SAINT BARTHOLOMEW'S HOSPITAL JOURNAL

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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.

Other practical tasks that come to mind include time spent in the labs and special departments; this would be a good way of seeing the reality behind the mass of little green or white cards that students are taught so blithely to fill in. A guided tour is no use; what is needed is a week or so doing some routine practical job, seeing the conditions under which paramedical staff do their work. A day or two out in an ambulance might be another aspect of this essentially practical approach.

Because, all in all, it is not the mode of teaching in itself that is the cause of so much disillusion. Ward rounds, tutorials, and lectures are useful and necessary, but when overcrowded, or performed in a sort of theoretical vacuum, they lose much of their appeal, and thus much of their value. In fact on a full day they can be actively useless. A 9 o'clock tutorial, followed by a 10.30 ward round and a midday lecture is quite a strain on the input circuits; an hour in the library and a pathology practical at 3.30 going on until 5 p.m. or later and most brains are badly overloaded. A leavening of simple routine amongst all this solid data intake would help to prevent the mental constipation that usually leads on to apathy. Let's face it, battery chickens are not renowned for their taste, or their zest for flying.

. . . 2) APATHY 'midst the August haze. A Day in the Life

It's hot outside; more traffic building up. . . . Get up, turn on the radio and slump back into bed again. . . . Get up again, and lumber around in a vaguely purposeful way, eating, washing, brushing, dressing, yawning all the while. Downstairs and into the bright sunlight . . . enter the hallowed hospital portals about 10 o'clock, slide gently into the opening bars of the ward round, fixing the tie and adjusting the fresh-starched white coat. Yawn again. Stumble around the ward amid your fellow zombies, clutching onto every bedpost you can get near, feet aching, eyes staring. Answer a few questions, but not too many in case people suspect you of "reading up" or alertness. . . . Wilt under the heavy heat of the ward, shirt clinging to your back, mind befogged. Yawn again. Emerge at last and stagger for coffee, idly mumbling of simple things. Hang around, glad there's no midday lecture. . . . Drift into an early lunch, and linger over more coffee. . . . Wander up to the wards, take a few notes, chat with the nurse with the good legs, check your patients are still there, perhaps clerk a new one, perhaps examine him or her cursorily. Tea-time. . . . Linger over the tea . . . and have a second cup. Yawn again. Amble off to billiards and/or home and/or the pub. Somehow you always end up at the pub. Another long, hot day. . . . Evening headache and alcohol to cure it. Yawn again and slump out. Lights off. Sleep, the non-active version.

ANNOUNCEMENTS

Deaths

ALDRIDGE—On July 21st, 1974, John Steel Aldridge, M.R.C.S.Eng., L.R.C.P.Lond. Qualified 1925.

DALE—On July 10th, 1974, Charles Hughes Dale, M.R.C.S.Eng., L.R.C.P.Lond. Late Cas. Ho. Phys. Qualified 1928.

WOODMAN—On May 7th, 1974, Edward Musgrave Woodman, M.B., M.S.(Lond.), F.R.C.S.Eng.

Engagements

WELLS—GLASSON—The engagement is announced between Dr. Richard Wells and Miss Lavinia Glasson.

FINNEGAN—STEMBRIDGE—The engagement is announced between Mr. Timothy Finnegan and Miss Sue Stembridge.

ELECTIVES IN CARDIOLOGY:

Students interested in undertaking an Elective in Cardiology at the North Staffordshire Hospital Centre, Stoke-on-Trent, should contact Dr. Malcolm Clarke, Consultant Cardiologist, City General Hospital, Newcastle Road, Stoke-on-Trent, Staffs.

IMPORTANT NOTICE

College Hall Trunk Room

On the weekend of November 23rd/24th the Trunk Room of College Hall will be cleared of everything except *TRUNKS* possessing the owner's name, and the date of deposition.

An auction will be held on Sunday, November 24th, of the junk removed.

Any volunteers to help with the above work should contact Peter Meade at College Hall.

OBITUARY

Ivan de Burgh Daly, C.B.E., M.A., M.D., F.R.C.P., F.R.S.

Dr. Daly died suddenly while working at his desk at home in Long Crendon, Buckinghamshire, on February 8th, 1974, at the age of 80 years.

He was born at Leamington and was educated at Rossal School, Gonville and Caius College and St. Bartholomew's Hospital.

At Cambridge, he took the Natural Science Tripos in 1914, but his clinical training at St. Bartholomew's was interrupted by a period of service in the Royal Army Medical Corps as a private and then as a fighter pilot and bomber instructor in the Royal Naval Air Service. After qualifying M.B. Cambridge in 1918, he was given a commission as a Temporary Captain in the R.A.F. Medical Service with three months' leave to take up an appointment as house-physician to Dr. John Drysdale and to Dr. Thomas (later Lord) Horder Drysdale, with his vast experience as a clinician with a scientific outlook combined with his analytical and highly critical approach to clinical problems, played a large part in influencing Daly to consider a scientific career. After a short period during which he demonstrated in the Physiology Department at Bart's, under Professor Bainbridge, he went to work under Professor E. H. Starling at University College, London, where he was to start his life-long studies of the physiology of the cardiovascular system and particularly of the pulmonary circulation. Later, he was Professor of Physiology at the University of Birmingham (1927-33) and then at the University of Edinburgh (1933-48) before becoming in 1948 the first Director of the Institute of Animal Physiology at Babraham, Cambridge.

During the Second World War he was Director of the M.R.C. Physiological Laboratory at the Armoured Fighting Vehicle Training School at Lulworth, Dorset, and at the same time was directing research work for the Ministry of Supply and Air Ministry in his department at Edinburgh.

He was a Louis Abrahams Lecturer and Baly medallist of the Royal College of Physicians, and President of the Thoracic Society (1954-55). He was elected F.R.S. in 1943.

Although he officially retired in 1957, he was awarded a Wellcome Trust Research Fellowship (1958-62) and he continued his research work in the Department of Physiology at Oxford until 1970.

His early research work was directed towards developing the use of thermionic valves for the amplification of physiological action currents, and for amplifying heart sounds. He was responsible for making the first broadcast of heart sounds from a normal subject and from a patient with mitral stenosis on a BBC programme from 5WA (Cardiff) Station on February 19th, 1925. But his main line of work was concerned with the functional innervation of the pulmonary and bronchial circulations, which is epitomised in a monograph he published in 1966 with Dr. Catherine Hebb. His aim was to demonstrate unequivocally that the pulmonary blood vessels themselves were under control of the autonomic nervous system. This meant devising complicated perfusion systems whereby all the effects known to affect the pulmonary circulation passively could be eliminated so that the active nervous component could be demonstrated. This he succeeded in doing, and more recently he demonstrated the site of action of the nerves on the pulmonary vascular bed, the reflex control of the vessels, and in work carried out in the Department of Physiology at Bart's, the nervous control of pulmonary vascular impedance.

Dr. Daly had the capacity of making friends of all ages and in all walks of life, for he was genuinely interested in people. He had a quiet sense of humour which was made apparent by his apt remarks made between puffs on his ever present pipe and endeared him to those of a younger generation who were lucky enough to make his acquaintance.

Although his services and devotion to physiology in many spheres are on record, his personal kindness to those who served with him and under him, as well as to those who enjoyed his friendship in his private life, will remain largely untold.

I. de B. D. was not just a physiologist but also an expert engineer. He made a lot of his own equipment on his lathe and in more restful moments enjoyed fishing and gardening.

He leaves a widow and an only surviving son who is Professor of Physiology at Bart's. His younger son was killed in an aeroplane crash in 1959 while serving in the Royal Air Force.

JENNIFER E. ANGELL-JAMES.

LETTERS

James Gibbs House,
St. Bartholomew's Hospital,
London EC1A 7BE.
August, 1974.

BART'S RESEARCH TRUST

Dear Sir,

Many people will know that during the year of our 850th Anniversary celebrations we had hoped to establish an appeal for Research. It was considered an appropriate time, particularly, when it had been announced that under the reorganisation of the Health Service, the Boards of Governors of Teaching Hospitals would be dissolved and the control of the Endowment funds would pass into the hands of special Trustees appointed by the D.H.S.S. Some of us feared that with inflation, the Trustees would be unable, however willing, to set aside the large sum previously donated to the Joint Research Board from our Endowment Funds. It was decided in the latter half of 1973 to abandon the major appeal, as the political and economical climate appeared unfavourable. It was, nevertheless, agreed that a Trust should be formed for the

purposes of Research by Bart's men and women and that the Trust should be outside the control of any Government Department. This was passed by the Charity Commissioners and legally and effectively established in March 1974. The Trustees were set up in the names of Sir Max Aitken, Mr. D. Curling, Professor G. Hamilton Fairley and Mr. James Robinson.

Money has already been donated to the Trust and I would ask anyone who is able to donate anything to send a cheque to me made out to the Bart's Research Trust. I would add that when the time seems appropriate the Trustees will launch a major appeal so that we may strengthen and enlarge our major Research projects.

JAMES O. ROBINSON.

24, Blythe Mount Park,
Blythe Bridge,
Stoke-on-Trent,
Staffs.
July 25th, 1974.

Dear Sirs,

I read with interest your editorial comments, "No way to treat a lady", in July's *Journal*. Although what you say is perhaps true, I wonder if you have considered the reasons behind the "restrictions" you have enumerated.

Very few hospitals allow nurses to wear uniform outside the hospital. Uniform is basically a protective garment, and as a nurse's uniform is worn when treating the sick, it should be kept as clean as possible. Hardly feasible, surely, if one travels on train, bus, and tube to and from work in it as well. One certainly cannot travel anonymously in uniform, when one's actions are open to criticism—and the general public are great critics. It is also for our safety. Imagine a very junior nurse involved in a major accident perhaps, hopelessly ill-equipped with knowledge to help her, yet expected to know what to do because she is instantly labelled by her uniform.

I do not think it is at all unreasonable not to allow the wearing of part uniform. Surely, if one takes pride in one's unform (and I like to think most of us do), one wears it correctly. Have you ever seen a grenadier guardsman without his bearskin? What is the matter with a uniform cloak? I used to find mine a lot warmer than some of the thin fashion garments that are all one can afford these days.

The problem of visitors in nurses' homes rears its ugly head yet again. I do realise it isn't exactly everyone's idea of home from home, but I think you have to accept that any establishment has to have some regulations to prevent chaos. After all, not everyone wants to be viewed trailing out of the bath at midnight in nightie and rollers by one's next door neighbour's current boyfriend! It wasn't all that long ago that I was a student, and we had to be in at 10 p.m. sharp, or we were on the carpet the next day. Men weren't allowed beyond the confines of the main hospital hall either. There has been some progress!

It is a general rule that nurses do not eat on the ward, and I would presume that includes night as well as day. I would have thought a break from the ward would be welcome. If you can only think of nothing as an alternative to microwave plastipak for sustinence, I feel sorry for you. Bring-your-own is infinitely more preferable to most hospital food I find.

Where *do* you get your information about overtime forms? I hate to say it, but for a start the four hospitals I have worked in used them. How else do you expect the salaries office to know what overtime you work—E.S.P.?

I don't think I can remember any instances when I had to ask a nurse to go on night duty with just a few hours notice, but I was only one Sister of many. I appreciate that sometimes due to illness one had to give a couple of days' notice, but as you say, that unfortunately couldn't be helped. A stand-by cover would be marvellous. By whom? Nurses are hard pressed enough. How about medical students? I'm sure they would have plenty of time in between beer drinking, rugby playing and non-attendance at ward rounds.

I survived the "petty restrictions" as you put it, for eight years as a nurse, and I don't consider myself to be an exception. People who didn't like it left, but there are still plenty around to tell the tale. If I had wanted to be a trendy secretary I could have been without any difficulty. Yer pays yer money, and yer takes yer choice. I took it, and I don't think I have suffered because of a few rules. Nursing today is hardly Victorian. We've come a long way since Florence made her rules, but we still need them to keep our professional standards as high as we can. Otherwise, we shall slip slowly into the ranks of the gum chewing trendies.

Yours sincerely,
JANE CLARKE.

7 The Green,
Horspath,
Oxford.
July 30th, 1974.

Dear Sir,

The July issue of your *Journal* has given me great pleasure because at last I have seen it. In Recent Papers by Bart's Alumni, Chir.M. is given as a co-author with C. N. Hudson. This can be added to another reference I once saw: a co-author of a paper was given as Winston-Salem N.C., when this is somewhere in North Carolina.

Yours faithfully,
MILO KEYNES.

NOTICE

The Editor apologises for the delays in publication of the *Journal*. We trust that things will improve in the future.

WHO CARES FOR THE DYING?

by

RICHARD LAMERTON

In St. Luke's Home, the Sheffield hospice, they hold a post-mortem meeting on every patient who dies there. But it is not a messy pathologist's PM in quest of the supposed cause of death. Instead the whole multidisciplinary team who helped to look after him meet to ask whether the patient had a good death, and if not, whose fault was that?

We have all heard lip-service paid to ideas of co-operation between the many professions involved in health care—"The Greater Medical Profession" as Sir Theodore Fox called it.[1] When the patient goes home cured, his thankfulness overlooks gaps in the service, but when he is dying the result will be a shambles if the team is not pulling together. The situation puts a stress on the system. If it is a traditional system, with a godly and unapproachable consultant whose potential team are divided by professional jealousies and jargon, who never meet together and communicate infrequently, then this stress will reveal the deficiencies. Someone will suffer.

Mr. F. was dying at home as an out-patient of St. Joseph's. He was an old war horse who had been a very fine leather craftsmen in his youth. Both he and his wife were rather deaf, so they barked at one another. He delivered stentorian orders to her and to anyone else in the house, with an iron will that never faltered. One day I took him home from the clinic because the ambulances had let us down. We had to heave him out of the car and help him across a square, surrounded by council rent-slabs, to reach the tower block in which he lived. His pyjama trousers began to slip.

"Tie me pants up!" he ordered.

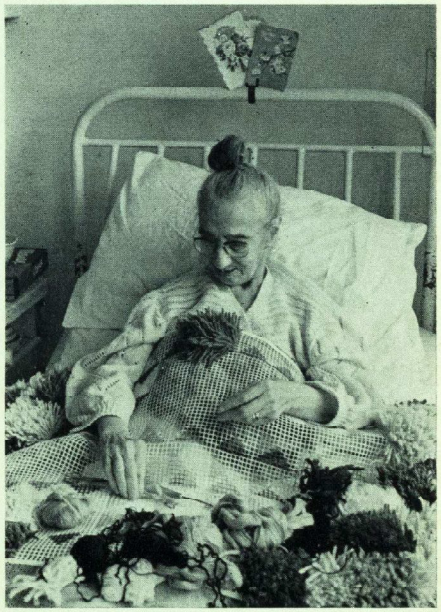
"What?" his wife asked.

"Me pants! Me pants! Get them fastened."

"Oh damn you" and she knelt before him to retie the cord, but it was not to his liking. We proceeded a few more paces and they fell down completely. Fascinated faces appeared in windows all round the square as he stood, bottom half naked, shaking with rage and bellowing abuse at the poor woman until she hitched his trousers up again.

He wanted desperately to stay in control of the situation around him, and to stay proudly independent. In spite of a troublesome colostomy he had firmly left the hospital which had been treating his rectal carcinoma, and refused to return to their out-patients. "I wouldn't be in this mess but for them," he said. After all, it was inconceivable that *he* could be going to pieces, such disasters could only be imposed from outside.

When we first met him he certainly was in a mess. Incontinent of urine, with a leaky colostomy and bedsores, he was a pathetic figure. His wife, obedient but resentful and dyspnoeic, also worried us. The out-



This lady was receiving 20 mg. Diamorphine every 4 hours. Good pain control by the doctor meant that the occupational therapist could held her.

Richard Lamerton is Outpatients' Medical Officer at St. Joseph's Hospice.

patients sister visited them and reorganised the colostomy bags with a better adhesive. She catheterised him and taught his wife how to manage the bedsores.

Socially acceptable again, he found a new lease on life, and demanded rehabilitation. This proved too much for his district nurse, and in a case conference his GP grieved that domiciliary physiotherapy is not yet available on the NHS[2]. Eventually this need was filled by enthusiastic youngsters from the local parish who were sent by the vicar to help Mr. F. to walk.

The social worker made the acquaintance of Mrs. F. in the clinic, with a view to helping her in bereavement. In spite of their explosive relationship it transpired that these two were deeply devoted in their own odd way. When she was told he had only a few weeks of life left she became very quiet and soft. I never saw her yell at him again: his every imperious whim was carried out at once.

As he became weaker, however, the nursing became heavier and heavier for his wife. I watched her jugular pulse and ankle oedema with increasing concern. But when I put it to him that his wife's heart was failing he just reassured me that there was no such problem; "She's coping marvellous," he announced. Then one morning I found her gasping for breath and decided that he really must come into the Hospice to give her a rest. Mr. F. was adamant, however. He was going to die at home.

"Before or after your wife?" I ranted. That was Saturday. On Sunday the vicar went in and spoke of the duty to give in and trust. On Monday the last straw was added by Sister who turned on the blarney as only an Irish nun can. Making a number of conditions and provisos he agreed to come in, and in fact died contentedly in the Hospice a few days later. His wife's health was saved in the nick of time, and she has kept up her friendship with us by becoming a voluntary worker, making tea for the out-patient clinic. Bereavement follow up has thus been easy.

Only with the closest teamwork was this outcome possible.

The Members of the Team

If physiotherapy helps the patient to die comfortably, it is valuable. He may be uncomfortable simply as a result of immobility. Stiffness and bedsores can often be avoided by good gentle physiotherapy encouraging the patient to move about as much as he is able. And if he is too weak to move very much, the old art of massage, not always used by modern physiotherapy to its full advantage, can bring enormous relief. If there is good communication between the doctors and physiotherapists they can discuss when to keep a patient's chest clear, and when to leave him in peace in the company of Osler's Old Man's Friend.* And they can discuss a patient's likely prognosis, which will influence decisions as to how much rehabilitation a patient should be subjected to. The important point is to discuss these questions at all, rather than to commence automatically treatment which is based on a tacit refusal to accept that the patient is dying.

Part of making a good end is to be sure that one's affairs are in order, that surviving relatives will not be impoverished, and that old feuds are resolved. Counselling the patients on all these levels will be the duty of the social worker.[3] She will find that the relatives' needs will occupy her even more than the patient's. In the social worker's communication with the doctors and nurses she will have to keep them alert to the needs of the family. It is easy for them to narrow down their view so that they see the patient only, isolated from his family and his past. The social worker brings this information to the team, inevitably thereby influencing the patient's treatment. She is also going to build up a bereavement register, because some widows will need close follow-up for support.

The doctor's principal contribution is in symptomatic relief.[4] It involves very careful questioning and listening to find exactly what is causing a patient distress, and then a dogged persistence in treatment. Each symptom as it arises must be assessed, and every possible trick and device used until it yields. The doctor gradually fills an arsenal with these ideas, so that there is always a second and a third line of defence to fall back on if a favourite treatment fails. Daily reassessment is needed.

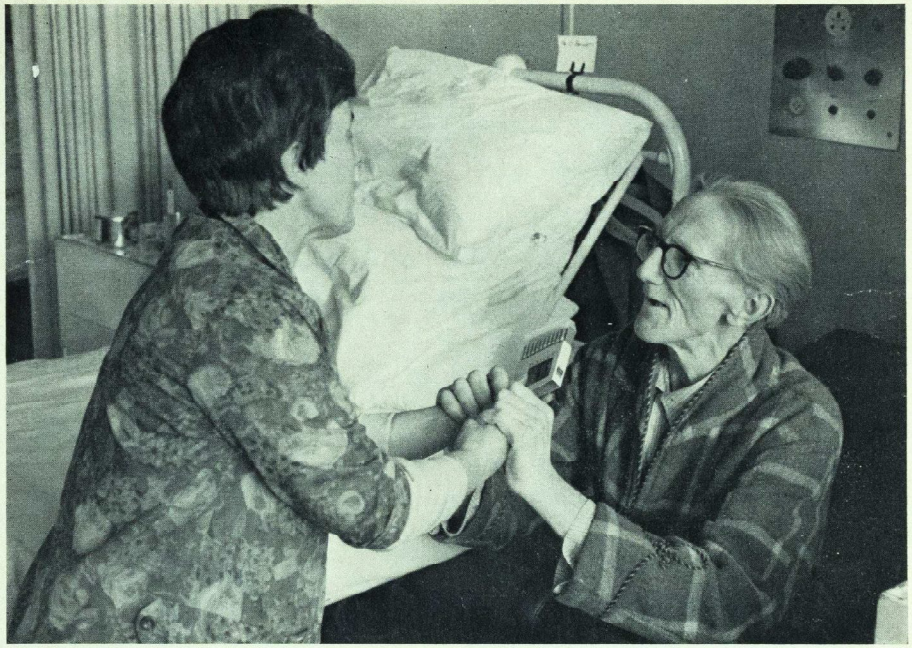
The same determined persistence is required from the nurse.[5] She is the person who is there all the time. Clearly, therefore, she is the one who could most effectively maintain control over the patient's symptoms as they arise. A new pain at 5 a.m. cannot wait for the doctor's 2 p.m. ward round. The nurse must therefore work closely with the doctor, and learn how to use a wide range of drugs which he can prescribe "PRN". In the case of analgesia she must be given leeway to alter doses as she finds necessary. But the main thing is just that she is there with the patient. Whether or not a man dies in peace depends on the ward sister. There is indeed an enormous amount that we can *do* for the dying, but our being counts for even more. A nurse sitting on the bed of a dying man, and just listening or holding his hand, or sitting quietly beside him during his last hour or two *is working*, as surely as the one who empties his bottle. If you are not convinced that this is work, try it! The mind must be constantly brought back from dreams to the needs of the patient who is dying. A thousand things that you could be doing instead present themselves to the mind, but the discipline of staying there is one of the most important things for any nurse to learn.

In St. Joseph's there is a regular doctor's ward round. But that is not all. The chaplains also do one. The priest must be familiar enough in the ward for his advent not to be ominous.[6] "Have you any problems, Sister?" is utterly inadequate. He should make himself known to every patient, and then listen a little. On his third or fourth visit the patient may begin to open up. Fears may be ventilated. Preparation for death will often involve some religious thinking, even for people who have taken no interest in the Church. In unfamiliar territory you need a guide.

The One Team

Needless to say, none of these roles is in a watertight compartment. Almost anyone in the team may find he has to overlap with the work of almost any other member. The chaplain may be asked about prognosis, the nurse may find the patient needs passive movements or massage. All of them may need to turn their caring attention to members of the patient's family.

* Hypostatic bronchopneumonia



The ward orderly may be an essential member of the Team.

On the other hand the family may become part of the caring team, participating fully in decisions or treatment.[7] If this is not permitted to them, their bereavement may be made sharper by feelings of guilt, a feeling of having abandoned their loved one to others just when he most wanted them near him.

Perhaps the best example of continuing communication between members of these various professions is to be found in St. Christopher's Hospice. In every patient's notes they have a conspicuous sheet of pink paper to which all of the team have access, chaplains included. On this any of them may record any comment made by the patient which indicates a change in his insight into his condition or prognosis, or anything they have said themselves which may affect his insight. Thus, before going to see a patient, any of the professional people can quickly glance at the "pink sheet", see what conversations have gone before with other members of the team, and thus avoid a distressing blunder.

In order to stress to students this team approach to dying patients, St. Joseph's Hospice is holding a series of interdisciplinary conferences for students on Care of the Dying. The next one is from 9.30 a.m. to 12.30 p.m. on Saturday, October 5th. The speaker will be Dr. F. R. Gusterson, founder of St. Barnabas, the hospice in Worthing. Student nurses, social workers and physiotherapists, theological and medical students, and any others studying paramedical disciplines are invited.

References

1. Fox, T. F. "The Greater Medical Profession". Lancet, 1956, vol. 2, p. 779.
2. Pennefather, M. E., and Tanner, E. R. "Physiotherapy in General Practice". Practitioner, 1968, vol. 200, p. 933.
3. Player, A. "Casework in Terminal Illness". Almoner, 1954, vol. 6, p. 477.
4. Saunders, C. M. "The Symptomatic Treatment of Incurable Malignant Disease". Prescribers Journal, 1964, vol. 4, p. 68.
5. MacMillan, S. "Margaret". Nursing Times, 28.12.72, p. 1644.
6. Yale, R. "Terminal Care of the Cancer Patient—The Hospital Chaplain". St. Mary's Hospital Gazette, 1961, vol. 67, p. 123.
7. Saunders, C. M. "The Care of the Dying Patient and His Family". London Medical Group conference on euthanasia 1972. Subsequently published by the L.M.G.

B.P.M.F. COURSES FOR G.P.s

The following three courses (recognised under Section 63) will be offered during the Autumn session. Bart's men particularly welcome.

