that mothers of large families endeavour to welcome each baby in spite of poverty and the strain of repeated child bearing and child rearing and that the appearance of an unplanned baby born into an unprepared, possibly reluctant family may result in anxieties about financial security which can often lead to tension between parents. The report "Unplanned Pregnancy" by the Royal College of Obstetricians and Gynaecologists Working Party (1972) stated: "The evidence which we received from the Medical Women's Federation expressed well some of the problems associated with an unplanned pregnancy in the very multiparous woman. They emphasised the risk to maternal health, the environmental stress, and the lowering of standards of living in the family. The social and economic problems created for the mother responsible for bringing up an illegitimate baby by herself need little declaration in the Report because they are so widely known".

It has been estimated by the Family Planning Association that approximately 11 million men and women use contraceptives out of an estimated 20 million people who are probably sexually active. Approximately 267,000 unwanted pregnancies occur each year in this country, many ending in abortion. In 1971 there were 126,000 legal abortions and in 1972 the figure was 156,000. Many unwanted pregnancies therefore continue to their natural outcome and the children born do not have the advantages of their "wanted" peers. In a survey of 120 children born after termination of pregnancy had been refused (Forssman and Thuwe, *Acta Psychiat. Neurol Scandinavica*, No. 42, 1966) it showed that in this group the incidence of delinquency and psychiatric illness was increased and educational attainments lower in comparison to families whose children were planned.

There is a need for family planning to control the population problem. There are approximately 3,700 billion people in the world today and this number is likely to double by the end of this century unless fewer children are born. The world population problem has occurred because of the rapid decline in the death rate during the last century as a direct result of improved housing, working conditions and developments in medical science. The progress made in economic and social conditions will be lost if the world population growth rate continues to increase as rapidly as it has in the past.

Already many countries face the problem of providing increased health services, building programmes in areas where there is already a shortage of space, food resources, educational facilities and other services from money which could otherwise have been used for development and to improve living conditions. Environmental problems are increasing day by day; they vary from country to country and are a reflection of the economic development which has or has not taken place. In some countries contamination of water supplies and soil degradation through misuse are the problems encountered and differ from industrial pollution of other countries, such as problems of solid waste, air poliution and marine pollution.

The advantages of a stationary population outweigh the disadvantages of an expanding population.

For family planning to be effective for society as a whole it is important that information reaches everyone. The medical and nursing professions have an important part in promoting family planning which, by controlling population, will provide greater security for future generations.

SPRING FEVER AWARD

Nominations were poor this year, but the yellow BMW (with tinted windows) in the Square gained most votes.

Obviously competitors will need to be more imaginative in future—perhaps a car actually through the door of James Gibb House would have been more highly praised. All entrants found wallowing in the fountain were disqualified for repetition.

Will winners collect their prizes (lead blinkers) from the Brain Ablation Lab.

Don't look behind you, Trev!

THE CONTRACEPTIVE PILL
ACTIONS AND ADVERSE EFFECTS

By ALAN RICHENS

The ability of progestogenic hormones to suppress ovulation first came to light in studies performed by Pincus and his colleagues on women who were unable to conceive. These agents were being tested in the expectation that a rebound increase in fertility might occur after stopping the hormone. Shortly afterwards, in 1955, formal trials were undertaken in Puerto Rican women to evaluate the contraceptive property of Enovid, a combination of 10mg of norethynodrel (a progestogen) and 0.15mg of mestranol (an oestrogen). So promising were the results that trials were soon under way in many centres, and before long the "pill" was a household word.

The pills most widely used are, like the original Enovid, combinations of a progestogen and an oestrogen. Only two oestrogenic compounds are used in the pill (Table 1), whereas a variety of progestogens have been used, synthesised either from 19-nortestosterone or from 17α-hydroxyprogesterone. Derivatives of 19-nortestosterone are metabolised to a small extent to oestrogenic compounds, unlike the 17α-hydroxyprogesterone derivatives, and this may account for their powerful ovulation suppressant action. Most combination pills contain a 19-nortestosterone derivative plus an oestrogen (Table 2).

TABLE 1

OESTROGENS AND PROGESTOGENS USED IN THE PILL

OESTROGENS	PROGESTOGENS
Ethinyloestradiol	**Derivatives of 19 nortestosterone**
	Norethynodrel
Mestranol (3-methyl ether of ethinyloestradiol)	Norethisterone
	Ethynodiol diacetate
	Lynestrenol
	Norgestrel
	Derivatives of 17α-hydroxyprogesterone
	Medroxyprogesterone acetate
	Megestrol acetate
	Chlormadinone acetate

Mode of action

The oestrogenic compounds ethinyloestradiol and mestranol suppress ovulation and, unlike stilboestrol, do not allow "break-through" of the pituitary resulting in ovulation. In combination with a progestogen, particularly a 19-nortestosterone derivative, the anti-ovulatory effects largely account for the contraceptive action. Other changes take place, however, and contribute to this action. For instance, pseudodecidual reactions occur in the endometrium and implantation of a fertilised ovum is impaired. The secretion of cervical mucous is reduced and its nature altered so that spermatozoa are less able to penetrate into the uterine cavity. Furthermore, it is possible that the function of the corpus luteum might be disturbed by 17α-hydroxyprogesterone derivatives.

Disturbance of pituitary function is evidenced by a failure of the normal premenstrual rise and midcycle peaks of luteinising hormone (LH) and follicle-stimulating hormone (FSH) to occur. The rise in plasma progesterone in the luteal phase is absent, and the biphasic urinary excretion of oestrogen, with peaks at midcycle and in the luteal phase, is lost. All these changes are consistent with inhibition of ovulation.

Types of contraceptive pill

These types are available:

(a) *Progestogen-oestrogen combinations* (Table 2). These are usually taken for 21 or 22 days of the menstrual cycle, starting the initial treatment on the fifth day (counting from the onset of menstruation). A tablet-free interval of 6 or 7 days is then allowed, making a 28 day cycle. Withdrawal bleeding occurs, of course, during the tablet-free interval. Some preparations include 21 active and 7 inert tablets so that patients who have difficulty in managing cyclical therapy can develop an unbroken routine.

(b) *Sequential pills.* These were developed in an attempt to achieve a more physiological control over ovulation. In the first part of the cycle, usually up to day 16 or 20, an oestrogen-only pill is taken, followed by a combined oestrogen-progestogen pill until day 25 or 26. A drug-free interval of 7 days is then allowed. Because of the predominant oestrogenic effect of sequential methods, cervical mucous production and endometrial development compatible with conception and implantation occurs and doses of 100μg of the oestrogen are required to achieve a low failure rate. Concern about the risk of thrombo-embolic disease with high-dose oestrogen preparations (see below) has limited the popularity of sequential pills.

(c) *Low-dose progestogen-only pills.* Concern over the adverse effects of oestrogen therapy has stimulated the development of pills containing only a progestogen in low dosage which is taken continuously. The contraceptive action with these pills is more limited, and ovulation can occur in up to 40 per cent of cycles. Biochemical changes in cervical mucus probably account largely for the contraceptive action. Break-through bleeding is common producing a high percentage of irregular short cycles. Although increasing the dose of progestogen reduces the pregnancy rate, the incidence of menstrual irregularities increases. This method cannot be recommended when a low failure rate is essential.

Alan Richens is Senior Lecturer in Clinical Pharmacology at Bart's.

TABLE 2

COMBINATION PILLS CONTAINING 50μg OF OESTROGEN

Proprietary name	Progestogen (mg)	Oestrogen
Anovlar 21	Norethisterone acetate (4)	Ethinyloestradiol
Gynovlar 21	" " (3)	"
Minovlar *	" " (1)	"
Norlestrin 21*	" " (2.5)	"
Norinyl-1 *	Norethisterone (1)	Mestranol
Orthonovin 1/50	"	"
Demulen 50	Ethynodiol diacetate (0.5)	Ethinyloestradiol
Ovulen 50	"	"
Eugynon 50	dl-Norgestrel (0.5)	"
Ovran	"	"
Minilyn	Lynestrenol (2.5)	"
Volidan 21	Megestrol (4)	"

* Minovlar ED, Norinyl 1/20, and Orlest 20 are preparations which include 7 inactive tablets to follow on 21 days of the active drug.

Adverse effects of the pill

These may be divided up into minor adverse effects which occur very commonly on starting the pill, much more serious effects which fortunately occur only rarely, and other less serious abnormalities which are reversible on stopping the pill.

(a) *Minor adverse effects.*

(i) *Nausea and occasional vomiting* is common in the first cycle but usually settles in subsequent months. If it persists, pregnancy should be excluded. Nausea is caused by the oestrogen component and a change to a less oestrogenic pill may help.

(ii) *Breast tenderness* and slight enlargement may occur during the first few cycles, but seldom causes persistent trouble. It is an oestrogenic effect similar to that occurring in pregnancy.

(iii) *Weight gain* is common with some progestogenic preparations but is usually small (a pound or two) and is lost after a few cycles.

(iv) *Break-through bleeding*, i.e. menstrual "spotting" occurring in mid-cycle, is seen frequently at first especially with low-oestrogen pills and low-dose progestogen-only pills.

(b) *Serious adverse effects.*

Thrombo-embolic disease. In the early 1960s, soon after the introduction of the contraceptive pill, reports began to appear of venous thrombo-embolism occurring in young women using the pill, and by 1966 a large number of case reports had appeared. As the cause of the disease in these patients could not with any certainty be ascribed to the pill, formal epidemiological studies were begun by the Medical Research Council and Committee on Safety of Drugs (now Medicines). These studies were retrospective, using matched control series of women. The results indicated that deep vein thrombosis and pulmonary embolism occurred more often than would be expected by chance alone in women taking the contraceptive pill. The relative risk was approximately 6-8 times greater in pill takers.

Supporting evidence has come from a number of studies. A trend has been shown in the death rates from venous thrombo-embolism in young women compatible with the increase in use of oral contraceptives and with estimates of the associated risks. An increase in the incidence of thrombo-embolism has been reported in elderly men receiving oestrogens for prostatic cancer, and in women in the puerperium who have been given the drug to suppress lactation. Changes in venous distensibility and blood flow can be produced by administration of oral contraceptives in some women. Furthermore, the clotting of blood may be potentiated by an increase in the levels of various clotting factors and an increase in the stickiness and aggregation of platelets. A possible predisposition to develop venous thrombosis has been suggested in one study because abnormalities of the fibrinolytic defence system were found in vein biopsy specimens taken from women who had previously had venous thrombosis while on the pill.

Not all studies are in agreement with the above findings. Although some of the earlier American investigations found an increased incidence of superficial thrombo-phlebitis, deep vein thrombosis and pulmonary embolism, a recent 7-year prospective study has failed to show a change in incidence.

Ischaemic cerebrovascular disorders. Two controlled epidemiological studies have supported the impression that the incidence of cerebral thrombosis is greater in women taking the pill. The risk is increased 5-6 times. Cerebrovascular disease is normally rare in young women, which makes even more impressive the numbers of such cases reported in relationship to the contraceptive pill. Several angiographic studies have shown a marked increase in the incidence of occlusive cerebrovascular disease between 1960 and 1966, during which time the use of the pill had become widespread. Although studies using mortality data have failed to find an increase in the death rate from cerebral thrombosis, this is perhaps not surprising for the absolute risk of death appears to be small in such cases.

Other cerebrovascular syndromes may be worsened by the pill, e.g. migraine. Focal neurological symptoms such as paraesthesiae or transient hemiparesis may occur for the first time. There is evidence that vascular headaches are more likely to occur in women who have well-developed rather than inconspicuous arterioles in the endometrium in the early phases of the normal cycle.

Assessment of the risk of thrombo-embolism associated with the use of the contraceptive pill requires consideration of a number of factors. The morbidity, and even the mortality, produced by other forms of contraception is not negligible and the risk of unwanted pregnancy may be higher than with the pill. Pregnancy itself causes an appreciable risk of complications, and legal abortion when unintended preg-

nancies occur is also not without hazard. It has been pointed out that one oral contraceptive pill is as dangerous as smoking one-third of a cigarette once a day for three weeks out of four[1]. Table 3 attempts to put the relative risk in perspective.

TABLE 3

Estimates of risk of death from pulmonary embolism or cerebral thrombosis in users and non-users of oral contraceptives compared with risk of death from certain other causes.*

	Age in years 20-34	35-44
Estimated annual death-rate/100,000 healthy, married, non-pregnant women from pulmonary or cerebral thrombo-embolism:		
Users of oral contraceptives	1.5	3.9
Non-users of oral contraceptives	0.2	0.5
Annual death-rate/100,000 total female population from:		
Cancer	13.7	70.1
Motor accidents	4.9	3.9
All causes	60.1	170.5
Death-rate*/100,000 maternities from:		
Complications of pregnancy	7.5	13.8
Abortion	5.6	10.4
Complications of delivery	7.1	26.5
Complications of the puerperium:		
Phlebitis, thrombosis and embolism	1.3	2.3
Other complications	1.3	4.6
All risks of pregnancy, delivery and puerperium	22.8	57.6

* Taken from INMAN, W.H.W. & VESSEY, M.P. (1968) Br. med. J. *2*, 193.

In 1970, the Committee on Safety of Medicines considered that the evidence incriminating the oestrogen component of the contraceptive pill was strong enough to recommend that preparations containing no more than 50μg of oestrogen should be used. Low-dose progestogen-only pills seemed to be associated with a low risk, whereas sequential preparations produced a high risk.

Myocardial infarction. Conflicting reports have appeared on the incidence of myocardial infarction in young women on the pill. Although earlier studies indicated that the risk was not increased, the incidence of pill taking in young women admitted to one coronary care unit was recently shown to be considerably higher than the expected incidence.

Hypertension. Several studies have now shown that the systolic blood pressure is on average significantly increased by the contraceptive pill, but the increase in the diastolic pressure is, in comparison, small. Some women seem to show a marked rise in blood pressure and several high risk factors have been identified, such as obesity, a past history of toxaemia of pregnancy, and a family history of hypertension.

Jaundice. It is not surprising that oral contraceptives can cause jaundice, for many are 17α-alkyl-substituted steroids, and compounds of this type were known to be capable of causing cholestasis before the pill was introduced. Women who develop jaundice often show mild abnormalities of liver function, such as impaired bromsulphthalein excretion, when not on the pill, and might therefore have mild disturbance of bilirubin excretion such as occurs in the Dubin-Johnson and Rotor syndromes.

(c) *Other adverse effects.*

The contraceptive pill has been held responsible for a number of other adverse effects, although in some cases the relationship has not been convincingly proven.

(i) *Amenorrhoea* on stopping the pill occurs occasionally and can sometimes be prolonged. It is most common in women in whom regular ovulatory menstruation has never been properly established, and in those with long cycles.

(ii) *Depression, headaches and loss of libido* occur frequently and are the most common reasons for stopping the pill. They occur more often in women who have a previous history of depression. It must be remembered that these symptoms are common manifestations of anxiety, e.g. about an unplanned pregnancy, and should not always be put down to the pill.

(iii) *Impairment of glucose tolerance* can be caused by an effect on peripheral glucose metabolism, and occurs particularly in women with a family history of diabetes. Pre-existing diabetes may be worsened. Elevation of plasma trigylcerides, cholesterol and lipoproteins is sometimes seen, and pancreatitis accompanied by hyperlipidaemia has been reported.

(iv) *Fluid retention* can occur, and care should be taken when prescribing for patients with renal or cardiac disease.

(v) *Vitamin levels* can be altered. Low serum folic acid levels and high vitamin A levels have been reported, but the clinical significance of these changes is uncertain.

(vi) *Pre-existing diseases* may be modified by treatment with the pill. Patients with hormone-dependent cancers, such as breast tumours, should not be given the pill. Chloasma and skin pigmentation may increase. Varicose veins become more pronounced.

Conclusion

Most of this article has been devoted to a discussion of adverse effects caused by the pill. Because the pill is given to healthy young women any adverse effect is important, but the great rarity of serious effects should be stressed. Although the risk is a definite one, it is taken by women who would otherwise run the risk of pregnancy and its complications. The pill carries the lowest failure rate of all available methods except sterilisation, and remains one of the most acceptable of contraceptive techniques.

Reference

[1] POTTS, D. M. & SWYER, G. I. M. (1970). Br. med. Bull. *26*, 26.

ON THE GRAPEVINE

By JANET EVANSON

Grapevine is an experimental project sponsored by the Family Planning Association, which is testing ways of involving young people in bringing reliable information about health and sex education, as well as more general information, to out-of-school adolescents and young adults. It is now in its second year and will shortly be evaluating its findings and making proposals for the future.

The situation which prompted this experimental work was as follows:

1. the Registrar General's statistics show a rising trend in the number of abortions, shotgun weddings, illegitimate births and cases of VD among teenagers and the under 16s;
2. sex and health education programmes in schools are uneven in quality. Often the emphasis is too biological or clinical to have any effect on actual behaviour, even in those cases where the language is understood;
3. many parents feel ill-prepared and embarrassed about broaching the subject of birth control, which implies sexuality, with their children; this results in a repeating pattern of inadequate sex education by one generation of the next;
4. many young people pick up their information from school friends who may themselves be grossly misinformed (Schofield, 1973). They do not know where to turn for reliable help with their emotional problems.

Community Approach to Health and Sex Education

The groups of young people which Grapevine is most concerned to reach are those who are least likely to be influenced by normal channels of communication and are suspicious of what they might see as propaganda aimed at the young by the Establishment. They are the groups most likely to have missed out on helpful preparation for life by parents or teachers and are particularly vulnerable to the mishaps which may result from sexual experimentation by the naïve and misinformed.

Such young people do not visit a clinic or their family doctor for birth control advice even though they are sexually active, and would be most unlikely of their own accord to take advantage of the young people's counselling services on offer (whether by counsellors, teachers, doctors or others) in the event of a serious personal problem. The reasons for this reluctance are various but include rejection of the supposed values associated with such services and sheer nervousness, based on ignorance or misinformation, about the medical and other procedures to which they may be subjected.

A basic assumption of Grapevine is that since this is to a large extent a communications problem, those most likely to make contact with the target groups in any meaningful sense are other young people, and the best place for them to meet is in the pubs, discos, and coffee bars which they normally frequent.

The Grapevine approach is therefore to build a team of young people drawn from the local community who between them provide a network of communications at every level. The age range of team members is 16 to 30 and they work with out-of-school adolescents and young adults from 13 to 30. So far, Grapevine has recruited 77 young people, who, after training, work in a voluntary capacity with Grapevine in the evenings and at weekends. These volunteers, between 20 and 40 of whom are active at any one time, are trained and supported by other young people with professional qualifications in health and sex education, youth work or counselling, who are retained on a full-time or part-time basis. The project is supported by the Project Manager and External Supervising Consultant (a Consultant Psychiatrist), who take a special interest in the counselling, training and research aspects of the work.

Grapevine's attraction for young people is probably due to the fact that it so obviously is what it claims to be—a group of young people just like themselves, drawn from a wide range of backgrounds, who are prepared to help in practical ways, and have access to reliable information and useful friends. There is no élitism about Grapevine workers and they are prepared to take their share of brush-offs in their efforts to let it be known how Grapevine can help.

In the first 15 months in the Centre, over 1,000 personal contacts have been made with young people locally, and slightly over half of them have proved to have a need for information or help of some kind. In addition to these face to face personal contacts, there have been innumerable fleeting contacts in the course of leaflet distribution, and a considerable body of work with groups of young people in clubs, schools, at the Centre and various other places. So the total number is much larger. Groups of Grapevine workers have also gone down to Pop Festivals but this is exceptional, as the target area for the two-year experimental period is the two Inner London Boroughs of Camden and Islington.

Another side of the work is the telephone information service which, after a predictably slow start, is now picking up well. Over one-third of the information calls received in the first 16 months have come in the first quarter of 1974, many of them in response to advertisements in *Time Out* and advertisements on a number of local buses. A surprising number of these calls come from young people with serious psychosexual problems and while a proportion of them no doubt ring round all the agencies in turn, on the whole they represent a population which seldom reaches the hospital psychiatric unit. Success has been achieved in a number of cases, after a series of telephone conversations, in getting the person to call in for a preliminary "chat". This in itself may be sufficient as a temporary measure, but in cases where the client expresses a wish for ongoing professional help another difficulty arises: as likely as not the client will be sufficiently confident to present himself again at Grapevine in order to meet the doctor or counsellor but almost certainly he will be unable to keep a hospital appointment *unless* he has first met the therapist at Grapevine.

Janet Evanson is Grapevine Project Manager.

Much of Grapevine's work is carried out among boys and young men, both at the information and counselling level. It is therefore important that the young volunteers should have a good understanding of the correct use of the sheath both as a protective against conception and as affording some measure of protection against VD. Up till now contraception has usually been thought of as the responsibility of the woman and, as it is usually she who consults her GP or the clinic, there are more opportunities for women to seek advice on any sexual problems which may exist. There are in fact very few places where a young man can go easily to talk over a sexual problem and such places as exist are little known to the young.

All Grapevine volunteers go through a basic Workshop training when they join, in the course of which they see some sex education films, discuss the various contraceptive methods with a FPA doctor, and in the course of many discussions, examine their own attitudes to sex education, to their own sexuality and how Grapevine should be approaching its work. In the course of the Workshop, volunteers usually visit a Special Clinic and a birth control clinic specialising in young people so that they can ask questions freely about the procedures and thereafter speak from first-hand knowledge. They also visit some of the work situations and meet the volunteers working there before committing themselves to a particular work group.

Work groups usually specialise in a particular aspect of the work, be it work in musical pubs, in the streets and street markets or by invitation in clubs and schools. Each group is supported by a Counsellor or Field Officer and training continues by means of experience in the field and group discussion. There is also a volunteer information/training group which suggests speakers, visits, social events and other proposals which they feel will help forward their understanding and enjoyment of the work. The vanguard group, by contrast, does not meet regularly but its members can be called on for special jobs.

It may be asked: how does all this relate to doctors and medical students at Bart's? The point to emphasise is that Grapevine's young workers are working as bridgebuilders between the medical profession and the target groups. They have no wish to involve themselves in matters which are better left in medical or nursing hands. Having informed and reassured themselves in the course of their training, they are ideally suited to spread reliable information among their peers and to encourage others to take their medical and emotional problems, at the earliest opportunity, to the right people.

In conclusion, it needs to be emphasised that Grapevine takes a comprehensive interest in meeting any need for information or help which young people present and records are being kept showing the breakdown of problem areas and the outcome. It has been found so far that roughly half of all young people contacted by Grapevine have a need for information or help of some kind, and 55 per cent of this group have needs which can be subsumed under "sexual relationships".

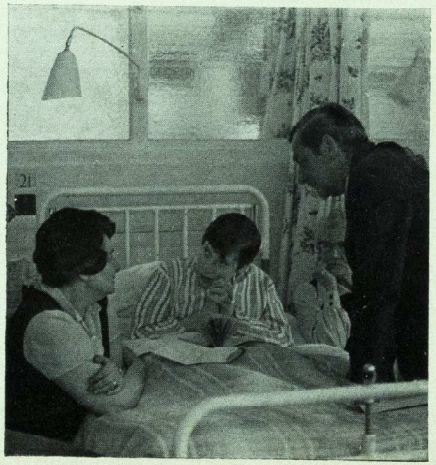
A full report on the developments of the first year and a half in the Centre will be available later in the year.

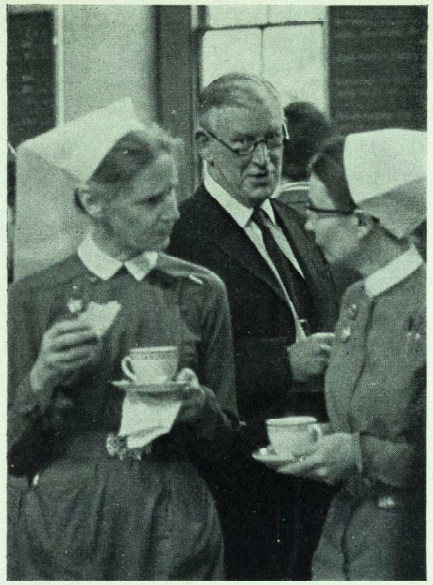
VIEW DAY

Above: The Procession was informal this year.

Below left: Tea in the Great Hall.

Below right: Mr. D. Jones (District Administrator) in Waring ward.

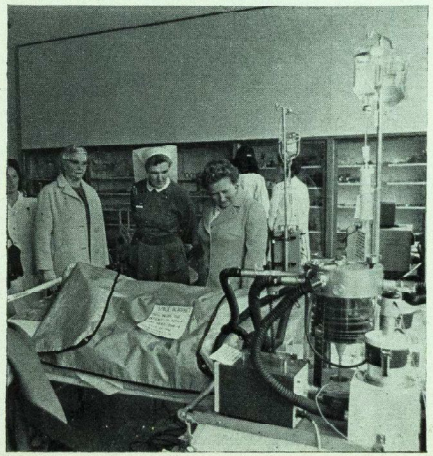




Above: Left, Dr. G. W. Hayward, at tea? Right, a houseman in traditional garb.

All photographs: Tony Randall

Below: Two Nursing Demonstrations—Left, Intensive Care; Right, Nursing in the Community.



THE SPECIAL TREATMENT CENTRE

By Dr. R. N. THIN

Before the First World War there were very few clinics specially for the treatment of patients suffering from venereal disease, although many physicians treated such patients either privately or in general wards or outpatient departments. Following legislation enacted during World War I a Venereal Disease Service was started with a nationwide network of clinics. Patients could walk straight into these clinics without a letter of referral from their own doctor, consultations were confidential, and treatment was free. Clinics were administered by the local authorities sometimes in association with local hospitals. When the National Health Service started clinics came under the control of Boards of Governors or Regional Hospital Boards. With the NHS Reorganisation they will be controlled by the local health authorities.

The "Venereal Diseases" were defined by Act of Parliament in 1917 as syphilis, gonorrhoea, and chancroid, and for many years venereologists were busy treating these three conditions. Recently it has been realised that many other infections can be transmitted by sex contact and the term "Sexually Transmitted Diseases" is now used to describe these infections. These include the legally defined venereal diseases, and non-specific urethritis, trichomoniasis, candidiasis, genital warts, genital herpes simplex, pediculosis pubis, scabies, genital molluscum contagiosum, and non-specific balanitis. Chancroid is now rare in Britain, while together syphilis and gonorrhoea account for only 25 per cent of new cases. On the other hand unusual forms of gonorrhoea are now being recognised more often and some conditions such as candidiasis and herpes are increasing importance with the realisation that infected mothers can transmit disease to their babies during parturition.

St. Bartholomew's Hospital has always admitted patients suffering from venereal diseases. For instance in 1856 there were 81 beds for such cases and 656 patients were admitted (Acton cited by Wyke 1973). Bart's was one of the first hospitals to start a special outpatient clinic for the treatment of venereal disease. Initially the clinic was situated in the Shelter in Golden Lane. During World War II the Special Treatment Centre moved to the Central Criminal Court—Old Bailey. The male clinic moved to its present premises after World War II and the female clinic moved into a modernised suite in 1972.

During 1947 three clinics were held each week in the Special Treatment Centre and 750 new cases were seen in the year. Since then the case load has risen and in 1973 there were 3,840 new cases and 13,325 total attendances. The Special Treatment Centre is now open for nine sessions in the week and in spite of the modern female suite, the department as a whole is too small for so many patients. The increase in cases is roughly similar to the general increase in the rest of Britain. Most other countries are also reporting a rising incidence of sexually transmitted disease.

Recent advances in therapeutics have simplified the treatment of most conditions. For example a single injection of penicillin or several tablets swallowed together under supervision in the clinic is now the usual treatment for uncomplicated gonorrhoea. This contrasts with the pre-antibiotic days, when patients had to be admitted to hospital for repeated irrigation of the lower genito-urinary tract with dilute antiseptics which were relatively ineffective in the elimination of infection and often led to the development of strictures in the male urethra. Even with modern drugs cure cannot be guaranteed and an important part of the management of all patients is re-examination after treatment.

It is apparent from the figures quoted above that effective treatment has done nothing to control these diseases. In fact it is one of the many factors influencing their increase. Control of these conditions is difficult and the most important short-term measure is tracing patients' contacts. This is especially important in the case of patients suffering from syphilis or gonorrhoea. Most men with these conditions have symptoms and attend for diagnosis and treatment; many women have no symptoms so most contact tracing is for women. This may be done by the original patient himself or by a special contact tracer who uses great care and tact in interviewing patients and approaching contacts.

Many patients suffering from sexually transmitted disease also have social problems, and some are more obvious than others. Pregnant women are usually worried in case the baby may be affected, and they need careful reassurance. Married patients may acquire infection as a direct or indirect result of an extramarital affair; it is better to discover and if possible remedy a marital problem after the first episode than simply to treat the patient for a series of infections. Young teenagers periodically present themselves at the clinic and they require careful assessment for it is known that a small group of young teenagers behave promiscuously and may acquire repeated infections. If any predisposing causes for such behaviour can be discovered and remedied further infection may be prevented. Furthermore, promiscuity may be associated with drug abuse and other forms of delinquent behaviour. In fact the infection with which the patient presents may be regarded as a symptom of an underlying medico-social problem. The assessment and treatment of the underlying situation may be comparatively simple and easily managed by the doctor. Often it is difficult and time consuming even for an experienced medico-social worker. Unfortunately owing to the many demands on their time social workers are not as freely available to the clinic as is desirable. Some patients are reluctant to mention their problems to the doctor but may talk about them to other members of the staff. Everyone working in the clinic must realise the importance of such confidences.

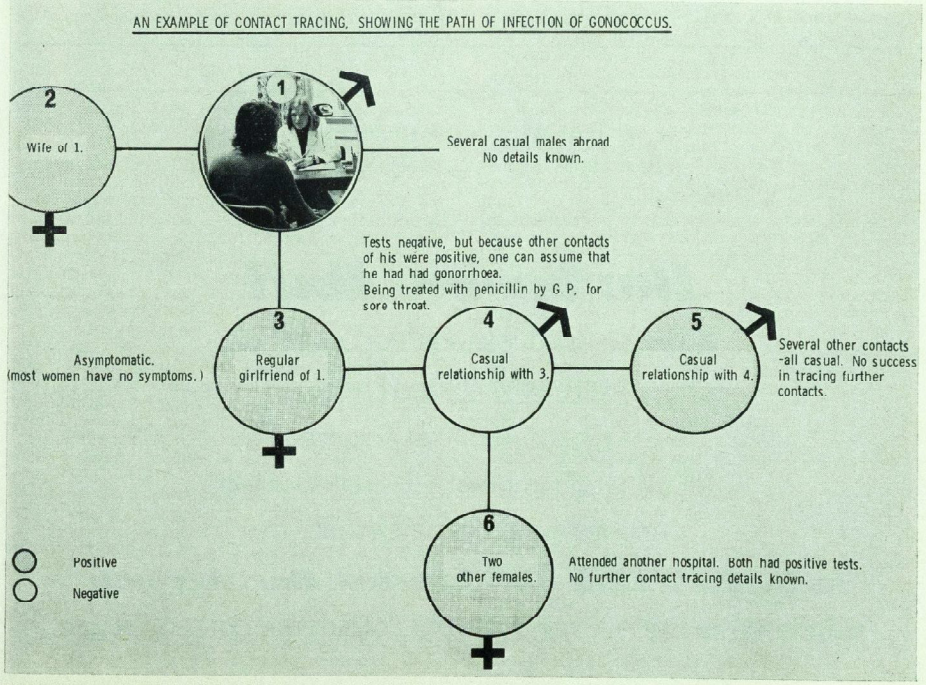
Teaching forms an important part of the work in the Special Treatment Centre. It takes the form of formal and informal instruction for nurses, undergraduate medical students and postgraduates. With the increasing incidence of disease wider spread of knowledge about them is of great importance.

Research also has an integral place in a department such as the Special Treatment Centre. The most common condition which is seen in the clinic is non-gonococcal or non-specific urethritis. This is a condition which affects men and resembles gonorrhoea. In the past many infective agents have been suggested as the cause of this condition but none has so far survived critical evaluation. Recent work has suggested that Sub Group A Chlamydia (formerly called TRIC agent) is the cause in about 40 per cent of cases. A study is being carried out in the Special Treatment Centre in collaboration with the Virology Department at the Institute of Ophthalmology to evaluate the role of chlamydia in non-specific urethritis. One of the problems of non-specific urethritis is that no corresponding clinical condition has so far been identified in women, and part of the investigation is to examine the men's female partners to see if chlamydia are sexually transmitted.

Another common sexually transmitted disease is genital herpes simplex. It has been suggested that there may be an association between this viral infection and carcinoma of the cervix, and a long term study is in progress on this subject. A double blind trial of idoxuridine, a new preparation for treating this condition, is also being carried out. A further study is in progress on the value of the Papanicolaou stained cervical (cancer) smear as a screening test for genital infection.

Many people wonder what prompts doctors, nurses and others to work in the Special Treatment Centre. One does not have to work in the clinic long to realise that the patients come from all strata of society and that there is nothing special or unusual about them. Sexually transmitted disease is acquired as a result of the sex drive which is one of man's primitive instincts. In many cases it is possible to make an accurate diagnosis and prescribe simple treatment with a sound knowledge of the probability of cure (which is usually high). There is emphasis on the complete examination of patients and this may reveal an unrelated condition which requires investigation and/or referral to another department. The doctor needs a wide knowledge of general medicine, and co-operation with other departments, particularly bacteriology, is important. While there is little scope for dramatic measures there are many opportunities for research in medical and related fields. Sexually transmitted diseases predominantly affect people aged 18 to 24 years, and probably the greatest satisfaction of working in the Special Treatment Centre is in treating these young patients.

AN EXAMPLE OF CONTACT TRACING, SHOWING THE PATH OF INFECTION OF GONOCOCCUS.



Dr. R. N. Thin is Consultant Venereologist at Bart's.

BLOOD MONEY?

A look at Pentagon financing of research in British higher education

By
ZOË FAIRBAIRNS

St. Bartholomew's is one of four medical schools in the United Kingdom whose facilities are being used for a research project directly sponsored by the United States Defense Department.

The project, mapping of human blood groups, is part of a 20-year programme of a research being conducted in the department of haematology. The programme far pre-dates any Pentagon interest in it; but they have recently shown sufficient interest to offer £1,000 for copies of maps showing worldwide distribution of blood-groups. Such information would be of obvious interest and use to a military establishment with worldwide networks of bases, and worldwide ambitions; once you know the blood-group composition of a people, you can better plan for its destruction, or its welfare, or a judicious combination of the two . . . such as in Vietnam, where some areas were blessed with American-built hospitals and others with American nerve-gas.

Other British medical schools receiving Pentagon support include Bristol, where the sponsored work is on the regeneration of mammalian skeletal muscle; Guys, where it is on the Isolation of Protective Antigens from Plasmodium Ealciparum, and Liverpool which is working on the Chemotherapy of rodent Malaria. Pentagon work on Malaria—a subject of obvious interest if the expected arms build-up in the Indian Ocean goes ahead—is also being conducted at three other institutions of higher education in the UK: Glasgow and Kent Universities, and Chelsea College, London.

Altogether $288,000 worth of research projects are being funded in the UK by the Pentagon, at 35 universities and colleges: some of the projects are of such obvious military significance as the work on explosives at Cambridge University, atomic reaction at Queens University, Belfast, and "the Oscillation of loads suspended beneath Helicopters" at Bristol.

The Vietnam war has caused widespread revulsion among the American academics about the use of colleges for war research; and even the relatively small presence of the Pentagon purse in British research laboratories raises important questions, at once moral, political, academic and economic.

It can be argued (and frequently is) that research money is short, and must be accepted from the highest bidder, and that there is nothing incongruous or sinister about military sponsorship within a system that already finds room for such things as a "Volkswagen Professor of German" (to be found at Warwick University); that academic freedom is not endangered, since none of the projects is secret, and the Pentagon has no control over personnel; that the military applications of a lot of sponsored work are not immediately apparent, and, even when they are apparent, they are often the reverse of harmful (as in the case of the muscle-grafting project at Bristol); and that in any case it is no part of a scientific investigator's work to ask questions about politics: theirs not to reason why, theirs but to collect the money and get on with the job.

None of which is without truth, although the safeguards on academic freedom are not as simple as the Pentagon spokesmen would have us believe: they reserve the right to withdraw their funding if a particularly important investigator leaves a project, and, more importantly, students at a sit-in at Southampton University, discovered and published (in 1970) Pentagon research contracts which made clear that publication of findings could be forbidden if anything was discovered which might affect "the national interest".

Only if one defines "political" in the narrowest possible way—so that it means little more than voting for a particular party or fighting in a particular war—can one claim that the politics of the Pentagon are of no concern to the academic working for it. When the Pentagon sponsors medical research we are confronted with an irony too crude to miss: for militarism and medicine represent, to most people, the clearest cut manifestations of applied science as respectively destroyer and friend of the human race. The possibility of advancing medical science at the behest of the institution that gave the world napalm and carpet-bombing, foetus-damaging defoliants and nerve-gases, plastic shrapnel (that won't show up on X-rays) and tiger-cages, inevitably presents a political choice: either one accepts the money, and with it the politics and rationale of the Pentagon; or, recognising that every weapon began once as an idea in the head of a scientist, one refuses. The Pentagon speaks for itself as to the usefulness of the unclassified work it sponsors in universities; when in 1967, there were demands from within Pennsylvania University that all classified Pentagon projects be withdrawn, Dr. John Foster, Director of Defense Research and Engineering at the Pentagon, argued for the continuation of unclassified work even if the classified projects were rejected: "Most of the value of university research work is in the unclassified area . . . the most important part is the basic unclassified work performed by the universities." The Pentagon itself eschews any "public service" interpretation of its academic role: " . . . those in universities who work under contract to the Army on basic research are sincerely and positively dedicated to . . . the pursuit of knowledge. They should understand, and most of them fully recognise, that the knowledge may and probably will be used to strengthen our military posture." (Lt. Gen. A. W. Betts, writing in *Army Research and Development*, Nov. 1968.)

The author is editor of "Sanity" (newspaper of the Campaign for Nuclear Disarmament)

But the projects are few, the sums of money are small. It is hard to imagine that Britain has many academic facilities to offer that are not available in the United States. So what other possible interpretations are there for Pentagon largesse?

Brigadier Frank Kitson's book "Low Intensity Operations" is a textbook guide to the attitudes of right wing military to left-wing activists, and to prevailing ideas on how best to forestall and suppress them. Kitson advocates "military aid to civilian institutions" as a powerful way of gaining preliminary footholds in potentially revolutionary areas, particularly at a time when the political climate is still too cool to allow open subversion by the right. This possibility has been recognised by growing numbers of academics, one of whom, a Professor of Physics, has written privately that " . . . the aim of some of these grants, however harmless they may seem, could be to enlist the help of scientists if more urgent military matters were to turn up." In this Professor's department, a departmental ban has been placed on the acceptance of military contracts without the knowledge and approval of all colleagues.

According to Kitson's theory, "military aid" is at its most effective when it can be used to "remove the source of a grievance". This, taken with Pentagon acknowledgement that they will only fund a project in Britain if the investigator certifies that he or she is unable to get funding elsewhere, with Kitson's interpretation of student unrest as being in many cases a "training ground" for adult revolutionaries, and with his admission that the Americans are far ahead of the British army in developing counterinsurgency techniques, can throw a new and different light on military funding of academic work. This interpretation may be quite wrong, but one cannot have it both ways; the Pentagon is not a charitable institution or an academic foundation (and neither, for that matter, is the British Ministry of Defence, which funds £1.7 million worth of military research in universities per year); either they fund research to improve military technology, or they do it to get a toehold in a potentially revolutionary area, or they do it for both reasons; whichever interpretation is preferred, the research workers involved can hardly shelter from the implications of their involvement by claiming to be "apolitical".

As straightforward, no-strings finance for education gets tighter, the dilemma will become keener; money from any source will often be preferable to abandoning a project incomplete. But Lord Bowden, of Manchester Institute of Science and Technology, warned a recent meeting of scientists at the Royal Society to discuss the effects of war on science, that American academic involvement in war technology had had dangerous implications for American technology as a whole. "The American universities have long had a tradition of supporting any research work that seems important to the Government," Lord Bowden said, "and this tradition, which made the Universities great, might have destroyed them once the welfare of the public become identified with the progress of the Vietnam war. I was told when last I was over in the States that the use of defoliants in Vietnam had a dramatic effect on the opinions of young people and led almost immediately to a refusal by many students to study chemistry at university."

Hands can be washed and blind eyes turned for just so long; the danger is that when revulsion and suspicion finally become overwhelming, dependence on military money will be too great to shake it off. In the meantime, the pressure must be for adequate funds from Government Research Councils which are not specifically tied to a particular ministry or government, so that research may be conducted as independently and as apolitically as possible.

NEWS AND VIEWS

GO BIKING

Despite the attempts of World Football, "the weather", indoor games fans, and other assorted impedimenta, "sumer is y comen in" as an early Mediaeval bard (known to most of us as Anon) once so prophetically sang. The usual jokes about summer in Britain will be dusted down for re-use in 1974; the cynics will moan and mutter about the "land of the midday drizzle", decrying that sweet rainfall which keeps the country so green and pleasant and makes us the envy of the drought-stricken, starving millions in Africa, India, the Middle East, etc.; the determined trendies and sun-fetishists will head for the arid, gaudy beaches of the Mediterranean with its flies and over-crowding and gastro-enteritis and tourist gewgaws; the Friday evening rush out of London will treble in duration and intensity as a million motorists honk and hyper-stress themselves along their chosen arterial highway; yet in the middle of all this summer madness the wise man and his bicycle can find some real outdoor pleasure.

The advantages of cycling regularly into and out of work are many and various. There is virtually no cost, bar the initial outlay; there is minimal stress, whether of the squeezing-shoving variety as in tubes and trains or of the stop-start variety as in the morning traffic jam; there is the exercise which can soon remove the winter coat of flab, and the fresh matutinal air to savour once you've worked out the backstreet route. No more will you have to wait around on platforms or in queues for the tube or bus that's been delayed/cancelled/run away/gone to lunch/gone on strike, etc. The joys of sliding rudely through congested traffic, of knowing exactly how long your journey will last without having to allow an extra 15 minutes in case of delay, are comforting and exhilarating. Then, come the evening, a quiet ride back can unwind the most twisted of problems, and there's no breath-test for bikers. You can visit the Zoo, the Opera, the late-night movies, and be sure of your returning without recourse to taxis or dubiously sober friends.

Come the week-end, a gentle stroll round the City is eye-opening, you could almost be in some futuristic world where only the buildings exist. Once your fitness is equal to it the rides to Greenwich or Hampton Court or Crystal Palace or where e'er you will are easy, and remember, bikes can travel by train. If the normal bicycle makes you feel small, there's penny-farthings for eccentrics, tandems for those who prefer travelling "in duo", and tricycles for the unbalanced. Anyone can go biking, but we live in the age of obesity and heart disease and that most convenient of banes, the motor car, which now costs some £15 a week to run if one includes depreciation (i.e. nearly £800 a year). Imagine a London full of trams and cyclists, no fumes and roars of boy-racers, just the gentle rattle of wheels. A reality if enough people ACT towards it.

NURSES' CHARITY ROW

News has recently come to light that on Saturday, July 6th, about 20 of the more energetic members of Set One will be found rowing a coxed four somewhere between Marlow and Cookham. This marathon, which is being held in aid of the Royal National Institute for the Deaf, will take place for 12 hours continuously from 8 a.m. to 8 p.m. The event is being organised by by Set One members, and will be rowed in a boat lent by the Scout Association from their National Water Activities Centre at Longridge in Bucks. Since the nurses already know, presumably, that they won't be able to fit 20 into a coxed four all at the same time, it only remains for any self respecting reader of the *Journal* to contact their Treasurer, Oona Dowd, c/o Nurses' Post Office, Queen Mary's Home, and she will be pleased to relieve you of a few pence for a very worthy cause.

THAT POOL AGAIN!

When is the Swimming Pool going to be reopened? There was every reason for its closure during the recent power crisis, but we hope that period is now over. Already, a petition is being raised, and we hope that this may have had some effect by the time that this is published. If affairs are still the same by the middle of June, I suppose they could always blame the N.H.S. reorganisation.

BEWARE

A Bart's Shotgun Society is being formed, with the strangely obvious nickname of the "S.S." Its aim is to procure a clay-pigeon trap from the Union funds, but why all the kerfuffle about forming a society and getting Union recognition, etc.? A £12 trap should hardly be a burden to those able to afford an £80 shotgun and the cartridges to fire from it. Anyway, is there not already a Rifle Club that could take this fledgling society under its kindly wing? The whole thing seems a waste of the Union's time and money. Clearly anyone has the right to form a society, but to do so merely with the cynical intent of financing one's own unthrifty tastes is a wee bit immoral.

MADA' IN THE SQUARE

In line with the recent N.H.S. reorganisation, the Bart-square Motor and Drivers' Association (BARTS-MADA) is to restructure the daily events around the fountain in order to streamline a situation that is at present a bit disorderly. To give members an added morning stimulus and to regulate the flow of traffic there will be a competition every day, divided into three classes of entrants.

CLASS 1. Large Saloon Cars. This will take the form of Musical Chairs, the entrants driving round and round the square to the tune of "Rollsing Along" played on the bells of St. Barts the Less. Those unable to find a parking place after the bells stop must then leave ceremonially by chasing a cyclist out through the archway. Only quiet-engined cars may enter so that they will not be heard by the patients nor by those silly enough to walk suddenly round the sharper corners.

CLASS 2. Large Articulated Lorries. This will take the form of drag-racing, competitors having to drive through the archway from a standing start at the Henry VIII gate, but without running into the fountain. Points will be awarded for the weight of scraping/rubble, etc., knocked off the archway. Meanwhile the rear entrance is to be sealed up and turned into an outdoor queuing "overspill" area for the main dining-hall.

CLASS 3. Minis, Beetles, Lotus Super-7's, Boy-Racers, etc. These will have an obstacle course laid out for them, starting at the flower shop. After a slalom amongst the trees and beds arranged in the square they will proceed to the fifth floor of the Main Block (lifts are strictly out of bounds) alternately entering a surgical ward or medical ward on each floor. However, no two female wards may be entered in succession, nor any two wards having the same second letter. Then round the rooftops, down via the Path. block, up the ramp towards casualty (the faster ones can expect to reach 60 m.p.h. here) and through the Outpatients hall and back to the flower shop. First into the fountain with a goldfish impaled on his aerial is the winner.

N.B. It is hoped staff will accept the temporary inconvenience of some minor reconstruction work needed to facilitate these events.

PAPERBACK LIBRARY

This Library is coming soon, and will be open to all Students of the Hospital (physios, radiographers, nurses, technicians, medics, etc.). Suggestions for books should be sent to Olivia Hudis, c/o W.S.C.R.

PHYSIOTHERAPY BALL 1974

I think that it must be the name of this grand occasion that scares some people from attending. One expects either to be surrounded by girls fitting the description drawn by the traditional image of the physiotherapist—a sort of muscle-bound Amazon; or one just sits and wonders how a Ball could be formed by the 20 or so Bart's physios with their partners.

What actually took place at the London Hilton on April 27th ranks as one of the most enjoyable functions that I have attended. In contrast to most of the regular Bart's Balls, there was none of the pushing and shoving that has become characteristic of those held in the relatively cramped confines of College Hall; neither (as far as I know!) was there any sugary behaviour directed towards anybody during the weeks preceding the event, as tends to happen before Matrons' Ball! There was space to move around, with enough people present to make it interesting, and not too many to make one feel "lost".

In fact, 336 people attended on the night, amongst whom only Messrs. Cook, Parry, Ashton, Cassidy and Davies, together with your correspondent, represented the medical students. (Apologies to anybody that I didn't notice!) After a reception at 7.30, places were taken for an excellent dinner of Truite de Rivière Meunière (though perhaps there was more Rivière than Meunière on my plate), followed by Coq au Vin, and a dessert of Omelette en Surprise Alaska.

Dr. Oswald, who, as a Research Committee member of the Chest and Heart Association, was in the Chair for the evening, then made a short but adequate speech, in which he thanked Elizabeth Rogers and her Committee for doing such a splendid job in organising the Ball. He announced the fact that he was very pleased with the Tombola ticket he had just drawn; unlike other numbered tickets, it seemed that this one had the name of one of the Physios written on it! Dr. Oswald then made the point that Chests are rather poor relations when compared with Hearts for their coverage by the media, but he was very happy that the evening's profits were being donated to a charity for which he had so high a regard.

Dancing to Van Strattens band then started in the Ballroom, while upstairs in the Crystal Palace suite, there was a discotheque, which was well patronised by those who had obviously not been attending their Gloucester House ballroom dancing lessons.

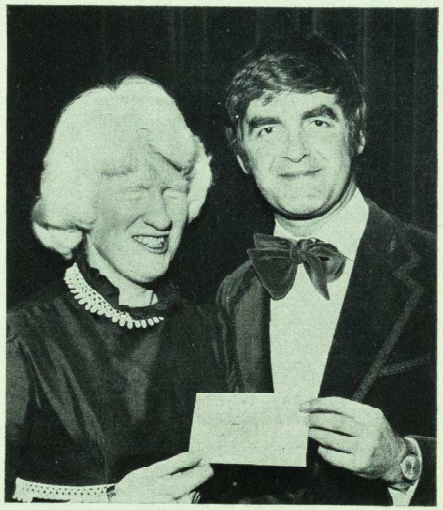
Shortly before midnight, Derek Nimmo arrived to receive a cheque on behalf of the Chest and Heart Association. After finishing his speech, he signed a number of autographs, one of which may be viewed, on payment of a small fee, in the *Journal* Office.

A Hairy Legs competition, held in the disco shortly afterwards, attracted an entry of four, including Mr. David Cook, the well-known evening Custodian of Queen Mary's Nurses Home, and also Mr. Philip Foster, the equally well-known personality from the Accident and Emergency Department; alas, neither gentleman won the prize.

The evening's entertainment finished at 2 a.m., with all those who managed to stay the course considerably out of both breath and pocket. Rumour has it that this is to be the last of the Bart's Physiotherapy Balls, at least in its present form, because the cost will be prohibitively high next year.

I, for one, sincerely hope that the Physios' Ball will continue.

R.T.J.



Derek Nimmo receiving cheque on behalf of the Chest and Heart Association.

VERDI REQUIEM

On Thursday, June 20th, the Choir and Orchestra of Christ Church, Woburn Square, under John Lumley's direction, will be performing Verdi's Requiem in Bart's Great Hall. With this in mind, it seems opportune to examine the work: as space is limited I shall concentrate on one particular aspect.

Verdi began composing this Requiem Mass in 1873 to mark the death of Alessandro Manzoni (the famous Italian historian, novelist and poet). Despite both the solemnity of this undertaking, and his ability to compose within the bounds of ecclesiastical music tradition (the fugue at the final curtain of Falstaff is witness enough), Verdi chose to abandon customary formulas of sacred music in favour of his own operatic idiom.

"Verdi's greatest opera" is a platitude frequently applied to the Requiem.

Verdi was neither the first nor the last to write sacred music in his everyday musical language; Rossini before him (in the Little Solemn Mass) and Delius after (with A Mass of Life) both threw tradition to the wind.

However, the first great Requiem in this vein was written by Berlioz in 1837, and it is this work which influenced Verdi most. Any composer who could orchestrate a complete movement of a Mass with trombones and flutes alone, must be considered to have broken with past conventions! Little attention has been paid to Berlioz in this respect compared to that given to Verdi.

Both Berlioz and Verdi took a fundamentally romantic—and at times theatrical—approach in their respective settings of the Latin text, and the influence of the French composer's earlier version on Verdi is seen most strongly in the "Last Trump" section of the Dies Irae movement, which Neville Cardus has described thus:

"Verdi . . . with his trumpets goes beyond pictorial and obviously realistic description: he seems, as we listen, to make a manifestation of the dread event and scene. This is the music, these are the sounds, which the earth and the rising dead are truly likely to hear at doomsday."

But this very effect described by Cardus had been originated 30 years earlier by Berlioz, with a remarkably similar notation and orchestration—even so far as the use of contrapuntal triplets echoed between the brass instruments—to that found in Verdi's version.

I am not intending by any means to denigrate Verdi; indeed, elsewhere in the work he takes religious romantic writing to a height that Berlioz was nowhere near reaching. The melodic and harmonic lines Verdi uses to evoke the "Salva me" and "Lacrymosa" parts of the Mass, are beautiful beyond description.

In conclusion, listening to both interpretations is essential to discover for oneself the development of the "secular" approach to religious composition, and for the sheer enjoyment of hearing truly great music.

ALLEGRO MA NON TROPPO.

DANCING THE ROUND
Ballet Rambert at the Roundhouse

The development of the old railsheds and shunting area at Chalk Farm by the Roundhouse Trust into a theatre/studio/play centre is a miracle which is taking a little time. The impossible has already been achieved in the establishment of a highly popular theatre at the Roundhouse itself. This beautiful monster from the Golden Age of rail is definitely worth a visit for both its experimental productions ("Catch My Soul", "Stomu Yamashta", and so on) and its relatively cheap and eminently palatable good food. The occasion of my first visit was the opening of Ballet Rambert's season at which they were to present two totally new compositions.

The reception for "Ziggurat", the first dance arrangement, was mixed to say the least. This was largely predictable for the dancers' mastery of the choreography could not overcome the jarring asynchrony of the musical score. The latter, Karlheinz Stockhausen's "Gesang de Junglinge" and "Kontakte", was by present standards carcophonous and was surely never intended as ballet music. "Ziggurat" was a highly stylised and sombolic representation of worship of the "earth-soul" of the Assyrians with various White dancers prostrating themselves before, and carrying on high, the predictable impassive Black male. The symbolism was rather overdone on all sides: sexual, religious, ethnic. Similar criticisms could be levelled at the long costume piece, "Deserts" which followed the interval. The costumes, it should be noted, were heavy sackcloth capes—in the chic of bedouin vagabonds. The music here was "electronically organised sound" by Edgard Varese (who also writes bad prose) which attempted to represent "not only all physical deserts . . . but also the deserts of the mind of man". I almost deserted my seat out of boredom.

These productions both dated from 1967 and perhaps that was in some measure the reason for their failure: the other two arrangements dated from 1974 and were superb. The first of these, a short piece called "Weekend" for two couples, also used electronic music, but this time of a melodically bearable form. The movement and music were here fully complementary, and the technical expertise and control of Rambert finally emerged. Perhaps it is more difficult to dance perpetually *out* of time with the music, but the beauty of this arrangement surpassed even the mechanical brilliance of those already described.

The true pinnacle was the other 1974 presentation, "Spindrift". This was the only piece to be accompanied by a live modern jazz ensemble: soft, flowing and sympathetic. The choreography was all I'd hoped for and more—no classical stilting here, no discord, just colour and movement and empathy with the music. The effect was hypnotic, mesmeric, any cliché that you will. This production had all the gaiety of "Revue Bar" choreography without the brashness; all the style of classical ballet without the naïve story and stilted actions. Frankly, a mixed programme but an excellent evening.

T.D.

BARTSFILM PREVIEW

By FILMFREEK

June 11th The Decameron
June 18th Butch Cassidy and The Sundance Kid
June 25th You Only Live Twice

THE DECAMERON

"Bawdy humour" is the catchnote of this entirely delightful offering, which was made by Pier Paolo Pasolini, director of such succulent goodies as "The Canterbury Tales", "Pigsty", "Theorem", "Oedipus Rex", etc.; this may all sound rather heavy and arty but really he is a great entertainer. The movie consists of a random collection of Boccaccio's Decameron tales, many of which were the inspiration behind Chaucer and other best-selling tale-tellers, including our own immortal bard, W. Shakespeare, Esq. Many of them are

about sex, getting it easy, on the sly, with difficulty, in the open; while others are quirky stories of a less explicit nature. My hero was the "innocent" peasant who by acting dumb landed the most envied job in the Italian Renaissance, gardener in a nunnery. His further adventures were somewhat exhausting, but the whole movie is a refreshing and highly human riposte against the dull Victorian decorum that so many people mistake for "morality". It's a sane, simple, funny celebration of lustful, loving man, and all that the liberated, easy-going 20th century can do is slap on an X certificate; a fine example of the absurdity of censorship.

BUTCH CASSIDY AND THE SUNDANCE KID

Robert Redford and Paul Newman star in this famous semi-western about a couple of genial crooks who manage to get away with it, most of the time; they wisecrack their way through the West, then head for Bolivia when things get tight, but the last laugh is certainly not theirs. "Raindrops keep fallin' on my head" provides the interlude song as Paul Newman goes into his "goon on a bicycle" act for the benefit of the lovely they somehow seem to share, without it causing any real strife of the "lay orf my bird" variety. It's slick and witty, but come the second half the movie seems to run out of steam, to lack the originality needed for the full 100 minute stretch. The whole thing is pure superficial fantasy of the glossier type but most folks enjoyed it and the box-office made a bomb. So if you want to see two handsome hunks plus pretty lady in-between wise-guying their way around some classy robberies, scenes, moments, etc., it is highly recommended.

YOU ONLY LIVE TWICE (or Jimmy Bond visits Japan)

"You only live twice, once when you are born and once when you are staring death in the face", or so says the gay little haiku (that's Japanese for a sort of serious limerick) from which Ian Fleming drew his title. But forget about the somewhat bleak view of human existence for this is really nothing more than the standard Bond film set-up with tourist Japan acting as backdrop. It's all there; Sean Connery trying to hide his Scots accent behind a thick hairy chest and a rich mop of black wig; gadgetry enough to thrill the heart of any normally deprived N.H.S. technician; girls multiform but rarely maidenform; snappy dialogue for easy laughs (that is if you can laugh and swoon at the same time); an enormous explosive ending where the whole set goes up like Hiroshima and Krakatoa all at once. Presumably they get it all back on the insurance. Anyway it makes for good watching if you want to improve your command of the easy verbal riposte. Connery swore he would never do another Bond film after this one, but the latest offer was so gigantic that even he with his accrued zillions could hardly refuse. He doesn't have to act anymore. He just walks on, spouts a wisecrack, slugs a baddie, lights a fag and sets about the latest nubile young sexlet. Yawn.

N.B.—COMING NEXT MONTH — GRAND PICTORIAL COMPETITION. Make sure of your copy of the *Journal*.

FLABBERJACKY
or
THE TAMING OF A CLUMSY STUDENT

'Twas Bartslew and the blithy studes
Did furb and bartle in the ward,
All giggly were the nursey brood
As the Chiefman multi-bored.
Beware the Matron's Ball my girls
The bores that bind, the wetbag's welch,
Beware the Burbler's locksy curls
And the tumourous Bellybelch.
She took her shyly self in hand,
Long time the Bartsome beau she sought,
Till happened she to a cup of tea
For two mere coppers bought.
And as in bashful thought she sipped,
Young Flabberjack with eyes a-blear
Ungainly tumbling by her slipped
And blumphed beneath her chair.
One two, achoo, hallo, how do,
The dolly eyes went flicker-flack,
She left him hooked, truly kooked,
And went a-tweetling back.
And hast thou nabbed young Flabberjack,
Then to the Ball my gleamish girl,
For Blacktie suit and polished boot
Will tame that beer-blonked churl.
'Twas Ballnight, and the smarty dudes
Did schmaltz and rockle with their pards,
All dimpsy was young Flabberjack
As spright and neat as the Guards.
(With apologies to Lewis Carroll)

WORDSFELLOW.

BARTS SPORT

MOTOR CLUB REPORT

Eighteen months ago the Motor Club was brought back to life. Several years previously it had been a thriving Club with many active members.

Autumn 1972 saw the re-birth of the Club with new found President Dr. D. Nancekievill and Vice-President Professor G. W. Taylor. To date the activities of the Club have included two rallies (won by Mr. D. Hague and Mr. S. Parvin respectively), one Treasure Hunt and a film night.

Concerning facilities, we have been given the use of a garage, down in the lower car park in the College, in which is stored many tools and equipment for students to work with on their cars. Access to the garage is easily obtained by signing for the key with the Hall Porter.

Motor Racing is a keen interest of many of the members and so we negotiated an agreement with the British Racing and Sports Car Club allowing us to send several students to each of their race meetings as Assistant Medical Officers. This has worked out to be most interesting and enjoyable. The highlights of the year being the Race of Champions at Brands Hatch and the British Grand Prix (organised by the RAC) at Silverstone. Dr. Nancekievill who is Vice-Chief Medical Officer of the BRSCC kindly liaises on our behalf and arranges for the tickets to be sent to us. We would hasten to point out that this is a special agreement we worked out with the BRSCC, only available to Bart's students who are keen to learn about motor racing rescue.