23/24 November—Renal Diseases

3/4 December—Gastroenterology

5/6 December—Gynaecology

Details from Assistant Postgraduate Dean, The Medical College of St. Bartholomew's Hospital, West Smithfield, London, E.C.1.

JOURNAL GUIDE TO THE DIFFERENTIAL DIAGNOSIS OF THE RABID DOG

As you all must know rabies is at present sweeping across the continent towards our British shores. Therefore the *Journal* presents a picture of a rabid dog (at great expense) and asks the question, could *YOU* diagnose a rabid dog? We present a multiple choice paper for your perusal.

N.B. See opposite page for Diagram

1 (a) Hydrocephalus
(b) Microcephaly
(c) Bird brain

2 (a) Convergent strabismus
(b) Iridoconjunctivitis canis
(c) Nasty look

3 (a) Raspberry naevus
(b) Cherry naevus
(c) Droop Snoop

4 (a) Sclerosing angioma
(b) Doggocoele
(c) Dog eared

5 (a) Rabid snarl
(b) Advert for Colgate
(c) Congenital non-separation of teeth

6 (a) Syndactily
(b) Duputrens contracture
(c) Splinter haemorrhages

7 (a) Malignant melanoma
(b) Malignant beagleoma
(c) Benign paint mark

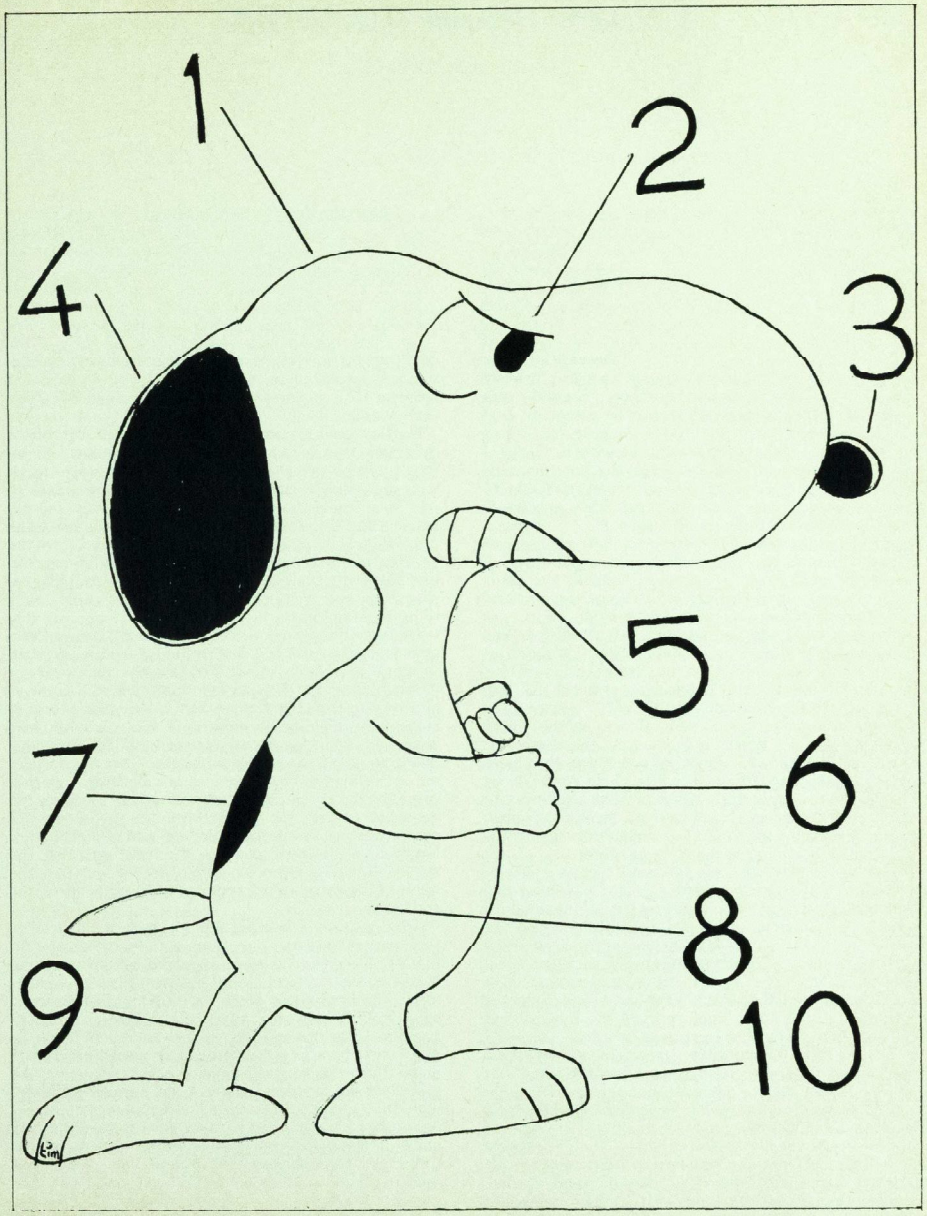
8 (a) Cushingoid habitus
(b) McBeagles point
(c) Beer paunch

9 (a) Rickets
(b) Osteomalacia
(c) Awinalotaemia

10 (a) Acromegaly
(b) Flat feet
(c) Beagelephantiasis

Cartoon, etc., by Tim Bunker.

ANSWERS: If you answered (a), (b) or (c) to any of these questions you had better give up veterinary surgery and try something easier such as medicine since, after all, there is nothing wrong with this dog at all!



LETTER FROM AMERICA

By JEFFREY TOBIAS

Brookline, Mass.

Like most Englishmen, I've always thought that the day of the Great Summer Fuss here was July 4th. After all, Independence Day is the one American date that has filtered through—and I suppose that's fair enough as it did have a little to do with us. What I wasn't prepared for, though, was that in terms of whooping it up, this day is a total non-starter compared with the other great July date that nobody in the U.K. knows a thing about. July 1st.

July 1st is the one day when (even more than usual) nobody dares to be sick, much less to be admitted to hospital. On July 1st I spent three hours in the clinic and saw one patient. On July 1st I witnessed two senior consultants hacking at each other for two hours in a chart meeting over the question of whether clinic notes might be glanced at by the less than holy eyes of the ward medical staff. Oh, July 1st is such fun! It's the day of the Great Changeover, and on this day everybody (often including the Chief) is a New Boy. All the training programs start afresh, all the young doctors have just flown in from L.A., Kentucky, or London, England; and we all yawn our way through a day of hopeless confusion, the blind both in the front and rear. The staggering realisation that continuity of care is not a concept that American medical administrators have any regard for, is something that takes the English doctor very much by surprise.

But bigger news was yet to come. Listen carefully when I tell you that the lower a doctor's position and the less his experience, the greater is his medical power. In America (said my dismayed English informer), the Intern is God. Attending or Consulting Physicians have no right to do anything on the ward except advise. They can't write prescriptions for patients, nor can they insist on a particular course of action. It all has to be done through the Intern. And Interns, like their Housemen counterparts, are variable; they have their off-days, especially when they've been up for three days running (yes, just the same, I'm afraid). If they ask for advice from a senior man, there is little pressure to accept his suggestions. If they don't want to ask, nobody can force them to, even when they're clearly being stubborn, and failing to accept their limits. So you can run into a situation (and this actually happened), where an over-diuresed cardiac patient was compelled to live with a serum potassium of 2.0 g. for a week because of a particularly bloody-minded intern, who didn't believe in replacement therapy. The students on that firm learned all about arrhythmias.

Before you run away heaving a satisfied sigh about the mediocrity of American medicine, let me tell you that you'd be wrong. For the most part, young Americans are prepared to work harder and longer than we do—both before and after qualifying. They put up with enormous clinical loads, poor hospital food, the possibility of being held up at gunpoint to and from the parking lot (this happened, too, last month), and the likelihood of travelling enormous distances to find good jobs. Many of my American friends have come as far to be here as I have.

General Practitioners (they call them Family Practitioners here, which I rather like) are also prepared to work to a pitch which would make many of our G.P.s blush. One 50-year-old practitioner I know is also on the teaching staff at Tuft's University (one of at least three major universities in this extraordinarily academic city), but recently decided that his neurology had gone a bit rusty. His solution to this was to take on a residency—i.e. become a registrar—in that specialty for six months, to brush up. In addition, he managed to run his general practice by seeing his patients from about four o'clock onwards. Whether his motivation was genuine, I can't say; but the approach has a typically American vigour, and the habit of steaming into a problem head on is one I find endearing.

Most doctors in Boston, though, have nothing to do with general practice or even patient care, for that matter. Mostly we've been attracted by the outstanding research facilities here. Twelve floors of laboratories for paediatrics alone, not to mention a brand new building devoted entirely to children's malignancies. Here the aspiring young researcher might be given carte blanche if he's promising enough, and there doesn't seem to be a shortage of cash, technicians, or skilled advice. Professors attack the raising of money with the splendid style that I mentioned just now—only today I bought tickets to the next Boston Red Sox baseball game, all proceeds to come directly to the Children's Cancer Research Foundation. What gets done with all that money? I'll tell you about that another time.

NEWS AND VIEWS 1

NUPE—A TRADE UNION FOR NURSES

What sort of organisation do nurses need to get them the pay and conditions that everyone seems agreed they deserve? People often say how unions demanding exorbitant pay rises are responsible for the present inflation and most of the economic ills of the country. So they're not going to join a union. But the lie to all this is given no more clearly than in the Health Service. All over the country hospitals are under-staffed, and nurses and other workers such as technicians and radiographers are leaving because they are fed up with working long hours for bad pay. The result is the present crisis in the NHS. As can be clearly seen by the use of agency staff, hospitals cannot get enough staff at miserable NHS rates, so they have to get them through costly agencies. So unions in getting large pay increases are saving the NHS from its present crisis, by maintaining proper staff levels. With badly paid nurses, it's the patient that suffers. All hospital workers are badly paid, but nurses are worse paid than most. There are a number of reasons for this. Most nurses are women, and management think they can get away with paying nurses less because of this. Another reason is that nurses are so-called professionals. This is another excuse to keep the pay low. We all know the argument, "the pay may be low dear, but you're doing a worthwhile job, and that should be the main thing!" Only if nurses regard themselves primarily as workers, admittedly workers with some specialised knowledge and skills, and join a workers' organisation—a trades union—will they get the pay and conditions they deserve.

But there's always the RCN, isn't there? That's the organisation that's meant to be the official voice of nurses, isn't it? But we trades union nurses don't think that the RCN does represent us properly. We prefer to belong to a democratic organisation which RCN clearly is not. For example, although over 30% of RCN members are students they have no seats on the RCN Council, because the RCN is a "professional" organisation and only professionally qualified nurses can have full (as opposed to student) membership; yet student nurses are expected to act professionally and, in most hospitals, contrary to regulations, students are often left in charge of wards. Whereas in our trade union NUPE (the National Union of Public Employees) *all* members have a say in deciding the policy of the union through their hospital branch. Biannually NUPE has a conference. Each branch elects delegates and sends them to the conference where they decide the policy of the Union until the next conference. They also elect the Executive of the Union.

This was written collectively by NUPE members.

What does the union have to offer then? To start with, NUPE gives legal aid and full protection to all its members unlike the RCN whose protection does not cover students in practice. Who can think of a case when the RCN fought to prevent a student nurse from being chucked out? NUPE also provides accident benefits to its members. But the most important job of a union is to fight for better pay and conditions. So let us look at the RCN's record on this front. The RCN has about 100,000 members. NUPE has about 30,000 nursing members (although there are 485,000 workers in the union altogether). COHSE, the other union, which has its membership mainly in mental hospitals, also has about 30,000 members. Which means that the RCN has always had more seats on Whitley Council, the body where nurses' representatives and management sit down to negotiate over pay and conditions. Each time the question of nurses' pay has come up the RCN has voted to accept small percentage increases. Now the trouble with percentage increases is that so many percent of a little is still a little, whereas the same percentage increase of a lot is a large increase. So the senior nursing staff have always done better out of the RCN negotiated deals than have the students and junior qualified nurses. What the unions have always been campaigning for, however, is a flat rate increase, i.e. giving £10 a week more to all grades. This benefits students just as much as higher grades.

When it comes to action the RCN just sits back and relies on public sympathy, and we've all seen just how far that's got us. Unions are much more active because they are organised through branches in the hospital. The central headquarters just co-ordinates the activities of the branches. And what the branches do is decided democratically by all those in the branch at branch meetings. So it's never a question of being told what to do by the union. We are the union and we decide what the union does in our hospital—the patient will always be looked after as far as we're concerned. After all, our fight for better pay and conditions is in fact a fight to save the NHS from collapsing under staff shortages, and that's really where patients are suffering now. The RCN on the other hand doesn't involve its members, and that's why there's such a lot of apathy in this hospital amongst nurses. They don't really see what they can do.

When you signed your contract at the start of your training, you were encouraged to join either a professional organisation or a trade union. Make sure you make it a trade union and the Union at Bart's is NUPE.

For details—see Morris Kollander in Casualty.

NEWS AND VIEWS 2

INVOLVEMENT

The life of a medical student at a teaching hospital is an enviable one. Attendance at the various ward rounds, lectures, and so on is not compulsory, one's own conscience being the only guiding criterion. Thus it is very easy to slide into an apathetic life style. One common complaint of medical students is their lack of involvement in the actual care of patients in the hospital. They serve no functional purpose in the "medical team", except as perhaps a friend or confidant for the patient (though this should not be undervalued). This lack of purpose works to promote an increasing lack of interest in attending to patients, and the student begins to feel that he is yet another person disturbing someone who is not really at his or her full strength. The result is that the student merely does what he *should* do rather than what he *wants* to do.

To counter this problem I am going to suggest a compulsory activity, so on those grounds alone there are bound to be objections from all sorts of viewpoints. Anyway, here it is. I propose that a medical student should be required, by statute if necessary, to do a REGULAR SESSION OF NURSING, either a month during one of the pre-clinical holidays, or once a week in term-time for the requisite period. The beneficial effects would be several.

From the patients' angle, any extra assistance available on the wards on a regular basis would clearly be of value. For the nurses it would lighten their cumbersome work load and would provide a means of understanding the students', and subsequently the doctors', point of view. Some of the annoyance towards "lazy" medical students would disappear if nurses felt that their work was appreciated, and the student would see at first hand what may be involved in looking after sick people. For the greatest benefit would be obtained by the student himself. The day to day chores of bed changing, bed baths, care of pressure areas and generally cleaning up would be a real eye-opener to the average consultant, let alone the average student. Furthermore, if the student were on the ward for a full session a week, he would soon get to know the majority of patients on that ward so increasing the amount of clinical material he would see. Also he would get a better idea of the running and organisation of a ward full of sick people. But, primarily, he would be INVOLVED.

Geographia Tremens

Dr. Oswald: How many types of chorea do you know of?
Student: Two, Sir. North and South.

'X' Certificate

TURNER—KLINEFELTER—The engagement is announced between Mr. Trevor Turner and Miss Dawn Klinefelter.

Ed.:—What odds on the kids?

And Now . . . a really bad joke

Question: What is the difference between a keen medical student, and a lazy medical student?

Answer: A keen medical student takes a history and makes an examination. The lazy medical student makes history by taking an examination.

Ed.'s note: Brown paper bags are available in the office.

PLAYING WITH FIRE: from an idea by S.A.S.

BOOK REVIEWS

MEDICAL

DIAGNOSIS

BEDSIDE DIAGNOSIS by Charles Seward. Published by Churchill Livingstone. Price £4.00.

Since it was first published 25 years ago, this book has become established as a classic. It is directed primarily at first year medical students and chooses to classify ill health by symptoms rather than by disease. This approach is intelligent. The student who is confronted by a symptom such as head pain is led to consider logically all its possible causes, and how best to differentiate them. This is a great help for the student (or doctor) who wishes to ask direct questions and yet does not know in which direction he would like to be directed. But I have always found this book a little disappointing. In its thoroughness it is tedious; in emphasising the first principles, it leaves little space for the second ones. But if it is not worth buying, it is worth borrowing.

Dr. W. J. JEFFCOATE,
Medical Registrar.

THE BASIS OF CLINICAL DIAGNOSIS by R. A. Parkins and G. D. Pegrum. Pitman Medical. Paperback edition £4.00. Cased edition £6.00.

This is undoubtedly a book written by clinicians for prospective clinical doctors, and one which has been long overdue. The text is well set out and very easy to read. It is well illustrated, with a very adequate selection of clinical pictures, key X-rays and very clear, neatly annotated line drawings.

The book is unusual in beginning with such fundamental points as the approach to the patient and an introduction to history-taking. Instead of listing the history, rather like a questionnaire for an interrogation, it offers insight into the value of the history in leading to the final diagnosis. It also deals in a very professional way with the routine physical examination.

The book is then organised on a chapter-per-system basis. Each chapter opens with an account of the structure, followed by normal and disturbed function. It continues with a description of symptoms and signs and how these signs may be elicited. It leads on logically to relevant investigations, arranged in order of priority, with a mention of the hazards of some of these investigations.

I found the book enjoyable and very informative, and it deserves to become an essential part of every student's personal library. It is certainly value for money.

Dr. K. G. TAYLOR,
Medical Registrar.

E.N.T. DIAGNOSIS

A COLOUR ATLAS OF E.N.T. DIAGNOSIS, by T. R. Bull. Published by Wolfe Medical Books. Price £4.50.

This latest publication in a series of atlases has over 300 illustrations of excellent quality. The author took most of the original photographs and the results are very convincing. Included are pictures showing variations in the normal appearances of ENT regions, a highly commendable feature. Some of the plates require careful scrutiny in order to discern the condition being illustrated but as careful inspection is a necessity of clinical examination this is hardly a criticism. The section on the pharynx and larynx contains some of the best photographs I have ever seen of this region.

The book is intended to be an introduction to ENT and an adjunct to the standard textbooks. The text is brief and, although basically sound, some of the terminology is outdated and occasionally inprecise. The section on hearing tests would be improved by the omission of Bekesy audiometry in favour of a description of tests of loudness recruitment, speech discrimination and tone decay.

These criticisms are minor. I liked this little book; it should prove useful and interesting to all those who are likely to encounter an ENT problem.

P. KITCHEN,
Senior Registrar, ENT Dept.

CARDIOLOGY

POCKET ATLAS OF ARRHYTHMIAS by Neville Conway. Published by Wolfe Medical Books. Price £1.50.

The full title of this book is Pocket Atlas of Arrhythmias for Nurses. It seems to me ridiculous to produce a book whose intention is to teach nurses the difference between, for instance, the Lown-Ganong-Levine syndrome and the Wolff-Parkinson-White syndrome. Those nurses whose special interest is in coronary care might be interested but I suspect they would find it a little superficial. There is little attempt to outline treatment. Having questioned the value of the book's existence, it is only fair to say that it is very nicely produced. Eighty-eight different arrhythmias are clearly illustrated and succinctly described.

Dr. W. J. JEFFCOATE,
Medical Registrar.

GYNAECOLOGY

HUMAN REPRODUCTION. Published by Paladin. Price 60 pence.

This book consists of essays by 11 top scientists from various disciplines and countries on aspects of human reproduction including comprehensive descriptions of supporting animal research.

Much of the material is already available to the medical student in his pre-clinical course—spermatogenesis: oogenesis: fertilisation and embryological sexual development, but in addition the clinical application of such knowledge, e.g. egg transplantation, artificial insemination and abnormal sexual development are described together with chapters on the reproductive hormones and their control, the physiology of coitus and the hazards of birth. Contraception and sterilisation are not discussed in what is otherwise a full account of the reproductive processes.

Each essay is clearly written and readily understood, although by no means simplified; the illustrations are clear and well slotted into the written material although identification by plate and figure numbers would have made the reading easier. The book, however, lacks editorial control which would have spared the reader minor contradictions and enabled a system of more detailed cross referencing to be used; almost all such references direct the reader to whole chapters rather than specific pages. The North American definition of stillbirth—foetal loss after the 20th week—should have been qualified for the U.K. reader where stillbirth is foetal loss after the 28th week, and the statement that "termination of pregnancy is perfectly safe if done professionally" would not be echoed by any gynaecological department in this country.

The essays are reprinted from a special issue of Science Journal and are aimed at the educated reader seeking up-to-date information on the science of reproduction and this aim is completely fulfilled. The major disadvantages for the medical reader are the absence of an index and the lack of any reference material; if one accept these limitations and can tolerate the cover, it is a useful addition to any bookshelf.

Dr. P. LAST,
Contraceptive Clinic.

ENDOCRINOLOGY

FUNDAMENTALS OF CLINICAL ENDOCRINOLOGY, Second Edition, by Reginald Hall, John Anderson, George Smart, Michael Besser. Cased Edition £9.50 net. Paperback £7.00 net.

This book, now in its second edition, maintains the refreshing approach to endocrinology in its many disciplines that the first edition gave to the reader. Make no mistake, this book is stimulating, advocating the reader to take a part in the vastly expanding field of study of endocrinology. Much of this is attributable to the dynamism of the authors themselves and is conveyed in their writing.

It is a very easily read book, the fascinating story of each disease process being so clearly linked between one disciplinary approach and the next. The professed aims of the authors are that the book does not aim to be comprehensive, but within readable reason this is exactly what it is without boring anybody.

The format of the book is excellent with two columns of type per page giving the short reading line. The headings and sub-divisions of chapters are also clearly laid out, but could possibly be aided by the addition of the topics covered per chapter, listed under each chapter heading.

The main negative criticism that can be levied at such an excellent and necessary book is that the delicate balance between advanced recent research and solid principles has been handled badly. In some instances only one side of a yet to be resolved argument has been given and in the light of new information, could prove misleading. Where detailed factual evidence has been stated, it has not always been stated accurately, one must assume by complete oversight on the part of a multiple authorship. A statement like this obviously needs chapter and verse, hence for example on page 3 in the description of the number of chromophobes present in the anterior pituitary gland. Further, the outright damming of the bioassay as a valuable investigative tool, may in the light of present and future developments prove to be incautious.

However, with all these criticisms in mind, the total force of the book is not to be ignored. It is a book for "here and now" and may well mean that the authors have written themselves into a further job of the third edition next year, following the success of this year's edition.

The authors state that the text is aimed at senior medical students. It is probably more appropriate to say this text should be read by medical students of all ages from 19 to 90.

J. I. D. SADOW,
Dept. of Physiology, University of Leicester.

THE LIGHTER SIDE .....

THE MEDICAL HANDBOOK TO END ALL MEDICAL HANDBOOKS, by Dr. L. Pheasant. Published by Wolfe, Price £2.50.

Since there is no "Pheasant" in the most recent edition of the Medical Directory, the author must be using a pseudonym, because such is the accuracy of this book that he must have been medically trained. I could even believe that he is Bart's trained, since every word of the book could easily be transposed into the confines of the Royal and Ancient.

It is intended as a book for either doctor or patient, but I think that the patient might be made a little uneasy by it—in quite a few cases, the text is, like the pretibial cutaneous tissue, "a bit near the bone". And for the doctor? The whole book is more or less a collection of the stories that are to be heard most days in the Nurses' Dining Room (to the accompaniment of a certain amount of coarse laughter), together with a series of character studies of the hospital personalities we already know so well.

Read about the nurse who rushed up to Sister from a curtained-off male bed, only to be told, as the steam rose in billows from behind the curtains, to the accompaniment of bass shouts, "No, no, nurse, I told you to prick his boil".

. . . the man who, when asked how he was getting on with his course of suppositories, replied "Not only are they difficult to swallow, but for all the good they're doing me, I might just as well have stuffed them. . . ."

. . . the venereologist who is believed to have written the song "I was seated one day at the organ".

. . . the absent-minded consultant who met one of his female patients in the street, and enquired after the health of her husband, also a patient of his. He was told that the man had died three weeks previously while under *his* care. "Good, well done, keep it up", replied the consultant as he ambled off.

All this, and much more in a book that I would highly recommend. It has kept most of the *Journal* Committee in fits of laughter, but at £2.50, if I were buying it, I would wait for the paperback to come out, as indeed it must.

R.T.J.

MUSIC - At the Proms

It is with a feeling of euphoria that every summer I religiously scan the magazine shelves of Mr. W. H. Smith's bookshop, eagerly awaiting the appearance of the Proms prospectus. Once purchased, it then rules my life for the next three months; having read and inwardly digested it, I then mark in it those concerts I must go to, those I should like to go to but owing to financial restraints will have to settle for listening to on Radio 3, and finally those which I must avoid at all costs.

This year was no exception, so it was not surprising for me to find myself on the way to the Royal Albert Hall on July 22nd to attend the first concert of the season which had been duly marked down as one I had to hear live.

For the past three series of Proms, one has had the pleasure on arriving of seeing the Albert Hall looking splendid from the outside as a result of the long-awaited face-lift. This year there is the added delight of the completed internal rejuvenation.