On Thursday, April 25th, a Rally was held and the competitors assembled (minus their cars) in the College Hall Recreation Room. As in the previous rallies the maps and the routes were given out and the navigators worked furiously to plot the route in time for the start. Then the 16 cars competing, plus five marshals' cars left in convoy towards a large car park in Epping Forest (which at that time of night was deserted by everyone except courting couples). The marshals were despatched to their time controls and then at 9.30 p.m. precisely, the cars were sent off, at one minute intervals. Tipped for victory were the cars of Parvin, previous Rally winner, Guy in a quick Dutton B Type, Parry in the E Type and the Capper/Aiken Lotus Cortina (ex-works?). Only seven people "cleaned" the first stage, surprisingly including Hubbard in the Opel Manta, Saywood in the TR4 and Meyrick-Thomas in the Mini Clubman. By the second stage the Rally was falling into a pattern. Hubbard, who was so quick in the previous stage was the only person to clean Stage II. Close behind him, on lateness points, were Parry, Guy, Meyrick-Thomas, Parvin and Cartnel. Half-way round this stage the Peries/Bansel Mini Clubman had an argument with a steel barrier, but continued at unabated speed. Stage III was a really tough one, and nobody cleaned it. Parvin was quickest followed closely by the Hubbard, the amazing Meyrick-Thomas, Guy and Saywood, looking rather "hairy", Parry and Cartnel followed close behind. The Capper/Aiken Cortina took several wrong slots and didn't go past the control at all. Hobman, driving a Morris Minor, gave up at this stage and took a short cut back to the party. Approaching Stage IV Hubbard, looking all set up for a high placing, went off the road and visited a neighbouring field. He returned quickly to the Rally, but unfortunately something was very amiss in the engine department and he was forced to retire. Meanwhile Meyrick-Thomas was again quickest at this stage followed closely by Saywood and then Parvin. On the penultimate stage the struggle for the lead between Meyrick-Thomas and Parvin was narrowed as Parvin came in a clear two minutes ahead of the other driver, who was followed in by Parry, Guy and Saywood. Although the last stage had many long stretches on it Parvin was unable to catch up that one minute between himself and Meyrick-Thomas and had to be content with second place. Third was Saywood who had an excellent, if dramatic, drive in the TR4 and fourth was Parry's E Type, a good placing for a car so unsuited for country lanes. Guy came a rather lowly fifth due to some unfortunate navigational errors. The first and second place prizes, bottles of Champagne, were presented at the party afterwards.

Rally-scarred.

The Coupe-des-Dames was won by Miss Jackie Head, who completed the course just in time to miss the Prize Giving ceremony!

I would be most pleased to hear from anyone who is interested in helping the Club or participating in any of its activities.

PETER MALIMSON,
Secretary.

7th ANNUAL HIGHLAND PENTATHLON

Thirty teams of versatile athletes assembled at Aviemore, Invernessshire, on the evening of April 26th for the 7th Annual Highland Pentathlon. This event is generously sponsored by John Players, whose money was much in evidence, but fortunately not their products. For the third year, Bart's entered a team which achieved consistently good results, in what is now becoming a highly competitive event.

Over 60 teams applied for entry this year, including a Swiss team, and various other military and pentathlon society teams. The programme of events starts with a 100 metres swim on the Saturday morning, with a target time of 1 min. 16 secs. This is followed by a wild rush up to the Cairngorm for the skiing, which was a taxing 55 gate Giant Slalom.

Saturday evening is more relaxed; this is the time for the target curling section, along with a few well-earned beers. The aim is to score 76 points out of 100, which requires eight out of 10 curling stones, each weighing 44 lbs., to be placed within 2 ft. of the target at a range of 30 yds.

Sunday morning inevitably dawns with a hangover, and the thought of .22 shooting over 25 yds. when a par score of 90 is required. The last event is a 2,000 metre cross-country run over a very rugged course, with a lot of pain involved to achieve the par time of 7 mins. 20 secs. Throughout the competition, an Army statistical team was computing the cumulative scores.

Bart's team assembled at the swimming pool, clutching their swimming trunks nervously, and watching the Army physical training team limbering up with a half-mile "warm-up" swim. As it worked out, Ross Adley had an excellent swim in 1 min. 13 secs., while Tony Lipscombe and Graham "Mark Spitz" Aiken just managed to break the 1 min. 50 secs. barrier, to improve on their last year's time.

The skiing course raised a few eyebrows, being much harder than last year with a steep tight finish, much rutted and bumped after a fluent opening section. Ross Adley, who had promised much on the train journey upwards, was much the same colour as the snow when he saw the course. With his goggles adjusted and his crash helmet tightly strapped on, he made a game exit from the starting gate, and showed much promise through the first gate, before wrapping himself around the second. Only 53 more gates to go, so he sportingly continued his meteoric descent of the mountain, in about an hour and a half, to narrowly miss scoring any points. Graham Aiken had a good run, slaloming around a few reindeer who had strayed onto the course, and with a few jet-turns in the bottom section, he finished in a time of 1 min. 25 secs. Jean-Claude Lipscombe had an immaculate run in 1 min. 15 secs.

The evening curling session went comparatively well, with only one of the 90 competitors scoring the target 76. Ross recovered from his bruises to get a couple of stones in; Tony had a score in the 30s, and Graham scored 44.

On Sunday morning, the target shooting was a little hit or miss; a bit more hit for Ross and Tony, and a bit more miss far Graham, whose infra red sights failed to home in as expected. In fact, both Tony and Ross had good scores in the 80s, achieved with a borrowed rifle and minimal practice.

The final event was the cross-country run, in which Bart's showed their true colours, and fitness, by finishing 9th in the running, behind some super-fit service teams.

Overall team position moved up to 15th at the finish, to ensure our selection for next year. Individual placings were as follows:

35th Tony Lipscombe
39th Graham Aiken
54th Ross Adley

The team wishes to thank the Board of Governors of the Voluntary Hospital for their generous donation towards travelling expenses.

GRAHAM AIKEN.

TENNIS CLUB TOUR
Devon, April 1974

Results:

v. Exeter University lost 2-7
v. Torquay drew(?) 4-4
v. Exeter Golf and Country Club lost 4-5
v. Cranford Club lost 2-7

Not the best start to the tennis season, resultwise! Played four, three lost definitely, and a dubious drawn result—darkness thankfully stopped play.

For the second year running, the Bart's tennis team travelled down to the West Country. A breezy journey down to Exeter, where we were to stay four nights at the George and Dragon Hotel (this was nearly cut to two days due to complaints by the chef, whose room just happened to be on the floor below ours—this was the evening that my bed, somehow, found itself in the bath. . . .).

Exeter University, which has a beautiful campus, reached the semi-finals last year in the Inter-Universities competition and once again produced a very solid team: Peter Mortimer and Chris Millford, as first pair, won our only two matches. The match on Friday against Torquay was very entertaining both on and off the courts. With the moon coming up over the sea, we decided to end the match at four all; this was certainly in our favour.

Exeter Golf and Country Club proved more equal opponents (the secretary was not playing!). Nick Perry and Peter Mortimer won all three of their matches, while David Stewart and Chris Millford were able to win one. Charles Wellingham and Roger Bulley played valiantly—but didn't win! Perhaps Charles, after an excellent round of three over par on the golf course (?) had exhausted himself. A very good evening followed with a discotheque at the clubhouse—the team probably performed better here than on the courts!

We were decisively beaten by the Cranford Club on the Sunday: nevertheless it was once again an enjoyable occasion. The tour was enormous fun, and we all felt our tennis has improved. (John Cooper's serves are now going in splendidly!) The season begins in earnest within the next few weeks, and with a pool of new players, it should be, like the tour, a very successful one.

N.B.—John Cooper has broken the Exeter to London road record. Any claims for three hours or less?

J.B.H.

PUZZLE PAGE

CROSSWORD: RONTY 2.

ACROSS

4. Doctor and wise man have two points between them, and try to train a horse. (8)
8. A room about the age of a river? (6)
9. Gets up about a hundred balls, divided by six. (8)
10. Bloody poppy family loses song and ends on a note. (8)
11. Sounds like bird talk. (6)
12. It spoils the view—of water? (8)
13. In an archaeological expedition a net is misused in a pretty poor way. (8)
16. Church thanks one, losing point but including fifth pupil, and then finds an antiseptic. (8)
19. Gross start and a lean end. Does he think its inevitable? (8)
21. Dictator from French place. (6)
23. These officials are certainly not a collection of stars. (8)
24. Troubled mates had gone to the top of the boat. (8)
25. They happen to be flat on the backstreet. (6)
26. There's liquor all round the tray, but he is giving it away. (8)

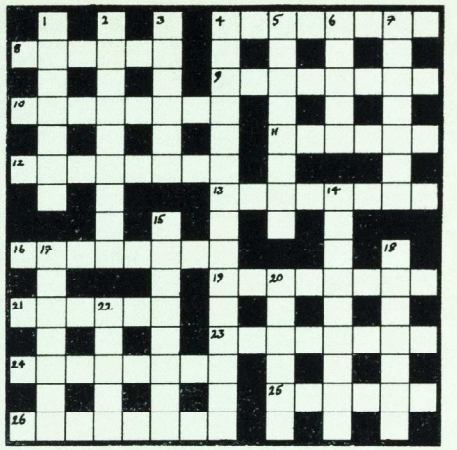
DOWN

1. Right for left, in crazy Mandala festival. (7)
2. Fashionable area, yet a vile garb suits it. (9)
3. Father and a girl show signs of wear. (6)
4. One who runs to earth and order for radio gear. (9, 6)
5. Mischievous adventure to get away with around our age. (8)
6. Was thrifty and came to the rescue. (5)
7. Dog caught in rain somehow—knotty. (7)
14. Viewing halls of a regal isle. (9)
15. Cook late tea inside, but it gets you nowhere. (8)
17. Ate five eels, lost their tails and brought them up! (7)
18. Snake and troubled group show different points of view. (7)
20. I delt it, returned and was honoured. (6)
22. Fade away saint. (5)

Solution next month.

SOLUTION TO RONTY No. 1

ACROSS: 1. Centre forward; 7. Trampoline; 8. Kris; 9. Asthmatics; 10. Reave; 11. Unobliging; 15. Eructation; 16. Arson; 17. Spruce hair; 18. Knot; 19. Exhaustion; 20. Assembly lines. DOWN: 2. Exaction; 3. Rhotacize; 4. Reeks; 5. Availed; 6. In the long run; 7. Traducianist; 12. Gets cruel; 13. Lit a fire; 14. Bounces; 17. Steam.



JOURNAL MATHEMATICAL PROBLEM No. 6

by R. Treharne Jones.

Many of you may have watched and wondered at the amazing Romark when he appeared on television recently. Alternatively, you may not have wondered if you had worked out the theory behind some of his "tricks". After all, he denies any knowledge of telepathy or other supernatural powers.

The Chinese Magic Square, which appears on the act, is not a new idea, as one may deduce from its name; after all, the Chinese have been first with a number of things.

In a 4 x 4 grid are positioned numbers, a different number to each of the 16 squares, such that the numbers in each horizontal row add up to the same total—the Magic Number. A Magic Square may be constructed for any particular Magic Number. I should perhaps mention that the Magic Number is the total of each vertical row; also of each diagonal; also of each of the two broken diagonals; also of each group of 4 at each of the 4 corners of the Square; also of the 4 corner squares themselves; also of the group of 4 squares at the centre of the grid.

Problem: construct a Magic Square in which the Magic Number is 4192.

Answer to last month's problem.

Let r be the radius of the earth. Then the length of the string tight around the earth is $2\pi r$ feet, which may be called c, the circumference of the earth. Adding the additional length of string produces a string $(2\pi r + 3)$ feet long, which may be referred to as C. If the radius of the bigger circle of string is R, then the answer to the problem is represented by the expression $(R - r)$.

Now $C = (2\pi r + 3) = 2\pi R$

Therefore $2\pi R = 2\pi r + 3$

$$(R - r) = \frac{3}{2\pi} \text{ feet} = 5.731 \text{ inches.}$$

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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WILLIAMS, S., *see* MERCER, J. L., and ——.

WILLS, E. D., *see* REYNOLDS, Claire, and ——.

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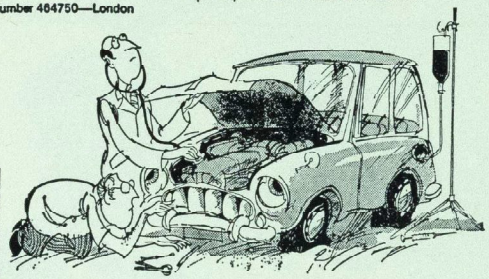

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Founded 1892

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NO WAY TO TREAT A LADY

Everyone agrees that nurses' pay is a scandal; for that matter everyone agrees that pay throughout the NHS is a scandal, which isn't to say they ever do anything positive about it. But superimposed on this background of exploitation there is another less publicised aspect of nursing life, namely the treatment handed out to nurses by their own seniors. It takes only a few months of life as a clinical student to realise the glaring contrast between our plentiful freedoms and the mass of petty restrictions placed on nurses. Among others, these include:

1. Nurses are not allowed to wear uniform outside the hospital, even as far as the post office. (Are the powers that be *that* embarrassed at their uniform?)
2. Nurses are not allowed to wear any coat or mackintosh over their uniform when travelling to and from the hospital on the coaches. It is "unprofessional". (There's nothing like a frosty December morn to promote 'flu.)
3. No male visitors are allowed up into the rooms at Maybury, Bryanston, or Queen Mary's unless "he" is a father or brother. (Presumably the lawgivers in this instance regard any male-female relationship as automatically immoral, unless of course it's kept within the family!)
4. Even at night no eating is allowed on the wards, not the merest little toasted snack. It's either Microwave Plastipak grub in the warming cheer of the canteen, or nothing, folks.
5. In order to get paid for overtime, there is a "local rule" (i.e. it only applies here) that insists on you filling in an overtime form; and if the form is late you may not even get the money!
6. Off-duty nurses are liable to get called up at a few hours notice for night-duty, both for the odd night and a whole week.

This probably can't be helped if someone goes off sick. Perhaps a "stand-by" status could be arranged to cover for such occasions.

7. Compassionate leave is only allowed for the death of one's father or mother, and even then it is for ONE DAY ONLY. Brothers, sisters, grandparents, other relatives and close friends do not, it seems, warrant one's attention, whether they are ill, get married or die.

What stands out about these regulations is that, in the eyes of the rule-makers, nurses cannot be trusted, with clothes, with men, with food, or with money. Of course, the uniform might get muddy outside, or beanfeasts at midnight may spring into fashion, or canoodling just might take place in the sanctified casements of Queen Mary's, but nurses should be TRUSTED, as they are trusted to look after their patients. To undermine the good intentions that motivate most nurses is, to say the least, tactless. Nor is there any justification in the argument that goes: "We had to abide by these rules therefore you should be

able to stick them out". One might as well insist on boiling up glass syringes because pre-sterilized plastic ones make life too easy. Or perhaps we should ban Penicillin so as to make things more like the "good old days" of hospital fever and erysipelas running rampant.

Compare the life of a trendy "temp" secretary, she has regular hours and no rules of dress and twice as much money and can have as many men as she likes in her flat, whether they be her great-uncle Tom, or Bill the chimney sweep. So let us face the unpleasant fact that it is not just the pay that is driving away potential nurses; it is just as much (or more) the rigid and hierarchical structure of petticoat regulations that insists on interfering in nurses' private lives. No one denies the real need for rules in dealing with patients, but to extend these beyond the ward is nothing short of downright impertinence. The increasing number of men joining the nursing service should begin to break down some of the sillier barriers but this is no answer in itself. The Victorian girl-school atmosphere of nursing at Bart's has got to change or there won't be any girls left who are willing to be thus submerged.

ENDS AND MEANS
(Oh no, not more Union drivel)

My apologies to readers bored with the everlasting debate about teaching and other internal Union affairs, but the latest events in the heady world of student life do merit some discussion. For this year the NUS has obtained two "good things"; a big increase in grants and a half-fare concession on British Rail. Since we at Bart's are not in the NUS we have done nothing to help in all this yet we have benefited enormously from both reforms. The cynical will say, "Great! Let's keep raking in the goodies and hang on to the money that would have been our contribution to the NUS." But one day we just might come unstuck, and anyway our consciences can't really be that clear. Because we are getting something for nothing, which means other students, perhaps more needy than ourselves, are subsidising our lives. In other words we're achieving our ends by somewhat underhand means.

However, at the same time the NUS has passed an amazing motion, banning Fascist and racist speakers from a platform at their meetings. Apart from the knotty problem of who decides exactly what qualifies one as a fascist or racist (is not the suppression of free speech a fascist demand, thus at once excluding any supporters of the motion from speaking; a pretty pickle!) there is the old saying of Voltaire about, "loathing another man's ideas yet defending to the death his right to express them". No one can deny that "free speech" isn't as totally available as we like to imagine, but to use a partial injustice in the status quo as an excuse for further expanding that same injustice is, quite simply, illogical. No one can deny that it also would be very nice not to have to listen to things we find immoral and unjust, but to achieve that idealistic end we can't use these un-ideal means.

Lenin (I think) once said, "The end justifies the means". But he got it all wrong, because the end is *defined* by the means. Thus the "elimination" programmes of early revolutionary Russia have led to the present Gulag Archipelago of concentration camps. Or, on a more homely level, badly brought up children tend to become less than adequate adults. So, to quote comrade Lenin once more, "What is to be done?" The correct thing to do is for us to rejoin the NUS because a few more moderates in there might dispose of some of the more absurd pronouncements emerging from that motley crew. On the other hand it might merely provoke the extremists into banning even more speakers. Still, we are living by false means, off the fat of the land, and that is a sure sign that "something is rotten in the state of Bart's."

ANNOUNCEMENTS

Allan House has been awarded First Prize in the Medical Students' Essay Competition of the Mental Health Trust and Research Fund. Dr. Roland Littlewood won the joint second prize.

Teifion Davies and Jeremy Sanderson received Special Commendations in the *British Clinical Journal's* Medical Student Prize.

Engagements

PAES—COX—The engagement is announced between Trevor Paes and Margaret Cox

NEWTON—LOVE—The engagement is announced between Peter Newton and Susan Love.

Birthday Honours

MISS G. O. GARDINER, District Nursing Officer for the City and Hackney D.H.A., and formerly C.N.O. of the St. Mary's Hospital Group, has been awarded the O.B.E. in the recent Birthday Honours.

N.B.—The *Journal* has moved its office up to the dizzy heights of the Third Floor of the West Wing (Room 64). Intending visitors please note.

LETTERS

The Dental School,
University of Newcastle upon Tyne,
4th June, 1974.

Dear Sir,

I have received a reprint of Mr. Clavell Blount's article in the May issue of your Journal. I am somewhat concerned that an article with such a propagandist tone and containing such serious fallacies should be published in your journal. The author is, as you may know, a leading opponent of fluoridation in this country and the arguments which he uses, including those in the article in question, are unsound. I have corresponded with him several times over recent years and pointed out the errors in his arguments, yet he still raises the same material and completely ignores the points I have taken up with him. It seems unfortunate that Bart's Journal should publish this article without at least an article presenting the other point of view. I enclose an article of my own which discusses some of the fallacies and also presents a general case for fluoridation.

I hasten to add that there are some weak spots in the case for fluoridation and several points which require thorough investigation. Nevertheless, Mr. Blount does not raise these legitimate doubts but bases his case on fallacious arguments that have been answered many times. I need hardly add that I am in no sense questioning Mr. Blount's right to query the "establishment" support for fluoridation.

I shall be pleased to discuss in more detail any aspect of fluoridation if you wish.

Yours sincerely,
G. NEIL JENKINS,
Professor of Oral Physiology.
(Lecturer in Physiology at Barts, 1939-46).

Professor G. Neil Jenkins' article appeared in ON CALL, 4th March, 1974. We are unable to reprint it here for reasons of copyright—Ed.

Sandy Balls House,
Godshill, Fordingbridge,
Hants. SP6 2JZ.
19th May, 1974

Dear Sir,

As an old Bart's man I have taken the Bart's Journal for many years now in order to keep abreast of modern medical thinking and practice, and I am delighted with recent Journals, particularly the May issue which had such a variety of interesting topics.

You are especially to be congratulated for your publication of the article on Fluoridation by Mr. Clavell Blount, as this is a most controversial subject. The true facts have so often been distorted, or kept from the medical and lay public by Government-financed propaganda, in favour of compulsory mass medication —something which should be abhorrent to the medical profession.

Yours sincerely,
AUBREY T. WESTLAKE.

A review of Dr. Westlake's new book, "The Pattern of Health" (published by Shambhala, £1.30), will be printed shortly—Ed.

Abernethian Room.
May 23rd, 1974.

Dear Sir,

Mr. J. House, in his letter to you in the May 1974 issue, dealt with that part of the student grant which the student has at his own disposal. I should like to consider that portion of the grant which is paid as a subscription to the Students' Union and is used to finance the student activities within the Union. Currently this subscription is at 12 guineas, but it is soon to be raised to £15 owing to inflation.

The Financial Secretary outlined in the February 1974 issue of the *Journal* the main Union income and expenditure, which can be summarised as follows: —

Income: £10,500
Expenditure:
Clubs' grants (e.g. Art & Design Cricket) £6,000 — 7,000
Union facilities (e.g. ENTS. Comm. Newspapers) £2,000 — 3,000
Subscription (e.g. *Journal*) £1,000

(For details—contact The Financial Secretary, M.S.C.R. Bart's.)

The point I ask readers to consider is—are they satisfied with the way this money is distributed, or do they feel that better value for money could be achieved? The question is relevant at this time as the Financial Committee of the Union sits in the near future to decide next year's fiscal policy. Now is the time, therefore, to state your support or air your grievances, rather than next year, when it will be too late.

Whatever your opinion, I am interested to hear it, and I am sure that the *Journal* would be only too pleased to print some of the replies.

Yours faithfully,
T. P. FINNEGAN
(Chairman, Students' Union).

Abernethian Room,
May 28th, 1974.

Dear Sir,

Those of your readers who might be considering a subscription to "Medicine" magazine might also appreciate the following information.

When in February I realised I hadn't received 11 out of 24 copies, I began to make a few inquiries; and it soon became apparent that this sort of thing was by no means uncommon. It also appeared that letters to the magazine's management were either ignored or met with discourtesy.

Those who had received the magazine, did so in twos and threes, with intervals of several months in between. This surely defeats one of its objects, which is to supply easily digestible packets at regularly spaced intervals. Meanwhile attempts to recover my unfulfilled subscription have not, nearly three months later, been met with a refund of the money spent for magazines not received, though so far I have been offered a little over half.

There are many calls on a student's meagre income, and those who may be thinking of subscribing would be advised to think very carefully before committing themselves.

Yours faithfully,
C. J. SEDERGREEN.

Gilfachweddog,
Felinfach, Lampeter,
Cards.

Dear Sir,

Sir Charles Harris and I made a very little mark in the history of Bart's. In the late 1940's he appointed me to teach on the healthy child in the family to the Students doing their Paediatric. He was then also Dean. He told me he had seen many more far better qualified for the job, but of all those whom he had interviewed I was the only one who had a sense of humour enough to see the funny side of the job . . . "And without that you can't live here." How true! but he quite forgot to enlighten me that I was the first woman to cross the all male portal of the Medical College. It was left to poor Mr. Morris to enlighten me on that score on the day I arrived!

From then on, and for 15 years, I was privileged to be a sort of midwife and health visitor to the brain children of one of the greatest minds I have ever met. He had the ideas, he left me to translate them into workable facts. He also had a great heart . . . what other chief, or at least there are not many others, who, when I asked if I might try out something, would answer "Yes, if it succeeds, it's all yours, if it flops, don't worry, I have allowed it in my Department and I alone am responsible for the flop". This he not only said, but he acted on it.

When he wrote to me after Christmas this year, so as not to spoil mine for me . . . and told me his news, in his usual characteristic way . . . I could only answer "When I get through the Celestial Gates I hope you will be on the selection committee again, you let me bluff my way into Bart's . . . and you always said bluff was my second name . . . but you always let me get away with it. Please do it one time more . . . and once more we will shake the heavens with our laughter."

Thank you Bart's for letting the "Chief" make his impact on so many of us.

Miss MARIE DESBOTTES.

Diagnostic Radiology Department.
May 24th, 1974.

Dear Sir,

I read with some interest that Miss Susan Eaton is concerned about the irradiation received by various non-designated persons in Bart's.

Firstly, the radiation emitted from the microwave ovens is stated by the authorities to be non-ionizing radiation. It is, therefore, not the responsibility of the radiation protection officers and is not measured in the units of ionizing radiation, but in units of electrical energy.

The legal limit in Britain at present is 10 milliwatts/square cm. continuous exposure measured at 5 cms. The manufacturers limits for the ovens installed at Bart's is 2·5 milliwatts localized measurement. Therefore the power allowing for the inverse square law is very considerably below the legal limit at 5 cms. The firm check the ovens at intervals, particularly the door seals (and of course the ovens must be operated with the protective doors closed).

With regard to the Casualty X-Ray Department, which is certainly my responsibility, the relevant doors are invariably closed when the X-ray tube is energized, but even so, if the doors were left open, the tube is so arranged that radition cannot be directed through any of the open doors, and again the inverse square law, so attenuates the scattered radiation that there is no measurable dose in the vicinity of any of the doors.

I do sympathise with the concern of the public, with regard to the genetic implications of ionizing irradiation, but I wonder whether Miss Eaton is aware of the risks involved in sitting in front of a hot fire, viewing colour television whilst eating Brazil nuts

Yours sincerely,
AUDREY K. TUCKER,
Radiological Safety Officer,

4, Clemson House,
Haggerston Estate,
Dalston, E.8.
May 20th, 1974.

Dear Sir,

I wish to send a note of thanks and gratitude to the doctors, sisters and nursing staff of this hospital for the wonderful care and attention they gave to my dear husband, Mr. C. White. None of them could have been kinder or have done more for him while he was in Harvey Ward.

Please print this letter in the monthly *Journal*.

Yours most sincerely,
Mrs. E. WHITE.

Dear Sirs,

House jobs

As you know, for the latest appointments and the previous January appointments, I had persuaded the Committee of Physicians and Surgeons to adopt a new scheme for the method of appointment.

In return for the candidates selecting up to 15 posts and indicating those which they would not accept, the Committee agreed in general to accept the students' choice provided they had been ranked in an order of academic merit by the Sub-Dean. To allow for incompatibilities any Consultant could veto any candidate for his job. This method has been evolved after many meetings of the Consultants and of the Sub-Dean with the students and housemen.

This time 12 candidates so appointed have declined their posts. Most of these resignations were at least two weeks after the Committee had met and all the unplaced candidates had made their own arrangements. The direct consequence of this is that we have to let down colleagues at peripheral hospitals who had relied on us.

Very shortly I shall be writing to these hospitals asking them if they have any jobs for next January. I for one will not be surprised if we get a dusty answer.

A. P. FULLER,
Sub-Dean.

If "DHP" would care to identify his/herself it would be possible to publish the letter he/she omitted to sign.—Ed.

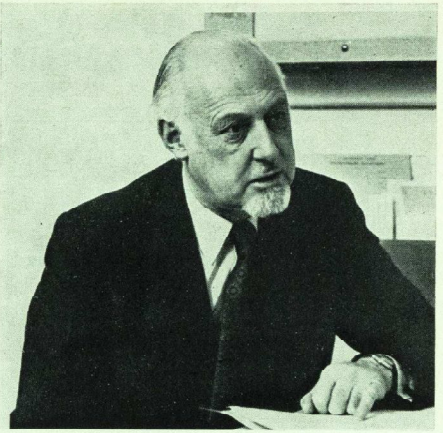
THE DUKE OF GLOUCESTER

FOURTH ROYAL PRESIDENT OF BART'S

On June 10th the death was announced of the Duke of Gloucester, President of St. Bartholomew's Hospital. He was the fourth Royal President. In 1867 the Governors decided to ask the Prince of Wales to become a Governor and after the Prince had accepted this invitation, he was elected President of the Board of Governors. When he succeeded Queen Victoria in 1901 as King Edward VII, his son George, Prince of Wales, was asked to take his father's place. The King died in 1910 and the Prince of Wales succeeded him as George V. No President was elected until after the first World War for the new King's eldest son was still too young in 1910. In 1919 the Prince of Wales was elected President and he held this office until 1937 when the Duke of Gloucester took his place. In his Presidential address on December 14th of that year he promised that he would "always take a close personal interest in the Hospital's welfare and activities". The outbreak of the second World War prevented him from visiting the Hospital, though in March 1941 he came to see personally the extent of war damage. The Medical College elected him an Honorary Perpetual Student which is an honour conferred on distinguished visitors because of their association with the work of the College.

In 1945 the Duke was appointed Governor-General of Australia and though he was called back to England in 1947, he travelled extensively, representing the King and afterwards Queen Elizabeth II in Ceylon, Nairobi, Malaya and Abyssinia. He did not get much opportunity to pay another visit to the Hospital and when by 1960 his health began to fail he lived almost continually at Barnwell in Northamptonshire.

Dr. KERLING.



Percy Jayes last out-patient clinic at Bart's in December 1973. *Photograph by Mr. Tredinnick.*

PERCY H. JAYES
AN APPRECIATION

With characteristic care to avoid personal publicity, Percy H. Jayes retired in December last after 21 years as Consultant Plastic Surgeon to Bart's, and from the Queen Victoria Hospital, East Grinstead, after 25 years in a similar capacity.

His association with Bart's extends over more than 40 years from his student days. Trained in his specialty under Sir Harold Gillies and Sir Archibald McIndoe, he continued their tradition of service to the Hospital. His reconstructive surgery is singularly safe, conservative whenever appropriate, and never showy despite his involvement in cases as celebrated as the separation of craniopagus twins in 1964. His reputation is international, and his particularly close links with Yugoslavian surgeons began in 1946 when he was surgeon in charge of the U.N.R.R.A. Plastic Surgery Unit in Belgrade.

He has made many contributions to the literature of his specialty and gave the McIndoe Memorial Lecture at the Royal College of Surgeons in 1964. Presidency of the British Association of Plastic Surgeons in 1960 and of the Bart's Hockey Club for more than 20 years have given him equal pleasure.

He recently wrote: "I think that in many ways I am going to miss the Hospital very much—I am determined to keep in touch as much as possible". His distinguished presence in the operating theatre and out-patient department is very much missed. With the time now gained he plans to enhance his professional relationships in this country and abroad, and devote more time to his family and beautiful home at East Grinstead.

We offer him our sincere thanks and good wishes.

HEALTH EDUCATION AND THE MEDICAL PROFESSION

By PAUL CARY

To most doctors, health education is a subject of virtually no interest and of which they have little knowledge. In contrast the three year increase in the life expectancy for males over the last 25 years is a tragic indictment of sophisticated medical care systems directed exclusively to the cure of disease instead of its prevention.

The benefit of medical knowledge when applied to the mass of the population rather than individuals, is seen in the success of immunisation programmes. Large numbers of people no longer die of infectious diseases. Instead they die of arterial disease in part due to obesity, or from lung cancer due to smoking cigarettes. The suffering caused by chronic mastoiditis or pulmonary tuberculosis is no longer a problem but the number of cases of gonorrhoea reported has reached 50,000[1] per year while the abortion rate is over 100,000[2] a year and rising steadily.

Meanwhile the cost of curative medicine in money and manpower rises remorselessly, but there is a finite level above which the nation cannot afford to spend more of its resources on health. The National Health Service is estimated to have consumed 5.75 per cent of the national income in 1973.[3]

Education to change attitudes and behaviour which result in "killing" diseases is urgently required if the health care system is going to be of any benefit to the majority of the population. In turn this would help to relieve pressure on the curative side of medicine.

A great deal more research into behaviour and how it can be changed is needed, but the behavioural sciences lack the preciseness that now exists in medicine, which makes it an unattractive field for researchers.

It is an alarming paradox that the medical profession who seem not to realise the necessity for efficient health education, provides the only successful model of its effect. The reduction in smoking among doctors following the first report[4] of the Royal College of Physicians, resulted in a measurable decline in their overall mortality.[5]

In competition with curative medicine for a proportion of the health service budget, health education inevitably fails. Even a curative medical programme that claims to extend survival by weeks, will obtain adequate budgets. Other items are justified solely on the basis that every hospital should have one regardless of whether their effectiveness has been proven. The current controversy over coronary care units is a case in point. Starting with very limited budgets when one is talking in terms of populations, ensures that failure will result so the budget is likely to be cut still further.

The psychological criteria for producing effective methods of transmitting information or causing behavioural change are not known. Media advertising does not have the dramatic effect in health propaganda that it does in marketing. This may be due to advertising techniques being geared to the advertising of finite products rather than the less definite concepts of health. It is more likely due to the simple fact that advertising reinforces behaviour patterns already established and does not seek to change them. In addition, many health education campaigns are in direct confrontation with major industries. The cigarette manufacturers advertising budget is estimated at well over £50m. a year.

Behaviour patterns are established in the young but one cannot expect the teaching profession to accept further additions to their already crowded teaching curriculum, when they themselves are not convinced of the value of disease prevention by education. Parents also have to be convinced of the benefit of inculcating healthy habits in their children. The general population still look to the medical profession for guidelines on their own attitudes to health. All the profession has given them through the media so far is a diet of sensationalised reports of unconfirmed research or technological skill directed at minutiae.

Ideally the doctor's responsibility in health education should encompass his life as completely as his interest in the cure of disease involves him at present. A doctor who smokes and by example condones a habit that is the major avoidable health hazard of this society, is as guilty of professional misconduct as any practitioner who fornicates with his patients or over-prescribes opiates for personal gain.

Clinical practice is already involved in health education problems such as obesity and smoking. Doctors find themselves ill equipped to impart the advice and give the support that will bring about a lasting change in the behaviour problem of over-eating and cigarette smoking even in spite of good motivation from the patients themselves. The few successes are usually confined to those patients whose illusions of immortality has been shattered by serious illness and in whom health damage has already occurred. Medical schools have a vital part to play in health education by providing teaching time so that the new doctor's armoury, in addition to the sterile lists of drugs and treatments, also contains the concepts of communication.

For those who are in a position to determine the funding of medical budgets, the main consideration should be whether money spent on long-term prevention will not always outweigh the benefits of short-term curative medicine.

The author is a Medical Officer with the Health Education Council.

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TALKING TO THE DYING

By Dr. RICHARD LAMERTON

How?

Talking to the Dying. The very phrase fills the mind with a crowd of "I can'ts", "I won'ts" and preconceived notions amounting almost to superstitions. For a number of erroneous beliefs about the feelings of people who are dying are transmitted tacitly from one generation to another without being questioned.

We avoid conversations with dying patients in case they ask us difficult questions. We fear a violent outburst if we are truthful about the diagnosis and prognosis. We assume that a wife can bear all alone the news of her husband's cancer, but that he could not possibly stand up to it. Surely we can deceive even intelligent people with such turns of phrase as "You'll feel worse before you feel better", and pretend the radiotherapy is for piles?[2]

But last week a lady said to me "Well of course I know what it is. They don't do a bone scan lasting nearly an hour if they aren't looking for something, do they?" So I asked "You mean a cancer, do you?" to which she replied "Well . . . yes". It was necessary for me to take the bull by the horns in this way and to drag the dreaded word into the sunlight, just because it is a dreaded word. In the mind of the layman "Cancer" brings up pictures of a violent death, with awful pain and mutilation or ravagement. These fears can cause suffering far worse than all the physical symptoms put together and are usually completely unfounded. Only if they are dredged up and seen for what they are can the patient be reassured.[3]

Recently one of my outpatients with carcinomatosis was having 40 mg of diamorphine every four hours, supplemented by other pain killers and tranquillisers. He had two nerve blocks and steroids, all to no effect—the pain was apparently insurmountable. With his wife and priest I sat down one evening and talked the whole matter over. He was not a very outgoing person, so I could not draw from him exactly what his fears were, but they were evidently connected with the process of dying, which he assumed would occur in St. Joseph's Hospice. So I described in close detail exactly how we care for a dying person, and what he does, from about an hour before the death to an hour afterwards. The next day saw a reduction in his pain and we were able to reduce the dose of diamorphine and withdraw the tranquillisers.

I have seen people overawed, joyful, sad or philosophical at the prospect of death, but never shattered and lamenting, nor so depressed that they stopped eating or communicating and just died. By far the commonest reaction when a fatal prognosis is confirmed is a deep sigh of relief and "Thank heaven someone has been honest!" Then one can get on with reassurance that symptoms can be controlled and that the process of dying will not be a terrible one.[5] Once a patient realises that a doctor has been deceiving him, all trust is lost, and future reassurances will be taken with a pinch of salt. One of the patient's most important props would thus be denied him.

A review of Dr. Lamerton's book, "Care of the Dying", will be published shortly.

When?

Honesty, then, is essential: but does that mean bombarding every dying patient with his diagnosis and prognosis, and taking away all his hope? The answer is, of course, No.

My title "Talking to the Dying" is deliberately inaccurate, so that I can make a point of demolishing it. This is not just something the doctor decides to do, braces himself outside the ward, and marches in like a Napoleon. If there is to be any conversation about death and dying, the patient will lead it. The role of the doctor, nurse, chaplain or other member of the caring team is to listen.[4] The patient should be allowed to say anything he wants to.

This is the point of difficulty. Denial of death, and the taboo on talking about it have recently been built into our very culture. There is a tendency, when a risk that the patient may ask about it is perceived, to talk, change the subject, and give hearty reassurance. The decision to do so is subconscious, and in his subconscious the patient gets the message: "Death is not a subject for polite conversation, please." We must catch ourselves at this moment of turning off. If the patient ventures a little probe—"When do you suppose I'll be walking again then, doctor?" "I've lost another half a stone since I came in to hospital." "That lump's bigger I think."—and behind the trivial comment you can hear the real question, that is the signal for you to sit down and listen. "Yes, that must be worrying you" is the kind of useful opening which lets the patient know that he has permission to unburden himself. Silences in the conversation need not be alarming. Only if we fill the silence with tension will it be uncomfortable. Gaps in the conversation can be regarded as rests, or the patient may be plucking up courage to speak about his fears.

Only in the actual situation will you know how much to confirm and how much to reassure. But resist the temptation to get out of an uncomfortable situation by lying, because someone else will tell the patient a different lie later and produce hopeless confusion. It can be very hard for the nurses, when the patient realises later that the doctor was waffling, because they have a two-way allegiance both to comfort the patient and support the doctor. The information as to how much the patient wants to know comes, logically enough, from him. Therefore one's attention should be on him. To look down and think furiously, "What on earth shall I say now?" is to ignore this flow of information, so the result is bound to be wrong. Is he frightened? Is he amused by your embarrassment? Is he satisfied with the little you have said? Is he impatient to know more? When he has heard enough the patient will dismiss the subject. Many will never bring the matter up, and so be it, as long as all are given the opportunity to talk.

Talking to the dying is not like walking on a minefield. With a little practice you can be very surefooted, and this firmness and confidence will be much appreciated by the patient and his relatives. It is now that they need one another's support more than ever. If a wall of false cheerfulness about "when you get better" is separating them, the patient dies lonely and the relatives are left with a sense of incompleteness.[1]

People often want to prepare for death. It may simply be a matter of making practical provisions for the children, writing a will, paying off the mortgage. One man in the Hospice first showed his awareness of his prognosis by asking one of the chaplains "Is there a way of contacting long lost relatives, Father?" He had a feeling that loose ends should be tied off and everything completed neatly. Husbands and wives, in particular, will want to say goodbye. Old feuds may be buried, forgiveness made evident, last little services given, togetherness enjoyed. An outpatient recently said, with some regret in his voice, "I never took religion seriously, doctor." I picked this up and asked if he would like to speak to a clergyman. The answer was Yes, so I listed the local clerics and asked which he would like. The Methodist minister was chosen, and the last I heard was that my patient had quite spontaneously asked him how to pray: they are now working at it together three times a week.

It is a privilege to be a party to this mellowing and inner growth which so many people undergo as death approaches, and this is why terminal care is such rewarding, joyful work.

Who?

Any member of the caring team may be asked a leading question. There is no particular reason why the patient should choose the doctor. He may have more trust in the ward sister, or that lovely little junior nurse who is so sympathetic. Or the social worker might strike him as the person most concerned for his welfare, or the chaplain because he listened. He may relate best with the physiotherapist because she touches him most. All these team members must, therefore, come under the discipline of confidentiality and be in a position to handle a conversation about dying. It follows that there must be very full communication among the whole team caring for the dying.

To show how this may be done, St. Joseph's Hospice is holding a series of interdisciplinary conferences on Saturday mornings. Medical and nursing students, trainee social workers, priests, physiotherapists, and students from any paramedical disciplines are invited. At the next one, on Saturday, July 13th, from 9.30 a.m. to 12.30, the speaker will be Dr. Cicely Saunders. Interested students should give their names to Mrs. Rumsey at the Hospice (Tel: 985 0861).

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INDISCRIMINATE JOTTINGS OF A PORT DOCTOR

By Dr. DILWYN JONES

There are not many doctors nowadays who consider that their main work in life is the prevention of disease by the control of the environment, whether that be in the form of an infected or suspected human being or an infected animal or contaminated food or polluted air or whatever. Since the Reorganisation (or whatever else you care to call it) of the Health Services, there are even fewer of us.

One of the great attractions of working in a great seaport, such as London, is the assortment of weird and wonderful jobs which one may be expected to carry out. When, as with Corporation of London appointments, port work is harnessed to preventive work in the City itself, the possible spectrum of experience becomes very wide. It has been well said that one of the qualities required for this sort of job should be "a vast experience in dealing with the impossible".

To illustrate this point of view let me give a few selections from some experiences in this Health Department over the last decade.

Communications in a Port the size of London are of prime importance. In this case, the Boarding Medical Officer on watch at Gravesend received a message via North Foreland Radio from a Russian ship, due in London later that night, to the effect that a reindeer aboard the ship was parturient. The doctor could not communicate directly with the ship because she was not fitted with VHF radio. Therefore, discussion with the ship's master was carried out by telephone to North Foreland Radio who passed the message on by Morse telegraphy. At the end of a long and palpitating period for the doctor, and just as the ship was entering Gravesend Reach, he was informed that the shipping company's agents had found a veterinary surgeon who would attend. The doctor concerned reported very solemnly that he was vastly relieved that he did not have to act as midwife to the reindeer, because he felt that it was a job for which he was inadequately trained. Medical academicians please note.

Smallpox is a disease which, while not affecting so many countries nowadays, is nevertheless infecting more individuals. It is always an impressive performance to be got out of bed at two o'clock in the morning to drive up to town and see a patient in one of our great teaching hospitals (which shall be nameless), in order to give an opinion on a suspect rash. It is the one and only occasion on which you feel like the eminent consultant of your student days, leading, with solemn and portentious mien, a crocodile of doctors and students through darkened corridors to see the patient. Pride is followed by the fall, however, when, having decided that the case is not smallpox but some other relatively innocuous infectious disease, an attempt is made to get the patient admitted to an isolation hospital. The bureaucratic walls of medical red tape come up at a quite astonishing speed and are higher and thicker than anything the Civil Service could contemplate in its wildest dreams. Despite protest, no one will accept a case which has at any time been labelled "?smallpox" unless that diagnosis has been debunked by no less a person than a member of the smallpox consultancy panel, and so you must await the arrival of a *real* consultant and, worst of all, endure the contumely of those who, only minutes before, were hanging on your every word. Ah well, it was good while it lasted!

People fall into the River Thames with monotonous regularity. Many of us have macabre memories of chugging slowly along the river on one of the port health launches, with the night as black as the proverbial back doors of Hades and the searchlight on top of the wheelhouse swinging out across the dark, swelling waters in an attempt to find a body which may yet be alive. Something pale shows up under the piles of a jetty, there is a rapid clanging of telegraph bells, a voice speaks urgently into the radio which makes indistinct but equally urgent reply, several boats swing in towards the jetty and the smallest of them gropes in amongst the piles, hauls out something limp and sacklike and the doctor sets to work to blow some sort of life back into the apparent corpse. Some of them you win; some of them you don't. The river is an ugly, cruel beast at times.

The City of London is very ancient. A by-blow of its age is the fact that buried, in its ground, are many remains, quite a few of them of human origin. Until recently, it was necessary for a doctor to turn out if human bones were found, to certify whether they were "ancient bones" or, presumably, of forensic or public health interest. I imagine that it gave the workmen on the excavation sites much pleasure to watch the nattily dressed medical gentleman climbing awkwardly down into their filthy hole and clambering along to examine a little clutch of bones, which surely deserved their eternal rest. Sometimes a ripple of interest was caused among the historians as when a most odd collection of limb bones was found deep underground near Bishopsgate. They would have been passed as a routine find if it had not been for the fact that each of the bones had been neatly sawn off and were apparently the results of amputations. Research demonstrated that the site had been previously occupied by the hospital of the East India Company, and the find brought to mind unpleasant pictures of people injured or diseased in the Far East, enduring the weeks or months of the homeward voyage only to have a limb removed and buried by some unknown means in a communal pit.

Occasionally one becomes involved in the sort of job which requires more muscle than medical expertise. In the early days of "the clean river Thames", excitement ran high when a porpoise appeared off the "beach" at Gravesend. Unfortunately, he was a little too adventurous, ran himself ashore and became stranded. The Quarantine Station at that time was located on a hulk, appropriately named "Hygeia", which lay just off this beach, and so, not to be outdone by man or beast, some of the launch crew members took to the dinghy, attached a rope to the porpoise and, to the cheers of the assembled multitude, hauled it bodily back into the water where it was released and was last seen heading rapidly in a nor-nor-easterly direction. This was fortunate as, if the poor animal had not taken off so rapidly, there would undoubtedly have been a demand for the doctor on watch to treat him, which would really have been by guess and by God!

Working in the City means that the heart of the newspaper world is within one's parish and that they and the other mass media expect profound opinions on all matters remotely concerned with medicine, over the phone at a moment's notice. Expertise on selecting those questions which one wants to answer and adroitly parrying the others is an essential part of the job. Even so, one can still read or see or hear reporters quoting medical opinions which cause one to demand to know "what damn fool said that?" only to realise upon reflection that the opinion is a well-nigh unrecognisable edited version of what has actually been said by oneself. It should be necessary for all medical students to be given a course in public relations. In later life they would regard it as one of their most valuable skills.

Embarrassments in this job come thick and fast. One needs to be pachydermatous to say the least. Can you imagine trying to sort out a problem in Smithfield Market to the accompaniment of the very audible comments of a number of bummarees who are observing your antics with great glee and describing it with a selection of well chosen phrases? Or boarding a large ship and finding that the Master does not consider that the health control measures were meant for him. Verbal fisticuffs follow, but as you have the upper hand in terms of legal sanctions, eventually your demand for a muster of the crew is accepted and you are left alone to contemplate your victory. The last word is, however, heard over the ship's Tannoy system when the Master calls the crew for the muster and, to the huge delight of the crew members just arriving, takes the opportunity of embellishing the passing moment with a description of your qualifications and ancestry, the most polite of which is a reference to "that b—— f—— Welsh quack". Take it from me, one feels very alone on such occasions.

Obviously, these anecdotes have been selected. Much of one's job is straightforward and some of it is routine. One does, however, have the satisfaction of doing the work and of practising preventive medicine. Since Reorganisation it seems that this will no longer be possible. One must either become a chairborne warrior or a clinician. There is still, however, a question as to whether money is better spent by allowing a doctor to control the environment in such a way that perhaps hundreds of people are prevented from falling ill, or by insisting that that money should be spent on a highly expensive and complex procedure which will enable the life of one patient to be prolonged for perhaps a few years. In an ideal state one should not have to make such a choice. As it is, the politicians and the medical profession would do well to ponder on the problem rather more deeply than they appear to do at the moment.

Prior to the reorganisation of the National Health Service, Dr. Jones was deputy Medical Officer of Health to the Port and City of London.

THE OTHER SIDE OF THE FLUORIDATION STORY

By BRIAN A. BURT

Readers of Mr. Clavell Blount's article on fluoridation in the May issue could be excused for thinking that fluoridation was conceived solely by ruthless industrial combines in the U.S.A., The Reader's Digest and our own Department of Health and Social Security. Certainly the subject is complex, but presenting it in this fashion demeans the huge volume of legitimate research it has attracted over the last 40 years.

Fluoridation of water is now carried out in 38 countries reaching a population of 150 million. Can we accept that all public health authorities, all public decision makers and all researchers in those countries have been hoodwinked? Also, the first artificial fluoridation began in U.S.A. in 1945 (in Britain in 1955). If it was dangerous, ineffective or uneconomical, would it really have lasted that long, and would new projects still be commencing?

In Britain some 3.8 million people are now drinking fluoridated water, a much smaller proportion than in U.S.A., Canada, Australia or New Zealand.

Dental decay is a public health problem in Britain. The dental services now cost £120 million per year, putting dental disease second only to mental illness as the most expensive disease entity in the country. Sugar consumption remains around 100 lbs per head per year. It is true that consumption of fermentable carbohydrate, sucrose especially, is a major factor in the chain of events causing decay. However, it remains a fact of life that sugar consumption, like smoking, over-eating and other practices which are deleterious to health, will not go away in the foreseeable future.

Space does not allow for discussion of many facets of the subject which merit close examination, for example fluoride in the diet, effects on adults, enamel fluorosis, skeletal deposition, excretion effects on persons with defective renal function and the ethics of fluoridation. Concerning ethics, it is worth pointing out that the Privy Council in 1964 ruled that fluoridation does not alter the wholesomeness of public water and that it is a legitimate procedure for a municipality to carry out.

Some specific points made by Mr. Blount, however, demand immediate, if brief, comment:

1. Dr. Gerald Cox died some years ago so presumably can now be attacked in peace. The idea of artificial fluoridation did not originate with him, it had grown over a period of time through the 1930's.
2. The table from the Department of Health and Social Security's study can be misinterpreted. The study involved Watford, Herts., fluoridated in May, 1956, using Sutton, Surrey, as the control community, and Gwalchmai, Anglesey, fluoridated in November, 1955 with Bodafon, Anglesey, as control. Holyhead, Anglesey, received water fluoridated at 0.7 ppm and was looked at separately without a control community. Two other communities, Kilmarnock and Andover, withdrew from the study.

The figures in the table shown in Mr. Blount's article are for Watford-Gwalchmai-Holyhead combined and Sutton-Bodafon combined. In examining them it should be realised that:

1. Children over age 10 had not had lifetime benefit of fluoride.
2. Children aged 12-14 were examined in 1965 in Gwalchmai and 1967 in Watford, and thus had received different exposure to fluoride.
3. Bodafon, originally a control community, began fluoridating in 1964 and was thus strictly lost as a control.
4. Holyhead, fluoridated only to 0.7 ppm and therefore providing only partial benefits, was included in the study communities.

If the results for Watford against Sutton or for Gwalchmai against Bodafon, are examined in earlier tables in the report, then fluoridation's benefits are clearly shown.

Fluoridation is by far the most effective, and cost-effective method, of reducing dental decay community-wide. It produces no side-effects in a temperate climate at 1 ppm. The ethics and legalities question have been examined by the Privy Council, the High Court and Supreme Court of Eire, 13 State Supreme Courts in USA, a Government Committee of Enquiry in New Zealand, and by a Royal Commission in Tasmania, Australia, that sat for over a year and produced 989 paragraphs in its report. All reported in favour of fluoridation as a public health measure.

Dr. Burt is Lecturer, Community Dentistry Unit, The London Hospital Dental School.

IDIOSYNCRATIC RESPONSE TO THE LOCAL APPLICATION OF COCAINE TO THE MUCOUS MEMBRANES OF THE NASAL CAVITIES

By A. J. SMITH

Cocaine solutions, with or without adrenaline, in various strengths are routinely used to anaesthetise the mucous membranes of the upper respiratory tract by E.N.T. and oral surgeons, by anaesthetists and also by ophthalmologists to anaesthetise the cornea and conjunctiva.

The central pharmacological effects of chewing the leaves of the plant Erythroxylon Coca have been valued for many centuries by some South American Indian tribes but Sigmund Freud was the first to investigate the drug for local anaesthesia. Köller, his colleague (as Freud writes in his autobiography) completed the animal experimental work and is usually given the credit for introducing the drug into medical practice. The use of Cocaine, however, is not without its dangers, even in therapeutic situations, as the following case history shows.

Mrs. L.M., a 48-year-old housewife, presented in the E.N.T. department for bilateral antral puncture and washout for recurrent maxillary sinusitis. A 20 per cent solution of cocaine containing one in a thousand adrenaline was administered by the insertion of two pledgets of cotton wool soaked in the solution, one in each nostril. Ten minutes later she complained of feeling unwell, of a headache, pains in her back, and that she was nauseated. She appeared agitated and exhibited pallor. After being transferred from the clinic to a side-bay, she vomited several times and became semi-comatose and restless.

At this stage, her pulse was 80, full and bounding. Her blood pressure was 200/130 mm/Hg, and respirations increased in depth and rate. 10mg of diazepam were administered intramuscularly with little effect, and oxygen was given. The resuscitation registrar was called and the situation reassessed. Her blood pressure was now 190/120 mm/Hg, she began to be dyspnoeic and the headache and vomiting persisted. An intravenous infusion of normal saline was set up and 2mg of phentolamine was given intravenously. Cardiac monitoring was instituted and with increasing dyspnoea, postural rales were noted. She developed ectopic beats and 1mg of propranolol was given intravenously, following which her blood pressure dropped dramatically to 90/60 mm/Hg. She began to cough up blood stained sputum. Pulmonary oedema consequent upon left ventricular failure was diagnosed. Frusemide 100mg. was administered intravenously together with ouabain 0.25mg and 10mg of dexamethasone. Her pulse then became regular at 90 per minute, but her blood pressure remained low at 90/70. By this time her vomiting had ceased. She was transferred then to the intensive care unit where general resuscitative measures were continued and within 12 hours her signs and symptoms had disappeared.

DISCUSSION

The bottle of cocaine solution was sent for chemical analysis. This revealed that 28 per cent of the adrenaline had broken down but that the products were considered innocuous. On her subsequent admission, a cocaine sensitivity test was performed in which 10mg of cocaine in 0.18ml solution were given subcutaneously. No change in blood pressure or pulse were recorded during the 30 minute test period. This result, however, does not rule out the possibility of cocaine idiosyncrasy since higher increments of cocaine dosage could easily have provoked a cardiovascular response and fatal cocaine reactions have been recorded when similar testing has been performed before operations using cocaine anaesthesia.

It is possible that her symptoms of headache, backache and vomiting could have been caused by raised intracranial pressure consequent on the rise in blood pressure or because of the central excitatory effects of the drug. In the literature it is noted that a rebound fall in blood pressure is not uncommon in such cases although it could be argued that the alpha and beta blocking drugs might have been responsible.

Lane and Lockart in 1951 describe an eczematous local allergic reaction following administration of cocaine to the mouth, and Criep and Ribiero in 1953 report a fatal anaphylactoid reaction in an asthmatic. However, it is likely that in the case under discussion, the reaction was due to dose-related idiosyncrasy rather than to an allergic phenomenon. Goodman and Gillman suggest that such reactions are not rare but no figures are given in support of this claim and an effective satisfactory alternative has not yet been found.

Acknowledgements

I would like to thank Mr. Dowie for allowing me to report this case history and Dr. Richens for his kind help and advice.

SPOT - THE - UNIFORM COMPETITION

First Prize £1.50

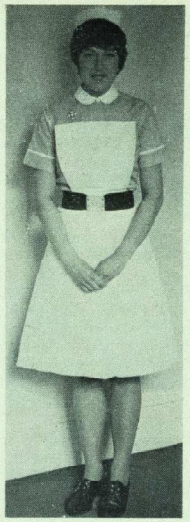
2 Second Prizes of 50 pence

On these pages, you will observe photographs of a nurse from each of the other 11 teaching hospitals of London. All you have to do is to match up each nurse with the name of the hospital she comes from. What could be more simple? Well, a lot of things could, so to help you out, we've added a list of the 11 hospitals:—

Charing Cross Hospital; Westminster Hospital; Guys Hospital; St. Thomas's Hospital; London Hospital; Middlesex Hospital; University College Hospital; Royal Free Hospital; St. George's Hospital; St. Mary's Hospital; King's College Hospital.

The closing date for the competition is **August 10th,** and the winner will be the first correct entry drawn out of the ubiquitous hat on that date.

All photos by Tony Randall; Rob Treharne Jones did the footwork!



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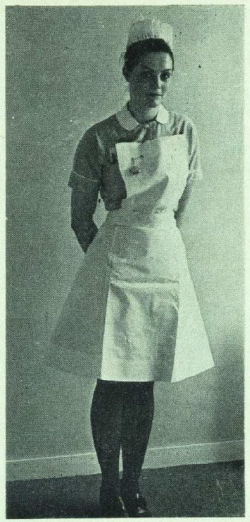

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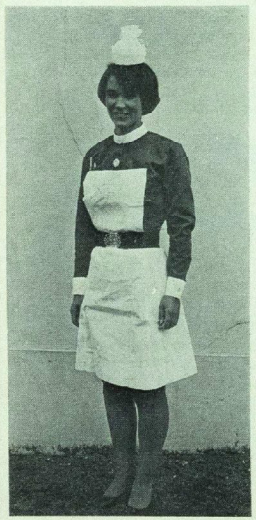

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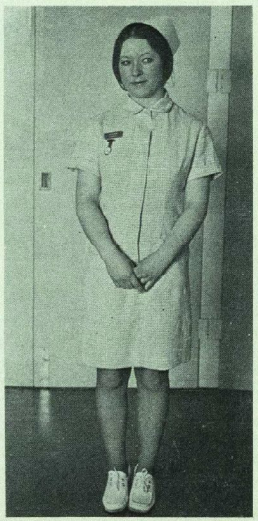

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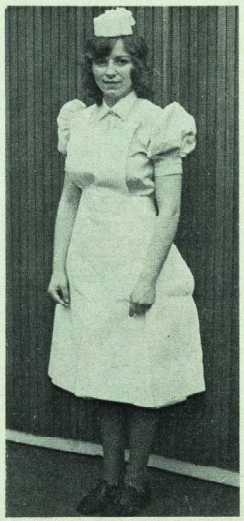

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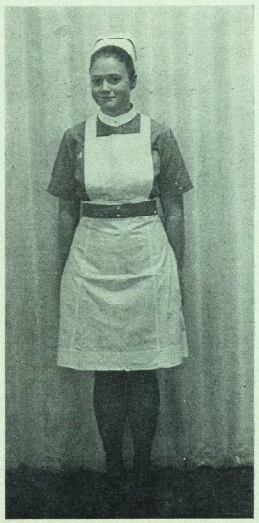

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NEWS AND VIEWS

Scandals

1. Our congratulations to the "Charterhouse Six" for getting themselves banned from the bar at the end of May after an "over-boisterous" club dinner. Presumably they will live long in the vandals "roll of honour". But the people I feel most sorry for were the ones on the verge of taking their exams who had to miss the crucial late-night drinking so essential for warding off the horrors of pre-2nd M.B. insomnia. For the bar was closed down for a week before the exams as a result of the above-mentioned fracas; so all failed examinees are invited to attend the *Journal* office if they wish to find out who deprived them of their rightful drinking time. The "Six" however are only themselves the vicitims of a general malaise which has kept the glazier in luxury for the last few decades and has not been averse to smashing the odd bike or car, or tossing the odd colour TV out of the window. Perhaps we just can't be trusted any more with our own bar.

2. A Senior Consultant Surgeon at this Hospital has recently blown an enormous hole in Mr. Fuller's "fair" arrangements for house jobs. Despite a letter confirming his appointment and its announcement in the printed list of house posts, the would-be HS was told there had been "a mistake" and that the post had been promised to someone else. What is so galling about this little incident is the total lack of respect for other people's convenience or feelings. If patronage is going to be the order of the day, at least make it efficient and non-disrupting.

Q. Fever

Is it not time that the Medical College ceased the barbaric and unnecessary practice of announcing the results of the 2nd M.B. examination to the candidates personally? This seems to be one of the few institutions left, where this procedure still exists. The simple posting of a notice on the wall enables all to see their own result, without releasing those marks which are "confidential", and also allows those who have failed, to go away on their own without the obvious embarrassment of having to meet others who have all passed after going out of the same door.

Pseuds Corner: from **B.M.J.** 9.2.1974

A 16-year-old girl has an excessive growth of hair on her upper lip, which is making her self-conscious. What treatment can be given?

If the general endocrine symptoms have been excluded, this is presumably idiopathic hirsutism or primary cutaneous virilism, where the cause may be an increase in androgen metabolism by the skin itself.

ORGY at the R.C.O.G.

The conference was held to mark a meeting to discuss the more serious population disaster facing the world at the Royal College of Obstetricians and Gynaecologists opening tomorrow.

From the *Evening Standard*, 17.6.1974.