During the interval of the Prom (whilst anticipating the harpsichord solo in the fifth Brandenberg concerto —the next work on the programme) downing the statutory 20 pence worth of lukewarm lager, I started musing about certain aspects of this unique institution —"The Henry Wood Promenade Concert Season"; a summary of those contemplations takes the form of 10 rhetorical questions:

Why is the atmosphere at a prom concert so entirely different from any other concert?
Why is the audience so responsive and appreciative?
Why is the audience so young?
Why is the audience so happy?
Why if the audience at a prom can be entirely silent during the music, do the audiences at other concerts have to make so much noise?
Why are the promenaders prepared to queue for three hours for their tickets, and yet the box owners frequently fail to use or "sub-let" their seats, thus wasting them?
Why is the standard of orchestral and solo playing usually so much superior to that found at many other concerts?
Why, when a particular concert is "sold out", are there, on the night, 10 times as many expensive seats unoccupied as there are empty cheap seats?
Why has the management of the Albert Hall seen fit to increase all the ticket prices by 50-75% compared to last year? (What about the Pay Board, that's what I'd like to know?)
Why didn't the short season of Winter Proms in 1972 receive the same support from the public as the summer concerts? (And it is not because the weather dissuades potential promenaders from queueing, since the seated audience was smaller by a greater percentage than the promenading audience.)

I don't know many of the answers (though I have a few ideas about some of them). However, I consider we are extremely fortunate in this country to have had such a wonderful benefactor as Sir Henry Wood, whose concept has been kept alive and thriving thanks to the energies and generosity of that other invaluable institution in the world of music, the BBC.

ALLEGRO MA NON TROPPO.

SPORT

GOLF CLUB REPORT

WELSH TOUR—July 5th to 8th

"Live by the foma* that make you brave and kind and healthy and happy."

The Books of Bokonon 1:5.

After our loss of form at the end of last month (see August *Journal*) it was decided by the committee to send a small representation of the club down to Wales, to enable them to rekindle their competitive edge. The team was selected on their ability to survive a gruelling four days "on the road" and yet still play competitive golf at the highest level. The team chosen was: J. Foster (Capt.), F. McLeod (Sec.), J. Chapman, J. Capper, G. Aiken, M. Bird, H. Maurice, J. Frame, R. Morris (new cap).

Match v. Whitchurch G.C. on July 7th, at Whitchurch. Whitchurch, the "R and A" of Welsh golf, fielded a side packed with talent and had every intention of making us beat a hasty retreat back to London. However, they had underestimated the depth of character in the Bart's Golf Club.

Our first pair, John Chapman and Hugh Maurice, narrowly lost to a very strong Whitchurch combination. This defeat was primarily due to an upset in our boys' Circadian Rhythm, thanks to the time change involved in travelling down to Wales.

Our second pair, an "all-committee" blend of Jim Foster and Fraser McLeod, were both at the zenith of their considerable golfing powers and had little trouble in notching up a victory for Bart's.

Our third pair contained the now legendary "Mr. Invincible", John Capper, along with Jim Frame. As expected they pulled off another sensational victory and enabled Bart's deep-thinking intellectual, John Capper, to achieve his sixth consecutive victory.

Our fourth pair was the connoisseur's blend of Graham Aiken and Mike Bird. Unfortunately they did not blend very well and lost their match, enabling Whitchurch to halve the match. Once again, Graham Aiken, our wayward Scottish superstar, has let the bright lights affect his golfing skills.

Match Result: Bart's 2 — Whitchurch 2.

The following day was declared a rest day and the Golf Club visited Royal Porthcawl G.C. for a practice round to prepare for the next set of fixtures (see October *Journal*).

J. FOSTER.

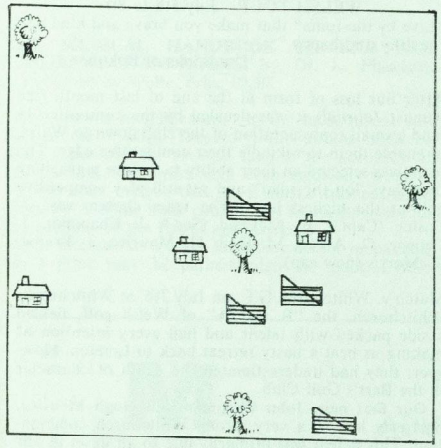
*=harmless truths.

PUZZLE COLUMN

JOURNAL MATHEMATICAL PROBLEM No. 9
By R. TREHARNE JONES

When old Farmer Giles passed away (from Farmer's Lung?), he lay on his deathbed and announced that he was dividing his land equally between his four sons. However, the land, a map of which is shown below, was to be split so that not only would each son receive an equal area, but the four areas were to be of exactly the same shape, and each division was to include a tree, a cottage, and a five-barred gate.

How was the division made?



Solution next month.

Solution to last Month's problem

Bowlby was in bed No. 11, Abernethy in No. 12, Colston in No. 14, Elizabeth in No. 13, and Dalziel in No. 15.

SPOT THE UNIFORM COMPETITION

The winners of the competition in the July issue of the Journal are Dr. and Mrs. A. E. Fraser-Smith, The Cottage, Yealand Conyers, Carnforth, Lancs., who receive the first prize of £1.50. Even the winners did not get every answer correct . . . the full solution is as follows:

1. Royal Free; 2. UCH; 3. George's; 4. Charing X; 5. London; 6. Guy's; 7. Tommy's; 8. Mary's; 9. Westminster; 10. Middlesex; 11. King's.

Judging by the accuracy with which certain nurses around the hospital were solving the clues, as observed by our reporters, it was a pity that they had not sent in their entries!

R.T.J.

N.B. RONTY returns next month.

SAINT BARTHOLOMEW'S HOSPITAL JOURNAL

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Vol. LXXVIII No. 10

Journal Staff

CLASS OF '74

October is the month of great change at St. B.H.M.C.: freshers are no longer that but suddenly enter the 2nd MB-burdened second year. Joy of joys, others return from their last long summer vacation to achieve the ambition of all right-thinking medics—the run of the wards. And a new generation of fresh young faces is seen blinking at the carcases in Smithfield market. Some, too, are not so young but instead are forced to forsake their bicycles and brick-blue scarves for tube tickets and white coats.

At Charterhouse, the xenophobes put away their scowls, and the ambitious return their Italian phrase-books to their dusty shelves: the new term shuffles warily in. The peaceful, plague-pit, lawn atmosphere, so long starved of adequate amounts of feminine company, should this year see an almost civilised proportion of aspirant lady doctors. This is the new population bubble which must now make its way slowly up through the murky waters of the medical course.

This group, the Class of '74, will be at Bart's during times of extreme change. Not only has the N.H.S. reorganisation just begun to bite, with all that means for Bart's and its group—and for this *Journal*, but the dread amalgamation of Bart's and London's Medical Colleges will also come within their time, And of course, all of these gloriously exciting changes will be accorded that doyen of medical student attitudes—apathy. This has always been the fate of issues of, dare I say it? medical student politics.

So it has been in the last year. Why else did B.M.S.A. die such a lonely death? Why else did N.A.H.S. receive such paltry support? Why was the issue of aye or nay to joining N.U.S. of no interest? And now that there is a Health Students' section of N.U.S., why is the question of membership still a bore? On a different tack, why else did nobody support the wage-claims of the N.H.S. workers, or even the claim from the nurses?

The answer has always been apathy—it is not even that medics are against these things—they just don't care. Not even about the fate of the N.H.S. The patients care, obviously; the public care—witness the number of films and television serials about hospitals, if nothing else; the workers care—listen to the amount of heartsearching surrounding every call for industrial action. But the ones who will reap greatest rewards from the system don't care, and never have.

Welcome to Bart's, Class of '74. And let us hope that you are different.

TIES

Why do men wear ties? What is the purpose of the tie? It doesn't keep your shirt up like a belt does trousers. It adds nothing to warmth. It has a very limited decorative value. In fact, were the average Martian explorer to study the rush-hour crowd he would have a puzzling time trying to work out what those stringy appendages were doing, tied like so many elongated fish around each man's neck. He would be forced to assume they were for tying onto something,—a hook perhaps in the hallway? Nevertheless, this absurd piece of sartorial equipment has achieved an unbelievable importance, so much so that whole nations are divided by it. For we classify our work status with the erroneous terms "white collar" and "blue collar"; but the colour of the collar is quite irrelevant. What matters is whether or not you wear a tie. It has become a symbol of differentiation, of normal formality, (or formal normality, but what's the difference!) of acceptable dress.

The student emerging from pre- to clinical work is faced among other things with the need to don a tie. The very first words that a consultant, in his wisdom, said to me were, "Where's your tie? You must have a tie, doctor." And there is a strong traditional defence for this mode of dress. The doctor must be able to project an image of reassurance, thus confirming to the patient that he (the doctor) is a sane, intelligent, "properly" dressed, middle-class member of society. Since a collar and tie are representative of such a status, the doctor must wear them. Also most people *expect* their doctors to be dressed thus, and would be suspicious of an open-neck shirt or a cravat (the tie's predecessor) or a polo-neck or a turtle-neck or a Mao-style collar or what you will. These alternatives are, by definition, scruffy, worrying, and not allowed. Even in the height of a humid summer we sweat it out, begrimming myriads of innocent collars in our determination to avoid any deviationist tendencies. As an argument this is largely pragmatic, defending something merely because it exists, accepting uncritically the status quo. Remember, once upon a time it was heresy to say the world was round (what did it matter anyway so long as the sun kept coming back in the morning?), then Columbus didn't sail off the edge and everyone had to think again. Not that the simple and minor detail of putting on a tie has such significance, but imagine life without one.

For a start our collars, whatever their style, would last twice as long, both in terms of wear and tear and in terms of cleanliness. Then we could vary the whole style of the pre-sternal region, and as the ladies use their cleavage to hint at hidden treasure we could use a few curls to hint at our virile chests. No more sore necks after work, no more carotid body stimulation and sudden faints, no more apoplexy when you are straining forward to look in someone's fundi. No more tickling the patient's nose as you lean over him, no more tangled up stethoscope, no more an easy stranglehold for those of a more violent bent. No more soup-stained symbol of enchainment! Dentists now sometimes wear a very sharp dog-collar style of tunic, the army have some superb dress uniforms that need no tie, so why can we not find some better mode of dress that is both neat and practicable?

Really I think most people are not bothered either way. "We're here because we're here because we're here" sums up the standard attitude. It is probably true that some men actually ENJOY adorning themselves with a large-knotted, multi-coloured tie which they then proceed to thrust into the gaze of innocent by-standers, and to these men a tie is clearly a phallic symbol, the 20th century version of the codpiece. I find it more a symbol of unthinking conformity, like long hair and jeans (blue of course) and those appalling dark suits that pack the commuter trains every morning. Watching the City's "cannon-fodder" troop by on London Bridge, all noosed up as if displaying some sort of mass death-wish, is a disturbing sight. They could for all the world be a squad of p.o.w.'s returning to camp after a day's work in the salt mines. Let's be honest. The tie is a noose around the neck of each and every one of us who wants to work in a "white-collar" job. So why don't we follow the example of those early surgeons who took the mocking title of "Mr." given them by the exclusive physicians and turned it into a mark of achievement? Theatre tunics come in several fine cuts, square-shouldered or round-necked, and they are so comfortable. Away with ties, we have no need of such useless baubles.

CHANGES

In line with the changes predicted in our August issue, we would like to warn our readers of an impending alteration in our format. For this will now consist of a three-column page, unjustified; that is to say, the end of each line is not aligned with other line-endings. We hope this will give us more flexibility in the layout of the *Journal* as well as being of considerable material assistance in terms of finance. All we ask is that a few allowances be made for early errors while we adapt to the new format. Further changes of both style and approach are also in the offing but they await the deliberations of various committees, and, as we all know, such matters take time. In the meanwhile we trust the new layout proves a success with as many people as possible and welcome any criticism which may be of use.

ERRATUM In our August issue we announced the marriage of Dr. T. C. Naunton Morgan as having taken place on May 15th. In fact it was on June 15th, and we apologise for the error.

ANNOUNCEMENTS

APPOINTMENTS

DR. C. J. DICKINSON has been appointed to the Chair of Medicine. B.Sc. 1952, B.M. 1960, D.M. 1968, F.R.C.P.

DR. R. BONNER MORGAN, F.R.A.C.S., has been appointed Honorary Ophthalmic Surgeon to the Princess Elizabeth Hospital, Guernsey.

AWARD

STEPHANIE GERMER has been awarded a joint First Prize in the 1974 B.M.A. Medical Students' Competition.

ENGAGEMENT

HANNAN-MASTERS—The engagement is announced between Mr. Mark Hannan and Miss Gillian Masters.

CHANGE OF ADDRESS

DR. R. BONNER-MORGAN (late of Morwell, Victoria, Australia), to 87, Victoria Road, St. Peter Port, Guernsey, C.I.

Lord Mayor's Show

We're doing it again! On the strength of last year's success we have been asked to represent Medical Care in this year's Show. The wheels are already turning—the 22-foot articulated trailer will show Health Care through the "Ages of Man", from obstetrics to geriatrics, and we hope to have representatives from every branch of Medicine walking beside the float.

Help and support would be appreciated, so as to make it a Hospital effort. Sign-painters, paint-sloshers, sewers, carpenters, good old labourers and enthusiastic walkers are all needed, for on Saturday, November 9th, Bart's is on the road again.

SU BODDY.

P.S. Anyone interested please contact Dave Craufurd, M.S.C.R.

College Hall Trunk Room

On the weekend of November 23-24th 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, of the junk removed during the clear-out. Any volunteers to help do the above should contact Peter Meade at College Hall.

LETTERS

Abernethian Room.
August 29th, 1974.

Dear Sir,

Among the many changes that occur at the beginning of the Academic Year, the election of Club and Union Officers passes by almost without notice. I have made a rough calculation that 1 in 4 students holds some official post—i.e. Club Secretary, Year Representative, or Union Official.

I should like to make a plea to *all* students that they take some thought over these elections, and that those interested in running their own affairs, be it sporting, entertainment, financial or teaching, should make some effort to get elected.

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

11, Tysoe St.,
E.C.1.
August 18th, 1974.

Dear Sir,

I should like to take this opportunity to thank all the students of Bart's Hospital who have contributed in so many ways to the work of our Group. In 1972 a Sunday Club for local elderly was set up on the hospital premises and weekly the most appetising dishes were prepared. This Club is now held at the Dingley Centre in Dingley Place, but is still fondly referred to as the "Bart's Sunday Club". Many students visit, befriend and support the elderly, handicapped, inadequate, and the mentally and physically ill in the Community. I have also often had recourse to phone College Hall in an emergency and ask for an escort for a mentally or physically ill person; these pleas have rarely been unsuccessful.

The Group works very closely with the Finsbury Area Team of the Islington Social Services Department and Volunteers are encouraged to work in conjunction with the Social Workers. As mentioned above Volunteers are involved with various groups of people and activities, depending entirely on their own interests and also on the amount of time they can spare.

As well as running two Sunday Clubs—one is held at 11 Tysoe Street, the other at Dingley Place—the Group has also started to take out small parties of housebound and disabled people every four to six weeks. We are hoping to start a Club for the middle-aged group—for people who are lonely, bereaved or who just need a bit of support. Bart's students have always been a tradition in the Group and I hope that again this year many will feel encouraged to help us in our work.

Should anyone be interested to learn more about the Volunteers' Group either Bryan Sheinman at Bart's (c/o *Journal* office) or myself will be very happy to supply more details. We always need more Volunteers.

Yours sincerely,
FELICITY R. HART,
Organiser.

THE SOCIAL RESPONSIBILITY OF SCIENTISTS

By J. ROTBLAT

PART I

It has always been axiomatic that service to the community is the basic and prime aim of medicine. Not so with science. In fact, for a long time the reverse was true: the scientist took great pains to proclaim his complete detachment from society. His aim was to understand the laws of nature; since these are immutable and unaffected by human reactions and emotions, therefore—he argued—these reactions and emotions had no place in the study of nature. The approach to scientific investigation must be neutral and impersonal; the aim of research is to discover the truth, and whatever effect this may have on human affairs is outside the scientist's province. Thus, the scientist built an ivory tower in which he sheltered for a long time, pretending that his work had nothing to do with the welfare of man and society.

This was a fallacy and an illusion, even before the dawn of the social sciences; despite his protestations, the work of the natural scientist always had an impact on society, although perhaps not as fast as nowadays. The results of so-called pure research often found important practical applications in various fields of human endeavour. One can certainly trace this impact in relation to medicine. Quite apart from the direct relevance of findings in the sciences concerned with man, such as physiology or anatomy, many obscure results of pure academic research have been taken up by the more inquisitive and enterprising members of the medical profession and adapted to clinical practice.

The fact that science is an integral part of society became manifest as the effects of science began to be seen in concrete forms. The ever-growing material benefits to the community of the work of the scientists have gradually led to the realisation that science is too valuable an asset to be left to the whims of a few academics or eccentrics. In particular, the two world wars made it obvious that the whole destiny of a nation may be determined by its scientific effort and achievements. This realisation has resulted in a complete and astonishing transformation of the magnitude, character and orientation of scientific research. From a pastime of a few gentlemen of leisure, it has become a vast profession, in which several million people are engaged; from being run on sealing wax and strings, it has become one of the most sophisticated and expensive enterprises, absorbing some £30,000 million per year; from an abstract and academic pursuit, it has become a vital part of industry and defence.

These changes have occurred because governments and the public could see the tangible results of scientific research in terms easily understood by them—greater wealth, better health, more security, status of high prestige among nations—and they were prepared to pay for this. During the decade following World War II, science—in particular physics—was at its pinnacle. Scientists became the darlings of society; nothing was too expensive for them; any project—however fantastic—as long as it had the label scientific research attached to it, had a good chance of being accepted and financed; the public endowed the scientists with magic powers to solve any problem, remove every obstacle, cure all ills.

Later, however, all this has changed again. During the last decade we passed through the opposite phase, an anti-science attitude, which was particularly strong among the young generation. Scientists were blamed for everything that is wrong on the earth: for there being too many people, for polluting the environment, for squandering natural resources, for the threat of nuclear annihilation, and—ironically—for being too materialistic.

There is now evidence that the trend is reversing again, the confidence of the public in science is again on the increase, but actually long before the general public became aware of the adverse effects of the rapid development of science, these aspects and their consequences were the cause of worry and concern of some scientists, who realised that, due to the failure of social institutions to adapt themselves to the new power that science was giving them, the very advance of science and technology has created new and enormous dangers to society. Even medicine is among the disciplines where advances have given rise to perils. After all, it was the discoveries in the basic medical sciences that resulted in the drastic reduction in infant mortality, and in the population explosion, which is assuming unmanageable proportions, and which is responsible for the fact that there are more hungry

Professor J. Rotblat, C.B.E., was a member of the World War II Manhattan Project from which he resigned in order to take up work on the medical applications of nuclear physics. He is Head of the Physics Department of Bart's, and has for many years been Secretary-General of the Pugwash Conferences on Science and World Affairs.

people in the world now than ever before. The scientists and doctors, who carried out this research with the noble aim to reduce human suffering, never thought of the calamitous results of their work. But even if they did think of them, should this have stopped them from continuing work which was obviously bringing immediate benefits? This was the type of dilemma that faced the scientists who realised the social consequences of scientific advance.

The example quoted above is one of many instances of deleterious effects of peaceful research, resulting from lack of foresight in the planning of science. Much more serious is the deliberate misuse of science; it is frightening in its current consequences, and even more so in its future potentialities. An illustration of the first is the use of chemistry to defoliate enormous areas in Vietnam, thus depriving the inhabitants of their means of living for years to come. An example of the shape of things to come from medical research, although at present far-fetched, is the so-called genetic engineering, which, by transplantation of cell nuclei, may make it possible for a future Hitler to breed a master race. However, the most conspicuous example of the misuse of science and technology is probably the development of nuclear weapons and the means of their delivery. This has created an entirely new situation in the world: the extermination of the whole of the human species is now within the realm of possibilities, and already, at the present state of technology, could be achieved in a short time. We have been living under the threat of a nuclear war for nearly three decades, but the fact that it has not materialised so far does not mean that the danger has lessened; on the contrary, the arms race is accelerating; nuclear weapons are proliferating; the sophistication of the means of their delivery is increasing; and the probability of an accidental nuclear war is finite and, therefore, it will happen sooner or later. All of us realise the danger, even though we seldom talk about it. Indeed, since they do not know how to handle it, most people pretend that the problem does not exist, but this does not remove it from their subconscious; deep down the worry is there.

What can we, members of the scientific and medical professions, do about this problem? There is no easy solution, but since the problem has in a large measure arisen from the too rapid, unplanned, or misguided progress of science, it is incumbent on the scientist to consider his special role in relation to this issue: this also applies to the medical scientist, and, indeed, to the whole medical profession. If, until now, there has been no anti-medicine movement, like the anti-science movement, it is because the benefits of medicine are personal and obvious. But already certain aspects of medical research have come under close scrutiny, as, for example, the consequences of genetic engineering. Indeed, the very tenet of the medical profession, the prolongation of life, is now being questioned. With the reduction of infectious and other diseases which affect the young and middle age groups, the doctor's main effort now is to prolong the life of old people, who are unproductive and becoming an ever-increasing burden on the community; how long will the community be willing to carry this burden? This is one of many problems created by medical research that will have to be tackled soon.

The first thing is to realise that the whole character of science has changed; it started as an attempt to *understand* nature, and now its main purpose is to *control* nature. Whether we like it or not, science has become an important ingredient of social and political power. For those who do not like this trend, the remedy is not to outlaw, suspend, or even put a brake on science, although this is now being considered seriously by highly respectable scientific bodies. No, the answer is to use science wisely. This requires two positive measures: for the general public—to understand the promises and dangers of the progress of science; for the scientists—to show active concern about the social implications of their work, without abandoning objectivity in scientific quest.

Specifically, I am suggesting that every scientist, medical or non-medical, should have a social conscience. This can find expression in several ways; first, by being aware of the social consequences of his work, and ensuring that it does not conflict with his obligations to society; second, by informing the public of the implications of his work; third, by devoting a proportion of his time to help the community in finding solutions to the new problems which the progress of science has created.

When I use the word "conscience", I do not mean to imply a judgment of right or wrong. I am not advocating that we appoint ourselves as moral judges, set up an ethical code, and condemn those who do not follow this code. For example, I do not castigate those scientists whose political beliefs, or sense of patriotism, convinces them that they should do research on, say, nuclear or chemical weapons; provided that they are fully aware of the social implications of their work, and that they do not willingly delegate the concern about these implications to their superiors.

Most scientists are, of course, involved in beneficial work or pursue peaceful research, but this does not mean that they are free from similar dilemmas. I have already indicated the many, and usually unexpected, negative aspects of peaceful research. The situation is aggravated by the great complexity of modern society.

(Continued next month)

Announcement—Snark's Club

It is proposed to start a Snarks Club at Bart's. Membership will be restricted to ten, each of whom will be familiar with The Hunting of the Snark, by Lewis Carroll, and will either be a Bart's graduate or student. Those who can recite the five points for recognition of a genuine Snark will be especially welcome. Those snarks who are Boojums as well, had better stay away from Bakers or the temptation might become too strong. Enquiries, please, to the Agony column, c/o Bartsjournal, or to Dave Cooke, or to Robert Treharne Jones.

THROW AWAY YOUR STETHOSCOPES!

By MALCOLM CLARKE

(Consultant Cardiologist, Cardiac Department, North Staffordshire Hospital Centre, Stoke-on-Trent, Staffordshire)

Most people are under the illusion that a doctor without his stethoscope is about as effective as Norman Hunter without his football boots. Ever since Laennec rolled up a piece of parchment to avoid placing his ear directly on to a shy female's chest, the stethoscope has become a status symbol. If the general public on the bus or tube sees a stethoscope peeping out of the corner of one's pocket, one is instantly labelled as either a doctor or a safebreaker (frequently the latter, I suspect).

As a student, I was involved in placing a large and very noisy bluebottle into the tubing of my Consultant's stethoscope. When he returned from answering the telephone he auscultated for a short period, then gravely pronounced, "This patient has mitral stenosis and aortic incompetence—and there is a fly in my stethoscope!" In practice, legendary powers of auscultation such as this are unnecessary to make a good cardiac diagnosis. The important signs are in the venous pulse, the arterial pulse, and in analysis of the heart *sounds*. Murmurs are of secondary importance, in spite of the hours of tuition given, and the numerous pages in medical books discussing them in detail.

Unfortunately, the student may never be taught the correct way of picking up the peripheral signs and the pitfalls involved. This paper is designed to give some practical tips, based on experience, that the books do not mention.

VENOUS PULSE

"Is it a fantasy that plays upon our eyesight?"
Henry IV, Part I.