SPOT THE LESION

Introduction

This case is an illustration of gross mismanagement of a disease which has been endemic in this country for a number of years. The patient had had 238 years of uninterrupted good health, partly due to its sedentary occupation and to the quiet nature of its environment. Two years ago, the patient underwent a course of rejuvenation, at great cost to its guardians, but its condition deteriorated rapidly after that date, although evidence points to the condition being present for some years before the rejuvenation course.

Actiology

The gross anatomy of the offending pathogen bears a resemblance to the modern motor vehicle, which is a short rod shaped organism that does not stain by Gram's technique. This bacterium is chronically toxic to most things with which it has contact . . . one of the most effective therapeutic agents is a bacteriostatic metal matrix or "gate". Such is the mass of this organism that not only may suffering be brought on merely by being in close proximity to it, but also, actual mechanical trauma may occur. This is the situation occurring with the patient under discussion.

Recent history

On some date immediately prior to May 29th, 1974, a piece of constituent tissue from the host organ was broken off (Fig. 1). This occurrence was only the most recent of several attacks, all of which have been noticed, but none of which have been treated.

Prognosis

Unless the Hospital authorities prohibit the passage of traffic through the North arch, especially heavy lorries, this sort of thing will recur. Since this is only *one* of the hospital's buildings with a Preservation Order on it, how long is it going to be before the others are allowed to crumble into decay?

FIGURE 1. "Fallen Archway"

THE ROYAL COLLEGE OF NURSING

By RISSA CHAPMAN

Introduction

Nurses' pay is certainly a topical subject and a month ago nurses were demonstrating in support of their pay claim and made the front pages of most national newspapers. However this new found publicity was short lived—the evening headlines were more concerned with the death of Doublet, Princess Anne's favourite horse. We are told that all hospitals in England are affected by staff disputes but—as yet—Bart's appears unscathed. The two factors responsible for this situation are:

firstly that conditions at Bart's are far better than at most hospitals and although many nurses wouldn't admit it we are really very well off with regard to equipment, numbers of staff, etc.;

secondly that famous Bart's syndrome, *apathy*. I am certain that less than 50 per cent of Bart's nurses belong to the RCN or any other body claiming to represent nurses.

The RCN is a professional organisation run by nurses and all grades of nurses are eligible for membership. It is Britain's largest nurses' organisation and today membership exceeds 100,000. The College is Britain's official "voice" in international nursing affairs and is the country's representative body on the International Council of Nurses.

History

The need for an agreed standard of nursing and for statutory registration was first recognised 65 years ago and brought about through the efforts of Dame Sarah Swift—ex-Guys Matron and an influential member of the British Red Cross Society. During World War I the lack of organisation in nursing was evident and Dame Sarah saw this as an opportunity to form a College of Nursing. The first meeting was on April 1st, 1916, and took place at 83 Pall Mall, SW1. Firstly the College worked to secure a uniform standard of training and played a principal role in prompting state registration—which was brought into being by the Nurses Act 1919—under this Act the GNC was formed.

The work of the College was varied, it provided insurance schemes for its members; it was concerned with the promotion of post-registration education and was continually financing research projects into nursing.

Public recognition of the work of the College followed and in 1928 it was incorporated by a Royal Charter. In 1939 King George VI bestowed the title "Royal" and in 1946 it was granted its own coat of arms.

After the 2nd World War the College pressed for the setting up of national machinery to negotiate salaries and conditions of service and this was realised with the establishment of the Rushcliffe Committee—the forerunner of the Nurses and Midwives Whitley Council—the "pay body" of today.

Structure

I was once told that "A camel is a horse designed by a committee"—and from my experience I tend to agree there are as many committees within the RCN as at Bart's.

Basically, the council is the governing body and it is comprised of 40 members who are concerned with the laying down of *broad* policies. The implementation of these policies lies in the hands of the Chief Executive Officer—and others of similarly grand rank!

Nine committees report to the council—including the three National Boards—these cover the areas of Scotland, Northern Ireland and Wales—Finance Committee, Appeals Committee, etc. Each committee is governed by set legislation for its action. For example the Appeals Committee, "The Appeals Committee exists to receive and encourage donations to the College for purposes in accordance with the Royal Charter of the College".

However the real work of the College remains unchanged despite the always increasing number of subcommittees—it exists to promote the standard of nursing in this country.

Offers

Membership offers an effective voice in professional affairs—it was good to know that when the RCN met Barbara Castle recently the delegation included two student and two staff nurses. The College offers guidance on working overseas and complete legal protection in all professional matters. There are also some other benefits. The RCN publishes many reports—some of which are excellent reading—others however may fail to come up to expectation! The RCN continues to work for a completely new deal for nurses and results from its latest campaign are not yet known.

The RCN remains the official nursing representative body in this country and it requires the support of all nurses.

If you are not a member of the RCN and would like to join, please contact Holly Robeiro via the NPO for more information. She is the official RCN steward to this hospital. I would like to thank her for her help in this article.

EVEN MORE OF YER REAL THING!

Nurses are the most genteel,
They never show the way they feel.
No nurse would think of being rude,
They cannot be described as crude.
What a storm and fuss there'd be,
If urine was called wee or pee.
I'm sure you all would have a fit
At all the times we speak of shit.
And all those tubes we have to pass
Have no doubt go straight up your arse.
And "Hell, it's puked all over me"
Rings out in every nursery.
So if you shout "where are you nurse?"
You really must expect the worst.
If answering the lady calls
"Just washing crap off this man's balls"
Don't be too hard, I mean to say,
Could you put it a better way?

A. N. URSE.

NURSES' QUESTIONNAIRE

Towards the end of April, a questionnaire was circulated to all the resident nurses at Gloucester House, Maybury, Bryanston, and Queen Mary's Nurses' Homes, and also to a few non-resident nurses. Altogether, exactly 800 were distributed, in order to find out what nurses thought of the *Journal*, and what sort of changes they would like to see in it. So that as many as possible might be returned, we asked the nurses not to take an apathetic view, as seems to be the vogue nowadays; as a result, 132 were returned . . . an appallingly low number. This represents a percentage return of 16.5%, which is statistically valid, so that we are able to act on the results as representative of the views of the whole hospital Nursing Staff.

Of those returned, the distribution through the "ranks" was as follows: —

Grey belts	57
Stripe belts	35
White belts	20
Staff nurses	9
Pinks	3
Sisters	7
Nursing Officers	1

The only difference between these ranks, when considering the answers they gave, was that they preferred to read different subjects. For instance, it seems that the higher the grade, the more medical type of article is preferred. The opinions on *Journal* format from the different grades were roughly the same.

The second question of the questionnaire was "How often do you read the *Journal*?" Replies were as follows: —

Never	29%
Hardly ever	52%
Quite regularly	19%

From this, it is quite obvious that most nurses just happen to pick up a copy, and we hope that the incidence of this sort of thing will increase now that the *Journal* is becoming more widely available, and better advertised; this was a complaint made by a number of people.

Of those that did NOT read the *Journal* quite regularly, only 4% said that it was too expensive, and so we are forced to the conclusion that if we make the *Journal* good enough, readers will be willing to pay the increased price that has been forced on us, purely to read an enjoyable magazine. Thirty per cent said that they had never seen a copy, let alone bought one, and 37% thought that the whole thing was irrelevant both to nurses and to their interests. The other 29% gave a variety of reasons for not reading it, including lack of advertising, laziness, apathy, not being bothered, and not thinking about it. One girl said that there weren't enough copies at the Nurses' P.O. and another, who had obviously never seen a copy, asked whether it had a nice glossy cover! Yes, madam, this is a quality magazine printed on fine grain chalk finish quarto paper, giving it a highly reflective property.

We asked whether nurses would buy the *Journal* if we made it more relevant to them, and an overwhelming 91% said that they would. One girl said "No", but that was only because she was leaving soon, and the rest said "perhaps".

Eighty-seven per cent thought that a Nursing Section within the *Journal* format was a good idea, against the other 13% who didn't.

Ninety-seven per cent of the returns voted for a Nurses' representative to be elected on to the Publications Committee, and a look at the front page of this issue will tell you that this has already been done. There are two student nurse representatives, Rissa Chapman and Fanny Whitney, and we hope to elect a trained nurse to the Committee quite shortly. One girl said that she thought the election of a nurses' rep. was a good idea, "if we could find one". Thankyou, madam, it's optimists like you that make life worth living for the rest of us.

Perhaps the most interesting replies were gained from the question asking nurses to list their favourite subjects in order of preference. Nurses were then able to add any additional subjects that they would like to see, at the bottom of the list. To analyse the survey, figures next to each subject were totalled, so that it is the most popular subjects that have least "points".

Perhaps the top item in the list was rather predictable as being the most popular. Certainly, we would not have thought that "case histories" would have merited a place at 5th position on the popularity charts! The full list was as follows: —

1.	Hospital News	390
2.	Social events in Bart's ...	429
3.	Events in the rest of London	626
4.	Nursing topics	699
5.	Case histories	785
6.	Music and record reviews ...	1,010
7.	Book reviews	1,081
8.	Medical papers	1,141
9.	Restaurants	1,197
10.	Food	1,250
11.	Clothing	1,258
12.	Politics of the Hospital Professions	1,258
13.	Sports	1,288
14.	Poems	1,366
15.	Cosmetics	1,529

Other subjects suggested included holidays, fiction stories, nursing vacancies, historical articles on the Hospital, articles on the other London Hospitals, a "Humour in Uniform" page, cartoons, flat adverts, stories of hospital experiences, art, and more photographs. Articles requested by people who had obviously never even seen a copy of the *Journal* in its present format included Letters to the Editor, and a Crossword. Two topics suggested by a Sister were a Scandal Page, and a Medics Problem Page!!

Basically, it is the results of this questionnaire that we are now going to follow to make the *Journal* into something that we hope will be more acceptable to nurses. If you are a nurse and you don't agree with these points, you only have yourself to blame for not returning your questionnaire. However, you can still make your views known by contacting one of the nurses' reps., as mentioned on the front page of this issue, and she will, in turn, refer it to the Publications Committee.

Our thanks go to the girl who wrote three foolscap sides full of some of the most useful suggestions for improving the *Journal*. We could do with other people who are able and willing to help out in this sort of way. We were so pleased to receive this one "token of interest", that if the young lady in question (we know she is a white belt) will present herself at the *Journal* Office, the Committee will be pleased to treat her to a quick half of alcoholic liquor at the local hostelry.

But of all replies, the one we liked the best was the one including the beautiful plea—

"*Please* keep the *Journal* going!"

R.T.J.

BOOK REVIEWS

CONUNDRUM, by Jan Morris. Published by Faber and Faber, Price £2.25.

Having suppressed my initial revulsion to the flowery affected style of this book, I found it contained some thought-provoking material. Morris manages to raise some interesting questions concerning gender and concepts of sex roles. He seems to attribute to femininity a more spiritual state than to masculinity, though he goes to great lengths to avoid what he calls "the mystic trappings of transexuality". One cannot help but feel that this might be the crux of the matter.

The book is a chronological account of his life with a conviction of having been born into the wrong sex, culminating in the final attainment of womanhood by hormonal treatment and surgery. The account is largely devoted to his delineation of sex roles: to me his inferences of the differences seem not mutually exclusive, unless the physical joy of the body is an exclusively male attribute, and gentleness exclusively female.

Stereotyped femininity becomes inextricably mixed with spirituality as a desired end. One is left wondering just what state has been attained. Worth reading.

G.C.M.

PENGUIN MODERN POETS 10
Adrian Henri, Roger McGough, Brian Patten. 30p.

At their best the Liverpool poets offer originality, amusement, pathos and nostalgia for a period that already seems a generation away: at their worst their "poems" are pretentious drivel. This short book achieves its aim of providing a representative introduction to their style, although anybody who has seen Brian Patten performing his own work can only regret that so much of the poems' vitality is lost by presentation in anthology form.

Overall I found Patten's work the best—although McGough supplies the usual stimulating mixture of seriousness and throw-away laughs; Henri seems to have been selected to provide the pretentious drivel. Already in its 9th reprint and 2nd edition since 1967 this collection should run and run.

A.H.

CHILD PSYCHIATRY FOR STUDENTS
by F. H. Stone and C. Koupernik. Livingston Medical Text. £1.

In this condensed little book the authors certainly have succeeded in their expressed desire. They have presented principles rather than yet another quota of facts to be memorised. The resultant text provides a stimulating introduction to Child Psychiatry for medical students as well as all workers involved in the Child Guidance team, including nurses and health visitors, social workers, teachers and psychologists.

Throughout the book at the conclusion of each chapter helpful suggestions are listed concerning further reading. Particularly useful chapters concern Assessment Procedures, the Examination of the Child and Criteria of Emotional Health. The authors repeatedly emphasise the multifactorial aetiology of childhood emotional disorders, and their final chapter aptly concerns Family Psychiatry.

H. BEVAN JONES,
Consultant Psychiatrist.

A COLOUR ATLAS OF INFECTIOUS DISEASES
R. T. D. Emond. Wolfe Medical Books. £6.

This is an excellent volume for both the undergraduate and the postgraduate. Perhaps its best attribute is the excellent coloured illustrations. For most doctors in general medical practice, whether in general practice or within the hospital, this will be a useful reference book that could be carried in the brief case or in the car. The text is, of necessity, brief but it is very readable and seems to contain the essential information.

I would thoroughly recommend it.

K. G. TAYLOR, *Senior Registrar.*

MUSIC REVIEWS

BART'S MUSIC SOCIETY CONCERT

The programme of the Hospital's Music Society Concert in the Great Hall on May 2nd, was interesting and varied. The first half of the concert was, broadly speaking, devoted to chamber music (all of which was new to me); after the interval it was the turn of the Bart's Orchestra to play Beethoven.

The Oriel Singers (from Hertfordshire) began the concert with six unaccompanied Yugoslav folk songs by Matyas Seiber; each song leads into the next lending a continuity to the cycle as a whole; this Francis Oakes, the conductor, achieved well whilst at the same time conveying the contrasts between each individual song. The choral group produced a nicely blended sound—especially in the close harmony passages—though in places their attention to the entrances was not sufficiently assiduous. The Oriel Singers also performed Brahms' Liebeslieder Walzer song cycle with piano duet accompaniment (which was a little overpowering at times drowning the choral line).

Between these two choral items Richard Carver (accompanied by John Gibson) played Saint-Saëns' Oboe sonata. The opening movement was rather hesitant as the players were unable to come to a mutual agreement as to the speed, however they overcame this in the later movements and the ebb and flow of the music became more fluid. Despite the beautiful tone quality of Mr. Carver's playing, I found the overall performance rather detached, and lacking in the warmth and humour the Saint-Saëns' music requires.

The orchestral half of the evening comprised the first movement of Beethoven's C minor piano concerto, preceded by a spiritual account of his Overture to Egmont.

It was the spring of 1803 when Beethoven himself played the solo part at the premiere of this his third piano concerto; the concert for which the concerto had been written was a very rushed affair, the final rehearsal beginning at eight o'clock in the morning; Beethoven's pupil, Ferdinand Ries, wrote that by half past two everyone was exhausted and more or less fed up. However lunch provided by Prince Carl Lichnowsky in the form of "Bread, butter, cold meat, and wine fetched in huge baskets" revived the spirits of the orchestra sufficiently for a further two and a half hours of rehearsal before the concert, which began at six o'clock, and lasted some considerable length of time!

The performance by the Bart's Hospital Orchestra with John Gibson playing the solo part, was exciting. John Lumley the conductor, took the whole movement at a lively pace, but this did not prevent him from emphasizing the contrast between the ponderous first subject in the minor key, with the lilt of the second subject in the relative major key of E flat.

Mr. Gibson's playing was very lyrical, capturing the mood of the music; he developed the argument between the solo passages and the orchestra with conviction and demonstrated his fine technique in the rapid chromatic runs in the very demanding cadenza. (I regret that I could not enjoy his playing to the full however, on account of the muffled quality of the piano sound; I could not decide whether this was the fault of the instrument or the acoustics of the Great Hall.)

I cannot end without expressing my surprise, not to mention embarrassment, at the very poor support that this concert received from Bart's people in general, and students in particular. Of the tiny audience (numbering fifty at the most) there were no more students than could be counted on the fingers of one hand. After the considerable time and effort that so many people had extended in preparing this concert, and an excellent evening it was too, it was a great pity that there were so few present to enjoy and appreciate the work.

THE SEASONS AT WESTMINSTER CENTRAL HALL

In the past I have found it rather an uphill task to listen to all of Haydn's Seasons at one sitting—but not so when I went to the performance of the Oratorio given by the Bart's Hospital Choral Society on May 9th. I was enthralled and delighted throughout all of the two and a half hours of music.

After their rather unfortunate concert in St. Paul's Cathedral last December, when the careful preparation of Bruckner's 1881 Te Deum (among other works) was lost in the dome, their account of the Seasons showed their true capabilities. Robert Anderson (who demonstrated his intimate knowledge of the score by conducting the complete work from memory) must be congratulated for directing an extremely fine performance.

Haydn wrote the Seasons in 1801 at the age of 69 (only three years after he had completed the Creation). It was his last full scale work—he claimed it to be his "finishing blow". The Oratorio is a setting of James Thompson's poem which tells of Spring, Summer, Autumn and Winter as seen through the eyes of two lovers Jane and Lucas, and Jane's father Simon.

The orchestral playing of the Sinfonia of St. Bartholomew was precise and lively, capturing the spirit of each season; the string and brass playing was especially deserving of praise. For some of the recitative passages, the organ accompaniment was provided by Anthony Netherseil, whose approach to the music was imaginative and sensitive.

The part of Lucas was sung convincingly by Keith Erwen, and that of Simon by Geoffrey Chard, who in endeavouring to lend drama to his singing played too free with the rhythm for my taste.

The crowning glory of the evening was the singing of Jill Gomez in the role of Jane. Her voice control, tone quality and dynamic range were magnificent. Despite the high standard achieved by all the other performers, singers and players alike, it was Jill Gomez who stole the show.

FUSE THE MUSIC

No doubt everyone has at some time or another come across one of those people who think they know all there is to know about music. I suppose Robin Ray, of "Face the Music" face, should qualify for membership to such a group of walking Groves'—however I feel he is barred because of his apologetic air when he confesses that he was able to recognise Joseph Cooper's masterful rendering on the dummy keyboard (it makes no sound, just a bit of clatter (!)) as the Appassionato e con molto sentimento movement of Beethoven's Hammerklavier sonata No. 29 in B flat major, Opus No. 106.

If you are like me, then you are extremely envious of such knowledge, but can't bring yourself to say so, and worse still, long to catch out the owners of such encyclopaedic information. To this end, I have over the last few years collected five very important, not to mention indespensable, records. Each one is guaranteed to fool any Robin Ray who is unfortunate enough to attempt to name the work.

If you intend to embark on an evening of such musical catches, then begin with a piece which everyone knows, but one which when anyone tries to put a name to it, proves very difficult to pin down because it could be one of a multitude of works. I have found Brahms's second piano concerto ideal in this respect—not the beginning though, the slow movement is the part I play; this movement begins with full orchestra—and solo 'cello! Visions of the Dvorak, Elgar and Schumann 'cello concerto slow movements all go through the mind—Oh dear, which one of the three is it though . . . At the quiet piano entry with the second subject you can chuckle quietly to yourself as you watch the face of your "knowall" fall.

Next in my armoury is a choice of two Beethoven gems; either the transcription of the D major Violin Concerto for piano and orchestra (fade in the music mid-way through the first movement, playing the opening four drum beats is a bit of a "give away") or if you are feeling particularly nasty, play the even more elusive arrangement of his second Symphony for piano trio! Beethoven was responsible for both arrangements himself, so you can't be charged with playing unauthentic works.

Though the last two "teasers" are not quite such well known pieces of music, your pundit should have no trouble spotting the composers. I must come clean here I suppose; I said he should have no trouble, well perhaps that isn't one hundred per cent honest, as I have specifically chosen these last two works because they each contain parodies on other composer's styles. Did I hear someone say mean? well, I can't deny it, but surely meanness is the name of the game.

The first of these works is Saint-Saëns' second piano concerto, which starts with a long and intense solo piano introduction which Liszt himself would have been proud of writing. Having satisfied yourself that you have triumphed again, try playing the second movement of Smetana's first string concerto, and have a good chortle at some of the suggestions he will propose.

Once you have reduced your friend (?) to a deflated gibbering wreck, the only hope is to play Ibert's Divertissement—the parody to beat them all—then you will both be able to laugh together.

ALLEGRO MA NON TROPPO.

MATRONS BALL

Those of you who read my report on the Physiotherapists Ball will probably realise that I ran out of superlatives on that occasion, and now it has been left to me to report on this event, which is going to prove a formidable task.

Matron's Ball has one great advantage over any other Ball that I know of . . .

For those who are lucky enough to be able to attend, it is free. At least, the food and dancing are free. Devotees of the event will know that the other essential item on the agenda, i.e. drink, is anything BUT free; in fact, it will set you back a couple of weeks grant quite easily.

This is the reason for the somewhat peculiar sight to be seen by those passing by Grosvenor House on the evening of Friday, 24th May, when large numbers of well-dressed nurses were entering the aforesaid establishment with their attendants, who, it seemed, were suffering from a variety of little-know neurological lesions, typified by signs such as clutching the arms closely into the body, or limping significantly. An unusual sort of crepitus(?) sounding like the chink of glass upon glass was also to be heard; closer examination showed that these lesions were only to be observed in those who had attended Matron's Ball on a previous occasion.

Dancing started at about nine o'clock and continued until half past ten, when dinner was served. During the meal, a steel band took over from the traditional band; it was curious to see the waiters walking in time to the music as they descended en masse on the tables at each change of course.

Afterwards, the assembled company continued the dancing until the early hours. Interruptions were necessitated by some 21st birthdays which, so the MC was informed, were taking place that day. Halfway through "21 today", the company were then told that it was not Bruce Campbell's 21st, and a later mistake was made when everybody drew back to the edge of the dancing area, leaving a couple in the centre, somewhat engrossed in each other, whom we were supposed to be congratulating on their recent engagement. It was a great pity to learn five minutes later that it was actually *another* couple that were engaged!

However, the band provided a variety of music for a number of different dances, the more energetic of which included a conga around half the balcony of the Great Room, and a sort of neo-classical Spanish dance! A number of prizes were handed out (congratulations to John Howell and partner for being first on the dance floor), and the evening's dancing finished with the "Last Waltz" and "Auld Lang Syne".

Rumour has it that this is to be the last Matron's Ball . . . this has to be yet another story that will stand the earliest possible dispulsion.

R.T.J.

SPORTS REPORT: Rowing; Golf; Hockey; Tennis; Snooker

BOAT CLUB REPORT

Cambridge Regatta, May 25th

Bart's entered two fours at this regatta, one in each of the Junior and Novice coxed IV events. The Novice IV, consisting of John Holmes (Str), Tom Dehn (3), Oliver Dearlove (2), and Robert Treharne Jones (Bow), hadn't actually rowed together before, and neither were they too happy with rowing in a very inferior class clinker boat. Not surprising that they lost to a very fit crew from Star R.C., Bedford. The Junior crew consisted of Mark Patrick (Str), John Down (3), Dave Swithenbank (2), and Jim Close (Bow), this crew had rowed the previous weekend, with Peron Ziar at Bow, and had been the losing finalists at Thames Ditton Regatta, but this time they did rather less well, and lost to a very strong and fit Radley College crew.

Molesey Regatta, May 27th

Our Novice IV scratched at the last minute from this event, so it was left to John Down and Dave Swithenbank to represent Bart's by entering the Pairs event. They rowed Bow/steers and Strke respectively, and came up against the home Pair from Molesey B.C. To some strong encouragement by the only two Bart's supporters present, they lost by 1½ lengths, though completed the 1,600 metre course in a very good time of 5 min. 40 sec.

E.G.M., May 30th

Due to the premature retirement of John Holmes as Captain (Finals can be very trying!) an E.G.M. was held in the AR and John Down was elected unanimously as the new Captain.

UNITED HOSPITALS BUMPING RACES 1974

It is about this time of year that I become fed up with explaining to all and sundry exactly what happens at the "Bumps". Those people who are unlucky enough to know nothing of rowing see little sport in a lot of boats chasing one another up the river, and endeavouring to actually hit one another. Many see it as an opportunity, not so much for rowing, but for mass violence, with cries of "Stand by to repel boarders" being heard across the river. It is for the benefit of these unfortunates that I shall now explain exactly what should happen, and also what DID happen!

The event is for eights only, and is rowed between the constituent hospitals of the University of London, together with the Royal Vets and the Royal Dental Hospital, making 14 hospitals in all. Each enters as many eights as possible, by mustering together oarsmen of both serious and social types, so that an average total of 40 boats takes to the water—they are divided into two equal divisions. These divisions are made according to standard, so that the generally serious oarsmen of the 1st division row their race one hour after the more social 2nd division on each of the three nights on which the bumps are held.

I'm not going to push all the way, my thighs are freezing.

The 2nd VIII putting on as much work as ever. From stern to bow, they are Clare Vernon (cox), George Evans (stroke), Tony Douglas-Jones (7), Oliver Dearlove (6), Robert Treharne Jones (5), Dave Dossetor (4), Gareth Rees (3), Dave Simpson (2), and Roger Taylor (bow).

The boats line up along the bank, with about half a length of clear water between each, and at the starting gun, all row off and attempt to bump the next boat. If this procedure is followed correctly, there should be no damage done to either boat! Both boats involved in the bump then draw in to the bank, and change places in the starting order on the next night. Those boats which neither bump nor are bumped have to complete the whole course and are said to have "rowed over".

The same procedure is followed on all three evenings on which the bumps are held; the starting order for the first evening is determined by the order of finishing on the last evening of the previous year.

This year, Bart's entered 5 eights . . . well, 4 really, because of the 5th VIII only got as far as putting the boat in the water, before they managed to hole it on a convenient stone on the river bed. Somebody should have told them that one makes sure that the boat is actually afloat before getting into it.

The 1st VIII consisted of the best oarsmen in the hospital, or so they say. In actual fact, it was the eight best rowers that could be mustered at very short notice . . . so short, in fact, that they had no outings before the event itself. It was not surprising, therefore, that they went down on all three nights.

The 2nd VIII consisted almost wholly of Oxbridge graduates, apart from its Captain, who happens to be your correspondent. This gallant band had had two outings before the event, and were looking quite pretty, especially with the only female cox in the 1st division, even if there was not a lot of work being put in. This crew was the only Bart's boat not to do the same thing on all three nights; on the first night they were bumped cleanly, and on the second night they were pulling away from the boat behind when an obstruction by two boats in front caused a sudden halt in the proceedings and a very unfortunate technical bump from the boat behind. On the third night, they were pressed hard all the way, but managed to row over successfully.

The 3rd VIII was the Argonauts boat, led by "Jason" Aiken. All members of the crew were recognised graduates of the Rugger Club and College Hall bar. In this boat, rowing by numbers was the order of the day, so it was not surprising that they were a little outclassed in the 1st division, and were bumped on all three nights.

The 4th VIII crew members all had one thing in common . . . they had all rowed before. This was a decided advantage for them in the 2nd division, and they made a bump on all three nights, thereby winning their blades (a traditional gift when a crew goes up on all three nights).

The fact that Bart's did badly must have been expected, but every eight was a scratch eight, but nobody liked to think that way. The Boat Club are ever optimistic, if nothing else; there is, however, no denying that the Club is at a pretty low ebb at present, so that a lot of work and enthusiasm from existing members is needed to boost activities, especially at the arrival of the Freshers next October.

R.T.J.

GOLF CLUB REPORT

v. Staff on May 15th, at Denham GC

The season opened with the annual fixture against the Staff at Denham. It was a beautiful summer's day, and a youthful opposition finally fulfilled the promise they had been showing for several seasons when they beat us by one match. The Staff laid the foundation for their victory with a fantastic burst of birdies in the opening holes of the morning round, and although the students mounted a tremendous charge in the afternoon, we were unable to stave off defeat. Unbeaten for the Staff side were Mr. Lavelle, Mr. McNab Jones, Dr. Pare, Mr. Hadley, and Mr. Ross; ours was more of a team effort, nevertheless we had our heroes too. Jim Foster, Fraser McLeod (who is rapidly establishing himself in the super-star bracket), David Radley, a recent product from the Welsh P.G.A., and John Capper, the find of the season, all remained unbeaten in the cut-and-thrust of 36 holes matchplay. Match Result: Staff 9½, Students 8½.

v. Chislehurst GC on May 29th at Chislehurst

Having been severely trounced last year by 9½ to ½, much preparation went into team selection for this year's event against our home club, the emphasis being placed on mental stamina and flair, rather than pure shot-making ability. The team eventually chosen was: Jim Foster (Capt.), Fraser McLeod (Sec.), John Chapman, John Capper, Trevor Turner, Rob Robertson, Mike Bird, and John Parry.

Such preparation was well rewarded, for had not our No. 8 driven out of bounds at the 18th the match would have been halved. Our winners were: —

John Chapman, who at last cured his putting "yips" and showed us just how good the products of the Welsh Amateur circuit are by comfortably beating the Chislehurst No. 1.

Fraser McLeod, who improved with every match and cast his opponent aside with almost contemptuous ease.

John Capper, who due to his recent successes now employs a caddie, and was in a mean enough mood to score yet another resounding victory.

Match Result: Lost 3-5.

University Championships on May 20th at Walton Heath

Despite fielding the largest side in the competition, we were unable to field our strongest team owing to the impending 2nd M.B. examination. Still, we all had a pleasant 36 holes on a very fine but very difficult course. Our best performance came from Hugh Maurice who shot a 2-over-par 75 in the morning round, but unfortunately faded in the afternoon due to an extended lunchtime session at the bar; Fraser McLeod played steadily but a little below his imperial best.

Team: Jim Foster, Fraser McLeod, Hugh Maurice, John Chapman, John Capper, Trevor Southey (new Cap).

v. Tandridge GC on June 1st at Tandridge

It was decided by the selection committee to "blood" three new players for this one of the most popular fixtures on our calendar. Thus 17 players have now represented Bart's this season, which should stand us in good stead for the hectic second half; for we now have a large and experienced "squad" of players from which to choose our teams.

The side selected was: Jim Foster (Capt.), Fraser McLeod, John Chapman, Mike Bird, Trevor Southey, *Graham Aiken, *John Laidlow, *Chris Hands.
* Denotes "new Cap".