The height of the venous pressure is measured as a *vertical* level above the sternal angle. The patient is therefore placed in whatever position necessary to show the top of the pressure. There is nothing magical about the angle of 45 degrees frequently quoted. It may be necessary to sit the patient upright, or lie him completely flat. The commonest cause of inability to see the venous pulse is observer error. It is lamentable that every final year student has had the opportunity to examine hundreds of people, but is totally incapable of deciding whether the venous pressure is normal or not. The only way to accumulate experience is to examine the neck veins in every *patient* clerked—especially all the "normals" on the surgical wards.

Another reason why the neck veins are not visible is when they are grossly elevated and the pulsation cannot be seen. Gross elevation occurs in superior vena caval obstruction, tricuspid valve disease and constrictive pericarditis. It may be necessary to elevate the arm above the head to see the distension of these veins. (Actual waveform cannot be seen because of the valves in the veins.) The pressure column in such cases is higher than the length of the neck. (It is a personal, and as yet unfulfilled ambition to see constrictive pericarditis in a giraffe.)

The various waveforms are well described in standard books and repeated practice in normal patients will be rewarded rapidly when the abnormal patient appears. Suffice it to say that many cardiac rhythms, tricuspid and pulmonary valve disease, pulmonary hypertension and constrictive pericarditis can all be inferred from analysis of the jugular venous pulse.

ARTERIAL PULSE

"I stand in pause where I shall first begin."
Hamlet.

Traditionally, the use of the thumb in feeling the arterial pulse has been vigorously discouraged. I suspect that most medical texts have been written by pipe-smoking physicians who use their thumbs to tamp the burning tobacco. The resulting scarring from second degree burns then renders them as sensitive as feeling the pulse of a medieval knight without removing his suit of armour. In spite of what the books say, the best way to appreciate the *quality* of the pulse is to use the thumb. By feeling either the brachial or the carotid arteries, and gently compressing (but not occluding the lumen), both slow rising and bisferiens pulses become immediately obvious. A collapsing pulse is usually obvious and can be confirmed by raising the arm above the head. A true collapsing pulse is associated with a low diastolic pressure, and the term is best avoided when dealing with high output states such as thyrotoxicosis, in which there is a high pulse pressure but a normal diastolic reading.

All pulses should be felt, and both radials together. Radial and femoral pulses felt synchronously will exclude coarctation of the aorta.

In addition to identifying arterial disease, the arterial pulse can diagnose aortic stenosis, aortic incompetence, mixed aortic valve disease and give information on cardiac rhythm, cardiac output, left ventricular performance and constrictive pericarditis. The latter results in a "paradoxical" pulse, which is merely an exaggeration of the normal tendency for the arterial pressure to be lower in inspiration. (10 mm Hg difference between inspiration and expiration is significant.) The pulse may vanish altogether, and this explains the terminology. Our forefathers thought it was a "paradox" that the pulse was impalpable although the heart was still beating. One word of warning: the commonest cause of a "paradoxical" pulse is asthma.

HEART SOUNDS

"Had I three ears, I'd hear thee."
Macbeth.

Although two components to the first sound can be heard, the commonest cause of a "split" first sound is a first sound closely followed by an ejection click. Clicks are very common, and occur in aortic and pulmonary valve disease, aortic and pulmonary artery hypertension or dilatation, and sometimes in ventricular septal defects. Loud first sounds are well known in mitral stenosis amongst other things. A little known cause of a loud first sound is atrial septal defect, in which the increased blood flow through the right ventricle results in a loud tricuspid sound. (Many atrial septal defects in adults are incorrectly diagnosed as mitral disease.)

Variable intensity of the first sound when in *regular* rhythm indicates complete heart block or atrio-ventricular dissociation. However, it should be remembered that in many people with heart block the atrial rhythm is frequently flutter or fibrillation. In such circumstances, the first sound does not vary, and is indistinguishable from that of sinus bradycardia.

Two components to the second sound should be heard in everybody. The sounds separate in inspiration and close during expiration. The opposite occurs in reversed (or paradoxical) splitting as evidence of left ventricular dysfunction. Wide (but not exactly fixed) splitting of the second sound in all phases of respiration indicates delay in right ventricular emptying, and although a "classical" sign of atrial septal defect, is also found in pulmonary hypertension and stenosis and in right bundle branch block. Splitting of the second sound must be observed during quiet, normal respiration only. Deep breathing destroys the normal relationships and confuses the issue. Single second sounds occur in aortic and pulmonary valve disorders, and in many types of cyantic heart disease.

Fourth heart sounds may be left or right sided, and usually indicate cardiac disease. As they are associated with atrial systole, they are not found in atrial fibrillation.

Third heart sounds are often found in healthy young people, but indicate cardiac disease in older people. That of constrictive pericarditis is closer to the second sound than usual and may be confused with splitting of the second sound or an opening snap.

Opening snaps occur in timing between the second and third sounds. Although classically found in mitral stenosis, they are also present in mitral regurgitation and tricuspid valve disease. A tricuspid opening snap is also a feature of Ebstein's anomaly.

Loud heart sounds are frequently palpable, and this can be a guide to diagnosis. On an etymological basis, it may not be correct to talk about "palpable" heart "sound", but the meaning is conveyed.

SUMMARY

The stethoscope is obviously important in clinical medicine, but closer attention to other physical signs will result in more accurate assessment of patients. One can only learn what is normal by careful examination of the normal patient. It cannot be stressed too much. For example: A patient on one ward suddenly developed a very loud early diastolic murmur. "Acute aortic incompetence, ? dissecting aneurysm" said the urgent consultation request. But—there was no collapsing pulse, the venous pressure and heart sounds were normal. The "murmur" was a pericardial rub!

The normality of the other signs should have been heeded.

When examining the cardiovascular system, one should use the stethoscope last of all, and pay attention to the heart sounds before thinking of murmurs.

POST SCRIPT

As a medical registrar, I had to show the students to their patients during their finals. One unfortunate fellow had left his stethoscope in his car. He was asked by a kindly examiner to examine the patient without it, "and see how far you get." Apart from the mumbling of history taking, the silence of the next 20 minutes was punctuated only by a rapid dull thudding noise which we correctly assumed was the candidate's knees knocking together. Then he presented the case. "Mitral stenosis and aortic incompetence," he said, and then enumerated a collapsing pulse, a moderate "a" wave in the neck veins, a palpable first heart sound and a diastolic thrill. On his way out, I congratulated him and said that the importance of the physical signs had been clearly demonstrated. "Ye-es," he said hesitantly, then added quickly, "Actually, I asked the patient what was wrong with her and she told me. I spent the next 20 minutes making up the signs to fit the diagnosis."

Note: see September issue for Electives in Stoke.

BARTSFILM PREVIEW

October 1 Straw Dogs with Dustin Hoffman, Susan George.
"The Wild Bunch", "The Getaway", and "Pat Garrett and Billy the Kid" are among the products of that king movie-maker, Sam Peckinpah, and none of them are exactly sparing of the tomato ketchup. In "Straw Dogs" (the title is taken from Confucius) he attempts to show how even the most determinedly retiring people are part of a world where violence exists. It offers no easy answers and in this sense is entirely descriptive, but you can't help going away with a feeling of sympathy for Hoffman's bewildered hero. The critics generally slated it as being nothing more than a western style plot set in Cornwall, but it is a beautifully structured and climactic movie with every scene tailored to the needs of the analysis. There's no doubt about it, Peckinpah is a brilliant director, both in terms of technique and artistry as well as entertainment value, and the more you see of his movies the more you want to see them again. However, to say any more in this sort of vein might just give away the fact that his work is my personal favourite in the cinematic world.

October 8 Soldier Blue with Candice Bergen, Peter Strauss.
One of a recent glut of pro-Indian westerns, this lacked a big star to give some meat to the rather muddled plot. Buffy St. Marie sings a great song but the movie hasn't half the range of emotions that she puts in. Both the main actors are young and grim-faced and energetic and appealing to the opposite sex, but a few more rough-hewn visages would have somehow made it all more gutsy. Until the last half-hour the action lacks pace and any real structure, which leads one to suspect that some Hollywood hack writer thought up the final scenario in a fit of expansive remorse for what the white man did to the Indians. (He'd probably just read "Bury My Heart at Wounded Knee", the best-seller about the systematic extermination of the American Indian). They then added on the first two-thirds to bring the whole thing in line with the "accepted" time slots of today's cinema. Still, the otherwise unknown Peter Strauss has a lovely freckly face so beware your girlfriend's mothering instinct.

October 15 Asterix the Gaul (Cartoon)
If you liked the books, and I've never met anyone yet who didn't, then get a fix on this. It should be a real Gallic gas.

October 22 Junior Bonner with Steve McQueen, Robert Preston.
Another Peckinpah movie, one of his less violent shots, with the ever-craggy McQueen as a rambling rodeo star come home to compete in the big local show. It has a better "reputation" than Straw Dogs, but lacks a bit of the harder side of sentimentality. Still, all the fun of the rodeo, plus McQueen and a love affair and the usual eyewash that goes with any "rambling" character, AND a great director. What more could you want.

October 29 Dirty Harry with Clint Eastwood
The classic hard-line cop movie, 1973 version, with Clint (ex-star of the Rawhide series on T.V. and then the immortal "Spaghetti" Westerns of Sergio Leone) toting a very large, live, and kicking Colt 45 around. The scene where he smashes up a bank raid in between two bites of a hamburger (or was it a hot-dog?) will linger on for years in the T.V. review programmes until poor old Clint dies of ketchup poisoning. Luckily the director, Don Siegel, knows how to make a film that is fast and active yet able to dwell occasionally on the bleakness of the urban lives being portrayed. The boys will love it in all its virile heaviness; the girls may need to grab a shoulder here and there, so the boys will love it even more.

November 5 Summer of '42 with Gary Grimes, Jennifer O'Neill.
"In every man's life there's a summer of '42" according to the soft-sell blurb that pushed the film on its first release. Well, it's a real nostalgia trip all right, about some teenage boys' first encounter with the opposite sex. There are plenty of easy laughs as the hero gawks and stumbles his way into the arms of the welcoming older lady, but it all reeks of soft soap and "slushy" moments. "The Last Picture Show" was made at about the same time and is regarded at the moment as the better portrayal of youth in pre-T.V. America. Perhaps with time this will start to wear a bit better.

FILMFREEK.

MUSICAL ABOUT-FACE

"SOLOIST MINUS ALL QUESTION MARK"

The new question in the latest series of "Face the Music", in which the contestants (?) are asked to say whether a section of orchestral music is followed by the entry of a solo instrument or not (Mr. Cooper calls the question "Orchestra minus one question mark") set me thinking along similar lines; the development of my thoughts took me to contemplating not the orchestral introduction to solo concerti, but rather, those concerti where the solo instrument (or instruments) commence the work unaccompanied, with the orchestral entry delayed for several bars.

I could not recall any pre-Beethoven composer to do this, and so was forced to conclude that Beethoven—the man who broke so many old conventions and initiated so many new ones—was responsible for the first concerto to be heard in which the soloist alone starts the music; I am here referring to his fourth piano concerto in G major Op 58; the soloist having starkly stated the first subject of the opening movement, then has sixty-nine bars rest whilst the orchestra (heard now for the first time in the work) not only repeats what has gone before but also both announces the second subject and starts the development section.

Unlike many of Beethoven's other ideas, this particular one never caught on. Having thought hard and long, only three other composers who have followed his lead come to mind.

In chronological order, Brahms was the next to try this musical ploy, and is, I believe, unique in using it in a string concerto (his double concerto for violin and violoncello in A minor Op. 102). Rodrigo in his Guitar concerto (Concierto de Aranjuez) and Elgar in his violoncello concerto, both employ the same musical trick of giving the opening bars of the first movement to the soloist to announce the principal theme, however both composers give the soloist an accompaniment, in both instances comprising the bare tonic note of the key of the movement, played on 'cellos and 'basses. These latter two examples therefore must be excluded from my list. It is interesting that Elgar and Rodrigo both felt it necessary to provide some sort of substance to the opening of a string concerto over and above the sound of the soloist; had Brahms not been writing a double concerto, I am sure he too would have been obliged to add to the scoring because a solo stringed instrument used in such a context lacks the attack, authority and presence of a pianoforte.

Beethoven's "Emperor Concerto" (which almost serves as an example itself were it not for the one E flat major chord from the orchestra before the piano's arpeggio entry) inspired Saint-Saens' second piano concerto; here the soloist does start alone, with many bars or arpeggios and scales (which bear no relation to the following music of the concerto!) before the orchestra enters to hold the soloist to the straight and narrow.

Finally the opening piano chords of Rachmaninoff's C minor concerto leave no doubt that this work must also be included in this series.

Although many composers have come close to using this technique to start a concerto (Tchaikovsky, Grieg, Bartok, Sibelius and Strauss to name but a few), the only true examples I can muster number no more than four. So Mr. Cooper will not be able to try this line of questioning due to lack of material—though I should be delighted and grateful to hear from anyone who can furnish me with further examples.

ALLEGRO MA NON TROPPO.

M.D.U. FILM PREVIEW

WITHOUT DUE CARE

This new film, produced by the Medical Defence Union, under sponsorship of Johnson & Johnson, shows the mistakes that can arise in hospital practice if routine is ignored. The film, lasting 16 minutes, shows how easy it is for a set of small deviations from established routine to lead to loss of the wrong limb or organ and highlights the importance of patient identification by the surgeon, and the habit of marking the site of operation by the houseman.

"Without Due Care" is similar to the earlier MDU production "Make no Mistake", which must have been viewed by thousands of students and doctors during its decade of exhibition, but is closer to the mark as it takes the houseman, theatre sister, and consultant into the dock after the amputation of a wrong limb and subjects them to cross examination.

This film should be compulsory viewing for all clinical students so that unnecessary iatrogenic disability and mortality, which is becoming more frequently noted by the defence unions, can be eradicated.

H.S.B.

CHRISTMAS CARDS:

The Journal Christmas Card for 1974 will be on sale soon.

Enquiries to Bruce Finlayson, M.S.C.R.

HORDER MEMORIAL TRUST LECTURES

John D. Hamilton, M.D.
Chairman,
M.D. Undergraduate Education Committee,
McMaster University,
Hamilton, Ontario, Canada.

"McMASTER UNIVERSITY MEDICAL SCHOOL — A CRITIQUE OF THE METHOD OF EDUCATION"

At 5 p.m., Wednesday, 20th November and Thursday 21st November, in the Clinical Lecture Theatre, St. Bartholomew's Hospital, EC1.

HORDER MEMORIAL TRUST LECTURES

The Horder Memorial Trust Lectures are to be given this year by Dr. John Hamilton, who was a member of the Department of Gastroenterology at Bart's until 1968 when he took up a post at McMaster University Medical School, Canada. This medical school has developed a curriculum based on a number of innovative principles and has deliberately moved away from some of the older principles that have traditionally been held of importance in establishing a sound medical training. This medical programme has been in existence for five years, and the lecture will present the basic philosophy and some of the methods of implementation, and also a critical commentary on both the advantages and disadvantages of this approach to education. As Chairman of the Undergraduate Curriculum Committee, Dr. Hamilton has responsibility for the running of the entire programme and has worked on all its different aspects during the past five years. He therefore has a wide experience of its implications and its historic development.

Time will be available for free questions and answers.

The lectures will be held during week commencing November 18th. Full details will be given on notices published around the Hospital, or can be obtained from the Secretary to Professor G. Hamilton Fairley, Ext. 591 within the Hospital, or (01) 606 7512 which is a direct line.

POETS CORNERED

Of J.D.G. and A.T.B.,
And R.B.H. and I.J.C.,
This is a story I will tell
Including P. and A.J.L.
And all the rest like A.M.P.,
And I.K.F. and R.A.B.,
C.M.B.P. and L.N.D.,
And G.H.F. and M.A.B.

This hasn't yet been done, I know,
To write like this of N.C.O.
And A.G.S. and P.F.B.
And J.S.M. and A.J.E.
How many of these can you guess?
Like B.D.M. and W.G.S.,
And M.H.I. and P.V.C.,
Not forgetting J.A.B.

D.F.E.N. and A.K.T.,
And P.S. and L.R.I.B.
The Hospital is proud of them
And one C.W.S.F.M.,
And D.D.M. and K.O.B.,
And D.B.F. and R.C.C.
M.A.E.S. and E.G.T.
Will likewise rhyme with M.L.C.

C.B.S.W., J.L.R.,
I.J., B.F., and J.O.R.
Will rhyme with nothing, I confess,
Like I.M.H. or E.F.S.
J.C.B.F. and C.D.P.
Will rhyme with J.L. easily.
We still have greater things to say
Of C.N.H. and A.E.J.

And D.K.W., F.R.C.,
And J.T.S., and O.M.C.,
J.E.A.W., D.B.C.,
And J.S.M. and J.E.D.
W.D.N. and R.M.E.,
R.J.M.W. and D.T.
(the ode continues, going well),

And A.P.F. and R.J.I.
And S.H.S. and A.M.D.,
D.W. and R.N.T.T.,
And G.S.U. and W.R.C.,
R.S.O.R. and G.B.G.
Of J.E.F., H.W.B.,
R.F.M.J. and J.H.D.,
J.A.W.S., G.W.T.,

W.S.S., P.J.N.C.,
Of G.M.R., and I.P.T.,
And J.H., A.H., and D.C.
Of W.L.L.R. we tell,
Of A.H.W., A.W.F.I.
Only 24 names more!
A total then of one-o-four.
F.W.G., J.C.M.C.,
E.J.S., M.E.J.B.,
D.J.N., J.R.J.C.,
A.F.W., J.W.A.T.,
G.W.H., and T.T.S.,
R.F.M.J. and B.F.S.
Has chopped the list considerably.
Time to slip in W.E.G.,
Then D.G.N. and P.C.S.,

And W.F.H., and R.A.S.,
And J.A.F., M.C., G.C.,
R.I.W.B., and then A.B.
And two to end on—first, P.T.,
And last, but certainly not least, I.C.
By now, you will be asking "Why
Was this ode written?" By and by,
In years to come, when jokes are low,

Some sad producer (Bart's Ward Show),
Will pick it up and gladly say,
"Some awful joke—it's saved the day!
Some fool can say it off by heart.
The title? Why, it's MEN OF BART'S!"

R.T.J.

HIGHER MEANING—OR THE SONG OF THE LAUGHING STUDENT

Enter mighty Master-Surgeon!
Dress'd in green for operating;
Swift and sure his white-gloved hands are,
Keen and piercing is his eye-glance!
Master-Surgeon looks around him,
Lord of all to see before him.
Milling 'round inside the theatre
See the blue-dress'd people waiting;
Lost and wandering like cattle
Lo! They are the lowly students!
Filled with awe, these lowly people
Watch the mighty Chief with wonder:
Fast and blurring are his movements,
Swift and confident his movements!
"Is this your patient?" asks the Boss Man
"No Sir!" gasps the wretched student
"Tell me, though, what has been found in
"History and examination?"
"Well, alas sir, I know nothing!"
Cried the student, features blanching:
"This man open here before us
"Only came to see his mother!"
Exit mighty Master-Surgeon,
Operating green now sullied;
Red and bloodied now his hands are,
Paid up is his M.D.U. sub.!

B.J.F.

THE SOCIOLOGY OF MEDICINE

By MARGARET STACEY

What is the sociology of medicine and of what use is it to medical students? Why should it be taught at all when there is already so much (too much?) to learn?

Let me say at once that I approach these questions as a sociologist of some 30 years' standing who stumbled into the sub-discipline accidentally. As a sociologist and a consumer of the health services, I became interested in certain aspects of the treatment of children, particularly the effects of a hospital stay. From there I became fascinated by the whole field of the sociology of health and illness.

But perhaps some definitions are needed to start with because there is a good deal of confusion about matters social. By sociology I mean the academic study of social relations, social institutions, social interactions and culture. This study has to be distinguished from the study of social administration, social policy or social work. Sociologists and social workers are not the same thing at all. Social workers are one of the caring professions. Sociologists study society.

The sociology of medicine has also to be distinguished from social medicine. Social medicine is a branch of medicine concerned with certain social aspects of health and illness, e.g. the control of infectious diseases, environmental health, epidemiology. The sociology of medicine is a branch of sociology, not a branch of medicine.

A distinction has also been made between the sociology *of* medicine and sociology *in* medicine. The latter develops in medical schools as a technical aid to the practice of medicine. In this sense sociology in medicine has some affinity to social medicine. Probably the sociology of medicine develops best as a discipline outside the medical school, at all events I suspect it develops as a more critical discipline within a sociology department and most constructively in a sociology department which has friendly relations with the health service, both professionals and patients. In the context of a sociology department the problems presented relate to the whole context of medicine in society and not just to the social aspects of problems recognised in patient treatment in the medical school. Obviously, sociology in the medical school must develop along these latter lines if it is to be of relevance to practising doctors and doctors in training. But, at the same time, it must keep close links with its parent discipline and with the broader definition of the sub-discipline.

What the sociologist of medicine does is to examine analytically all aspects of health institutions, including the social concepts of health and illness themselves.

Why should the medical student bother with all that when what he or she has to do is to try and heal individuals? Essentially, I think he has to bother with it because, unless he has some understanding of the sociology of medicine, he will not know as a practitioner when to use sociology *in* medicine.

Sociology presents quite a challenge to medical students (although I suspect an even greater challenge to those who qualified some time ago). There are, I think, two quite different reasons for this. One is that sociology does not work with the biological model of the individual which is at the basis of all medicine and much psychology. Sociology does not deny this model, but it is not part of its central concern. When sociology is concerned with an individual it is as a member of a social group, or, more accurately, of several social groups of different kinds. The sociologist is interested in tensions and, indeed, conflicts between groups, as well as the circumstances in which groups work together. From the point of view of the individual, the sociologist is interested in the cross pressures to which individuals are subjected because of conflicting loyalties, or conflicts and tensions between groups to which they belong. Thus, a man may be subjected to tensions arising from the conflicting demands of his work place, his family and his doctor who is requesting that he enter hospital for treatment. A doctor may feel a conflict between the pressures from a professional association and from the realities of the situation in which he is treating patients. The sociologist is also interested in the social interactions between individuals, how individuals take account of each other in their behaviour, and take account not only of those whom they are immediately interacting with, but also of others not present, but to whome they are linked in various ways.

Sociologists, therefore, are not just interested in individuals, but in people in interaction. Much of their work is more about the interaction than the people. But when one comes to applying sociology to medicine, it may well be the effect of the interaction *on* the individual that becomes the focus of study. Very commonly for sociologists, however, it may not be the individual patient, but the patients' families or the wards they are being nursed in, or the interaction between the doctor and the patient which is the focus of study.

The second reason why medical students, but perhaps even more established doctors, may find sociology challenging is that it is a critical discipline. In seeking to describe and explain current social behaviour (and in defining medicine as social behaviour) sociology records and analyses the taken-for-granted and in so doing speaks the unspeakable. All doctors have certain social assumptions they make about their patients and about their interaction with them. These are essential parts of their ways of coping with their jobs. It is embarrassing to have these notions analysed, especially by "outsiders", and to be told their views are not consonant with the social situation of the patients or the patients' view of their interactions with doctors.

Strange and challenging though the sociological way of looking at things may be, it is nevertheless essential for medicine. It has long been accepted that there are social factors among the aetiology of some diseases, maternal and infant mortality, for example, and the "poverty diseases". It is important to the doctor also to know that his view of what is health or illness is not at all concordant with his patients' view. We now know that the population that presents in the doctor's surgery is not much different from the population which does not present. It is important also, if human and material resources are not to be wasted, that doctors should be aware of how much their advice and treatment is understood and acted on. It is important too that doctors should grasp and know how to handle the social causes which may keep patients in hospital. There is a great tendency to say "20 per cent of these patients are social cases", as if that was an irreversible act of God or nature. Generally, "social" is used to cover a multitude of non-clinical factors, but most of them human-made and controllable at some level.

As well as helping with the specific treatment of patients, sociology can help the doctor to understand his own work situation. This applies to the interaction between doctors and patients already mentioned. It also applies to inter- and intra-professional situations. The hospital, for example, is a complex social organisation. Unless those working in it have some understanding of this complexity and its meaning for themselves and others involved, much may go awry. Thus, in research in hospitals, colleagues have observed that doctors are given high prestige by all other hospital employees and seen as the leaders and initiators of much of the activity in the hospital. In many cases, doctors, while enjoying their high prestige, do not see the full implications of this. They see their work in a ward, for example, as associated with the particular morbid conditions of particular patients. The effective treatment of these patients and their conditions involves the articulation of many people. In this articulation the doctor is crucial (given the present authority structure of hospitals). But he may be quite unaware of the full implications of this and of the way his actions work through the complexity of social interactions involved.

Sociology by itself will not solve anything. It is not a panacea. But, properly read, it will shed helpful light on the condition of the doctor and his colleagues, and of his patient. It is one of the disciplines which includes part of the gift of seeing ourselves as others see us.

Margaret Stacey is Professor of Sociology at the University of Warwick. She has written on both the sociology of medicine and problems of social research.

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BOOK REVIEWS

GENERAL

PSYCH IT AND SEE...

RADICAL PSYCHOLOGY edited by Phil Brown. Published by Tavistock. Price £1.40.

Psychiatry has suffered for several years from a lack of underlying theory. There has been no attempted revision, let alone revolution, of its theoretical aims and scope. In fact it seems that the last great upheaval was due to Freud, and the rise of Psychoanalysis and was based on the rather shaky anatomical ideas of the late 19th century. Thus Psychiatry seems to have remained a descriptive science, drawing theory from practice rather than using the theory-into-practice method of more experimental sciences. And where data were available they were epidemiological and statistical: even the currently fashionable drug therapy is based on the "suck-it-and-see" ideology of the clinical trial.

The legacy of this descriptive background has been double-edged in recent years. Following the other biomedical sciences, one branch of Psychiatry has attempted to gain an experimental footing, a biomolecular validation: regrettably without much success. The other has involved the development of concepts largely divorced from experimentation, and thus, in some sense, is in the mode of its progenitor. There, however, the similarity ends, for Radical Psychology as the second likes to call itself, is an attempt to show up the old Psychiatry for what it is: the tool of a repressive society. This tool has been available to be used as a means of control over subjects who are malignant in the eyes of society, but not sufficiently criminal that they may be summarily incarcerated. Thus the therapeutic claims of Psychiatry have been neglected in practice, though played up for the sake of the public it might "defend".

Phil Brown's "Radical Psychology" is an attempt to draw together the various threads in the anti-shrink campaign and, I suppose, put the Alternative case (at least, the case developed at Alternate U. at which Phil Brown taught). Feminist, Marxist, Freudian and Anti-Freudian, Psychiatrist and Anti-Psychiatrist, therapist and radical therapist: presented as though fully complementary. For instance, Szasz is taken at face-value in his views of the mental patient as scapegoat—forgetting his agreement with Popper on the poverty of Marxist historicism. Early work of Reich is taken as representative of the views of a man who later came to respect democracy and reject Communism. Anyone can change his mind—but surely editors should remember that and note it in their introductions.

The longest section is that on "The Marxist Foundation", although it contains only one paper by Marx himself. The other papers are classics by such as Frantz Fanon, or essays on (and by) later Marxists like Reich: the paper by Keith Brooks being the new star in this familiar sky. Here he fairly convincingly destroys the notion of Freudianism as a Marxist view of psychology by contrasting the internalism of Freud with the socialism of Marx. He does, of course, lean on Marcuse's view of Freud, a view criticised sternly by Erich Fromm: the uncertainness of the premises do not detract from the excellence of the argument.

The shorter sections are on "Sex Roles" (though Phil Brown's view of Freud as male chauvinist pig is made old hat by recent Juliet Mitchell); "The Therapy Rip-Off" (where one finds Radical Psychology as she really is spoke!) and "Fighting Back" (which is surprisingly very short and extremely disappointing). Apart from some of the articles on Marxist influence, those best known already in this neck of the woods are on "The Sociological Approach" and "Antipsychiatry", mainly because Szasz, Goffman, and Laing and Cooper are well known here, though the latter's brand of existential psychiatry is now less trendy than hitherto. Perhaps more of the contributors will be household words (whatever they are) soon, for Penguin has just published an anthology of extracts from *Radical Therapist*, the journal-with-the-jargon to which they regularly contribute.

In his Preface and his Introductions to the sections, Mr. Brown shows these to be the central points of value in a collection of readings. His criticisms of Szasz, who remains a prime member of the medical profession and a conservative in practice, are especially valid. Scheff and Goffman come in for similar criticism, this time for omitting the class differential in psychiatric diagnosis. The notes on Laing, *et al.*, are just as good and note the male-centredness of Cooper's view of approaching family dissolution. However, the Introduction to "The Marxist Foundation" puts the psychology of alienation and class-related psychosis in the weakest of simplistic terms, such that everything of value is instantly doubted as a naïve con. For instance the point is valid that a people's psychology is only possible in a new, socialist society; but the mistake is that a trendy, cliquish approach is used to present that psychology which automatically excludes the "people". The style is thus irritating and condescending—in these sections only, thank heavens. My final criticism is that in this English edition all references are to American editions, even though English versions are usually available.

The basic attraction of this book, at least for the student, is not the *Varoomshkaesque* exterior, but that it is a collection of readings and comes in paper covers (at an almost reasonable cost). Many of the papers form part of larger individual works, but usually the essence is found here: possibly with little loss of detail but much gain in force. Better 28 readings for £1.40 than at a quid-a-time under separate covers—and just hope that the reader allows for editorial blinkers. Perhaps this is the Age of Readings as much as it is of other preselected, predigested goodies, so it is a shame that the weeklies seem reticent to review this category.

TEIFION DAVIES.

MAGICAL MEDICINE—A Nigerian Case Study, by Una Maclean. Published by Penguin. Price 50p.

Una Maclean's highly readable account of Medicine in present-day, urban Nigeria may not exactly uncover startling new evidence, but her approach is refreshing. She does, unfortunately, fall into the anthropological pitfall of patiently explaining that, although the Nigerians' approach to Medicine is "different" from ours, it is nevertheless equally valid. Maybe I'm optimistic, but I should have thought that hardly needed saying in our "enlightened" age.

This stated, Miss Maclean proceeds to draw together both the similarities and the differences between the medical treatment offered in Britain and that offered in Nigeria. For example, the behaviour of people of both countries is remarkably similar when confronted with relatively minor ailments, i.e. their first recourse is to self-medication. Should the minor ailment persist, or if something more serious is contracted, then the patient seeks professional help and advice—as much to reinforce his own definition of the illness as to effect a cure. It is here that the practice of Medicine in the two countries begins to differ.

The native Nigerian patient, unlike his British counterpart, has two types of Medicine which he may choose to consult. He is likely to turn first to the native brand, since this seems more capable of supplying him with the information he requires. Like most people, the Nigerian's first response on falling ill is to ask "Why me?" and since he believes that all affliction is caused by someone else's spite or malice, he is more likely to find an answer to this question than anyone in Britain today.

Hence he consults his local witch-doctor/herbalist/medicine-man to discover who in particular bears him a grudge and is causing his illness. If the illness consequently disappears, then he assumes that either that person has been appeased, or the attacker's magic/sorcery has been checked by his own defensive magic. Should the illness persist or worsen, then the patient may consult a European-style doctor in a European-style hospital. Because of the foregoing routine, a patient is usually very seriously ill, and often incurable, by the time he turns to modern medical techniques. This accounts for the relatively low success rate in the modern hospitals and the, in most cases, dubious faith of the natives.

For preference, a Nigerian would turn to the powerful, and dangerous, native practitioner who has obtained some of the equipment of Western Medicine, e.g. a hypodermic which he uses to inject "weird and wonderful" substances at random into the body. This practitioner is highly favoured since he has not only acquired the trappings, and therefore the secret and power, of Western Medicine, but has incorporated this into the native mould, and is more likely to give his clients the answer they want, i.e. *who* (not what) is causing my illness?

The only part of the book which I found rather

One has no reason to doubt the veracity of the information included in this book, since Martin Gilbert succeded Randolph Churchill as Sir Winston's Official Biographer in 1968. But the book is more than an account of Churchill's life; it is also a history of British politics since the turn of the century.

Whatever one's personal opinion of Sir Winston Churchill, one cannot deny that he is one of the greatest politicians of this century, as this book faithfully portrays him to be. I do not dispute this, but insist that Martin Gilbert does nothing to redeem my view of him as a rather pompous and unendearing individual —the original British Bulldog, in fact.

JANICE DAVIES.

CALCUTTA by Geoffrey Moorhouse. Penguin 75p.

The author has recently completed a book on his journey across the Sahara by foot and camel, and from all accounts that was a pretty terrifying experience. But just a few pages of "Calcutta", a cleverly written description of Kipling's "City of dreadful Night", are scaring in a far less remote way. For whereas few of us hope or expect to have to cross the Sahara by land (except the woolly-brained romantics who might regard dust, flies, dirt, heat and thirst as "fun") many of us do live in a very large city, and most of us are worried about our futures therein. "Calcutta" is about the breakdown, under the pressure of its own numbers, of the fourth largest city on earth, and it is horrifying.

Words like "poverty", "squalor", and "overcrowding" are part of the accepted canon of descriptive terms when one is reporting a flood in Bengal or a drought in Bihar or a typhoon in Bangkok. We hear

them every night on the TV news, and they become empty and meaningless. But in Calcutta they exist, as the norm of city life. For example, "Poverty". People in Calcutta have reached such a depth of poverty, begging is so rife and all-pervasive, that little children are deliberately maimed so as to increase their appeal as beggars. 'Squalor". In Calcutta some 50,000 or more people (counting isn't easy) sleep on the streets at night, bundles of filthy rags scattered round the roadsides or wherever they can find in the drier ditches. "Overcrowding". Each main railway station is reckoned to let through, every day, some 25,000 people who have not paid for a ticket; in the morning crush checking is impossible.

As an exposition of urban horror then the book is fascinating and appalling, but at 75p for under 400 pages, despite a good-looking index and evidence of much solid research, it has got to be overpriced. Also, for those wanting the raw stuff there are several long sections on the city's history and on its post-war politics that may seem rather hard going. But they do repay study, in that Calcutta's purely commercial origins and the greed of the British are all part and parcel of the cynicism and semi-anarchy that prevails in the present status quo. Also Moorhouse is always entertaining with his data, and full of casual asides without being overtrendy. He is particularly good on being white (and therefore rich and uninvolved) in such a society, questioning his own role as an observer who merely turns up, looks around, and flees back to safety in his own country. But the best part of the book is the summing-up in the last two pages, which is chillingly brilliant in its prediction of the inevitable outcome of a society that allows widespread horror to exist alongside a very few obscenely wealthy. Just to read this is amazing.

T.H.T.

CHURCHILL: A Photographic Portrait, by Martin Gilbert. Published by Penguin. Price £1.50.

Before starting on this review, I want to excuse myself by saying I found it quite difficult to review a "picture-book", which is what this amounts to. Because of this, I have no intention of criticising the quality or variety of the photographs included, since this would seem petty in view of what Martin Gilbert has achieved.

The book is basically a pictorial account of most of the major events in Churchill's life, and some of the more minor ones. It includes appropriate photographs and reports of Churchill's leaving the Tory Party to join the Liberals in 1904; being appointed Chancellor of the Exchequer to the Conservative Prime Minister, Stanley Baldwin, in 1924, though not a member of the Conservative Party; besides giving us the interesting information that Churchill was responsible for the first British tax on petrol introduced in 1928 at the rate of 4d. per gallon. Some of the more minor events recorded include a picture of "Sir Winston parking his car in Birdcage Walk" in 1925, while he was Chancellor of the Exchequer under Baldwin. I must admit I baulked a little when I saw the caption to this particular photo.

As well as photographs, the book also contains some very revealing cartoons and illustrations (revealing of contemporary opinion, that is). For example, there is a pen drawing of a suffragette attacking Sir Winston with a dog whip at Bristol Railway Station in 1909. What a pity there is no photo of this particular event! Needless to say, Churchill opposed giving women the vote.

The Army and War can safely be said to have dominated Churchill's career. He started as a small boy playing with toy soldiers and fleets, continued as a War Correspondent for the "Morning Post" (not Star) in South Africa, and reached his peak as wartime Prime Minister of Britain during World War II. This last can be regarded as the summit of his political and his military career. The prominence of the Army in Churchill's career is ironic when one considers the persistence with which he called for a reduction in the amount of money spent on defence. This might possibly be explained as loyal sponsorship of one of his father's, Lord Randolph Churchill, old causes, since Winston greatly admired him.
tedious was the discussion of a survey and questionnaire carried out in the suburbs of a large Nigerian town. This account would have been greatly helped by the use of tables and illustrations, but there may be some technical reason why these were not included.

Although "Magical Medicine" is a readable book, I would not classify it as "light" reading. To be recommended mainly to those who have an anthropological bent.

JANICE DAVIES.

THE SAVAGE GOD—A Study of Suicide, by A. Alvarez. Published by Penguin. Price 45p.

Al Alvarez is a distinguished poet in his own right; and as poetry critic of the *Observer* and *New Statesman* for several years he has made his mark on other people's poetry. He is also fascinated by suicide—and was almost a practitioner of that art, too. And it is his synthesis of critic and practitioner that make this book so worth reading.

The book is essentially both a study and an anthology of suicide. Examples abound not only of the practices of the suicides themselves, but also of the abominations committed by those around them who were insulted by the act. For instance, the neck of a man who had cut his throat was bound up with cloth so that he could die for his crime by hanging, in the approved and legal manner. Those who succeeded without the aid of their vindictive betters were denied religious burial rites, dismembered, burned or buried at that sinister place, the crossroads. Though suicide has not always been so regarded: the Romans thought very highly of it, as did the dandies of the "Age of Reason", as do some Japanese. Also, it was not only the century that was important—class was there too to guide one's viewpoint. The Roman noble and the 18th century gentleman were praised for staging a good show by their deaths: the poor were always castigated for taking the easy way out of a God-given situation.

Mr. Alvarez surveys the theories of suicide, Durkheimian and Freudian, but from a rather distant vantage point—i.e. not too closely. The bulk of the book is anthology-cum-history of suicides, from pre-Roman times through Dante, Donne, Chatterton, Goethe, and Dada to today. And today is represented by Sylvia Plath and Al Alvarez himself as Prologue and Epilogue respectively. In these sections Mr. Alvarez shows himself to be both human and poet, while giving some insights to the, as I had thought, brittle work of Miss Plath.

Sylvia Plath's death, by a combination of intention and ill luck, was the spur to Mr. Alvarez's own interest in suicide. He recalls their first meetings, when she was no more than the wife of poet Ted Hughes, with some of the regret of a lost first love. His whole history of their acquaintanceship is full of self depreciation: he did not understand her poems; he did not realise that she was close to suicide—at least not *that* close. The passages from her poems which he quotes show her to be overdependent on the vampire-myth of her long dead father. So periodically she would not so much attempt suicide as challenge death to snatch her, thus:

> At twenty I tried to die
> And get back, back, back to you.
> I thought even the bones would do.

And perhaps the last, fatal scenario was just another such challenge.

Mr. Alvarez's own attempt is just as faithfully documented, just as refreshingly approached, and written with the same grand sadness of involvement. The whole book is in fact a very personal account, and we should feel privileged to be allowed to read it.

T.D.

GUILLERIC: Selected Poems. Published by Penguin Modern European Poets. Price 80p.

This selection is drawn from Guilleric's work between 1938 and 1971. His poetry is always earnest and turns our attention to a refreshingly new perspective—he wants us to see all things in the world, both animate and inanimate, as having equal weight with man. Guilleric himself has knowledge of other modes of existence:

> "I've lodged in the blackbird."
> "I've lived in the flower." (*Dwellings*)

Even those things traditionally regarded as inanimate are imbued with life in this poetry—mountains, rocks and waves are classed with insects, trees and flowers. Guilleric thinks that man underestimates and misunderstands most of nature. This is brought out in the first poem in the selection, which also demonstrates his use of irony:

> "You frightful things that crawl
> outside of man's understanding
> must be referred back to heaven." (*Ant*)

What then does he see as man's place in the world? Man is portrayed as being different from yet not superior to the rest of nature—perhaps complementary.

Whatever

> "Whatever's not in stone,
> whatever's not in walls of stone and earth,
> not even in trees,
> whatever always trembles a little,
> well, that's in us."

Yet Guilleric thinks man has failed, both in the way he lives, and in his inability to understand natural phenomena. This selection includes poetry concerned with the Second World War, but there is no more sadness in them than in the death of ants by boiling water. Man traditionally claims nature is dependent on him, Guilleric maintains the independence of nature. He feels that man's relationships with nature should not be conceived instrumentally.

A favourite section of mine is *"Euclideans"* where characteristics of geometric shapes are explored. Here is the equilateral triangle speaking.

> "I've gone too far
> with my obsession for order.
> There's no future in it." (*Equilateral Triangle*)

So here is a varied collection based on the conviction that nature has consciousness. We might describe Guilleric as being in communion with nature. His poetry is convincing and well worth experiencing.

JENNIFER WEBSTER.

FERNANDO PESSOA: Selected Poems. Published by Penguin Modern European Poets. Price 65p.

Fernando Pessoa (1888-1935) wrote poems not only under his real name but also as Alberto Caeiro, Ricardo Reis and Alvaro de Campas. These were not simply pseudonyms but the fully developed form of tendencies which normally coexist and compete in one consciousness. I found the writings of these three personae more stimulating than those of Pessoa himself. Having read the three independent strands, one expects perhaps that the poems of Pessoa himself will be their battleground and the scene of their resolution in face of the need for practical action in a real world. Here one hopes there will be the development of a character—something denied to the other heteronyms who are locked by definition into a certain mould. Yet this is not the experience I had when reading this selection of Pessoa's work.

I return then to the other personae with whose utterances I could develop a deeper sympathy. Caeiro is the philosopher, noble savage, a self-confident hedonist, master of his own fate: for whom experience is all and reason is nothing. Things are what they are and their meaning is our experience of them (see e.g. p. 88).

Reis is Caeiro disenchanted with his frailty in a real world, abandoning himself to nature and snatching life while he can. Self-confidence has gone and he calmly accepts his self as a forum of thoughts and feelings over which he exercises no autonomous decision (see e.g. p. 105).

De Campas is the wearied yet not cynical realist who recognises his own capacities but knows that he will

never develop them to the full. Nevertheless, he pits his reason against fate in the belief that the struggle is all that is worthwhile. He may lack self-confidence but at least he sees his own individuality as problematic (see e.g. p. 111).

The translations are by Jonathan Griffin and in some places seem careless to the point of generating obscurity. His also is the introduction which is solid enough providing relevant biographical data and plausible interpretations, some of which differ from my own offerings above.

DAVID WEBSTER.

The *Penguin Modern European Poets* series has also recently published selections of poems by the following: Alexander Blok (70p); Juan Ramon Jimenez and Antonio Machado (70p); Marina Tsvetayeva (70p); and Paavo Haavikko and Tomas Transtromer (80p). All have a useful Introduction and some have notes on both poems and poet.

PENGUIN—POET TO POET

Ben Jonson selected by Thom Gunn

This edition has an effective cover. An old portrait of Ben
Jonson and a photograph of Thom Gunn. And then
there is a remarkable similarity between the two, in looks
at least. As for the contents of the book,
very disappointing. I'd never read any Ben Jonson before,
and I certainly don't intend to read any more.
I found most of it incomprehensible baloney,
the one poem I did enjoy was "Song" from Volpone.
As for the rest of this load of olde doggerel
it can't compare with the works of the Great McMonagle.

F.C.W.

Editor's Note: Who on earth is the Great McMonagle?

SERGEI by Sergei Kourdakov. Published by Oliphants.

This is the autobiography of a young Russian who, having lost both his parents in one of Stalin's purges, was brought up in a succession of state schools for orphans and children who were literally confiscated from parents deemed ideologically unsound by the authorities.

These schools were run by ex-party officials, who had failed, and as is inevitable in such circumstances were rather worse than the worst public school. Sergei graduated from this background having learnt one lesson, that only the strong survive. This was learnt as a result of having watched children starving to death in the school due to the disastrous harvests after Kruschev had begun to direct Russian farming policy.

Sergei graduated to a naval officers' training school where, after his efforts for "The Party", he became the Communist Youth Leader, which put him in a position of considerable authority. When on leave he stayed with old school friends who had made their marks in the Underworld, mostly by trafficking in drugs, a surprising revelation, though apparently alcoholism is a more serious threat to Russian youth.

About five years ago an important policy decision was made by the Praesidium in Moscow to try to combat the spread of the Christian Faith. As a result special squads of young military personnel were formed and attached to the KGB to act as raiding parties. Sergei was approached and offered substantial payment to form such a squad, which he did, although at first he did not know what it was for. His squad was used for breaking up brawls in the taverns and on the streets and it was encouraged to resort to brutality. Gradually the squad was called on more for raiding the secret meetings of the "Believers". On such occasions he and his friends, young judo and boxing champions, would break in on the meetings and beat senseless the old men and young women and others present, in order to discourage them and others who might hear of the raid from holding further meetings. All literature was confiscated. Inevitably some of the "Believers" died.

Sergei, sickened by the brutality and confused by the basic contradictions in communist doctrines, which preaches freedom of thought yet demands complete adherence to communist ideology (even if it means beating and murdering harmless people), found himself in deep personal conflict. This was further increased as he secretly read some of the confiscated literature which he was supposed to destroy.

In the end he could stand his Jekyll and Hyde existence no longer and he decided to defect. His escape from a Russian trawler sheltering from a severe storm near the Canadian coast was nothing short of a miracle. He was allowed to stay in Canada, but was quickly contacted by the local communist party and warned to be discreet about his activities on behalf of the KGB, with thinly veiled threats of the consequences of not obeying. However, Sergei had become a Christian and felt impelled to make restitution by campaigning on behalf of those still being persecuted in Russia. He also wrote his autobiography.

He was found shot dead on his 22nd birthday, two years ago, in an hotel bedroom. The verdict was accidental death. He had forecast that one day just such an "accident" would happen to him.

This book is a personal account of Russia today and it lends depth to an understanding of the books and articles which Solzhenitsyn and Sakharov have written and published about present day Russia. Their international reputation has, so far, protected these moral giants, but those less well known, such as Sergei, have paid for their revelations with their lives.

J. A. and P. M. E. LOWES.

Next month: Alice, Snark and the Human Lens—all in the same exciting issue.

MEDICAL

GERIATRICS

CARE OF THE AGED by Dennis Hyams. Published by Priory Press. Price 00p.

This excellent book in the Care and Welfare Library series is concise and clear and full of common sense. It is not a text book of Geriatric Medicine nor is it a book of Therapeutics but it outlines much of the thinking which has led to the development of Geriatrics and gives sound advice about the principles of treatment of the elderly. The author has appreciated that although there are now many people in the United Kingdom concerned with the care of the aged, many old people who become frail do not receive the help they need. The reasons for this apparent paradox are many but commonly difficulties arise because the problems are not accurately identified (and, therefore, the wrong remedies are sought) or people do not know where to look for advice or practical assistance.

The first half of this book is devoted to a discussion of Old Age and the problems which often surround it and emphasis is put on the concept of informed management—a concept which implies the proper treatment of a patient rather than piecemeal attempts to treat disease and social problems as if they were not related to each other or to the people who suffer them. There follows a valuable chapter on help available to the elderly including that provided by Local Authorities, Voluntary Services and Geriatric Departments and there is a list of useful addresses. Other chapters are about death, dying and euthanasia, the future of care for the elderly, some case histories, the Social Services and Aids to Daily Living.

This book is likely to be of value to all those who care for elderly people. All medical students and most doctors who see elderly patients would profit from reading it.

A. BRAIN,
Consultant Geriatrician.

PSYCHOPHARMACOLOGY

AROMATIC AMINO ACIDS IN THE BRAIN, Ciba Foundation Symposium. Published by Elsevier, Excerpta Medica, North-Holland. Price U.S. $19.60.

As our understanding of the biochemical basis of physiological activity has increased over the years, it has become evident that certain simple compounds play indispensable roles in vital processes. Among these important compounds are three aromatic aminoacids, phenylalanine, tyrosine and tryptophan, which are intimately concerned in normal brain function, in the pathophysiology of various disease states, and in the responses of the brain to various drugs. The Ciba Foundation, which exists for the promotion of international co-operation in medical and chemical research, brought together representatives of three areas of scientific investigation into these compounds in May 1973. The first group were scientists concerned with the factors controlling their concentrations in the brain, their movement from one tissue compartment to another, and their breakdown within the brain. The second group were particularly interested in the use of these aminoacids as precursors of the monoamine neurotransmitters dopamine, noradrenaline and 5-hydroxytryptamine. The implications of their work for the treatment of the affective disorders and of Parkinson's disease has already become obvious with the use of tryptophan in the treatment of depression and levodopa in Parkinson's disease. The third group consisted of scientists concerned with protein synthesis in the brain and other organs, particularly the importance of the availability of these aminoacids in determining this rate of synthesis.

This book is a record of the papers presented at the Symposium together with the discussion which follows each presentation. The discussions in particular are of great interest for they demonstrate how tenuous the cherished beliefs of one group of workers may appear when confronted by the critical appraisal of another group of experts. It is, of course, only by the mutual frank discussion of research in such high-level meetings of investigators that real progress can be made. While these proceedings will be of particular value to physiologists, pharmacologists and chemists working in the neurological and psychiatric fields, they also contain much information of more general interest to endocrinologists, nutritionists and investigators in various areas of metabolism, and it is to these workers that this book is warmly recommended.

PAUL TURNER,
Professor of Clinical Pharmacology.

NEUROPHYSIOLOGY

FEBRILE CONVULSIONS—A Reappraisal, by Margaret Lennox-Buchtal. Published by Elsevier, Excerpta Medica, North Holland. Price U.S. $21.20.