Morning Foursomes

The morning round was very fiercely contested, and we could have taken the overall lead had not our second and third pairs driven badly at the 17th and 18th. Our first pair, John Chapman and Fraser McLeod, were an unbeatable blend and played well within themselves to win comfortably. Our second and third pairs both lost, Jim Foster and John Laidlow (2nd pair) sliding from a lead of 2 up with 5 to play! Graham Aiken, a recent recruit to the Bart's GC circuit with the close of the Pentathlon season, and Chris Hands, an ex-hockey convert, celebrated their first appearance in the Bart's jersey to pull off a sensational "half" with a tremendous finishing charge.

Afternoon Foursomes

This was a different story, a superb lunch and a surfeit of Bacchic Juice taking the edge off our competitive spirit. Only John Chapman and John Laidlow won their match, even though the other three pairs tried valiantly to pull back their deficits by storming rallies in the back nine. So John Chapman, who with careful guidance has emerged as a player of the highest class, remained unbeaten throughout the day.

Jim Foster, the captain, having been beaten twice in the same week, flew at once to Penina, Portugal, for some advice from Henry Cotton, and to endorse some more golfing products.

J. FOSTER.

Editor's Note: The further fantasies of Jim "Alframsey" Foster will be appearing in subsequent issues.

LADIES' HOCKEY CLUB REPORT

Games played 15, Won 4, Lost 6, Drawn 3, Walkovers 2.

This season showed the increase in interest in Ladies' hockey throughout the Medical school and hospital. The commencement of the ULU Ladies' hockey league added incentive to recreation, and fuller teams produced better results.

Although the new league had many teething troubles, thanks are due to our secretary, Liz Adams, for coping so well and so patiently. For example, one Saturday match against St. Thomas' was confirmed three times in 24 hours before they failed to turn out! Hopefully these difficulties will have been ironed out before next season, when Sue Love takes over as secretary with Jenny Maitland as Assistant. At the AGM nominations for Vice-Presidents were put forward and will be announced at a later date. Di Robinson and Jo Bailey were voted captain and vice-captain respectively for the 1974-75 season. Also donations were gratefully accepted from Matron and Mr. Gooddy on behalf of nurses, radiographers and other Medical Staff who play for the team.

The Chislehurst Question

Although Colin keeps our hockey pitch in fine condition, our changing room facilities are sadly lacking. Gone are the days when girls were in a gross minority at Bart's. With a larger and larger intake of female undergraduates, Ladies' Sports Clubs are bound to receive more support; and since each student pays the same SU fees regardless of sex, surely they are entitled to equal facilities. At present the women's "Hut" contains two small changing rooms with ONE SHOWER EACH. Since the men's teams have two large baths and numerous showers, this seems not altogether fair! Our fixture list shows that we have had a full season, not to mention the mixed hockey. The argument that the "amalgamation" with the London Hospital and Q.M.C. will change things is of minimal encouragement, since the girls of today will, hopefully, have qualified by that time. Something could be done, and soon, at the smallest expense. Either extra showers in an extension for the "Hut", or a partition door to allow us to use the men's showers when, as we have so frequently seen, only several teams have home fixtures.

Hopefully Mr. Morris and the SU will soon come to an agreement, then work can commence. Action is what we need.

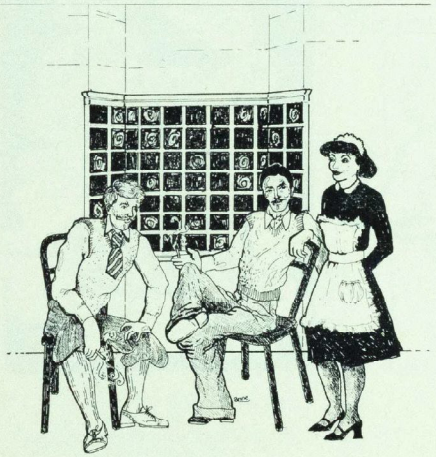
MARY HAMER-HODGES.

The Ladies' Hockey Club and "Coach". Photo: Jon Gibson.

SNOOKER CLUB REPORT

The month of May saw a great change in the state of the Snooker table in the Abernethian Room, because it was recovered for the first time in a number of years. By the time that this is published, we should have formed a Committee to arrange matches, tournaments, and generally care for the equipment. Already, a reasonably efficient Key system is in operation, and allows the A.R. to be locked when there are no games in progress. A tournament is in progress and a full report will appear in the next issue. Meanwhile, the cartoon will probably appeal to anybody who knows much about the game!

R.T.J.

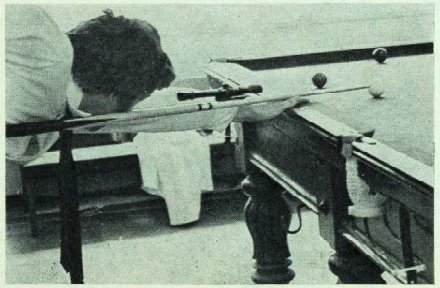


Scene: Seaside boarding house

Hearty young man: Do you think we may have the use of the billiard table this evening?

Maid (very anxious to please): Certainly sir, I'll go and get it for you.

(Redrawn from *Punch*. 1911).



A Bart's snooker pro' in action.

LADIES' TENNIS CLUB CAMBRIDGE TOUR, MAY 74

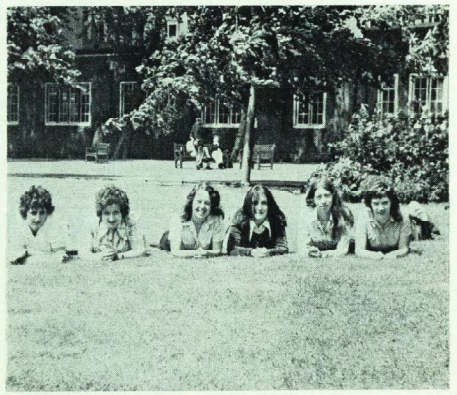
They were a band of ruthless, marauding women, who would stop at nothing but a pub. Never let it be said that Bart's girls are Weeny, Weedy and Weaky*. They went, they sight-saw, and they conquered.

Thanks for a successful tour to: —
Mary Brown, Sue Jones, Su Boddy, Sue Boyle, Sue Rodgers, Liz Adams, Di Harrison.

Results:
Homerton—won 5-4; New Hall—won 6-3; Girton—won 6-3; Newnham—won 7-2; Cambridge II—rained off.

SU BODDY.

* Copyright J. Caesar (deceased).



The Wild Bunch? The Angry Six? No. The Ladies' Tennis Club Tour party taking their ease on the College Hall lawn.

MIXED HOCKEY CLUB REPORT

Fixtures

All-Bart's 12-a-side Trials
v. Old Midwives 0-6
v. Old Midwives 4-1
v. Old Lloydonians 0-0

This, the most sociable of all sports, provided diverse enjoyment right from the beginning of the season, which started at the Bart's Trials without any obvious goalkeepers. This situation was soon rectified when a pair of pads and a box were strapped upon Norman Haacke as he emerged from the dressing rooms. However he then proceeded to give an almost graceful display of acrobatics, making the acquaintance of many worms in the goalmouth.

In our opening match of the season we found ourselves against the Old Midwives. What a team. Ross Adley leading this band of tricksters managed to secrete two Welsh Internationals and the Surrey Captain in his forward line. Despite all possible support from our umpire the match was lost 0-6.

History was made during the relatively slack midseason when the first Mixed Hockey Dinner was held. The Camden Head provided a rouge setting for a pleasant meal with Allan Hawley making a guest appearance on loan from the Casuals.

Refreshed by this intermission the second half of the season opened with another clash against the Old Midwives. We went prepared with our set of fractured Hockey sticks to loan to the opposition, and employing these and other somewhat devious tactics we won 4-1.

The Old Lloydonians match although well attended lacked the "je ne sais quoi" on the tea table.

Having learnt some of Croydon's more subtle tactics we look forward to a new season where we hope to increase the number of regular fixtures and the possibility of a Mixed Hockey Cambridge tour.

R.S. & M.H.H.

Obs Goblins! Cartoon by Chris Jowett, from an idea by Bruce Finlayson, from the book by Anon.

PUZZLE PAGE

CROSSWORD: RONTY 3

ACROSS

4. Changed a smile on a pudding (8)
8. Unable seaman meets bird and dog (6)
9. Student works and died about assymetry (8)
10. Grabs duck extra strongly before it flies (5, 3)
11. Seat five hundred and another in a sale (6)
12. Frank the beginning of the end of French rush (8)
13. One diminished? (8)
16. Barrow-boy about um— fitter? (8)
19. Lulu seek instruments? (8)
21. Broken abstainer Cris is tough (6)
23. Bedridden engine (8)
24. Young lady with 'igh class time—one river (8)
25. Pupil in 1C in Los Angeles makes bloomers (6)
26. Any sonnet without an article will give you this poet (8)

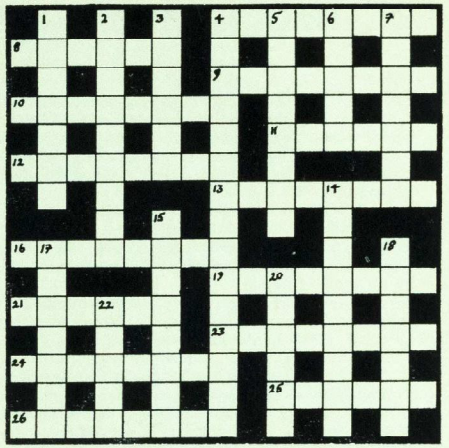
DOWN

1. Workers' score halved before they rent (7)
2. Green meat would not produce this with your butcher (9)
3. French word in river is taken down a peg or two (6)
4. Reductions left us without beginning and caused our end (5, 10)
5. Sadly my Polish is confused (8)
6. I lard the chief (5)
7. Almost needless to knit with (7)
14. What a way to live! (4-5)
15. Traumas have a point for volunteers (8)
17. Board out longer than one's contemporaries (7)
18. Me and your French church for this single encounter (3, 4)
20. United Nations tries to tangle bale, but is not really capable (6)
22. Ben is a playwright (5)

Solution next month.

SOLUTION TO RONTY 2

Across		Down	
4.	Dressage	1.	Ramadan
8.	Camera	2.	Belgravia
9.	Recovers	3.	Patina
10.	Sanguine	4.	Direction finder
11.	Pidgin	5.	Escapade
12.	Cataracts	6.	Saved
13.	Indigent	7.	Gordian
16.	Cetavlon	14.	Galleries
19.	Fatalist	15.	Flattery
21.	Despot	17.	Elevate
23.	Notaires	18.	Aspects
24.	Masthead	20.	Titled
26.	Betrayer	22.	Peter



JOURNAL MATHEMATICAL PUZZLE No. 7

By R. TREHARNE JONES

The firm consisted of Arrogant and Brash, the two consultants; Charles, the Senior Registrar; Dogsbody, the Junior Registrar; and Ernest and Frank, the two housemen. Arrogant was worth half as much again as Charles, while Brash was worth less than Arrogant by an amount equal to the difference in value between Dogsbody and Ernest. Charles was worth twice as much as Dogsbody, who was worth half as much again as either Ernest or Frank.

At Duty Weekends, four of the firm should be on duty, but one weekend, three of those who should have been on were stricken down with the Dreaded Lurgy, and their places were taken by the remaining two members of the firm. The total value of those finally on duty, calculated in terms of housemen, was exactly the same as the total value of the four who should have been on duty and was not a multiple of 10. If the numerical value of those on duty, and the total value of all six members of the firm, are two numbers which have two numerically different factors in common, who were the three members of the firm that were off sick?

Answer to last month's problem.

To arrive at the answer, divide the Magic Number by 4, and arrange the 8 numbers on either side of the resulting quotient in the form of the 4 x 4 grid, as shown.

1040	1041	1042	1043
1044	1045	1046	1047
1049	1050	1051	1052
1053	1054	1055	1056

Now reverse the diagonals to get one of the many possible answers, which is: —

1056	1041	1042	1053
1044	1051	1050	1047
1049	1046	1045	1052
1043	1054	1055	1040

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SAINT BARTHOLOMEW'S HOSPITAL JOURNAL

Founded 1892

Vol. LXXVIII No. 8

Journal Staff

HARD TIMES

As 1974 advances and the economists gyrate in ever decreasing circles, we journalists have sad news to announce. For the provision of paper has now become something of an art, in that it is very difficult to establish, at any given time, just what the price per tonne will be, and even having found that out, actually to obtain the paper is even more difficult. What is certain is that the cost has doubled in the last year and is well on the way to trebling. Add to this the increase in printing rates, the unions being naturally rather unwilling to see their members overcome by the rising cost of living, and we have, financially speaking, a "whole new ball-game". In fact, thanks to a most helpful and loyal printer, we still manage to get the *Journal* out at a cost that evokes whistles of admiration from those with a knowledge of the present situation in the trade. It does indeed compare unfavourably with last year, to the tune of some £80 per issue, and even more unfavourably with 1969, but despite "multiple therapy" we cannot continue on our present course.

For, allied to these increases we have the problem of being at the wrong end of a semi-fixed income derived largely from subscriptions and a Students' Union grant. We have raised the sub. but this will take some time to work through, and we hope to obtain an increased grant from next year. Of this latter source however we cannot be certain, since they also are having to tighten their monetary belts. We are also hoping to increase direct sales within the hospital and to increase the length of our subscription list, and in time we believe we can move out of the present stage of "negative balance". Were, for example, every subscriber to introduce one more subscriber, or were more leavers and members of staff to take out a subscription, we would almost at once be out of the financial wood.

In the meanwhile we can only imitate the world around us by offering an inferior product at an increased price. It will have to be thinner, less glossily produced and altogether more in keeping with harder times. We trust our readers will accept the necessity for these radical changes and hope they will only be a temporary aberrance. Still, perhaps there is a good side to it in that we can experiment with the format and produce a rather more "modern" journal, lacking some of the traditional items yet reflecting more the very active world of hospital life today. Our primary aim will be to provide a good read in clear print. Remember, it's only 18 years to our 100th birthday.

ANTIPSYCHIATRY

There are several ways of discriminating against someone: it could be his face which doesn't fit; or his colour—or his job. And if it is his job that isn't too popular then he can be discouraged by not allowing him his fair share of the cake. So it is with psychiatrists, and with geriatricians too, according to figures published in the *BMJ* on the state of the Merit/Distinction Awards Race at the end of 1972.

These awards come in four juicy varieties: A-plus, A, B, and C; worth £7,350, £5,577, £3,273 and £1,392 a year extra to their recipients. The mechanics of the awards system is almost as secret as the names of the actual recipients, but the numbers of consultants, and their specialities, receiving the awards are made public. And some of these figures are *very* interesting. For instance, although 80% of all thoracic surgeons, 69% of all neurosurgeons and 69% of all cardiologists receive awards, only 24% of psychiatrists and 21% of geriatricians get anything.

This seems to mean one thing: the established areas of practice get all the pickings (either for their inherent "death or glory" glamour, or for their conservatism) while the possibly more drab specialities are happily ignored. This can only mean that the bright boys (and girls) would do better to aim for certain jobs and leave the others as a bad investment. This is bad news for the underdeveloped areas of psychiatry and geriatrics, and does not augur well for the future of these branches, even though some predictions see these as forming 80% of all medical practice in 1990.

So medicine's Big Brother of the future (psychiatry, geriatrics, and, yes folks, psychogeriatics) is to be the poor relation in more ways than one. And this in a time when most national agencies are putting money *into* underdeveloped regions.

SCHOLARSHIPS AND PRIZES—SUMMER 1974

Following the recent Brackenbury Scholarships and other Prize examinations the awards listed below will be made:

Brackenbury Scholarship in Medicine—
Mr. W. B. Campbell
Brackenbury Scholarship in Surgery—
Mr. W. B. Campbell
Sir George Burrows Path. Prize—Mr. W. B. Campbell
Walsham Prize —Mr. W. B. Campbell
Roxburgh Prize in Dermatology—Mr. M. J. D. Cassidy
Ernest Withers Scholarship in Ophthalmology—
Mr. M. H. Johnson
Weitzman Memorial Prize in Cardiology—
Mr. C. A. Lewis
Matthews Duncan Prize in Obstetric Medicine—
Miss J. H. Parker
proxime accessit—Mr. J. Meyrick Thomas
Skynner Prize —Mr. G. R. Stanhope
Sydney Scott Prize —Mr. G. R. Stanhope
The Willett Medal will not be awarded this year.

ANNOUNCEMENTS

Deaths

MACALPINE—Ida Macalpine, 1899-1974 M.D., F.R.C.P. Qualified 1925. University of Erlangen.

CONINGSBY—On March 20th, 1974, Walter Frederick Coningsby, M.D. Ex. Department of Psychological Medicine. Qualified 1913.

MAYO—On May 22nd, 1974, Bernard Alfred James Mayo, M.B., B.S., M.R.C.S., L.R.C.P. Qualified 1925.

Marriages

BARRISON & NORBROOK—On May 27th, 1974, between Mr. Ian G. Barrison and Dr. Penelope Norbrook.

MORGAN & BRADSTREET—On May 15th, 1974, between Dr. Thomas C. Naunton Morgan and Dr. Rosemary A. Bradstreet, at the Roman Catholic Church of St. Etheldreda's, Ely Place.

Appointments

Dr. G. M. Besser, has been appointed Professor of Endocrinology.

Mr. J. S. P. Lumley has been appointed Senior Lecturer in Surgery (with an interest in Vascular Surgery).

NOTICE

COLLEGE HALL TRUNK ROOM

On the weekend of November 23rd-24th, the trunk room at College Hall will be cleared of everything except TRUNKS possessing the owner's name and date of placing there. An auction will be held on Sunday, November 24th, in order to dispose of the junk removed during the clear-out. Any volunteers to help do the above should contact Peter Meade at College Hall.

SUBSCRIBE!

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£2.50 internal

CONTACT: Bryan Sheinman

LETTERS

132 Harley Street,
London W1N 1AH.
June 10th, 1974.

Dear Sir,

The article in the June number entitled "The Contraceptive Pill Actions and Adverse Effects" was useful and most interesting but I think that there is one point at the end that is misleading. Under the heading *"Pre-existing diseases"* we read: "Chloasma and skin pigmentation may increase." In fact, the commonest cause of chloasma today is taking the contraceptive pill and chloasma is one of its commonest complications. This disorder is very rarely present before the pill is taken. Therefore there is no question of it increasing.

Yours faithfully,

E. LIPMAN COHEN.

Dear Sir,

I would like to bring to your attention a few points relating to the question on why bicycles should be pushed and not ridden within the "ancient confines".

Firstly a closer look at the bicycles in the hospital grounds would show that many do not carry distinctive high-pitched bells on them, or efficient brakes for that matter.

Secondly, "bikes" only bruise? It appears that the Editor has had little experience of casualty work. I have often seen folk with fractured femurs and legs caused through being knocked down by inoffensive bikes, and if the standard set by some who ride in and out of "the ancient confines" of Bart's is anything to go by I suggest that it is better to push these conveyances.

One further point I would make relates to all forms of mechanised transport within the hospital precincts, please park tidily and consider others.

Yours faithfully,

FRANK WRIGHT,
Deputy Head Porter.

Abernethian Room.

Dear Sir,

The squash courts at Charterhouse Square are being used, to an increasing extent, by people in no way connected with the hospital—city accountants, solicitors and taxi drivers, etc. This problem can only be overcome if those people entitled to play do not hesitate to ask any person on the courts, whom they do not know, whether they belong to the hospital.

The following people are entitled to play:
Past and present Bart's students
All other Bart's personnel

I should be grateful if people in the second category who wish to play regularly could send me their name and the department of the hospital to which they belong.

ALLAN COLVER,
Squash Club Secretary.

NOTICE

History of St. Bartholomew's Hospital,

by

Norman Moore. Published 1918 in

2 volumes

A limited number of these books is still available at £10 for the 2 volumes.

Please contact the Archivist, James Gibbs House, ext. 589.

SUNDAY MORNING and FRIED EGGS

by CAROL EVERY and RICHARD STANHOPE

This aeronautical saga was not written to describe an exotic pastime or for any educational aim, but as a challenge to the increasing number of dreary articles and grumbling letters which clutter these pages.

How many people at Bart's realised that a combined nurse/medical student team competed for the most coveted gastronomic trophy of 1974 . . . ?

"Look Dick! A free breakfast!" exclaimed Carol one evening after a long tiring day. Even for a brain which had been cooked in a hot aeroplane all afternoon, the response was immediate. A poster pinned to the wall of our clubhouse noticeboard explained the proposition. It was a *breakfast patrol* to be held at Bembridge airport on Whit Sunday. All that was required to claim the 'goodies' was to enter the airfield boundary, between 9 and 10 o'clock in the morning without being spotted by a defending aircraft. Could anything be easier! Delusions are a frequent accompaniment of cerebral damage.

Whit Sunday dawned clear. One of those beautiful sunny mornings with not even a single fluffy cloud in sight; such a day pilots only dream of. A little further south from Chislehurst at Biggin Hill, our hero and heroine (or more accurately the latter) were pushing a Beagle 121 out of its hangar. This physical feat occurred at a time of day when all good medical students and nurses should be either worshipping their maker or safely "tucked up in bed". Having wound up the elastic, the little Beagle, registration G-AXMW, was soon airborne and speeding on its way to Redhill. It is significant to the story that the registration letters were painted on the sides of the fuselage and under the wings; thus they could not be seen from directly above the aircraft.

"Gatwick approach, this is Mike Whisky, good morning". A sleepy radio controller, who had just finished a talkdown to a French airliner answered and cleared us through his zone. Immediately after, several other light aircraft requested clearances from Gatwick. No one had told the startled controller what the party was, and why everyone was going to Bembridge!

Past the Gatwick zone and on towards the coast. Carol, definitely the more attractive member of the team, was also the map handler, photographer, "hold this a minute" and sometime navigator. At this stage of the journey she was relieved of these mundane tasks, as pilot fatigue had become a pressing problem. The early morning start had taken its toll, but soon a cup of steaming coffee was repairing the damage.

The visibility steadily improved as we followed the coastline to the west. Then the major problem which we were to face in our task, became apparent. Over Selsey an Auster overtook us. All we could muster from the Beagle was an indicated 105 m.p.h. "fast" cruise. As the white cliffs of the Isle of Wight loomed out of the glistening Solent, we discussed tactics. A low fast dive, while coming out of the sun would give us the best chance.

Definitely the more attractive member of the team.

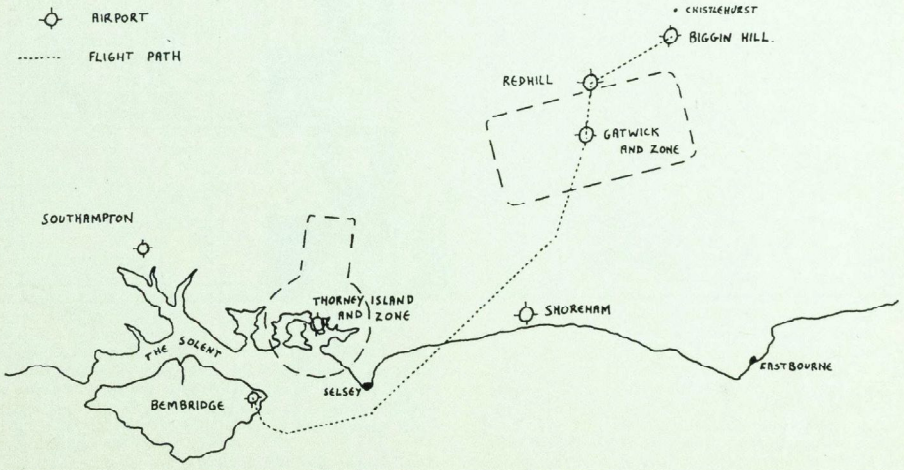
Three miles out from Bembridge the fun started. Two aeroplanes dived straight at us, head on, one on either side. A steep bank to the left, rapidly followed by a 180 degree change to a steep bank to the right, cunningly concealed the registration letters from the attacking aircraft even though they passed within forty feet of us. Bembridge appeared over a steep ridge and the beagle was diving towards the aerodrome, straining under full power. We were now clear. It was a straight race for the food. One of the defenders who we had cheated turned rapidly on our tail. Our little Beagle with its 100 h.p. engine flat out was little competition for a Nord retractable. The game was up; he briefly formated on our starboard wing just to gloat over his conquest and then peeled off in search of further prey.

"Bembridge tower this is Mike Whisky, overhead your field at 500 feet". The ensuing battle which developed when several dozen aircraft all attempted to land at the same time provided more interesting aerobatics than the official competition. The inhabitants of sleepy Bembridge village are probably still wondering what hit them that quiet Sunday morning. Soon we were on the ground after one of my usual superb landings although the look from the corner of Carol's eye would seem to contradict my experienced, if not biased opinion. Why my passengers always look slightly pale following a tight approach still eludes me.

An ugly and expanding crowd of aviators were gathering outside the organisers' office. Hunger acted as a catalyst to the hastle over "I spotted him" and "who spotted who". There was little need for spotted Dick to enter the discussion. We are both sure that success will not elude us next time. A purchased breakfast, although not quite the same taste as a free one was excellent even though the eggs were a little burnt. Our digestion was punctuated by several extrovert pilots who decided to trim the grass in a series of low swoops over the airfield.

An excursion to the beach followed, which while adding to Carol's bronzed glow did little to offset my own pasty complexion. And then it was time to set off, for it was almost lunchtime.

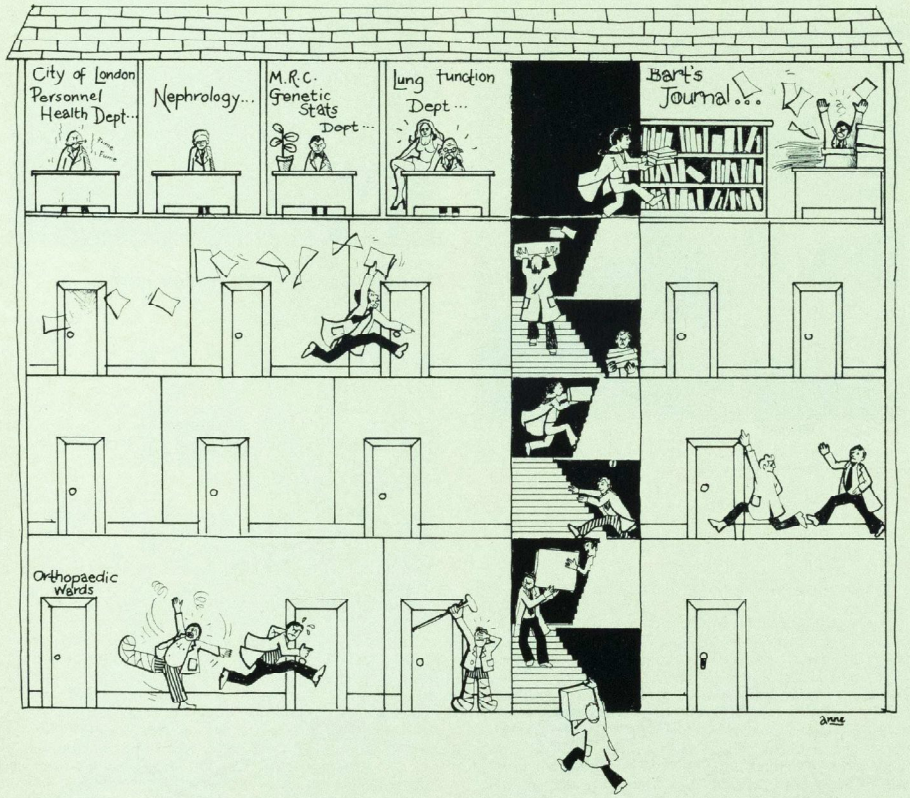
He Peeled off in Search of Further Prey.



The Saga Route.

ON THE ROAD AGAIN!

Only mad dogs and Journal *staff go out in the midday sun—and this is what happened when we did. Thank Heavens we only have to move home once in a lifetime.*



Cartoon by Anne.

NEWS AND VIEWS

THE PRICE SISTERS:
SOME COMMENTS IN RETROSPECT

There has been much discussion in the press over management in prison of the Price Sisters, and particular interest has been focussed on their forced feeding. It is perhaps over this latter issue that the argument has become most emotional.

The emotions have not only been aroused by the ethical problems of compulsion but have also been aggravated by the known dangers of forced feeding. Terence MacSwiney, the Lord Mayor of Cork, died as a direct result of forced feeding in 1920 and a second post portem has been ordered on Mr. Gaughan who died in Parkhurst on Monday the 3rd June, 1974, following claims that the pneumonia that caused his death was a consequence of oesophageal rupture.

While there has been much informed comment in the national press there has been remarkably little in the medical press. In particular, there has been very little discussion over whether prison doctors should force feed their prisoners at all.

While doctors no longer take the Hippocratic Oath, the code of conduct that they follow is still in the spirit of the original Oath and is enscribed in the constitutions of such bodies as the General Medical Council, the British Medical Association and the various medical protection societies.

The essence of the Oath is that all actions taken by a doctor can only be influenced by one consideration: that of the patient's welfare, which it is the duty of the doctor to try to improve upon at all times. The doctor, however, can only act as a medical adviser. That is to say that he cannot force his opinions upon his patients should his patients wish to disregard them.

There is only one exception to this rule and that is when the doctor considers his patient to be incapable of acting in his own best interests owing to mental incapacity. Under these circumstances the doctor, using the powers granted to him under sections 25, 26 and 29 of the Mental Health Act 1959, takes it upon himself to decide what the patient's best interests are and acts accordingly.

The dangers of this are self evident as can be seen in Russia today where non obedience to the Kremlin is itself taken to be a sign of mental disorder. In order to avoid making this sort of Value Judgement in which people who hold different views to ourselves are labelled mentally abnormal, in this country we only accept as evidence of mental illness the signs and symptoms of recognized disorders of brain function. That is to say that the judgement is made on medical grounds and not social ones.

If these criteria are applied to the treatment of the Price sisters it can only be concluded that the prison doctors acted unethically. There has never at any time been any evidence produced that either sister suffers from a mental disorder. Certainly their actions have been vicious and brutal, certainly their codes of conduct, morals and ethics are different to ours, but these in themselves form no ground for the diagnosis of a mental disorder and no such diagnosis has ever been made.

Thus we are forced to conclude that the prison doctors, in feeding the sisters against their will, have acted unethically.

But the prison doctors themselves are subject, as their title implies, to the rules of another code of ethics: that of the prison service.

The prison service, of course, aims to perform a valuable public service, one that has the support of all members of society. However, the organisation of the prison service, by its very nature, limits the freedom of prisoners and this is reflected in the altered doctor-patient relationship. While the prisoner is still the doctor's patient, he is no longer the doctor's client. The client is now the prison service. (Just as an animal is a vet's patient but the owner is the client.)