Approximately 3% of children suffer one or more convulsions during the febrile illnesses of the first five years of life, and some of them subsequently develop epilepsy and are liable to fits even when afebrile. Some workers have therefore sought to distinguish between children with benign "febrile convulsions" and those with a lifelong liability to epilepsy who happen to suffer their first seizures when febrile. In recent years various authors, notably Dr. Lennox-Buchthal and her Scandinavian colleagues, have argued that "severe" (i.e. prolonged or unilateral) febrile convulsions can themselves cause anoxic brain damage, particularly of

the temporal lobes, and thus give rise to epilepsy. The distinction between the two theories is important, for the one leads the clinician to attempt to identify those children with convulsions who are in fact epileptic, while the other justifies vigorous prophylaxis, and indeed treatment of the acute attack, in order to prevent the development of epilepsy.

The evidence on which Dr. Buchthal's theory is based is presented in detail in this monograph. It is largely statistical and often allows of more than one interpretation. For instance, the established association between prolonged or unilateral febrile convulsions and subsequent epilepsy does not of itself indicate that severe fits cause brain damage, but may simply indicate that epileptics exhibit a different type of febrile convulsion from others. In particular one is entitled to ask why children with normal brains should suffer unilateral seizures in the first place. Nevertheless, most readers are likely to agree that on balance the author proves her case beyond reasonable doubt. Finally, she presents criteria by which the risk of further and more severe febrile convulsions can be predicted and shows that, although it is difficult to abort the acute attack, prophylactic treatment with phenobarbitone, carefully controlled by estimations of the drug level in the blood, is extremely effective in preventing recurrences. If her main thesis is accepted it must follow that many cases of epilepsy are preventable.

The book presents a large amount of statistical evidence and does not make light reading; it is, however, concise and well written. The importance of its conclusions about a very common disorder should make it required reading for all those concerned with the care of children and of people with epilepsy.

C. D. BINNIE,
Consultant Clinical Neurophysiologist.

CURIOSA, a miscellany of clinical and pathological experiences, by William St. Clair Symmers. Published by Bailliere Tindall, price £3.75.

Although, at first sight, this book looked as though it might have been intended to be amusing, this is not the case. The contents consist of some 50 case histories presented with exceptional accuracy and conciseness, and in an occasional very witty style. Some obviously very rare complications of certain hospital procedures are given the coverage they need to prevent others in the medical profession from having to check that their M.D.U. sub. has not expired. In certain chapters, a fair knowledge of Pathology is required . . . in others, it would seem that the Pathology is of a highly esoteric quality. In either case, the average reader will benefit from the explanatory notes and comments on the organisms involved, and from the photomicrographs in each chapter.

To summarise, a very readable book (it is intended as the first volume of a series of three), but unless your chosen interest is histopathology, and you have the money to buy it, then I would borrow it for bedtime reading.

R.T.J.

SPORTS REPORT

ALL YOU EVER NEEDED TO KNOW
ABOUT SPORT, STARTS HERE

TENNIS

LADIES' TENNIS CLUB REPORT

The occult strength of last year, masked by "850th" and exams, revealed itself this season to the tune of two cup teams and a social team. The onslaught was too great for the opposition, who withered in our advancing paths. Undaunted by cancellations, fortified by home tournaments and enthusiasm, Bart's Ladies' Tennis teams took London and Cambridge by storm.

The turnout at the A.G.M., of the captain, vice-captain, Dr. Stansfield the president and food for 20 did not reflect future appetites for matches, or match teas! Apathy and awe were cast aside at the trials on April 24th, as 23 budding Chrissy Everts leaped lissomely about the two Charterhouse courts, smiling winsomely at the selection committee. The Judgement of Paris was never so hard!

A second cup team had seemed a joke, but the smiles of the opposition were swept away as Liz Adams led the "Second M. B. Mob" through round after victorious round of cup matches—9-0 against the London, 6-3 against U.C.H. As a first team member was heard to comment—A Bart's v. Bart's final? What fun—but it could be embarrassing. But sadly the Middlesex proved too much in the middle of 2nd M. B., and our noble warriors fell 5-4 in the semi-final, leaving the duty of retaining the cup to the first team.

The thirst for blood of the firsts had been thwarted from the beginning of the season. Since the victories of the Cambridge tour, their prowess had not been vaunted. Lacking in opposition, two home tournaments were played, and with this preparation they were "forced" to the semi-final of the cup via a bye and a walk-over. Under blistering sun, that semi-final v. Guy's was a tense match. With the match at 4-4, the final game at 5-4, deuce, and Sue serving, what was it? A double fault, my classical in the net volley! But two sizzling shots later we were in the final. We were victorious for the third year running. Spurred on by our supporter, we beat the Middlesex 5-4, and celebrated with strawberries and cream.

Throughout the season many sociable matches were enjoyed by all who answered the call of "Anyone for Tennis?" With the emphasis on social, many afternoons were pleasantly passed, away from books and patients, at Chislehurst and other grounds.

It was a good season—still to be completed in suitable style by a dinner with the Men's Tennis Club in October. Up girls and at 'em.

SU BODDY et al.

MEN'S TENNIS CLUB

U.H. League
As a result of last year's U.H. A.G.M., the league this season was divided into two groups. Along with the Royal Free and St. Mary's, Bart's were asked to provide two teams, one in each group. The matches took the form of previous years, that being three doubles and six singles, a point being gained for each rubber won. In League A the 1st VI were almost invincible. Out of a possible 54 points, Bart's won 53, losing only one singles rubber to the Royal Free and were thus convincing winners of League A, with Royal Free I as runners up. The results were: —

v. St. Thomas'	won 9-0
v. Westminster	won 9-0
v. Guy's	won 9-0
v. Royal Free I	won 8-1
v. St. Mary's II	won 9-0
v. U.C.H.	won 9-0

The players were selected from Nick Penny, Peter Mortimer, Jim Smallwood, Chris Milford, David Stewart, Richard Edwards, John Howell, Tony Dale, Mike Lean.

The 2nd VI, in League B showed what strength in depth there is in Bart's tennis. Playing against many other hospital 1st teams, they managed to gain 41 points and only lost 3-6 to St. Mary's I, perhaps the strongest opposition to Bart's in both leagues. This enables Bart's II to be runners-up in League B to Mary's I. The results were: —

v. Charing Cross	won 8-1
v. Middlesex	won 5-4
v. London	won 9-0
v. St. George's	won 7-2
v. St. Mary's I	lost 3-6
v. Royal Dental	won 9-0

The players were selected from John Cooper, Richard Edwards, John Howell, Dick Foskett, Mike Lean, Alan Yates, Alan Colver, Roger Bulley, Pierre Bouleaux, Charles Wellingham.

It was hoped that the top two teams in each league would play off in a semi-final, the winners moving to a final play-off for the League Cup. However, end of season crowding of fixtures meant that the semi-finals could not be played, and arrangements for a League Cup Final have yet to be made.

U.H. Cup
In this year's competition, Bart's, as No. 1 seeds, had a bye into the second round, where they beat St. George's 6-0 to move into the semi-final. There Bart's beat Middlesex 6-0 to reach the final for the sixth year in succession. Unfortunately, because of poor management, the other half of the draw was not completed by the date set aside for the final. As yet, the other semi-final has yet to be played between St. Mary's and the Royal Free so Bart's are still waiting for opposition.

U.L. Cup
The tournament proved to be far better organised than the U.H. Cup. In the first round, Bart's beat Queen Mary College 6-0 in what must have been the fastest win in Bart's history. Play began at 3 p.m. and Bart's had a winning 5-0 lead by 4.10 p.m. Perhaps the threatening clouds spurred Bart's to dispatch their opponents with such haste. In the second round, Bart's beat St. Thomas' 6-0 and moved into the semi-final. There Bart's beat University College 5-1 to gain a place in the final against St. Mary's, our old adversaries. The final was played at Chislehurst, and Bart's scored a fine 6-3 win to take the U.L. Cup for the third successive year.

The cup side was selected from Nick Perry, Peter Mortimer, Jim Smallwood, Chris Milford, David Stewart, Tony Dale, Richard Edwards.

On a more lighthearted note, the annual match against the staff side was played on Sunday, July 7th. The Bart's side was represented by David Stewart, Jim Smallwood, John Howell, Dick Foskett, John Cooper, Mike Lean, Richard Edwards and Roger Bullay. These players faced strong opposition in the shape of Mr. L. N. Doule, Mr. J. S. P. Lumley, Mr. R. McNab-Jones, Mr. J. Wellingham, Dr. I. Kelsey-Fry and Dr. C. Garrard. All but Mr. Lumley were well known opponents to the student team, and it was he who proved to be the dark house of the staff side. When after exchanging his wooden racket for a steel framed one of Jim Smallwood's, he began lashing scorching volleys and drives past a bemused student pair of Smallwood and Stewart, Jim politely asked for his racket back and some normality returned to the game and the student pair managed to scrape home. The overall result for the match was immaterial, and a most enjoyable day was completed by a very fine buffet supper at the home of Dr. and Mrs. Kelsey-Fry.

Despite the success of the club, the biggest honours of the season were yet to come. Nick Perry and Peter Mortimer were selected to represent the University of London at the British Universities Championship held at Malvern in late July. Nick was strongly tipped to take the singles title, but was unlucky to lose in the semi-final to Donald Lilliestone of the University of East Anglia, who went on to take the championship. However, to make amends for this defeat, Nick teamed with Peter to take the Doubles Championship after an exciting three set final against Horiton and Hunt from Manchester University, the score being 6-2, 6-8, 9-7.

Not satisfied with one title, Nick then teamed with Jane Plackett from Queen Mary College to easily win the Mixed Doubles title.

Although Nick and Peter were officially representing the University, Bart's can be suitably proud that two of their players took a large part in winning two National Titles at these Championships. In Nick's last year at Bart's, it is fitting that he should crown his playing career in College and University tennis with these fine performances.

D.S.

RUGBY

CASUALS REPORT

Who can fail to recall the condescension and sneers with which the Casuals were greeted at the start of the season? Indeed, who could have been blamed if they joined in with the general Casual-bashing? I mean, who or what are the Casuals? They contain a mere nine recognised rugby players out of their total number of twenty one. And yet, when all has been said and done, it emerges that the Casuals were Bart's most successful rugby team last year.

When the self appointed captain, Alan Hawley (one of today's great democrats!), raided the bar in November and found himself fourteen other players, the Casuals were born. It took a single game to cement the team together and to establish what the image of the Casuals was to be. Within a fortnight all College Hall knew of the Casuals in one way or another, and by the end of the season most of the other London Hospitals and Colleges had heard of them as well. Recent reports delivered to Whitehall indicate that Casuals supporters are massing in various parts of the globe including Cardiff, Nottingham, Sheffield, Paris, Gothenberg, New Jersey and Fiji!

So what was so special about the Casuals and their season. Firstly as one of the renowned Bart's Liberation army remarked innocently, "Casualty is like Communism and Catholicism. It thrives under oppression!" Certainly the fact that a proportion of the Bart's population waged a propaganda war against the club, helped considerably to foster an unyielding team spirit. Secondly, from the very first, the team clicked and surprised everyone, themselves included, by the good standard of rugby they played. As a result, enthusiasm and confidence in their abilities mushroomed.

It was the Royal Holloway College game that provided the greatest glory last season. Picture the setting. A cold, wet pitch and a vociferously hostile crowd (yes, a real crowd of about 60 people!) greeted the gladiators as they emerged from the bar. It was then that we discovered we were playing a team containing *eleven* first team players! Nevertheless, despite going four points behind and a snowstorm blowing in our faces all through the second half, we eventually came out on top. This game taught us that the best bait for Casuals games were long haired lefties. It was to be a lesson well learnt.

Rugby was not the only interest to which the Casuals subscribed. There were attempts to play soccer and hockey and a culture(?) night at a Bart's Drama production. Innumerable sorties were made into the jungle of London pubs and many friendly associations with certain publicans began. Indeed, at one stage, the rugby was in danger of becoming a very secondary occupation.

Respectability came to the Casuals with the first of our annual dinners. This proved a tremendous success and what is more, we have been invited back to the same place next year (can the Golf Club claim that?) Our next step was the appointment of higher dignatories and it was with great relief that we welcomed Dr. J. A. Clark (President), Dr. Wickham Balme and Mr. Nixon (Vice-Presidents). Our thanks are due to this courageous bunch who accepted a task lesser men would have been happy to shirk.

The summer session opened with a spectacular splash! It has to be admitted that whatever the Casuals may be, they are certainly not a rowing team. With characteristic zeal, the Casuals entered the bumps and proceeded to sink their boat on their first outing. Retiring to the bar in order to soften their shame, the Casuals were then banned from it, following heated exchanges with the barman about short change and bad beer. It was generally agreed that the rowing world did not welcome us.

Sports day provided the next venue when the two Casuals teams came first and second in the Casuals relay. The high jump saw the intrepid Rick Holtby bulldozed his way to victory for the Casuals. Then came the tug-of-war, which proved our downfall, pulling against a cross-country team reinforced with spikes and an extra man. Never mind, you can't win them all.

The whole season was reckoned an unqualified success, particularly with the news that only one Casual had failed 2nd M.B. (guess who?) Plans have been made to considerably extend our activities next season. Thus, there are two tours arranged to Oxford and Sweden, a complete range of social events from films to buffets and a sponsored charity competition. Further, the fixture list will be considerably enlarged (both in rugby and other sports) and we hope to found a Casuals cricket team (although we have still to come to terms with the Cricket Club). Next season then, is one of promise.

It only remains for me now to thank all those who made last season such a success. Particular thanks are due to Bill "Trifleman" Linsell who was elected Casual of the Year, Ross Adley for his many after game innovations, and Colin Sibley who endured us so good humouredly all last season. Also, many thanks to the Rugby Club for the support they gave us all through last season.

Results

King's College III	Home	52— 6 won
R.H.C. II	Away	8—4 won
Q.M.C. III	Home	40—10 won
Thames Poly	Home	0—16 lost
N.E. London Poly II	Home	28—10 won
Kingston Poly II	Away	30— 8 won

J. Vogel testimonial match
Casuals 11 17 Captain's XV.

ALAN HAWLEY.

GOLF CLUB REPORT

v. Thornton Park G.C., on August 28th, at Thornton Park

Throughout the 851 years of Bart's golfing history one fact has remained constant—the Bart's Golf Club have always lost to Thornton Park. So it was with a deep sense of history that the selection committee met to choose the side for this fixture, and a "no expense spared" policy was adopted. Our overseas players were flown in from various tournament circuits round the world: Norman Bradley from the U.S.A., Dave Radley from Wales, Chris Fenn from Afghanistan, and Nigel Findlay-Shirras from Monte Carlo. The team selected was: Jim Foster (Capt.), Fraser McLeod (Sec.), M. Bird, T. Turner, N. Bradley, N. Findlay-Shirras, C. Fenn, D. Radley.

Norman "bites your legs" Bradley and Trevor Turner were paired against the Thornton Park first pair and scored a sensational victory over two very experienced opponents due mainly to Trevor Turner's sunglasses—a gimmick he employs to look himself straight in the eyes.

Jim Foster and Fraser McLeod chose this tournament to lose their first four-ball match of the season.

Mike Bird and Dave Radley played to the peaks of their considerable ability and pulled off a win on the 18th green.

Chris Fenn and Nigel Findlay-Shirras, who were both travel weary from their journeys, faded after the first hole and lost their match.

Thus history was foiled, as we halved the match—the first time in Bart's golfing history that we managed to stave off defeat against Thornton Park!

MATCH RESULT: Bart's 2, Thornton Park 2.

J.F.

PUZZLE COLUMN

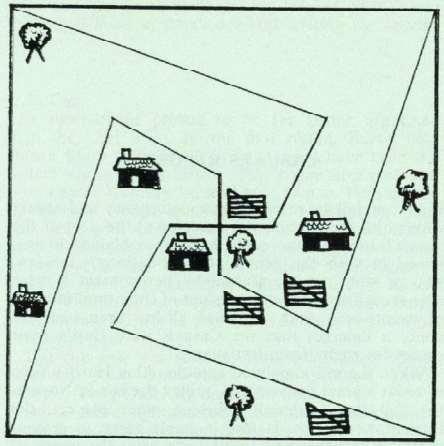
JOURNAL MATHEMATICAL PROBLEM No. 10
By R. TREHARNE JONES

For the sake of this puzzle, there are a certain number of beds at the Royal and Ancient, (not the actual number, so there is little point in looking at the Bed Return Lists!) Of the total number, $\frac{2}{3}$ are medical, $\frac{1}{3}$ are surgical, $\frac{1}{5}$ are orthopaedic, and $\frac{1}{7}$ are gynae beds. The total has a digital root of three, and lies between 214 and 1,298. How many beds are there at the Royal and Ancient?

Solution next month.

Note: For non puzzle-freaks, the digital root of a number is found by adding its digits together until only one digit remains, e.g., Digital root of 428 is 4+2+8=14 but 1+4=5.

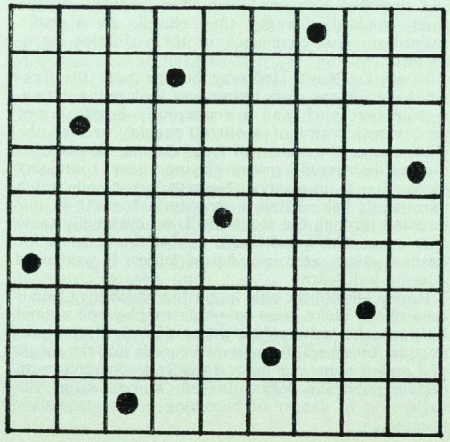
Answer to last month's problem



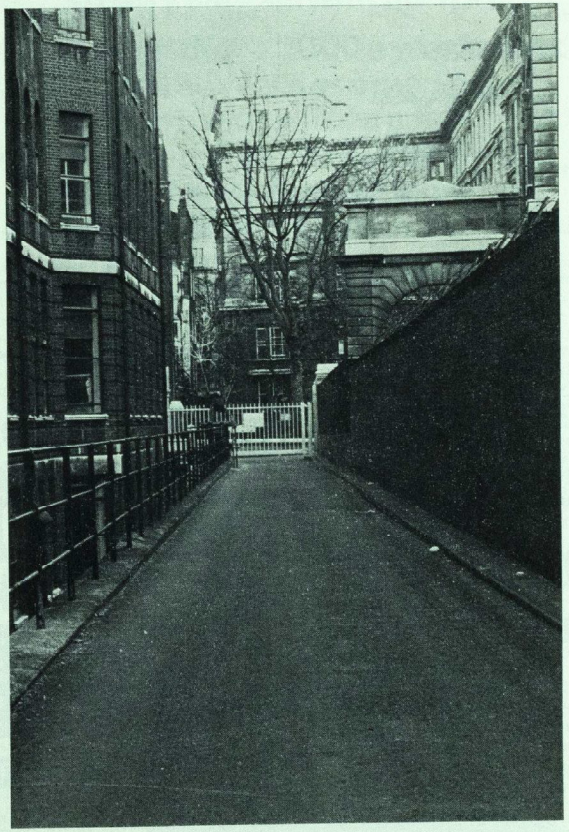
Addendum

Apologies to Jim House for not including his solution to the April problem at an earlier date. The problem, if you remember, was to plot 9 points on a 9 x 9 grid, such that no two points were in line either vertically, horizontally, or diagonally. My solution was rather haphazard, while that of J.H. shows a vague sort of symmetry . . . generally more pleasing to the eye.

Diagrams by Anne.



THE LAST LONG LOOK.....



All over Europe the gates are closing on old ideas, old attitudes . . . and old Journals. Remember to look out for the new-style Barts Journal next month.

SAINT BARTHOLOMEW'S HOSPITAL JOURNAL

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OH, LORD HALSBURY DO NOT TOUCH ME!
or
A TRIUMPH FOR MODERATION

Money appears to have been the subject of *Journal* editorials for some time now: nurses' pay; the distribution of consultants' merit awards; our own financial troubles – all these have filled this position through the summer months. Unfortunately, it can't be said that we have exhausted the list of possibilities, and already, like the painting of the Forth Railway Bridge, we must start again. For midway through September came the Halsbury Report, that 'quick but thorough' (Barbara Castle's words, not mine) piece of issue-avoiding which forget to mention that whatever percentage increase is made in junior nurses' pay, they still get peanuts. And not many at that.

The reasons for this are pretty obvious: there is little there to take a percentage of. The Report shows that, at April 1974 rates, a 'small number' (paragraph 48 of the Report) of nurses earned less than £1200 *per annum*, but student nurses earned an average of £1095 p.a., and that 'a small ...number...earn over £3000'. All this is true and very sad, but at least the Report mentions it with, one would presume, a view to correcting it. Well don't clap too soon. That is just about the last word of financial sympathy the juniors are going to get, for the actual increases, expensive though they are to the Exchequer, don't give much cause for joy to the students, or even to the staff nurse. It will still be possible for students to earn less than £1200 p.a. (in fact, if Briggs is implemented and the minimum age is reduced to 17, extrapolation of the Halsbury scales shows that these poor suckers will earn less than £1100), and staff nurses will only just manage to breach the £2000 a year barrier.

So what is all the shouting about? And, especially, why has the Royal College of Nursing called this 'A Triumph for Moderation' (*Snap* headline, 27th September 1974)? The basic reason is that senior members of organisations such as Rcn can be fairly well pleased with their increases. And there is nothing essentially wrong with that, for such increases are probably well deserved. But these gains only serve to emphasise the poor quality of the lower grades' marginal improvements. The tailing-off of the percentage increase in salaries as the lower grades are reached means that some grades gain only about 5% p.a.: and this must be compared with an estimated yearly inflation rate of anything between 8% and 30%, depending on whose statistics you find acceptable.

It seems to me that there can be no justifying this paltry offering. The argument that nursing is a vocation and as such needs less pay is unutterably silly; the suggestion that student nurses should receive the same sort of grant as other students will only have any force if Briggs is finally implemented, and nursing students become *real* students with only study to cope with and are not retained as cheap dogsbodies. To say that the larger increases for the higher grades make it all worthwhile is to miss the point that students and juniors are *not* higher grades, and never will be unless they are encouraged to stay. Regrettably, Halsbury is keen only to 'reduce wastage' at Ward sister level (para. 35) and has little interest in a bit of investment in the future.

For whom, then, has this been a triumph of moderation? For the Exchequer most certainly; for the Rcn and its ilk who were embarrassed by the whole thing. And for the lowest paid – but they'll find moderation in their pay packets.

AND ANOTHER THING....

Another sad thing about Lord Halsbury's Report is its puny, poorly argued, defence of the employment of agency nurses when the NHS is unable to fill its vacancies through normal methods. Such staff now comprise 1.4% of the overall manpower (whatever group that refers to), or about 4000 nurses in total (para. 55). These nurses come from licensed agencies, whose rate of commission is usually determined by the local authorities, and is roughly 12½%. The amount paid to nurses is not so controlled, so in fact the *absolute* amount of commission payable is variable too (para. 56). Halsbury also says that the *average* weekly earnings of an agency nurse are in fact lower than those of an NHS staff nurse. This is after tax, of course, although many agency nurses are paid before tax is deducted. Halsbury also had to make up the staff

nurses' pay by adding on such things as the value of the uniform supplied, and by taking employer's superannuation payments into account (*loc. cit.*) regretably for everyone these do not form part of the wages.

The impression the Report attempts to foster is one of a rather silly nurse who has left the NHS to go it alone, thinking she will be better off. The NHS then takes advantage of these unwitting potential opportunists to give patients a good service at what, Halsbury would like us to believe, is no extra cost to the taxpayer. Rubbish. Agency nurses aren't daft, but they are better off than NHS-paid staff; and once the commission and administrative costs have been added to the wage bill it is a great deal more costly to public funds than equivalent NHS staff would be.

Unfortunately, the use of agency staff undermines the security and cohesiveness of the nursing team as a whole – even if they were *not* better paid this would still be the case. Since no Government or hospital administration seems capable of taking this particularly thorny problem squarely in hand, either by abolishing agencies altogether or by increasing NHS wages and freedom in order to compete with the agencies, direct action from the nurses themselves is needed. The agencies obviously form as good a means of selling labour as any, so nurses (and other NHS staff of all grades) should join up *en masse* so offering their labour at the best rates possible. Once this was achieved nurses (and others) could bargain from the strongest position of all for the revitalisation of the NHS. And this is possibly the most important end of all.

SELF SERVICE

At the time of writing, a potential porters' strike has caused some senior members of staff to look to students for assistance in forthcoming difficulties. This sort of thing occurred during the General Strike almost 50 years ago: medics then had a great picnic driving buses and so on 'to maintain essential services'. Strikebreaking is strikebreaking, however, no matter what inoffensive cliché is applied to it.

The best service that medics and others thinking of interfering in these disputes can do themselves and the NHS generally is to avoid dabbling in such serious affairs. The best they are likely to achieve is the dislike and distrust of those for whom working in a lowly position in the NHS is not a picnic; the worst is the breakdown of all intercourse between the two sides. This latter case would of course reach its ultimate when medics were asked to maintain services indefinitely – to the detriment of all concerned. Interference with striking is interference with people's attempts to gain a better livelihood, and is not to be undertaken lightly.

LETTERS

Dear Sir,

World Population Year is nearly at an end, yet how many of the 15,000 British medical students knew of its existence and about the International World Population Conference which was held in Bucharest in August? How many realise that global overpopulation is all pervasive, affecting both underdeveloped and developed countries, and is closely linked in the former with massive famines, widespread starvation, unemployment, underemployment and increasing illiteracy rates and in the latter with environmental pollution of air, of water and of land, the energy crisis, inflation and increasing urbanisation? How many are aware that the present world population of nearly 4,000 m is expected to double in the next 35 years, and yet that even now two-thirds of the world's population is under-nourished?

There is no doubt that future doctors will have an increasingly important role to play in the field of birth control and in the implementation of population policies. Yet there is no agreed national policy on the education of medical students in the subjects of demography, human reproduction, contraception and abortion. B.M.S.A. recently introduced just such a policy but it (B.M.S.A.) was unfortunately made defunct before its aims were realised in every medical school – the position of the Health Students branch of N.U.S. on such matters is as yet far from clear. Although student members of 'Doctors and Overpopulation' and IMSOP (International Medical Students Organisation on Population) number many hundreds, only a few take an active role, this being reflected by the fact that only a minority of the medical schools now provide comprehensive teaching in all of the above aspects.

We are in contact with active students in some, but by no means all, medical schools in this country and would like to see *each* school represented by its active members. If any such students would like to help in initiating improvements in the teaching curricula on population please contact us.

Yours sincerely,

J. H. ARUSTU

Sec: London Hospital Environment Group

Stepney Way,
Whitechapel, London, E.1 2AD

Dear Sir (I wonder if it will ever be Madam!),

In my day I would know to whom to write but now so many have retired. I believe Prof Cave is still around and I am sure he is still hunting for corpses! but my problem is live rabbits. In my Welsh fastness I cope happily with a Donkey stud and goats and poultry ... but some joker landed me with two white does and a buck ... they are supposed to be meat rabbits but the Welsh don't like eating them ... and, Sir, they breed ... they breed! as far as I can make out they have anything from four to eight every 31 days!!!! I know in my day the rabbit together with the rat and guinea pig were valuable members of Barts staff ... I suppose they are of Cardiff's too, but having experienced Welsh medicine out in our bundu here, I don't think even my rabbits would help! though I had a wonderful Welsh Surgeon ... London trained! Anyway I would rather send them to the old firm if I could. I would have to get the local blacksmith to make me a chew resistant box to send them in ... they would leave Carmarthen at 8 p.m. and get to Paddington at 5 a.m. and British Rail would deliver around 11 a.m. ... this would cost a bit and I would need (a) the box sent back and (b) some reimbursement for the cost of it all.

I hope Barts still continues to be a little corner of Wales, judging by the Editorial names of late it would seem so ... I learned to love Wales from my Welsh contacts among the student body and the Staff ... and I must say when I came to it for the first time ... to buy Gilfach ... it has never let me down, even tho' I have one of our old lags as a G.P., Ambrose Lloyd, I had no idea he was here, but much to our mutual horror, we met again, and are now firm friends!

With every good wish,
Yours sincerely,

(Miss) Marie DESBOTTES

The firm "Nannie" to Charlie Harris & the Kids Dept.
i.e.
Lecturer in Child Health!

The last lady Editors were Deirdre Lucas and Mary Hickish, from March 1971 to February 1972. –Ed.

University Department of Dermatology,
The Royal Victoria Infirmary,
Newcastle upon Tyne

30 September, 1974

Dear Sirs,

I am grateful to the Barts' *Journal* for reviewing my book *Multiple Choice Questions in Dermatology*.

Your reviewer is of course asked to be constructive about the printed word and not the imagined *faux-pas*. I'm afraid in the last paragraph of his review he sadly misquotes me and does not do himself proud either. In the copy of my book (I assume he has a similar one) it quite clearly states in the appropriate answer sections that *median* rhomboid glossitis is *not* a cause of macroglossia and that chronic discoid lupus erythematosus is *not* a manifestation of systemic lupus erythematosus. For his comment on candidiasis and 'napkin' rash may I refer him to the 2nd edition of another dermatological work, entitled *Textbook of Dermatology*, Editors Rook, Wilkinson and Ebling, pp.193, and for the definition of 'dermatosis' to Dorland's *Pocket Medical Dictionary* 20th Edition, 1959, W.B. Saunders & Co.

Your reviewer promises me a good deal of mail, I look forward to hearing from him.

Yours faithfully,

S. K. GOOLAMALI

SMALL ADVERTS

For a limited experimental period it is proposed to allow SMALL ADS to be published free of charge in order to ascertain the need for a forum for sale and exchange.

The items best suited to this form of advertising would be the larger ones requiring a 'good audience' – greater than the cloakroom noticeboards can provide, at least. *Locums, cars, flats, furniture, meetings, parties, 'Personal'* etc.: all these are ideal subjects.

The *Conditions* are that the advertisement should be as brief as possible: not running to more than 2.5 column centimetres, (if it is longer we will shorten it, or ask you to pay the excess). The advertisement may not run more than 2 months free – excess time will be charged at current rates.

Send your clearly written advertisements to *Sue Boyle, Barts Journal, St Bartholomew's Hospital, E.C.1.*, by the Copy Date shown on the editorial page of the *Journal*.

USE IT – IT'S FREE!

ANNOUNCEMENTS

DEATHS

WHITTINGDALE
On 4th September 1974, John Whittingdale, aged 80. M.A. Camb. 1920, M.B. B.Ch. 1921, F.R.C.S. Eng. 1920, M.R.C.S. Eng. L.R.C.P. Lond. 1918, D.O. Oxon. 1924 (Camb., St.Bart's) Sen. Ho. Surg. St. Bart's.

EVANS
On 26th August 1974, Frankis Tilney Evans, M.B., B.S., F.R.C.S., F.A.R.C.S. Born 9th March 1900. Qualified 1922.

ENGAGEMENTS

ELLIOTT–McCARTNEY
The engagement is announced between Miss Alison Caroline Elliott and Mr. Peter Russell McCartney.

ENSKAT–LYNCH
The engagement is announced between Mr. Anthony Enskat and Miss Sioban Lynch. Especial congratulations from fellow Grads.

VIth INTERNATIONAL CONGRESS OF SOCIAL PSYCHIATRY

October, 1976

In October, 1976 the VIth International Congress of Social Psychiatry will be held in Yugoslavia, but it has not yet been decided in which town it will be held.

Colleagues, neuropsychiatrists, specialists in the other fields of medicine, general practitioners, psychologists, defectologists, music therapists, sociologists, social workers, nurses, and other specialists in medical and non-medical professions who are interested to participate in the Congress, are pleased to write for more detailed information on the Congress, to the president or the secretary of the International Association of Social Psychiatry:

General Secretary:
John J. Carleton, M.D.,
American Association for Social Psychiatry
The Santa Barbara Psychiatric Medical Group
232 Oak Lane
Santa Barbara, Calif. 93105, U.S.A.

President:
Prof. Dr. Vladimir Hudolin
University Department for Neurology and Psychiatry of Dr. M. Stojanović
University Hospital,
Vinogradska c. 29
41000 Zagreb, Yugoslavia.

IMPORTANT NOTICE
COLLEGE HALL TRUNK ROOM

On the weekend of 23rd–24th November the trunk room at College Hall will be cleared of everything except TRUNKS bearing the owner's name and the date of placing there.

An auction will be held on Sunday 24th November of the junk removed during the clearout.

Any volunteers to help with the above should contact Peter Meade at College Hall.

RESEARCH ASSOCIATE

The DEPARTMENT of NEUROLOGY, St. Bartholomew's Hospital.

A Research Associate of registrar grade is required for this Department to work on the interaction of voluntary movement and postural reflexes. A well equipped laboratory has recently been established. A limited amount of clinical work could be undertaken should the applicant so wish. Enthusiasm is more important than previous experience but an interest in physiology would obviously be an asset. Salary on registrar scale (£3198 to £3879).

Applications to Dr. Anthony Hopkins, Department of Neurology, Room 110, 38 Little Britain, London, EC1A 7BE.

THE SOCIAL RESPONSIBILITY OF SCIENTISTS Part II.

By J. ROTBLAT

Present-day society, with its emphasis on the pursuit of material aims – greater comfort, higher standard of living, ease of life – all of which have become possible thanks to the tremendous scientific and technological achievements of recent decades – is characterized by an ever-increasing interdependence of all members of the community. In a technically advanced society, each individual is helpless on his own, and can survive only if all other fellow-citizens play their part. We have all seen recently how the action of small groups can disrupt the functioning of practically the whole nation: the withdrawal of their contribution by a few people has an enormously amplified effect on the whole community.

In this context I define "community" as that group of individuals with some common interests, whose collaboration is essential for the well-being of its members, for the survival and security of the group. In the early days of our civilization, when the needs were very modest, a family was sufficient to constitute a community. Later on, when the needs grew this was expanded to a clan, or a township, and eventually to a whole nation. But this is where we seem to have stopped. Our education, our way of life, our economy, our security, are all geared to the concept of a nation. The slogan "my country, right or wrong" still seems to be the main guideline, and patriotism the highest virtue.

Much of this is outmoded. Our interdependence now stretches to all nations; our community is now the whole of mankind. With a few exceptions, no single nation can survive on its own, and even these exceptions are disappearing rapidly. The events during the oil crisis a few months ago brought home to each of us the fact that almost anything which happens in any part of the globe has repercussions in other parts. Although the cry for independence by various ethnic or other groups is still loud, although the number of so-called sovereign nations is still increasing – the opposite tendency, to form inter-nation alliances, axes or blocs, is growing rapidly. Ideologically we have two, or perhaps three, major blocs; economically, we see the formation of communities of nations, like the European Community, or the Economic Commission of Africa. Private industry too is acquiring an ever increasing supra-national character, as, for example, the ITT. Even the Mafia and other crime syndicates are operating more and more on a world scale.

Professor J. Rotblat, CBE, was a member of the World War II Manhattan Project from which he resigned in order to take up work on the medical applications of nuclear physics. He is Head of the Physics Department at Barts, and has for many years been Secretary-General of the Pugwash Conferences on Science and World Affairs.

The positive of these attempts at international collaboration, although they take us a certain way beyond the narrow limits of nationalism, are still not really enough, since they all contain divisive elements, the pursuance of partisan policies, the protection of tacional interests, which may lead to a conflict involving many nations. What is required is a true community of all nations, embracing all peoples, and aiming at securing the survival of mankind. If such an objective had always been desirable, it has become essential with the discovery of the atom bomb, which – as already mentioned – has made it possible for the first time in history for the whole of mankind to be extinguished. Ever since the introduction of nuclear weapons, the continued existence of the species Man on this planet has come into doubt, and only a determined, sustained and enormous effort will save mankind.

I submit that to achieve this we must develop a new loyalty, a sense of belonging to the community of mankind. In advocating this I am not suggesting that we renounce loyalty to the nation. Just as loyalty to the nation does not prevent us from having other, narrower loyalties, to our family, to our friends, to our professional group, to our football club, so the loyalty to mankind would be an addition to, an extension of the loyalty to the nation. Such an extension is an essential and natural development in human relations, to match the change in the world brought about by the scientific and technological revolution. Science has made our world very small: we can reach any point on the globe in a day; we can talk to each other and see each other instantaneously wherever we may be; we can destroy each other within minutes. In many ways we have all become like one family. To balance the radical technological changes there must be a corresponding radical change in our attitudes to major social issues; in particular, the development of a community of interest for the whole of mankind, irrespective of national boundaries or differences in economic or political systems.

It will be a long time before this ideal state of affairs is reached. The inherent distrust and suspicion with which the present generation has been brought up may prove too great a hindrance, and the goal may only be achieved by the next generation. To make this possible we shall have to change the aims of education. At present the emphasis in education is on separate, often antagonistic, ideals of individual societies. In the new system of education, we shall have to emphasize the permanent community of interest of mankind, we shall have to imbue in our children loyalties to the universal heritage, develop in them the sense of responsibility for mankind as a whole.

This brings me back to the role of the scientist. I believe that scientists, because of their special competence, have – in addition to the same obligations as other citizens – an extra duty to be concerned with these matters, to take an interest in and make an effort to help the community to solve these problems, particularly those which have arisen from the progress of science and technology.

Let me give the reasons for this assertion. First of all, science has always been cosmopolitan in nature. The methods of science, the ethics of science, are universal; the scientific truth is accepted everywhere, across geographical frontiers and political barriers. From time to time there have been attempts to interfere with the scientific truth. For example, during the Nazi regime, the theory of relativity and other scientific knowledge were denied for political reasons; in the Soviet Union we had the Lysenko episode, when attempts were made to modify scientific facts to suit a particular political ideology. But such attempts always led to disastrous results, and it is now well established that adherence to the scientific truth is most advantageous in the long run. One consequence of the universal method of science has been the close and friendly relations which always existed amongst scientists of different nations, the feeling of trust and confidence in the integrity of scientists. This means that the community of interest and belonging to mankind is already very highly developed amongst scientists, and this makes science a natural medium for fostering international understanding.

Secondly, the nature of the scientific advance calls for international undertakings. More and more scientific research is conducted on the basis of collaboration between many nations. One can envisage new world institutes coming into being, in which large numbers of scientists, technicians and adminis-

trators, drawn from all nations of the world, will collaborate in friendship and harmony. Apart from the direct material benefits which such scientific enterprises would bring, they would contribute to the establishment of the conditions essential for world security.

Thirdly, the immense increase in importance of scientific and technological factors in human affairs means that success in forecasting the future requires an understanding of these factors; in this respect, the scientist is in a much better position than other members of society. In particular, scientists can foresee well ahead of any other group the dangers which may arise from a new scientific discovery; it is, therefore, their duty to warn about such dangers, so that the community will be prepared for them and learn how to handle them.

Finally, an important service to mankind which scientists can perform is by helping actively in the solution of social and political problems. Scientists are perhaps more likely to be successful in such endeavours than other groups of society, because of the use of the scientific method. One of the reasons for the very fast rate of progress of science is that scientists have employed in their work a special technique – the scientific method. The use of this very powerful tool enables one to reach a solution to a problem by the shortest possible route, because the scientific approach disdains speculation and relies entirely on proven facts and reasoned deductions. Politican and social problems are, of course, in a different category from those encountered in science and technology. But in those areas where it can be applied, the use of the scientific method could help to sort out problems and find a solution to them. Since scientists are familiar with the scientific technique, it is incumbent on them to demonstrate to others the usefulness of this method of approach.

Let me make it clear that I am not advocating that scientists take over from politicians and statesmen. There is no reason why individual scientists should not enter professional politics – they are likely to be at least as successful as ex-film stars or football players – but they will then cease to be scientists. What I am concerned with is the role which *every* scientist can play, by devoting a small proportion of his time to these matters. I believe that scientists have a special role to play for the reasons just listed, i.e. because they understand better the nature of the new age and its requirements, because they are equipped both to educate the general public about these requirements and to help them actively in their realization, and because they are the most likely and natural group to take the first concrete steps towards developing the community of mankind.

LETTER FROM AMERICA

Brookline, Mass.

Ugly scenes have dominated the headlines of the *Boston Globe* this week, and we've had even more slanders than there were in Nixon's time. It started quietly with a bizarre tale of two members of the Boston Hare Krishna – a group that usually keeps itself unobtrusive and aloof.

Ed Shapiro and Lee Roth were a couple of nice Jewish boys gone wrong. Both had been the apple of the family eye, both were the product of comfortable middle-class professional families, and both were fed up with the materialistic life-style to which they had been accustomed. Attracted by what they had heard, they joined the Boston Hare Krishna, and by all accounts, were happy in their strange new surroundings where most of the day was taken up in prayer.

I can't say I'd care to be the father of either: it's not the sort of news a Jewish grandmother greets with glee. But Lee is 25 years old and Ed 20, so you would think the parents might allow them a little independence. At any rate, I don't think you'd expect those parents to kidnap their own children, which is in fact what took place. The stories are similar, so I'll stick to one of them. Shapiro, a diabetic, arrived home for what he thought was his weekly check-up (his father is Dr. Eli Shapiro, a well-respected practitioner in Newton, and a credit to the medical profession), to find that the furniture in the basement had been re-arranged to accommodate twenty people. Some he recognised as neighbours and friends, and some were complete strangers. The group was headed by a professional "deprogrammer" whose name has since become notorious around here: Ted Patrick, a former community relations specialist for Governor Reagan of California. The door was immediately locked and the curious business of deprogramming began. Bully boys, of course, but also strange mad actors that make this episode sound like the famous scene from The Duchess of Malfi. Poor Ed got pretty angry, managed to give his mother a black eye and smash up a tape recorder he thought was emitting blasphemy. They cut off his Sikah (that's the tuft of hair Krishnas leave when they shave their heads), ripped off his beads and made him denounce his sect. Oddly enough, it seemed to work for a while – soon they had him drinking alcohol and smoking again, just like the good old days. But their mistake was to let him alone too soon; he was allowed to fly to North Carolina by himself, and he met by chance another HK member in Washington who did a slick job of reprogramming him. So we close with Shapiro back safe and sound in the Boston Temple (he flew back at his parents' expense, having traded his N. Carolina ticket for one to Boston). He still puts his Jewish traits to good use as Temple treasurer.

I can't say I care one way or the other about the Hare Krishna, British or American variety. It's pleasant to have colourful people playing droney but otherwise attractive music in the middle of Harvard Square, but my admiration stops there. What really worries me is the emergence of the deprogrammer and his team, and the power of parents to direct their childrens' lives to a rather alarming degree. Shapiro isn't the first young man to depart from the family fold, and he isn't the first to be brought back into line by such brutal and unacceptable methods. But the courts have consistently upheld the fathers' rights rather than the children's, and when the children are twenty-five years old, I find these decisions unjustified and bigoted. Ted Patrick, by the way, has been implicated nearly a dozen times now in similar cases, but invariably gets discharged as he's careful to stay on the frings of the group. "I never touch them", he said on the news, "I leave all that to the parents." His fee is $1000 plus expenses, and he's in the Yellow Pages.

Bigotry of another and far more serious kind has played a large part in the recent attempt to desegregate all of Boston's public schools. "Bussing" is the latest dirty word. By Federal Law, it has been decided that the only way to true racial integration is to make a start on the schools. Boston's ghettos (Roxbury and Dorchester for the blacks, South Boston for the Irish and Lithuanians, and so on) are as impregnable as those of New York, and although the motives are intelligent and humane, many mothers are worried that their children are being used as means to politican ends. Certainly it's sledge-hammer tactics to take kids by bus to schools in areas remote from those in which they live, but it's not easy to come up with alternative suggestions. The parents, of course, are as usual far more inflexible than the kids, who were remarkably calm and responsible during the first days back at school. Even when buses were being stoned by parents who couldn't endure the thought of their kids sitting next to black children, the kids kept cool. It will need weeks of quiet examples like this to persuade poor white Bostonians that success could possibly be achieved; the fact that last week a staggering 92% of South Boston mothers defied the law and kept their children at home is an index of how far Americans have yet to travel to reach the ideals they set for themselves in 1776.

JEFFREY TOBIAS

DRUGS FOR THE DYING

CONTINUING OUR REGULAR FEATURE ON THE CARE OF THE DYING.

By RICHARD LAMERTON

The aim of treatment for a dying patient is to make his body a comfortable place to be, for as long as he will live in it. Then he can turn his attention to getting his affairs in order, saying his goodbyes, and pre paring his mind and spirit for death. Pain and other symptoms may effectively prevent this preparation by absorbing all the patient's attention.

When we commence giving symptomatic treatment only will depend on the doctor first deciding who is dying, a decision which should be firmly communicated to the whole caring team. From that point onwards treatment for a particular patient will no longer be directed towards curing his disease, but at relieving any discomfort. Obviously 'Abandon *cure*' does not mean abandon *care*. The patient's symptoms should be reassessed daily, and every one pursued until it yields. He may well be able to eat a good meal on the day before he dies, and be alert, and should be up and about during at least a part of his last week.

This kind of symptomatic treatment is generally ignored in medical teaching and left to be discovered piecemeal by the trainee G.P. Yet it is no less scientific once the principle is accepted that one is aiming at a peaceful death and not a magical cure. A case in point is the treatment of nausea and vomiting. Different drugs have different modes of action. Maxolon (metoclopramide) encourages forward peristalsis, keeping the stomach empty; Stemetil (prochlorperazine) and Largactil (chlorpromazine) act on the chemoreceptor trigger zone; while Valoid (cyclizine) acts directly on the emetic centre. It therefore follows that if a patient's nausea is due to the general toxaemia of carcinomatosis, cyclizine is the drug of choice. If it is a side effect of opiate analgesics, which activate the vomiting centre, prochlorperazine is the one to use, or chlorpromazine if the patient is also agitated. But if he is nauseated because of sluggish bowel actions and constipation (and provided there is no actual bowel obstruction), then metoclopramide will be more helpful.

Clearly, in treating one sympton one does not want to make the patient uncomfortable in another way. Transfusions, tubes down noses, masks over faces, and regular injections are unlikely to be justified.[1] I once asked why an obviously terminal patient's movement was hampered by a drip, and was told it was because he had such a dry mouth. Naturally I asked: 'But can't nurse make a cup of tea?'

Many of us have a very reasonable dread of dying in hospital afflicted by all the benefits of modern medicine, with last minute operations, tubes in every orifice, dramatic and violent resuscitations; our friends and relatives kept at bay by visiting hours and the hospital staff by their busyness. What we need to know is what *not* to do.[2]

For example, we are besotted by the power of antibiotics. A patient with crepitations in one lobe receives these as surely as if his signs had been fed into a computer. This mechanical medicine just won't do. The decision to use antibiotics in the terminally ill or very aged should be reached only after considering whether such treatment can be justified. If the patient is 92 and suffering his third stroke, or riddled with carcinomatosis which is unresponsive to therapy, his pneumonia is part of the process of normal welcome death. The doctor need only interfere if the patient is suffering unpleasant symptoms. He is unlikely to have malaise and fever, but if he has, they can be suppressed by steriods. He may be dyspnoeic and panicky. Striving to deal with this by urgently oxygenating his tissues – either with oxygen or bronchodilators – probably won't work, and is not really soothing the dyspnoea. The symptom can be most quickly suppressed, and the patient's anxiety eased, by a mixture of an opiate and chlorpromazine.

As soon as this is said, the mechanical mind, which loves to think in pairs of opposites, yells 'But this is euthanasia!' So that the alternatives of giving the wrong (curative) treatment, and killing the patient, are all the dullard can see.[3] But there is a third point to this triangle, where the patient is allowed to die in peace, untroubled by bodily suffering because of good symptomatic relief. This kind of treatment of terminal pneumonia does not, in fact, appreciably shorten the patient's life: if anything, it probably lengthens it a little because his distress is relieved and he is not so exhausted.

In the last hour or so, a patient may develop a 'death rattle': saliva bubbles up and down the trachea because he has not the strength to cough. The patient is usually comatose at this point, and unlikely to be troubled, but relatives and other patients may be very frightened. The death rattle can usually be banished completely by a 'pre-med'. Atropine and omnopon (or more commonly with these patients, diamorphine) can dry up the secretions remarkably. It also helps to turn the patient on to his side and tuck his chin in a little.

A constant trouble in debilitated people, is thrush. One should inspect the mouths of these patients on every ward round to see if curdy white colonies of candida are growing. Nystatin mouthwash, four-hourly for four or five days is always effective against this most uncomfortable of complaints. It can give rise to not only a sore mouth, but a painful sore throat and, worst of all, an asphyxiating pneumonia. The patient coughs up distinctive thick grey pus which smells pleasantly of new-baked bread. Antibiotics, of course, are worse than useless. I have heard gruesome tales of people who died gasping for breath. All such cases that I have seen were due to this infection, and it responded completely in just over a day to inhalation of oxygen bubbled rapidly through concentrated nystatin oral suspension. The new oral preparation of clotrimazole (Canesten) will probably render this logical but elaborate approach obsolete.

Steroids have a valuable role in treating the dying. In particular we in St. Joseph's use prednisone (or prednisolone which comes enteric-coated for patients with indigestion) and dexamethasone (which is much the same as betamethasone). Side effects are unlikely to be a problem because the patient is not going to live long enough for them to develop.