Furthermore, the framing of the doctor's contract goes even further than this. He is not so much a free agent acting for a client (the prison service) as a servant of the contractor (the prison service).

He is thus a servant of an organisation which may order him to perform actions prejudicial to an individual patient. Should he refuse to obey the order he has to accept the consequences.

A similar situation, of course, prevails in the armed services, perhaps even more so and this is in fact clearly implied in many service advertisements. In any situation where the patient is not the doctor's client, for example in the case of doctors working for drug companies, a similar situation may develop.

There is therefore a very real conflict of ethics over the actions of doctors in these public services in that the organisation of services which may be literally vital to the survival of our society (such as Defence or the Prison Service) may demand of a doctor actions that are an absolute violation of the spirit of the Hippocratic Oath and accepted medical ethics.

These violations may range from the forced feeding of prisoners to the torture, by doctors, of IRA suspects in Ulster. These actions may not themselves be totally bad, unpleasant though they are. If the torture of an IRA man produces information leading to the arrest of other IRA men with a corresponding reduction in innocent deaths in Ulster then it might be argued that it is justified. What is not arguable, how-

ever, is that torture performed by doctors is totally incompatible with medical ethics as they stand today.

Thus there is a conflict of ethics: Between on the one hand the ethics of organisations designed to protect our society and on the other hand the ethics that have evolved over the centuries to protect both doctors and patients in their relationships with each other and to secure the patients' confidence in their doctors.

Where does this leave the medical profession? First of all it must be recognised that many doctors are working to a code of ethics incompatible with that of the Hippocratic Oath and general medical practice.

One of the soundest principles of medical ethics, long upheld by the GMC, is that doctors subscribing to those ethics do not associate with those that do not. This is not to say that others' ethics are inferior to ours, this is no value judgment; it is a recognition of the fact that a code of ethics is essentially a pragmatic code of behaviour which has evolved to serve a particular function. A great deal of its impact relies on its universal acceptance by all who engage in that particular function. Thus a doctor who goes around killing all his patients or a soldier who goes around helping the enemy weaken their respective professions and codes of ethics.

Thus, if one of the aims of medical ethics is to increase patient trust and respect for doctors the effectiveness of that will be weakened if doctors are seen to associate with other doctors who do not act in accordance with the spirit of the Hippocratic Oath.

For the protection of the medical profession at large, therefore, for the clarification of medical ethics, let the bulk of the profession be seen to be separated from those doctors who do not subscribe to the Hippocratic Oath.

Doctors who serve in the Prison Service, doctors who serve in the armed forces, doctors who engage in perfecting germ warfare, doctors who engage in perfecting plastic shrapnel that does not show up on X-Ray, doctors who force feed prisoners: Let them be recognised for the valuable work they do for our society.

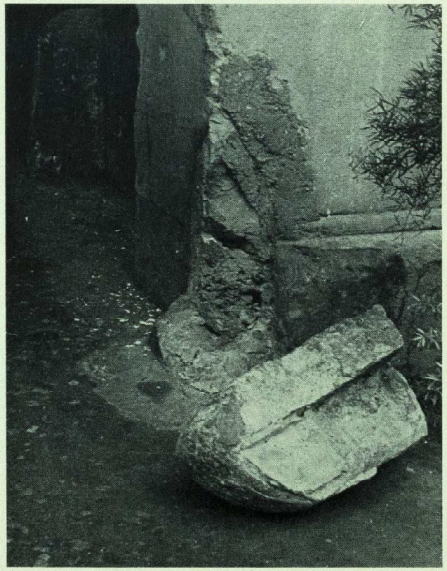
But put them on a separate register.

EXAM FEVER

At the end of June the first year clinical students were faced with a Pathology exam, consisting of an M.C.Q. paper for one hour, plus a "practical" (two slides with accompanying questions) for half an hour. Admirable, one might think; short, comprehensive and to the point. Well, in general this was true but there was no lack of inconsistencies. For example, is it really fair to include, in a basic first-year Pathology exam, a question on that well-known nonentity, *Toxoplasma Gondii*? Several people thought it was some obscure vegetarian pop-group, and even those who had heard of the silly beast mostly (and wisely) preferred to concentrate their learning faculties on the commoner microbes. Then of course there is the amazing business of the non-release of any past papers (or the present ones now) a policy that has created a thriving black market for those of a more unscrupulous temperament. Presumably the powers-that-be cannot be bothered to keep making up new questions, but this is merely assisting those driven by the "necessity" of lack of knowledge, because it is usually the desperate who seek out the prized objects that past papers have become. Surely they should be published, and the *Journal* will most happily publish any of this year's papers that "come to hand", promising strict confidence to the willing donor.

But the real absurdity of the afternoon was the announcement by the professor (no less) that he did not expect many correct answers in the Chemical Pathology section, since he knew quite well that we had received no formal teaching in that subject. In which case, why include it at all? Still, for those of a phlegmatic bent it was a nice change from ward rounds, and there were some good jokes, notably the "Dr. Alex Minimal" as the possible author of the term "Minimal Change Lesion". It would also be interesting to know how people marked their answers. Most seemed to either put a cross or tick beside their choice, or to circle their choice. There must be more imaginative ways. Personal "doodles" perhaps?

THIS MONTH'S ANGRY PICTURE:



How many more photographs like this need we print?

SUMMER BOOKS

DAISY MILLER, by Henry James. Published by Penguin, Price 25p.

It is difficult to review a book which was first published in 1878, and has now been re-issued this month after being out of print for 10 years, especially as its author is Henry James. James, born in New York in 1843, wrote many short stories, plays, an autobiography, and 20 novels. He became resident in London in 1876 becoming naturalised and was awarded the Order of Merit shortly before his death in 1916.

This rather short novel, being just over 80 pages in length, could best be described as a long short story based on what James termed "the international situation". Daisy Miller is a young lady transposed from her home in Schenectady in New York State to life in Europe. However she fails to make the change from the American way of life to the more rigid European social code and suffers the consequences accordingly.

This novel provides insight into life amongst the American colonists in Europe in the 1880's whose way of life and conduct Daisy found to be too stiff and rigid. She in consequence was rejected by them. Daisy however had only one real failing, she was too innocent and this innocence leads to her death.

H.S.B.

THE COLLECTED BULLETINS OF PRESIDENT IDI AMIN, by Alan Coren. Published by Robson Books, Price 60p.

On de front o' dis here book, it sayin' "Read dis book", and dere a picture o' de worl' famous dipperlomatic giant, Rear Admiral o' de Fleet Idi Amin VC, DSO, MC, an' sim'lar, pointin' de .45 Webberley at whoever readin' it. De way I seein' it, or so Idi bin tellin' me as he nailed ma bonce to de floor, is dat dis here is de noo breakthrough on de worl' o' Eng Lit an' how any bugger wot ain't buyin' his copy pretty damn quick gonna find de T43 tank rumblin' up de drive and lobbin dc 5 millimetre item through de parlour window wid de notorious pinpoint accuracy.

Anyway, as de title suggest, dis is de collection of reports from de pages of de worl' famous Punch, featurin' dc Field Marshal Amin an' sim'lar. Any o' you bin readin' these reports 'll have bin wond'rin' when dis fine volume comin' out, well here it are!

Not even de names have bin changed, 'cos dere ain't nobody wot's innocent!

R.T.J.

THE PURPLE PLAIN, by H. E. Bates. Published by Penguin, Price 50p.

H. E. Bates, who died a few months ago, created the Larkin family, of radio renown. In a more serious vein, The Purple Plain draws on his experiences in Burma during World War II. Young Pilot with Deathwish achieves salvation through relationship with Beautiful Burmese Bird after sojourn in Wilderness. Probably not book of the month.

BRYAN SHEINMAN.

THE CHILD'S CONCEPTION OF THE WORLD, by Jean Piaget. Published by Paladin. Price 75p.

First published in 1929, this book, together with its successor *"La Causalité Physique Chez l'enfant"* is concerned with an analysis of the content of child thought, as opposed to its form and functioning (studied in two earlier works). Piaget holds: "The content (of child thought) is a system of intimate beliefs and it requires a special technique to bring them to the light of day".

The introduction is concerned with the selection and development of the technique of 'clinical examination'. The main body of the work is in three sections: Realism, Animism and Artificialism. These contain many quotes from children by which Piaget illustrates the beliefs about the world which he hypothesizes children hold. He strives to look at children's thought both as it occurs and develops spontaneously, and also as it is influenced and changed by interaction with adults. Hence, if children were to grow up in isolation from adults, would they retain these original tendencies?

By Realism, Piaget means that the child cannot differentiate between himself and the external world, and is thus completely egocentric. Other manifestations of Realism are the inability to distinguish internal from external, 'sign' from 'thing signified' and 'thought' from 'matter'. Animism describes the tendency to regard objects as living and endowed with will, and Artificialism refers to the child regarding things in the world as the product of human creation. Piaget thinks that many children do see the world through the spectacles of Realism, Animism and Artificialism, and far from being separate stages related to chronological age, he cites a period in the child's thought where both Animism and Artificialism co-exist—when things are regarded as both living and created by man. Piaget shows how language encourages Animism and Artificialism because children take its metaphors literally, e.g. 'the steam is trying to escape' seems to indicate that 'the steam' is alive and has a will.

The book is thought provoking, but not necessarily in the area of child psychology. It has paved the way for recent studies on how the child sees life, and how this differs from the adult view. It helps to explain why it is so difficult to understand children sometimes!

One should not be mislead into thinking that the combination of a big name and a big topic will provide a definitive account. (One suspects that the publishers hope the public will be so misled). The work is partial in several senses. Firstly, Piaget himself counsels caution in interpreting the findings. (Although in a study in 1962 Laurendeau and Pinard substantiated many of Piaget's findings in this field.)

Secondly, because of its age, the work does fail to encompass certain areas now recognised as crucial. Piaget had scarcely discovered the social framework at this stage and there is no discussion of the effects of social background, or of the significance of social interaction in the generation of meanings. Also, of course, there is an absence of a sense of dialogue with ongoing research especially that related to language, the importance of which transcends its current vogue.

In short, partial but provoking, palatable but (at 75p) pricey.

JEN & DAVE WEBSTER.
The Authors are Teachers.

AN ALCOHOLIC IN THE FAMILY, by Mary Burton. Published by Faber, Price £2.50.

The single largest group of drug addicts in our society, with the possible and questionable exception of nicotine-users, are alcoholics. Because alcohol consumption is socially acceptable and even encouraged in many areas of society, alcoholism can be a particularly insidious and easily indulged form of addiction. Mary Burton analyses her own reactions to the realisation that her husband was an alcoholic, and she writes in a moving although unemotional way of her personal struggle to cope with his addiction whilst maintaining her marriage and family intact. Although much has been written on alcoholism from more technical angles, this is one of probably very few accounts written from such close quarters. As such, it cannot fail to provide an insight into the social and psychological complexities of the disorder, both for the professionally involved and for those who may themselves be confronted with an alcoholic in the family.

BRYAN SHEINMAN.

CARE OF THE DYING. Richard Lamerton. Published by Priory Press (Care & Welfare Library). Price £2.50.

For those interested in the euthanasia debate and the wider issues of terminal care, Dr. Richard Lamerton's book *'Care of the Dying'* will provide worthwhile reading. Dr. Lamerton courageously puts forward his opinions, not only on euthanasia, but on topics like the "ethic of necessity" and resuscitation. He stresses that euthanasia is not a necessity with present day knowledge of medicine. What he does stress as necessary is the proper medical and social care of those suffering from terminal illnesses. He is convinced that with medication and care no person's life need be prematurely terminated.

He puts forward in detail how this care could be administered i.e. in a specialised unit (a hospice) where each patient would be served by a team of workers consisting of doctors, nurses, social workers, clergymen. Most significantly the patient should be a member of the team. However, to be realistic, present day numbers of doctors etc. are insufficient to provide this type of service on a universal basis. No longer, says Lamerton, should patients be surrounded by a "wall of silence", and states that over half Britain's family doctors do not enlighten the patient either to the gravity of his illness or to the side effects or effects of the drugs being administered.

In his book, Dr. Lamerton gives a view of medicine that has developed one step further than merely treating a patient for a particular complaint. His idea of medicine combines medical care with the idea of trying to cope with all the social and emotional needs of the dying patient. Albeit an almost super-human task for any team of professional people but nonetheless a more humane way of treating the dying. In summary, Dr. Lamerton's book is an easily readable, easily comprehended piece of work revealing the author to be a man who sees a human being first and a patient second.

SUE CAMPLIN.
Social Worker.

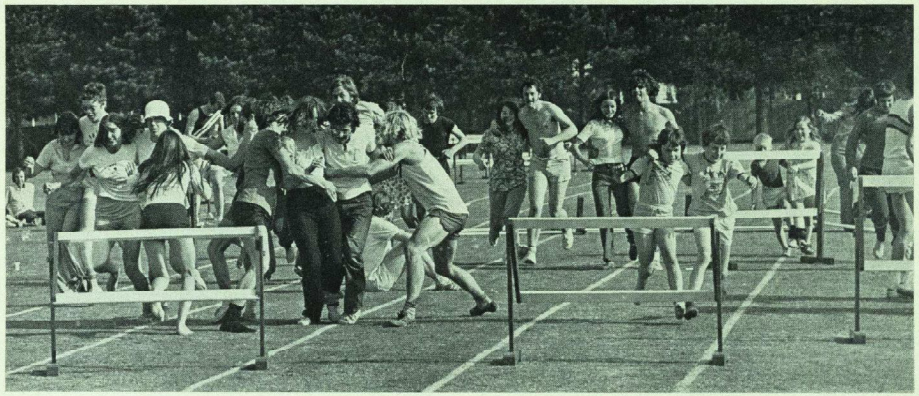
"MYTHOLOGIES"
by Roland Barthes, Paladin. 50p.

Very occasionally you come across someone who just simply *Understands*. Roland Barthes is one of those individuals with such astonishingly lucid insight into his environment that he is able to articulate its foibles and inconsistencies and expose its pretensions. His book "Mythologies" is a brilliant illustration of this ability. By means of some common examples ranging from Omo advertisements to wrestling matches and Citroen cars, he shows how many facets of society and its products can be analysed in terms of their myth content. Thus, for example, of plastic " . . . in essence the stuff of alchemy. . . . At one end (of the machine) a raw telluric matter, at the other, the finished human object. . . . So more than a substance, plastic is the very idea of its infinite transformation". Of wine, which "has at its disposal apparently plastic powers: it can serve as an alibi to dream as well as reality, it depends on the users of the myth. For the worker, wine means enabling him to do his task with demiurgic ease ("heart for the work"). For the intellectual wine has the reverse function. The local white wine or the beaujolais of the writer is meant to cut him off from the all too expected environment of cocktails and expensive drinks. Wine will deliver him from myths, will remove some of his intellectualism, will make him the equal of the proletarian; through wine the intellectual comes near to a natural virility. . . ." And of wrestling, "What is . . . displayed to the public is the great spectacle of Suffering, Defeat and Justice. Wrestling presents man's suffering with all the anticipation of tragic masks . . . Wrestlers who are very experienced know perfectly how to direct the spontaneous episodes of the fight to conform to the image which the public has of the great legendary themes of mythology".

The second part of the book is devoted to explaining myth as more than just a mechanism of language but as a means of communication in its own right. This part is fairly heavy going, but is probably best summed up by Barthes himself in describing myth as "depoliticised speech". Thus myth " . . . organises a world without depth, a world wide open and wallowing in the evident, it establishes a blissful clarity: things appear to mean something by themselves". He does hit some controversial ground, however, when he applies his method to matters political. He feels that myth is statistically to the Right, as exemplified by notions of Order, Nature, etc. But he does not analyse Revolution or the State as myth. Quibbles apart, the book is superb reading. I'll never look at a packet of soap powder the same again.

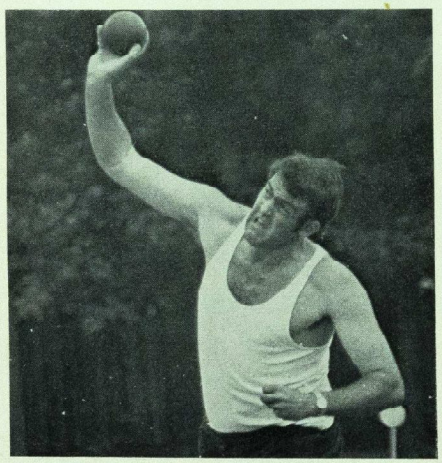
BRYAN SHEINMAN.

SPORTS DAY

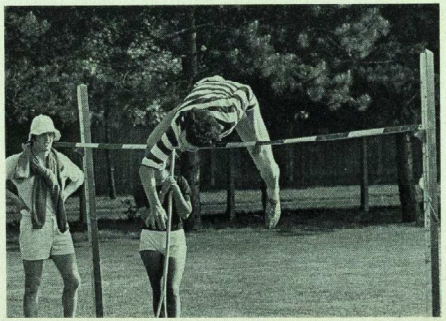


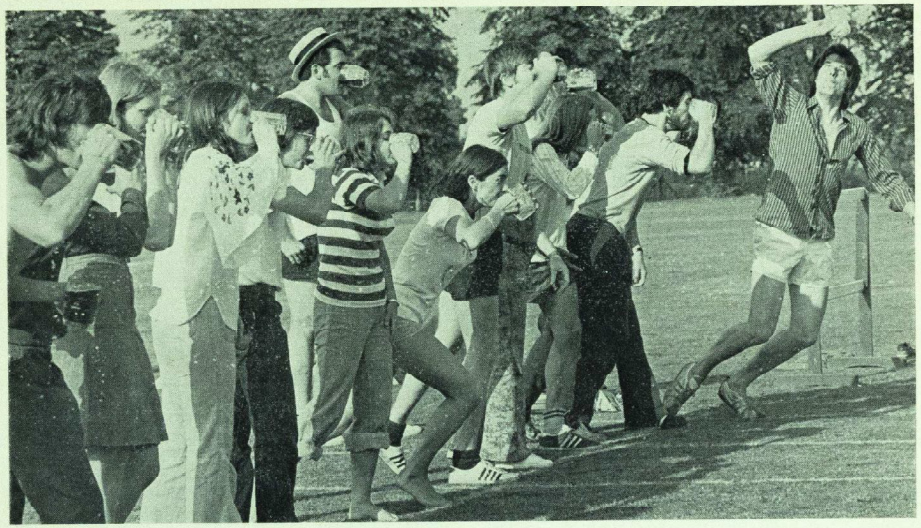
The 3-legged race, Bart's "rules".

Multiple exertion therapy

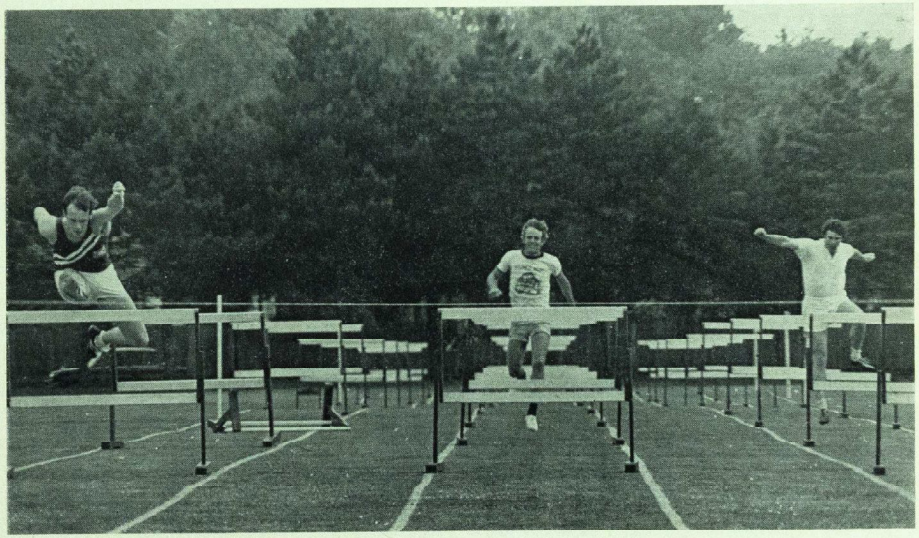


Uuugghhuuhh!





Tanking up for the Casuals' Relay.



The final perspective—"leaps and bounds. . . ."

MEDICAL BOOK REVIEWS

HODGKIN'S DISEASE, by Sir David Smithers. Published by Churchill Livingstone, Price £8.50.

HODGKIN'S DISEASE, by Henry S. Kaplan. Published by Harvard University Press and London: Oxford University Press, Price £8.25.

The publication of two major works devoted to a single disease is a reflection of the fascination this curious illness holds for those who study it. Fortunately, the interest of clinicians has been well rewarded, and the advances in our understanding and treatment of this malady over the past 15 years have been staggering. Even fundamental questions such as whether or not it is a malignant disease have only recently been set on firm scientific evidence, and Smithers draws attention to this early in his book. Probably the crucial event was the delivery of the 1958 Robert Knox lecture by Smithers himself, in which he hypothesised that the disease might well be a true tumour of immunologically competent cells capable of mounting a reaction against the host.

At the same time, the radiotherapist Henry Kaplan, working at Stanford University, was coming to similar conclusions (though from a quite different set of hypotheses), and it is delightful to see how each author in his book pays generous tribute to the other. What's more, the general standard of writing in both books is high, and many difficult concepts are dealt with in a relatively painless fashion.

The British book is largely a record of the work done at the Royal Marsden Hospital and St. Bartholomew's Hospital in the last 20 years. It is well laid out and easy on the eye. The chapters are written by experts, and the strongly clinical approach should please most medical readers. Particularly valuable are the general comments by Sir David Smithers, the section on immunological aspects by Derek Crowther, and the rather condensed account of the part played by chemotherapy. Professor Hamilton Fairley and Dr. McElwain are only allowed eight pages for their discussion of the principles and value of drug therapy, and I think this is too little.

Kaplan's book, on the other hand, is admirable for quite different reasons, not the least of which is that it is his offspring entirely; there are no other contributors. He clearly has an eye for the visually appealing, and the illustrations are first-rate. Many of Hodgkin's papers, specimens, and dissections are reproduced, and one cannot fail to be impressed by the high standard of schematic diagrams and X-rays. The text is comprehensive and mercifully, more English than American. One particularly attractive feature is the use of illustrative case-histories in the appendix.

Both books offer good value for money by today's harsh standards. I won't choose a best buy as they are both outstanding for different reasons. Bart's library ought to possess both.

JEFFREY TOBIAS,
Department of Medical Oncology.

MULTIPLE CHOICE QUESTIONS IN DERMATOLOGY. S. K. Goolamali. Publishers: Churchill Livingstone. Price £1.

The title is misleading as the book contains more general medicine than dermatology, this being the only rational way to present the speciality to a wider medical audience. To confine the text to dermatological problems alone would be pure tedium for all.

A wide field of medicine is covered with question and answer. The well prepared candidate, adding the score at the end of each paper, will see that it does not pay to guess. A wrong guess produces a loss of marks and is often the downfall of a good Part 1 M.R.C.P. candidate.

There are inaccuracies and misconceptions and I am sure that the author will receive a good deal of mail, and the next edition will be even better value for £1. Candidiasis is not a cause of napkin rash (much more the fault of the napkin). Anthrax is not a dermatosis. Medium rhomboid glossitis is not a cause of a big tongue. Chronic discoid lupus erythematosus is not a manifestation of systemic lupus erythematosus, but lesions resembling the former can occur with the systemic disease. We must try to get this common meeting ground of connective tissues disease clear to all.

JOHN KIRBY.
Department of Dermatology.

CONCISE ANTIBIOTIC TREATMENT. W. H. Hughes, H. C. Stewart. Butterworths 2nd Edition.

This book is written as a "portable reference book to be used both in an emergency by the practising doctor and for quick revision by the student preparing for examinations". As such it fills a gap not filled adequately by any of the commonly available textbooks of microbiology or therapeutics. Its presentation is clear, and its style appropriately dogmatic for its function, but it is unfortunate that its price—an extraordinary £2.75—is likely to prevent wide circulation.

A.H.

ANAESTHESIA AND RESUSCITATION. A manual for medical students. Edited by R. A. Gordon. 2nd Edition. University of Toronto Press, £2.80.

It is a pleasure to welcome the second edition of this excellent little book which was first published in 1967. Its two hundred pages are contributed by no fewer than fifteen eminent Canadian anaesthetists. A great deal of credit must therefore be given to its Editor, Dr. R. A. Gordon, who is also the Editor of the *Canadian Anaesthetists Society Journal,* for achieving such a remarkable degree of consistency of style and purpose with little or no repetition.

The volume is designed to provide the medical student and the novice anaesthetist with a basic knowledge of the principles which govern the practice of the modern physician anaesthetist in relation to his patient and to the members of other disciplines. It does not attempt to describe details of technique but it contrives to set the fundamental ingredients of anaesthesia, such as drugs, apparatus and technical procedures like endotracheal intubation, into their proper perspective in relation to the patient, his condition and the type of surgery to be undertaken.

This volume fulfils what your reviewer believes to be the essential criteria for the teaching of anaesthesia to undergraduates. It indicates the purpose and scope of the speciality without confusing with detail, and consciously or unconsciously, sets out to fire the imagination of the student to the extent that he will become a potential recruit to the speciality. It also imparts the rudiments of para-anaesthetic subjects such as acid-base, fluid balance and transfusion which will be of use to the reader whatever speciality he ultimately chooses.

It is almost invidious to select individual chapters for special mention from amongst such a wealth of good material but that on "General Anaesthesia" by Dr. W. E. Spoerel and Dr. G. R. Sellery is outstanding for its clarity and the one on "Special Considerations in Paediatric Anaesthesia" by Dr. T. J. McCaughey also deserves particular attention.

It is possible to take some issue with some details, such as the rather conservative attitude to corticosteroid medication and the use of the term "local *anaesthesia*" instead of *"analgesia"*, but these are matters upon which usage and opinion is divided; it must be recognised that in the pursuit of brevity, a certain amount of dogmatism must inevitably be tolerated in such a concise work.

There are very few diagrams and illustrations but those that are provided are to the point and easily understood. Some simple line drawings might have effectually supplemented the descriptions of cardiopulmonary resuscitation and a nomogram would also have been useful in the chapter on acid-base balance.

Bibliographies are provided at the end of each chapter. These are adequate and useful but it is not surprising that the references are mostly North American, when one considers the origins of the work. There is also an adequate index, and the book is attractively bound.

The price of the volume, which a student could easily read and digest in an evening, is modest. It should give him the essential background of the subject and stimulate him to seek practical instruction in the operating theatre.

T. B. BOULTON.
By permission of the Editors of "Anaesthesia".

ESSENTIALS OF HUMAN ANATOMY, fifth edition, by Russel T. Woodburne. Published by Oxford University Press, New York, Price £8.25.

Continued publication of this text, written for American Medical and Dental students, confirms its popularity.

The text is regionally organised yet, with the possible exception of the anatomy of the back, it avoids unnecessary repetition. The writing is clear and easily understood, but not concise since it extends to 629 large double column pages and still excludes a number of important aspects of the subject. The most noticeable omission is that of the central nervous system, while embryology is sporadically covered and only the bare essentials of histology are included.

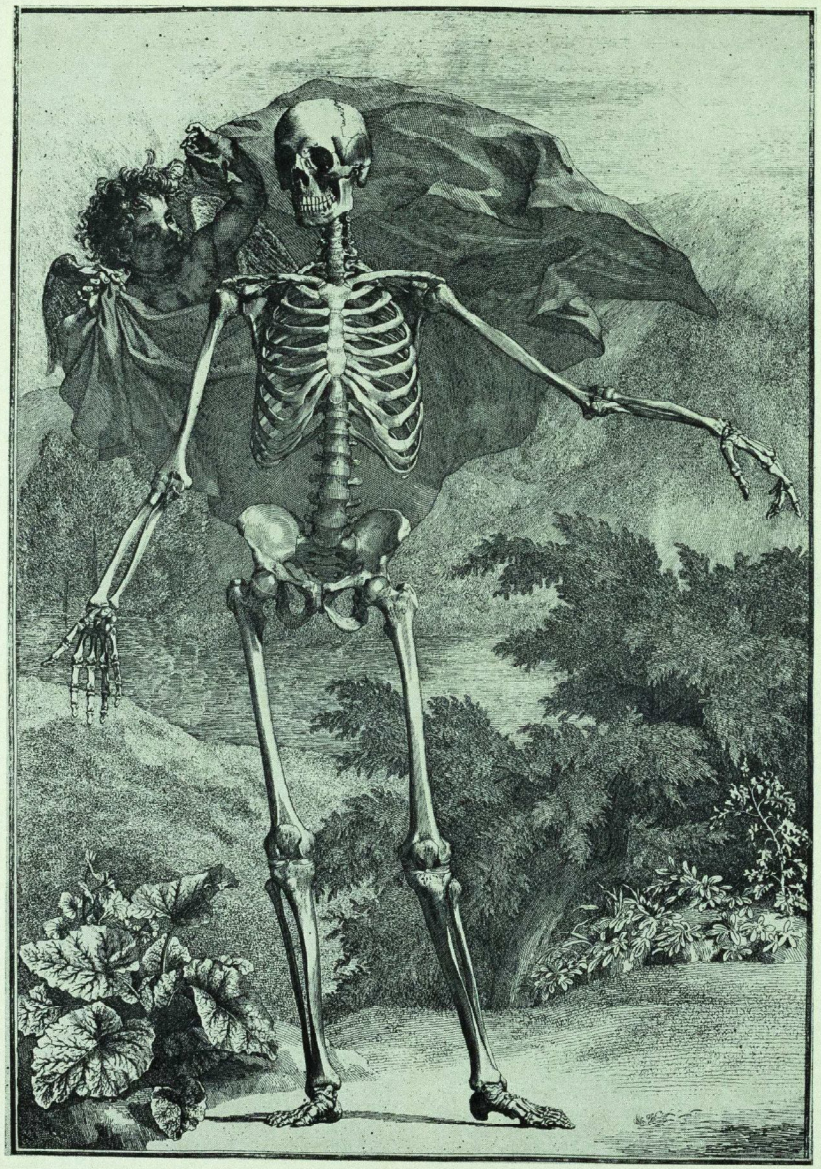
The 468 diagrams are generally informative even if not selective, a minor disadvantage being the distracting number of different artists and styles. The line diagrams are particularly effective but the more elaborate cross sections and the diagrams of the fine ramifications of autonomic and lymphatic systems lack clarity. The 14 coloured plates have been well prepared and reproduced, so much so that they could have been directly labelled thus dispensing with the need for key diagrams.

The index is full and although diagram references are not consistently included, there is ample reference to these in the text. The older terminology has been sensibly restricted to a glossary. The bibliography is of limited value being little more than an outdated publisher's catalogue.

In spite of the high quality of the text, the full illustration, and the pleasing layout and binding, it is doubtful whether this book will make great headway in the British market where the present tendency is towards a more clinical approach to the subject, neither does the book carry enough information to be used as a standard reference work.

It can however be recommended as a reliable, accurate and readable textbook of Human Anatomy.

JOHN LUMLEY,
Lecturer in Surgery.



"Here, take my cloak—it will make you warmer than you look at the moment."

THE MAGIC ROUNDABOUT

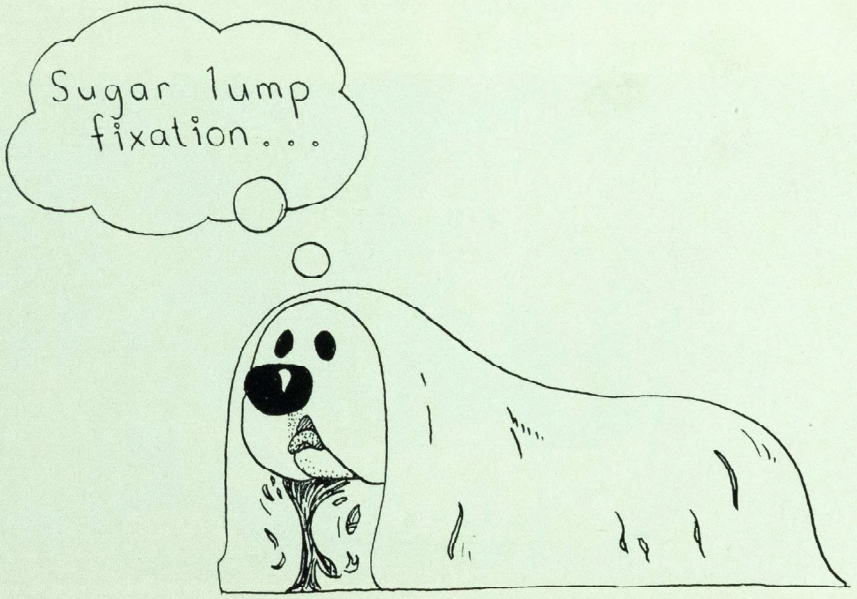
By R.T.J.

The Magic Roundabout, BBC's epoch-making saga of life, provokes grave thought in the mind of the serious student. Its psychology has a fundamental significance for us which assists us to fulfil our worldly purpose. The characters symbolise the conflict which assails our innermost convictions and moral standards. The situations are essentially an over-simplification of the pressures of the modern world.

What is the secret of Zebedee's motive power? You may call it a mere spiral spring, but what does it really imply? Surely, this is the source of what we call energy, be it material or even spiritual; it is only by delving into the metaphorical essence and rejecting the confusion of human prejudice that we can begin to see the underlying suggestion of his frustrated relationships. This inevitably links up, in the minds of thinking people, with the connotation of "hot, buttered toast" in that surrealistic epic of the small screen, "Noggin the Nog".

Where can those brilliant characters, Dougal and Florence, fit into this construction of Universal Truth? Their actions, coupled with the sinister magnetic influence of Mr. Rusty, give one the impression of that external yet internal force that we call Human Nature. In contradistinction is Brian, who, when viewed relatively, represents the slow reactions of Conscience. To my mind, the institution of the Roundabout, which undoubtedly delineates the world, is important in its absence from the action. Thus we can see that the action is, of course, escapist.

It seems that the enigma of "The Magic Roundabout" will remain hidden until future generations, with the advantages of hindsight, uncover the source of its intrinsic greatness and overwhelming influence.



Cartoon by Tim Bunker.

SPORTS REPORT: Golf, Climbing, Rowing "Strolling" and Caving

GOLF CLUB REPORT

"Every race which has become self-conscious and idea-bound in the past has perished" (D. H. Lawrence)

v. St. Thomas's on June 12th, at West Hill G.C.

It was with Lawrence's quotation reverberating through our minds that the selection committee spent a spartan evening choosing a side for this, the toughest fixture on the circuit. Such is the pride St. Thomas's have in their golf team, that they have recently re-carpeted their wards so as to sharpen up their short game. However, it was eventually decided that to beat St. Thomas's, one of the most revered institutions in the golfing world, we had to produuce a team which would be prepared to throw the text book aside, and yet still play within the limitations of the "Rules of Golf". The team chosen was:

J. Foster (Capt.), F. McLeod (Sec.), J. Chapman, J. Capper, M. Bird, G. Aiken.

Our performance can only be described as a revelation, as we laid to rest forever the St. Thomas's legend of invincibility. Graham Aiken, our wayward Scottish genius, was unable to play up to his usual form due to a heavy night in the fashionable "White House" with one of the local belles. As a result of this defeat he has been severely disciplined and suspended for one match.

Mike Bird, our snappily dressed, fast-talking No. 5 was given the task of subduing the opposition skipper. With a tremendous finishing burst of birdies Mike squared the match on the last green. John Capper, "Mr. Invincible", was next in the clubhouse having coasted to yet another sensational victory. At this stage the match stood at 1½-1½, so when the news was flashed round the liberally placed leader boards we all felt a surge of excitement. Could we hold this great golfing institution—or even beat them?

Fraser McLeod, who had adjusted his pivot due to a swollen left knee (Reiter's), went through the pain barrier to defeat his opposite number. The gallery went wild; it now seemed as if a minor miracle might occur. Jim Foster, who had flown direct from Henry Cotton's Golfing School in Portugal to West Hill G.C. did justice to his intensive two weeks' coaching by slaughtering his opponent and hence ensuring a famous victory. John Chapman, who played the 18th surrounded by thousands of hysterical Bart's golf fans rubbed salt in the wound by hammering a very dispirited St. Thomas's No. 1. Thus all the weeks of training and planning have at last come to fruition. With this victory we have established our right to be placed among the great golfing institutions.

Match Result: Barts 4½, St. Thomas's 1½.

v. Bart's Golfing Society on June 19th at Chislehurst G.C.

"Every cloud has a silver lining", although as far as we were concerned, "Every silver lining has a cloud" is more applicable.

Members of the Golf Club and two of their "ardent" fans.

On a cold, damp afternoon we travelled down to play the Bart's Golfing Society, virtually an "Old Bays" golf team. The selection committee decided to field a side packed with experience and to blood only one new player. Our new cap was Donald Bain, a mature golfer who has shown great promise in the junior teams of the Bart's Golf Club. The team chosen was: J. Foster (Capt.), F. McLeod (Sec.), J. Capper, H. Maurice, J. Frame, J. Parry, T. Turner, M. Bird, R. Robertson, D. Bain (new cap).

It was in this match that the first signs of mental staleness appeared. It has been a long hard season and many of the players looked forlorn and battle-weary as they stepped onto the first tee for another afternoon's combat. Our victors in an otherwise disappointing team performance were:

Jim Frame who, fresh from his 2nd M.B. triumphs, pulverised his opponent;

John Capper, who once again remained unbeaten, was awarded the "Rookie of the Year" prize in recognition of this tremendous achievement;

Donald Bain, our new cap, who revelled in the atmosphere of high-pressure tournament golf, to gain a victory in his first match in the Bart's jersey.

Match Result: Bart's 3, Bart's Golfing Society 7.

It was decided by the committee that to combat this mental staleness, a holiday should be arranged for the Golf Squad, and thus a Welsh Tour has been organised for the first week in July (See next issue of the *Journal*.)

J. Foster.

Editor's Note: For further information on this fascinating case, readers are referred to the seminal article by Freud in the Austrian Psycho-Golf Bulletin entitled: "Delusions and Megalomania on the Putting Green; the 'albatross syndrome' and its consequences".

APRES SKYE

By JOHN MEYRICK THOMAS

There's not much climbing done during the winter, and as far as Bart's is concerned there's virtually none! It's too cold, too wet and somehow all the climbers seem to do psychiatry during the winter months so couldn't get away before 7 p.m. on a Friday evening anyway. So, after two or three tentative weekends in Snowdonia and the Cheddar Gorge, and the odd evening performing acrobatics on Harrison's Rocks, the club (and in particular its post-M.B. Path members) went to the Black Cuillins of Skye for the first week in May. The most confident pathologist left before the results were out and the rest followed at intervals during the last week in April. Somehow everyone arrived in Glenbrittle on the same day: and the sun was shining—in Skye! We later discovered that this was the 60th consecutive day of fine weather on the island: if we'd known that before, we would probably never have tempted Providence with our arrival.

The sun shone, alas, for only two more days. Three ropes of two climbed on Sgurr Alasdair on the first of these, while others walked to the foot of the climbs and up to the summit via the Great Stone Chute. Perhaps I should explain that the walk from the campsite to the lochan at the head of the corrie (and the foot of the Stone Chute) constitutes the day's exercise: the climbing is more in the way of light relief, and an attractive alternative to plodding up the endless scree of the Stone Chute. Nine met at the top for lunch at 4.30, after which potential energy was exchanged for kinetic in the rapid descent of the Stone Chute and the walk back to camp. The problem with Glenbrittle is that it's a 15-mile drive (or an 8-mile run) to the pub at Sligachan, which puts up the price of a pint but has no other effect on the consumption of McEwen's Export.

Everyone's ambition when visting the Cuillin's is to "do the ridge"—a 10-hour hike from Gars-bheinn to Sgurr nan Gillean excluding the time taken climbing the first peak and descending from the last. Dave Wainstead undertook to walk it next day with Mac—a social worker whom we met in Glenbrittle. After a 5 a.m. start all went well until Dave injured an ankle after only an hour of the ridge itself; but they carried on in good time and got to within an hour of the end when he injured the other one, and they had to call it a day. Theirs was a great effort, and the failure to finish was a big disappointment to Dave who was confined to camp for the rest of the stay—happily no bones were broken.

While they were battling their way along the ridge towards Sligachan four of us drove to the pub, leaving them the car, to walk back to Glenbrittle around the base of the Cuillins taking in Loch Coruisk, hoping to see the seals which breed there. It's a seven hour walk with the loch half-way in time though nearer two-thirds of the way in distance: walking in the hills is measured in hours rather than miles to allow for differences in the "going". We were rewarded with a colony of some 30 seals to watch while we had lunch by the landing point for the tourist boats that visit the area in the summer. The last part of the walk was hard going with a lot of scrambling, and all were glad to see the small group of tents that meant home after rounding the last of an interminable number of spurs that fan out from the ridge.

It rained next day and the party went its separate ways round the island—eight of us to Niest Point to watch the gannets diving, and with the hope of seeing the eagles that live there: we found the gannets but not the eagles. It was still raining on Wednesday with strong winds and mist obscuring the peaks. Hugh Rogers and Mac set off to finish the ridge while four of us went for a less ambitious walk in the hills. The weather closed in, though, with mist down to 1,000 feet and wind strong enough to send one member of our party head-over-heels down the boulders: Hugh and Mac didn't reach the ridge and we too were forced to cut our walk short. Walking in the rain and strong wind can be very exhilarating, though, and the day was not wasted. Another four did the "seal walk" in reverse, and all met up at Sligachan for birthday celebrations in the evening.

It was still raining on Thursday and, with not very encouraging weather forecasts and dry clothes running out, all but three went home. The three stalwarts remained until Saturday and then followed suit after getting in some more hill-walking but, because of the weather, no more climbing.

As far as rock-climbing was concerned the holiday was not a great success, many being disappointed that they couldn't try their hands (and feet) at this sport.

But the Alpine Club exists to further mountaineering, which means being in the mountains, walking them and climbing on them: this we did and had a most enjoyable holiday into the bargain.

Further details of the Alpine Club's activities may be obtained from Will Elsden who is carrying on the running of the club.

CAVING—Moonlight Passage and all that.

I found myself in South Wales again on a caving expedition. I had been rather put off after my last trip to Tunnel Cave because I had convinced myself that it had given me a severe attack of prostatitis, just before I was about to take my Russian "O" level. I can still remember trying to get my prepositions right with my legs firmly crossed!

I was asked which Bart's party I would like to join and chose to go with David Wainstead and four "Physios". It was not that I was particularly partial to Physios but that with my advancing age I reckoned that the fairer sex would go at a more reasonable pace. Little did I realise at this time that our trip was going to be anything but leisurely.

We arrived at the old quarry at one of the O.F.D. entrances and after searching around for a suitable tether for our ladder I turned up with an old piece of piping that we slid through the electron ladder and jammed it against the entrance door. At this time my reaction was that this was going to be a "doddle" and I began to regret not having joined one of the stronger parties. I seemed to be grovelling for a considerable time on my stomach, passing through solid rock with gravel going up my nostrils. My glasses were steamed up and I was muttering, "Peter is a bloody fool, he said you could drive a double-decker bus up Welsh caves". I quickly changed my mind after the crawl, as the cave opened out and everywhere it was beautifully decorated. The floor was sandy and soft to walk on, Peter was right, Wales was a great place to cave in.

Just about now one of the Physios began to divest herself of her pants and I began to wonder what was coming off next, and what treat was in store for us two males. I was quickly disillusioned; the zip had gone in her pants and not one of the fairer sex had a safety pin between them. So, the trip was more interesting and more enjoyable. We had all negotiated rather a tricky short traverse only to find that we were off course and had to retrace our steps. This is where I had my first fright, passing across the traverse the bag I was carrying with my space blanket and other spares, threw me off balance and it was only through Dave's quick reaction in grabbing me that I did not fall 20 to 30 feet on to the rocks. My mouth went dry and my knees knocked a little.

We continued on our journey until Dave went on to check that our route was correct. He had been gone a minute when we heard a rumble, roar and crash and all ducked involuntarily . . . my first experience of a spontaneous avalanche of rocks nearby and not set off by anyone. Dave returned and we continued our journey arriving at the Stream passage. The scene changed and we were walking up a streamway lined with rock the colour of black marble. We passed up waterfalls and through deep pools. I was lucky here because I was wearing a wet suit and did not have to make the effort to avoid the water. We hauled ourselves out of the water to leave the streamway and had a small snack. The high adventure was about to begin.

First came the traverse; it takes quite a bit of nerve until you get used to it, to shove both your feet across a drop of anything from 100 to 200 feet, and jam your bottom the other side of the drop, edging along alternately with feet and bottom or worse still walking along ledges with feet each side of the drop or walking on one narrow ledge on one side with both hands on the opposite, sometimes you can take your pick at others, you have not got any choice.

After the traverse the Physios were roped because it was necessary to go over an exposed ledge and the hand holds were two flakes of rock. Before negotiating the ledge it was necessary to lower one foot on to a small support at the edge of a 100 foot drop. Dave life-lined them over whilst I held their wrists from my side to give them added support and a feeling of security. Then my turn came. I tied myself to my Karabiner, confidently lowered one foot, got the other nearly across the ledge when the rock came away in my hand, it was not a flake but a piece of rock weighing about a hundredweight teetering on my thigh! I don't think I was frightened at that moment as I was so surprised. Thoughts flashed through my mind that this sort of situation only arose in epic films or adventure books for boys, but it was happening to me. A rock that had been used by innumerable cavers as their main means of support had come away. Dave will only know whether my voice sounded steady when I said, in what I thought was a stupid voice, "I think I had better move this rock first" and Dave said something like "I think that would be a good idea"; so I tilted it and after what sounded like several seconds there was a rumble and a splash in the river below me. Dave gave me a heave and I was safely over the ledge; from then on I had a "thing" about hand holds and I am now quite paranoid about them because on at least two more occasions, flakes of rock came away in my hands that had been used by our predecessors as safe grips.

That incident must have been dramatic because the girls were looking away; I can only think that they didn't want to know the worst.

After travelling for a while we reached a sheer drop but it had a fixed rope over it which was knotted at intervals to allow a better grip. I was about to go over the edge when Dave suggested a life-line might be a good idea, especially after what had happened to Peter. I gather he began to abseil the drop and Dave noticed that the rope was slipping through his hands rather rapidly and just managed to grab him. In spite of my previous shaking up I did succeed in doing a good abseil but I must say by this time I was praying that the rope would not break.

The time had now come to watch a display of sheer guts by our Bart's Physios. They had been badly shaken by the traverse and by my near demise, also by the rock fall and yet without hesitation began their descent of this sheer face with feet firmly against the rock and leaning well out.

By this time our journey had used up our nife cells and they were dimming and almost useless. We were short of carbide and after having left the stream passage were short of water for the lamps. It was my duty to fill the surviving lamp because I happened to be the only member with a full bladder. (Useful at times.) Dave muttered something about every time we have a trip with Dr. Glanvill someone has to urinate into the carbide lamps!

We also lit half of the two and a half candles I had brought with me from the carbide lamp, just in case that suddenly failed. We were now nearing moonlight passage and were overdue. We held council and decided as we were all fit we would make our way slowly to the exit of the cave so that those who came looking for us would not have far to go.

Then the cave decided to treat us to a bit more drama and vent its malevolence on us. Dave was looking for the way out, when suddenly a pile of boulders underneath him gave way and the whole lot plunged into the abyss below leaving Dave surprised but unscathed.

We heard a voice and we answered. Lights appeared and Peter and Mark had kindly come to see where we were and brought welcome lights. We had got to within 100 yards of the exit, none the worse for our experience, thanks to the leadership of David Wainstead who came in for some unkind criticism from one of the Cave Rescue personnel who happened to be there when we came out.

In retrospect, an incident had not developed but could have done; having reported that we were overdue was the sensible thing to do. I personally feel that a "dressing down" in these circumstances achieves nothing and discourages people from seeking help until it is too late. It is far better that a P.M. is held afterwards with the leader and members of the party to see if any lessons can be learned. If there were no risks at all involved in our outdoor activities, would it be worthwhile engaging in them?

There is a sequel to this narrative; whilst returning home to Chard via Frome with three of my friends in the early hours of the morning, one of whom was a Police Constable, we decided it was time I phoned my wife to let her know all was well. I was walking towards a phone booth with one friend whilst the P.C. looked for a place to relieve himself in this built up area, when I had a sudden attack of cramp and behaved like a shot rabbit rolling around on the pavement in agony. I yelled out to my companion, "massage my legs" and was muttering a few obscenities. After I had recovered I laughed uncontrollably and wondered if the occupants of a local Panda car would accept our explanation of apparently unseemly behaviour on a pavement in Wales at one in the morning on the Sabbath.

MICHAEL GLANVILL.

Nurses rowing at Marlow. "An occasional spot of bother with the steering."

As reported in the June issue of the *Journal*, about 30 intrepid nurses of Set One were intending to row back and forth over a three-mile stretch of the Thames, over 12 hours, in aid of the Royal National Institute of the Deaf. Much to everyone's surprise, and not a little to their own, they managed exactly 12 hours, and clocked up 36 miles, 58 blisters, and 17 sacral pressure sores! If all sponsors are forthcoming, this very worthwhile project will have raised £800. . . . Caveat lector! Set One are after you!

GUINNESS STROLL—1974

When I returned to my flat after walking the course of this year's stroll, one of my flatmates asked me where I'd been. I told her that I'd just walked 32 miles, and her only comment was "What for?"

Feeling somewhat deflated at the decided lack of awe in her voice, I lamely replied "For a free meal and a tie".

"You walked 32 miles for a free meal and a tie?" Disbelief.

I suppose that it does seem rather silly for anyone to do this, and I think that it must have been a combination of other factors that drove 1,436 people to complete that stroll within the requisite time of 12 hours.

These factors may be classified as possible:

(a) An urge for fulfilment of a set task
(b) A masochistic desire for blisters on the soles of one's feet
(c) Not a lot else to do on a Saturday.

The day dawned on Saturday, May 11th, in a rather dismal way, and neither did the weather improve much on the way down to Compton, a little village just south-west of Guildford, where the stroll starts by tradition. One of the two Bart's coaches arrived 20 minutes late, a factor which did nothing to help Willie Fulford and other ultra-fit athletes in their bid for the fastest time over the course. (These timings commence at 8.30 a.m., whether everybody is present or not.) As we began to walk, it began to rain in dribs and drabs, and after about an hour, just as the bulk of the walkers were crossing Chantreys, a woody hill south of Guildford, the rain really began to chuck down. This lasted for only a short time, and the weather then improved, so that everybody spent the rest of the day drying off. The course led southwards over Leith Hill, and then north-east as far as the Guildford-Godstone road, where it turned west again to come back to Newlands Corner.

The scenery en route was very beautiful, but it seems that some of the strollers were a little too concerned with their feet to notice things like that!

The first stroller at Newlands was a Tommy's man, but Bart's held 2nd, 3rd, and 4th places, thanks to Willy Fulford (congratulations on *overtaking* another 1250), Bob Miller and Steve Mann. The Ladies' prize went to Bart's liberationist Su Boddy.

We all look forward to the less strenuous meal, later this year!

R.T.J.

VERDI REQUIEM

"Verdi Requiem in the Great Hall? . . . You must be joking." Such were the comments of many keen concert-goers. Verdi's Requiem normally requires a full size choir of about two hundred voices, and a full orchestra including eight trumpets, four horns, trombones, and a full percussion section.

Mr. Lumley did have full brass percussion and woodwind sections, but his string and choral sections were not of a comparable size. In fact in some of the fortissimo passages the orchestra overpowered the choir, who numbered in the region of sixty, and this imbalance was not helped by the acoustic properties of the Great Hall. However, in the quieter passages, the chorus excelled themselves in true Lumlian fashion, for their intonation and precision had the mark of the well trained choir.

Of the four soloists I was particularly impressed by the mezzo soprano Miss Mary Hamilton. Her Recordare sung in duet with the soprano was both intense and poignant. The other soloists all sang well and the soprano Miss Sydenham coped with an extremely difficult part but was a little strained on the high notes.

The orchestra had a small Bart's contingent, the majority being semi-professionals who very kindly donated their services. The first oboe and first bassoon played particularly nice solos and the brass section, who I am informed play together regularly, excelled themselves during the Deis Irae leading up to the Tuber Mirum. The volume of sound during the Deis Irae I find difficult to describe, and I think that only in very few concert halls could a choir and orchestra of a comparable size achieve a similar feat. However, although one gained an incredibly intense and extremely pleasant sound, one was virtually unable to recognise any of the words. Only those attending the concert can say whether this loss was important.

Mr. Lumley had a massive feat of organisation and is to be given great credit for the way in which he co-ordinated all the forces involved. I feel that these performances are becoming increasingly more professional and am only sorry that so few people can listen to these concerts in the Great Hall. This is due to the fact that after all the performers are in the hall only two hundred seats are available for the audience. A concert of this standard warrants an audience of at least twice this number and I hesitatingly venture to suggest that Mr. Lumley should move to larger premises so that more people will be able to enjoy The Messiah to be performed at Christmas.

CYFARTHFA.

THE MEDICAL MUSE
QUEEN ELIZABETH HALL, JUNE 8th, 1974

Anyone with any culture who frequents the Festival Hall will have seen the posters for "The Medical Muse", bought tickets and gone. Those who did not buy tickets missed a rare evening. The programme was made up of songs and recitations on all matters Medical from Chaucer to the present Century, though mainly from the 18th and 19th century. There were songs about doctors, about nurses, about procreation and about death. To those who might be frightened into thinking that the Festival Hall, nay the Queen Elizabeth Hall, would be too highbrow, I hasten to add that the words 'piss' and 'shit' were heard frequently and audibly. This was no mean feat, since the acoustics in the Hall were about equivalent to the acoustics in a well-lined coffin.

The audience, mainly medical, responded to the songs and sketches with aplomb and applause that are the hallmark of intelligent Medical Men. There were no boorish rugger songs, only sublime pieces of wit; especially a harrowing piece by Boswell on his love for Louisa and his subsequent attack of Pox. However, for me the highlight was a real, live Doctor, Dr. George Dazeley, playing the bassoon and singing, almost at the same time.

In short, this entertainment was a most superior kind of Ward Show, and should it come again I would urge everyone to see it. Perhaps some new ideas for the Christmas Ward Shows would be forthcoming.

PUZZLE PAGE

CROSSWORD: RONTY 4

ACROSS

4. Stripe a force about copies. (8)
8. A natural logarithm in one hundred and thirty-five degrees? Salty. (8)
9. Ship for couples, (5,3)
10. The most evil nest around about first class street. (8)
11. Marshy land and the German bumper. (6)
12. Two rods in charge of the uncivilised. (8)
13. Priest is inside to riddle and might do this just before exams. (8)
16. Gathers a hundred and yearns to be inside a queen. (8)
19. String of words for net scene. (8)
21. Wild tense love of single group. (3,3)
23. Award includes street account of student. You may trip over it. (8)
24. Klemperer's hearing-aid? Wild! So rotate. (5,3)
25. Boy! The German helps you up and down. (6)
26. Camper in old police force runs about wildly. (8)

DOWN

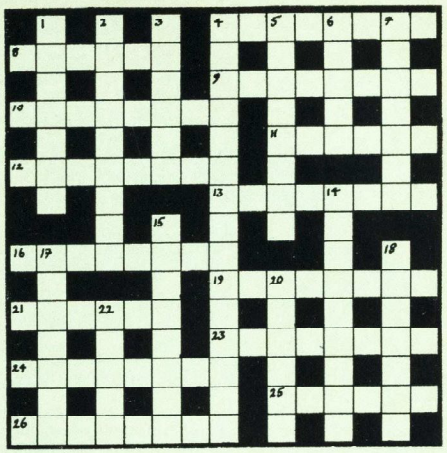
1. A fast a soldier and mother dance about in. (7)
2. Stick lists? No, you play ball on them. (3,6)
3. Veer about north-east for the superficial coat. (6)
4. You are doing one of them now. (5,10)
5. Quiet shape has latitude inside for elevated floor. (8)
6. Inns I went to when living together unmarried. (2,3)
7. You nest about crazy soup dish. (7)
14. Dray's vein won't get the product of these plantations. (9)
15. "Back to sea" the tender art appreciator said. (8)
17. On the moon with endless credit? Mad. (7)
18. Hairy skin and the Spanish knife. (7)
20. Home the French snuggle in? (6)
22. It rages up in form roster. (5)

Solution next month.

SOLUTION TO RONTY 3.

Across. 4. Semolina; 8. Beagle, 9. Lopsided; 10. Takes off; 11. Saddle; 12. Stampede; 13. Selfless; 16. Costumer; 19. Ukuleles; 21. Strict; 23. Traction; 24. Missouri; 25. Lilacs; 26. Tennyson.

Down. 1. Tenants; 2. Agreement; 3. Demote; 4. Self-destruction; 5. Mopishly; 6. Laird; 7. Needles; 14. Life style; 15. Amateurs; 17. Out live; 18. Met once; 20. Unable; 22. Ibsen.



JOURNAL MATHEMATICAL PROBLEM No. 8

By R. Treharne Jones.

Five patients, whose names are *Abernethy, Bowlby, Colston, Dalziel* and *Elizabeth*, occupy 5 adjacent beds, numbered consecutively, in a mixed (!) ward. Each patient makes 3 statements about the numbers of these 5 beds, but in so doing each alternately tells lies and truths. It is not known whether a patient is telling 2 truths and 1 lie, or *vice versa*, but of the total of 15 statements made, the truths outnumbered the lies.

The statements were as follows:

Abernethy:
1. My bed is directly between those occupied by Colston and Dalziel;
2. Dalziel occupies the highest number bed.
3. My bed is a prime number.

Bowlby:
1. Abernethy told more lies than truths;
2. My bed has the lowest number;
3. Colston's number is a multiple of 5.

Colston:
1. My number is 14;
2. Abernethy told the truth as many times as did Bowlby;
3. Bowlby is 3 beds away from me;

Dalziel:
1. My bed is directly between Abernethy and Bowlby;
2. Colston has the lowest number bed;
3. Elizabeth has the highest number bed.

Elizabeth:
1. There are more even numbers than odd numbers in the row;
2. Abernethy's bed is a prime number;
3. Abernethy's bed is in the middle of the row.

What number beds are occupied by each patient?

Solution next month.

SOLUTION TO LAST MONTH'S PROBLEM:

Brash, Ernest and Frank were ill, so their places were taken by Arrogant and Dogsbody.

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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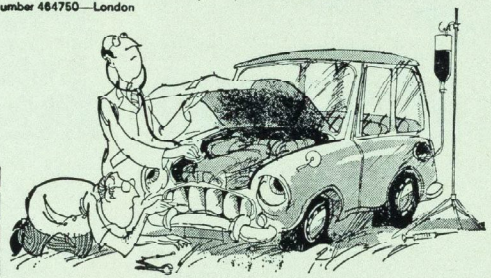

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ON REFLECTION . . . 1) CONCERN

Claustrophobia is the real problem confronting clinical teaching at Bart's these days, and it occurs in two ways; there are too many students, and there is too little roughage in the learning diet. Let us illustrate.

The present firms, of anything from 14 to 18 people, are proving to be an unmitigated mess. Students hardly get to know their teachers, and the teachers never get to know their pupils. One cancelled ward-round and a two-week holiday virtually halves contact with the consultant. Also there is little sense of being part of a group; you meet for a round and part as quickly. With so many others, no one notices non-attendance, and anyway, were everyone to turn up who should turn up, there would be semi-chaos as a mob of earnest (or bored, or sulky) white-coated young things trails in the wake of the chief and his assistants. As a result the most popular events of the year are casualty, where you see things "fresh", and going away for two weeks to another distant hospital. This can be excellent value. Not only are you the only student, so you get plenty of practice in day to day procedures, but you are the consultant's only pupil, so the teaching is personal and of high quality. This should be extended en masse. At any one time there ought to be no more than seven students per firm, with the other half of the year away in peripheral hospitals where they are needed and where they can gain much more basic experience. It is said we are going to use the peripheral hospitals much more, but to what extent has not been made clear. Certainly it must not be a mere gesture to suit current fashion, but a definite and radical alteration in the status quo.

Furthermore there should be introduced a system involving students in other aspects of hospital life. A month of nursing could at once minimise the "credibility gap" between working nurses and apparently "idle" medical students. It would also open the eyes of future doctors to what their instructions may entail in terms of nursing a patient. In fact were one to follow up this argument logically, it might be a most rewarding idea for every doctor, whatever his status, wherever his practice, to have to do a month's nursing every five years or so; this would both provide a break from clinical responsibility and a refreshing chance to return to the simple level of actually looking after patients.