Apart from the general improvement in appetite and mood which corticosteroids produce, they also have several specific effects. By increasing the urinary excretion of calcium, they help by correcting the hypercalcaemia which commonly accompanies carcinomatosis (with or without bony metastases).[4] The generalised weakness and aching, lassitude, anorexia and nausea of widespread cancer are often due to a raised serum calcium. If a patient has some of these symptoms, the best approach is to give prednisone 5 mg TDS empirically for two weeks. Then if there has not been a marked improvement in the symptoms, tail it off again. It is usually not helpful to send blood to the laboratory before commencing this treatment, partly because the patient is suffering and should not have to wait, and partly because the result may be misleading: in the presence of the hypoalbuminaemia common in cachectic patients, the total plasma calcium level may not be raised even though the ionised calcium level is.

Another way that steroids help – though the mechanism has not yet been fully elucidated – is by reducing the oedema which surrounds many tumours. This effect is most impressive in two sites: intracranial and mediastinal. Prednisone is usually sufficient to overcome mediastinal obstruction by malignant masses, starting with 10 mg TDS and then reducing the dose to 5 mg BD once the symptoms subside. In the case of tumours causing cerebral oedema and raised intra-cranial pressure, the drug of choice is 2–4 mg dexamethasone TDS combined with a diuretic and raised head of the bed.[5] This regime however, although dramatic in effect and able to restore some semicomatose patients to normal function for a while, must be used with great caution. With such large doses there is usually a gradual development of fluid retention with 'moon-face' and other steroid side effects. One should consider whether the patient would not have other disabilities severe enough to make the restoration of consciousness a doubtful blessing – e.g. paralysis or pain. Then, as time goes on, the patient's tumour will continue to grow, with a recurrence of the previous signs and symptoms. At this point the steroid should be tailed off.

Every patient presents his own problems. Constipation, conjunctivitis, insomnia – every possible affliction will need prompt action. The man with terminal cirrhosis may have intractable hiccups requiring large doses of chlorpromazine, the one wtih oesophageal carcinoma may need regular doses of honey to disinfect the tumour and stop his water-brash. The important principle is that doctors and nurses should never say : 'There is nothing more that we can do'. As long as dying patients have any unpleasant symptoms, there is something that they *must* do.

The treatment of pain will be considered in the January edition of this Journal. Meanwhile any students – nursing, medical or from paramedical disciplines – may like to come to a conference at the Hospice to hear more about the care of the dying. It will be on Saturday morning December 7th, from 9.30 a.m. to 12.30 and the speaker will be Dr. Robert Twycross. To book a place, please ring 985 0861 and ask for Sister Antonia.

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MUSIC

THE MESSIAH
– by Handel?

'Christmas comes but once a year' and with it arrives the season characterised musically by the many performances of Handel's Sacred Oratorio – Messiah. The style of approach varies enormously from the highly rehearsed King's College Cambridge performances, to the considerably more relaxed atmosphere to be found at Emanuel College Cambridge each year, when everyone is welcomed – singers, instrumentalists and audience alike – to a spontaneous unprepared play through. This year there will be a performance at Barts, given by the choir and orchestra of Christ Church, Woburn Square, under the direction of Mr Lumley, on Thursday December 19th.

Since its composition in 1741, many editions have been published, the first of which (excluding Handel's original manuscript) was prepared for the Handel commorations in 1784; in this edition, to Handel's orchestra of strings, oboes, bassoons and continuo (with occasional trumpets and timpani), there were added flutes, horns and trombones. In 1789 Mozart added clarinets, and virtually completely recomposed the trumpet parts. Gradually more editions accumulated until by the end of the 19th century there were many variously elaborated and supplemented versions to choose from.

The necessary and indeed, value of these many and varied editions is questionable; whilst it is reasonable (and nowadays well nigh indispensible) to have available a score which prints Handel's music in full– thus explaining the musical short-hand used by Handel – the modifications made by many editors have been so substantial as to alter entirely the sound quality. Whilst it has been argued that it was because of Handel's own somewhat confusing abbreviations that editors felt it necessary to clarify the music, this in no wat justifies their rewriting the music to be in keeping with the fluctuating tastes of audiences over the years.

The present vogue for performances as close to the original as possible is to be welcomed; I hope Mr Lumley follows this trend, as his choir and orchestra should be ideally suited to the Baroque approach in which the full contingent of performers should total about eighty, with players and singers in equal number.

ALLEGRO MA NON TROPPO

NEW PRECLINICAL CURRICULA

GERARD BULGER,
Chairman, Students' Union Teaching Committee

There is a quiet revolution going on in Charterhouse Square. A new timetable has been introduced for the course called M.B., B.S. Part 1. that is designed to include four new subjects. The title is the wrapping of an altered Second M.B. Course. Figure 1. is a table of the total number of teaching hours for each subject over the two year course.

Fig. 1

ANATOMY, HISTOLOGY, EMBRYOLOGY	:	465 hours
PHYSIOLOGY	:	295 hours
BIOCHEMISTRY	:	275 hours
PHARMACOLOGY	:	145 hours
PATHOLOGY	:	50 hours
SOCIOLOGY	:	25 hours
PSYCHOLOGY	:	25 hours
STATISTICS	:	20 hours
GENETICS	:	15 hours
EXAMINATION TIME	:	160 hours
TOTAL TEACHING TIME	:	1475 hours

(a reduction over the old course of 160 hours)

Fig. 2

	Theme	Term
INTRODUCTION	The Cell	1
	Muscle, Bone and Connective Tissue	2
TO	The Autonomic Nervous System - Respiration Circulation	3
CLINICAL	EXAMINATION	
	Abdomen Digestion Excretion	4
MEDICINE	Central Nervous System	5
	The Whole Body	6
	EXAMINATION	

The Ad-Hoc Committee that first discusses allocation of teaching time is made up of the preclinical Professors, Clinical Teachers, and two students from the Teaching Committee. Never before have Barts students been so closely involved in the initial planning of a timetable. So how is it that the New Curriculum appears to be so conservative? Part of the answer is that Barts students are themselves conservative. The Teaching Committee's function is to represent the majority view.

A number of items were brought forward in the discussions. Roger Peppiat's mammoth report of 1971 vintage (denied publication by the JOURNAL of the time) was used as a guide to the opoularity of the various 'core' subjects. Comparisons were made of the teaching hours at other medical colleges and also used as a guide. The Teaching Committee representatives used two arguments as follows.

1. THE INTRODUCTION OF THE NEW SUBJECTS MUST NOT INCREASE THE TOTAL WORKLOAD ON THE STUDENTS

The Teaching Committee cannot support a large allocation of teaching time to the new subjects unless there is a large reduction of the CONTENT of the old Core subjects. Simply to reduce the time allocation of any subject would not reduce the subject's CONTENT, but it may well mean that the teaching becomes more efficient! But to add 25 hours to, say, Sociology would add enormously to the overall content and workload of the course. This brings us on to the second argument which is fundamental to all curricula design.

2. THE CONTENT OF THE COURSE MUST BE DEFINED *QUALITATIVELY* AND *QUANTITATIVELY* AND IN TERMS OF THE DOCTORS' NEEDS.

This is the great sumbling block as there is only one way to do this, that is by defining the OBJECTIVES of the entire course. The educational concept of objectives is not understood and this argument is greatly resisted by the preclinical professors. The odd vague syllabus has been produced, it is impossible to find fault with them, and it would take a very courageous clinician to criticise the documents.

This new curriculum is an advance. The Teaching Committee is now concerned in making sure that the new subjects get off to a good start and that the workload on the student is kept down. It must not be forgotten that there has been an across-the board reduction in the number of teaching hours despite the introduction of the new subjects.

The examinations are to be held in three parts. Part One will be taken at the end of term three and will include sociology, statistics, psychology and parts of the core subjects. If a student fails in any subject then he will have to do a retake in that subject in the summer holiday. Part Three will be taken at the end of term six and will be like the 2nd M.B. exam, except that pharmacology will be taken at the end of term five. Again if a student fails any subject then he will do a retake in that subject during his holiday.

This continual examination is NOT approved of by the Teaching Committee. I have been told that students will have to work harder than ever before in this new curriculum. How can this be if there is a reduction of content? It is not as if preclinical students are lazy and need even further encouragement to work. (The 42% intake of women will ensure that standards are kept up.) Sloth is a reaction, known amongst clinical students, to the intensity of the preclinical years. The importance of the new subjects in the final assessment has yet to be decided. This year's intake will not only have a new preclinical curriculum, but also a new Clinical Curriculum to contend with.

The Ad-Hoc Committee is now considering more far-reaching changes.

TOTAL INTEGRATION WITH CLINICAL

This can be dismissed as nigh impossible. It runs against the Todd recommendations and hence the BARTS/LONDON/Q.M.C. merger plans. The educational merits of such courses are in considerable doubt.

TOTAL INTEGRATION OF THE PRECLINICAL SUBJECTS

This is much more practical and a detailed proposition has been put forward by Dr. Wills. An outline is given in figure 2.

Dr Wills' 16 page document is an excellent exposition of the problems of the preclinical course. He calls for a CO-ORDINATED curriculum and he would expect to see small interdepartmental working parties designing the basic units. Dr Wills' ideas must be taken very seriously and many can be supported by the Teaching Committee.

PARTIAL INTEGRATION OF THE PRECLINICAL SUBJECTS

This has been put forward for discussion by Professor Crook. An outline is given in figure 3. It fulfills some criticisms of the older courses. There is the co-ordination which was asked for by 95% of students in the Peppiat Report.

Another interesting feature is that a large proportion of the course would be made up of optional tracks, giving the student the choice that is denied to them in older curricula. Closer examination of the two ideas shows that the difference between them is not all that great, and that any new curriculum will be a composition from both documents and anything the clinicians have to offer.

The Teaching Committee is wary of integration for its own sake. There are a number of problems attached to such courses. Experience at Nottingham is that students find an integrated course very restrictive and demanding. (Text books are not integrated). American experience is similar. Integrated courses often give just as an illogical teaching approach as departmental subject teaching.

The Teaching Committee representatives argue that these ideas are of teaching methods alone. We would prefer to see the CONTENT discussed first and foremost. Then teaching methods can be discussed. A 'radical' integrated curriculum may only be a repackaged version with the same contant as an old second M.B. course. However, these new ideas being put forward are bound to bring about the biggest rethink of the preclinical curriculum for years. Those who do the teaching are more involved than before, also the clinicians have more opportunity to give advice than before, and students have a unique opportunity to influence the curriculum design which should be taken up.

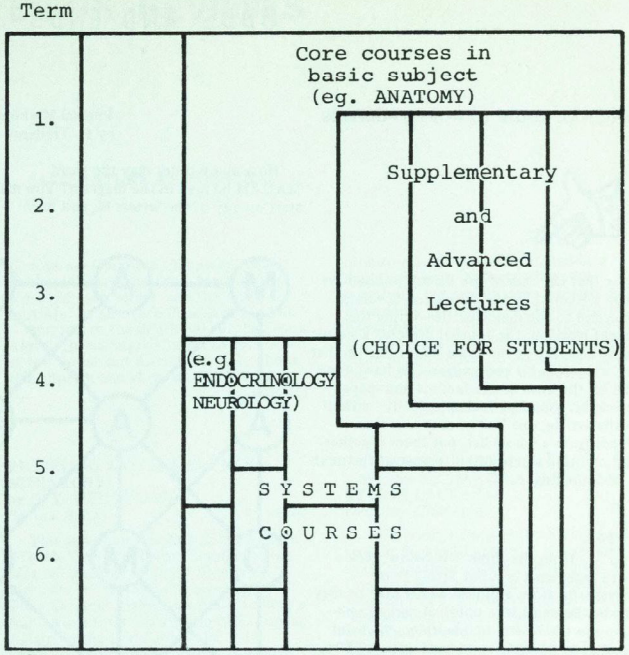


Fig. 3

Only "Core Courses" are compulsory to all students. Supplementary and Advanced lectures are shown as four separate sets but in fact would be expected to cross present subject boundaries and contain clinical material.

STOP PRESS **Tuesday, 8th October**

Since the article on the *Preclinical Curriculum* was received the following we understand that certain aspects are still of an experimental nature. The following is the case:

The examination system mentioned has not been firmly decided, but is only one proposal before the University;

The course is to be called *M.B., B.S., Parts I, II, and III.*

Mr Bulger wishes to apologise for the erroneous impression given.

ODDS AND ENDS

JOURNAL GUIDE TO WORLD POLITICS

Now that the ears of the British public have been withered by the saturation coverage afforded to the major parties during the recent election, the Journal presents a simple guide to some of the more minor parties that are struggling for recognition. We have done this on the lines of the famous newspaper article on sounding technologically 'with-it'; in the article, one had to pick any three words from a whole list, put them together, and mention the resultant phrase at the next board meeting.

So ...

from the three lists below, pick a word from each column, string them together to form a phrase which may or may not be the name of a political party *somewhere* in the world. Incidentally, the total number of possible combinations is 17,576, so this may give you some ideas for that breakaway faction that *you* were thinking of forming.

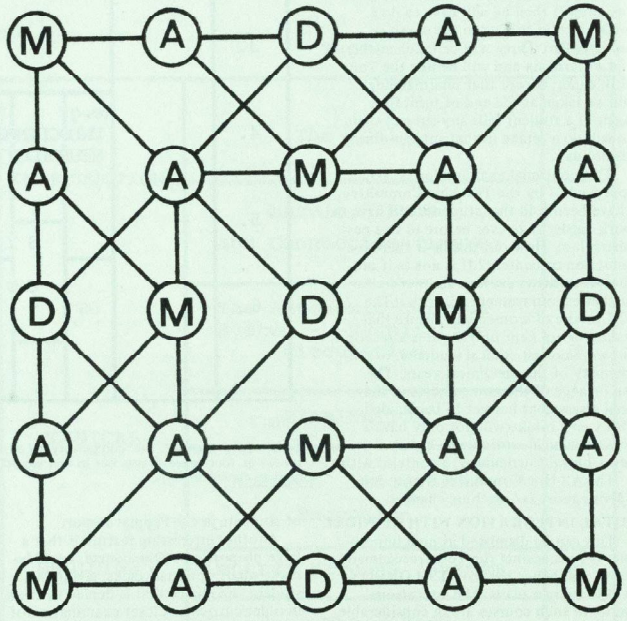
Alternative	Abolition	Activists
Anti	Anarchist	Army
Black	Communist	Body
Capitalist	Defence	Campaign
Free	Democratic	Community
Gay	Disarmament	Consortium
Insurgent	Dwarf	Enclave
International	Fascist	Extremists
Israeli	Government	Force
Left	Guerilla	Fraternity
National	Labour	Front
New	Liberation	Group
Palestinian	Loyalist	Junta
Peoples	Marxist	Lackeys
Pro	Military	Movement
Red	Nationalist	Organisation
Right	Reform	Pact
Sino	Republican	Party
Soviet	Revolutionary	Regiment
Subversive	Rights	Society
Totalitarian	September	Sorority
Ulster	Socialist	State
Underground	Solidarity	Treaty
White	Students	Union
Womens	Unionist	Unit
Workers	Wing	Unity

Journal Mathematical Problem No. 11

by R. Treharne Jones

How many times may the word MADAM be read in the diagram? You may start on any of the letters M, and may then proceed to forward-track, back-track, or whatever, as long as you keep to the lines.

Solution next month.



Answer to last month's problem.

There are 840 beds at the Royal and Ancient.

AT YOUR CONVENIENCE ?

3 Ironside Cottages,
Slagend-on-Tip

Dear Sir,

I should like to draw attention to the sign on the door of the ground floor toilet in King George V Building which states: PRIVATE MEN ONLY.

This is just another example of the discrimination rampant within our Health Service. Toilets should be freely available on the NHS as well as to the fee-paying sector.

Yours faithfully,

E. BYGUM

BOOK REVIEWS

LITERATURE AND GENERAL

THE ANNOTATED ALICE
by LEWIS CARROLL, with notes by MARTIN GARDNER.
Penguin Books. £1.10

THE ANNOTATED SNARK
by LEWIS CARROLL, with notes by MARTIN GARDNER.
Penguin Books. 50 pence

Those who previously thought that Charles Lutwidge Dodson (the true name of Lewis Carroll) was merely a writer of a few soppy Victorian kids' books, might learn well from these two volumes. The author was first and foremost a mathematician; he spent all his life as a don at Christchurch College, Oxford. One of his greatest joys was to go on rowing 'expeditions' with the three daughters of the Dean of the College, and it is the second of these three that has given her name to his two best known books – Alice in Wonderland, and Through the Looking Glass, which are both incorporated in Annotated Alice.

Martin Gardner's notes give a new depth to understanding of the books. Short quips from some of the minor characters take on an important meaning, as does the whole chess game on which Through the Looking Glass is based. Mathematics plays a part in the narrative; it is possible to see how, if four fives are twelve and four sixes are thirteen, you will never reach twenty. If you subtract a bone from a dog, the remainder is the dog's temper. If you divide a loaf by a knife, the answer is bread and butter! But seriously, if *you* prefer the country to the city, or fields heavy with corn under a summer sky to the fog of exhaust fumes, then The Annotated Alice is for you. Experienced Alice readers will be pleased to know that the illustrations are the Tenniel originals, although if your tastes are more modern, you might like to forget about the Notes, and rush off and buy the version illustrated by Ralph Steadman.

The Snark is similar in many ways, and so different from Alice in many others. Alice is a dream, or a series of dreams, whereas The Snark is pure allegory and allusion ... a nightmare, if you like. It could not be intended for children's reading. It is not a 'nice' poem, in the same way that Alice is a 'nice' book, but is still eminently readable on any level.

Both books are masterpieces of parody, such that in most cases the parodies are infinitely better known than the originals. The acrostic was another of Carroll's hobbies ... he wrote many of this type of poem, in which the initial letters of each line spell out the name of the person to whom it is dedicated. The most famous are Gertrude Chataway (where girt, rude, chat, and away are the first words of each verse), and the most beautiful of all, Alice Pleasance Liddell.

Interest in the Snark has reached such a level, that a Snark Club is to be formed at the Royal and Ancient. A note about this appears elsewhere in this Journal.

R.T.J.

RICHELIEU AND THE FRENCH MONARCHY
by C. V. WEDGWOOD.
Pelican Books. 45 pence.

This small book is part of the Pelican "Teach Yourself History" series, which uses biographies of major figures to illustrate the history of a given period. Thus Cardinal Richelieu's life is used as a framework for a description of European Affairs in the first half of the 17th century. As a popular history it is most enjoyable, and very easy to read indeed, which is a clear attribute to the author's excellent style; modern professional historians will however find the bias towards individuals rather than mass movements of popular opinion somewhat out of line with present-day historical methods. Still, Richelieu's career, and his determination to centralise government as fully as possible in the hands of the King, are described both in terms of justification and of contrast with the opposite tendencies in Britain. (The Civil War was brewing throughout much of the Cardinal's term of power). The struggle with Spain and the complex and multiple shifts of policy of the 30 Years War are lucidly analysed, but to the detriment of a more detailed study of internal French affairs. Sadly the very name of the book seems to have driven the author into defending Richelieu in all his actions, however callous or opportune, so that even his fit of rank cowardice is glossed over with much blurb about 'nervous strain' and so on. Along with this lack of criticism of his mistakes there is no attempt to criticise him in moral terms. When judged pragmatically Richelieu is entirely consistent in his efforts to establish French power on the basis of a strong central government run by the King and his chosen advisers. But when judged morally he is cruel and shifty, prepared to embrace all means to get his way. Admittedly, he evoked great loyalty among his staff, but popularly he has gone down in history as a semi-tyrannic figure, a 'baddie' to most minds. While allowing for the author's obvious intention to go against this standard approach, more honesty about his essentially unfriendly nature would have provided a better balanced account. Nevertheless, I found myself reading on into the night and look forward to many more of this series, no matter how much the 'professionals' may disapprove.

T.T.

THE HOUR OF OUR DEATH
edited by RICHARD LAMERTON & SYLVIA LACK
Geoffrey Chapman. £1.95

This book, edited by Dr Sylvia Lack and Dr Richard Lamerton, is a compilation of various papers presented at a Conference of the same title held in London in 1973. All the contributors, who include Cardinal Heenan, Professor Anderson, David Cargill, Dr Cicely Saunders, Professor Donald MacRae and the editors, belong to the anti-euthanasia camp.

The book, which is a rather slim volume, attempts to cover several interesting topics, e.g.: "The Elderly at the End of Life"; "Caring for the Dying"; and the sociologist's view of euthanasia from Professor MacRae of The London School of Economics. But despite diversified discussion, attitudes common to all the authors ensure an overlap of material, and rob the book of any dynamic reading. This is unavoidable, perhaps, in a conference, but a little more evidence of editorial control would have been useful in the printed report.

The chapter covering the Conference itself is the most informative, dealing as it does with discontinuing treatment of a patient, rescisitation, special training for nurses. However the chapters, mainly contributed by the editors, leading up to and away from this section are somewhat less interesting, and left me not wanting to plough through them again.

SUE CAMPLIN
Social Worker

FREEDOM AND RESENTMENT & other essays
by P. F. STRAWSON
Methuen. £3.20

In 1971 Strawson published 12 papers under the heading *Logico-Linguistic Papers*. They were concerned exclusively with logic and language. This second collection of essays – nine of which have

already been published over the past 20 years – covers a much wider range of topics and will interest both the layman and the logician. The topics covered in these closely argued essays serve as a good introduction to contemporary British philosophy.

Well trodden dichotomies like the mind-body problem are posed in a fresh light along with logical problems concerning the nature of existence and, more topically, the structure of language. There is even a reprint of his only venture into aesthetics, which considers, among other problems, what is involved in speaking of the uniqueness of a work of art.

Hopefully readers will not be dissuaded from buying the book on the grounds that Strawson's critical review of Wittgenstein's *Philosophical Investigations* has already been republished in an anthology edited by G. Pitcher. Its inclusion here enables the reader to assess the point of divergence between Strawson and Wittgenstein's conception of philosophy against the background of Strawson's own philosophical contributions. Briefly, if Wittgenstein's "therapeutic method" is to be interpreted as anti-metaphysical then Strawson is to be interpreted as wanting to re-admit a modest version of metaphysics together with a rejection of the anti-systematic implications of Wittgenstein's later writings. What needs to be given closer attention is the way both of these tendencies can be located in thi philosophical genuis of Kant.

Strawson, of course, has written a classical exposition of the Kantian *Critique of Pure Reason, (The Bounds of Sense,* 1966*)*, and those who feel that it gave an inadequate account of the Kantian doctrine of synthesis will be pleased to see this trail reopened in the three essays on Perception, one of which, incidentally, relies heavily on certain Wittgensteinian distinctions, (e.g. between 'seeing' and 'seeing as'), in an exposition of the Kantian doctrine concerning the imagination's contribution to perception.

Strawson's advice in the title essay, "to keep before our minds ... what it is like to be involved in ordinary inter-personal relationships, ranging from the most intimate to the most casual", reflects a general shift away from the formalism of many of his contemporaries. The search for the essence of morality and its correlative attitude of lifeless objectivity appears to have been abandoned, and Strawson exemplifies this change by stressing the importance of the social situation in which one develops a moral attitude. This entails a re-examination of what it is to see other people 'objectively' rather than as persons in their own right. Marxist literature abounds with references to reification, alienation and objectification, but it is always refreshing when an Anglo-Saxon philosopher discovers this phenomenon for himself. Depicting the "objective" attitude to inter-personal relationships as a "resource that we can use according to our needs", Strawson points out, quite correctly, how "being human, we cannot do this for long, or altogether". This raises the question: Why has so much effort been put into instilling this value in students of medicine and the welfare industry in general? It is worth considering the well argued passages in Strawson's texts which articulate the tension within human beings between the "participant attitude" and the "objective attitude". Marxists, of course, would demand an examination of the social basis of this tension. One feels therefore as if British philosophers are nearly, but not quite, ready to be let loose on political issues after almost a century of self-imposed abstinence.

This wish is partly met in the second essay which deals with the conflict between social moralities and the individual's picture of ideal forms of life. Pitting himself against those who dream of realizing a Tolstoyan ideal community or, worse still, of making a nation reflect an ideal image of "human solidarity or religious devotion or military honour", he argues that moral philosophers should pay more attention to "types of social structure and social relation". Strawson's final plea is for a liberal society in which no man seeks to impose a harmonious kingdom of ends but welcomes the ethical diversity which the society makes possible. All very noble, but though he has put the pertinent questions to those who would like to inflict an ideal form of life upon us he does not say anything about the historic reality of his "liberal society". Does it exist, has it ever existed, what are the necessary conditions for its existence, and is it even capable of existing? And if it were to exist and was to tolerate ethical diversity who would be expelled first: the communists or the fascists?

How, then, is a philosophical work to be assessed? Not by its conclusions but by the questions it poses. This is what distinguishes philosophy from other branches of knowledge. A philosopher is a man with questions to ask; his answers are relatively unimportant, which is why philosophy is frustrating to the unphilosophical. To have an answer is to be wise, a wise man is satisfied and no longer vexed by awkward questions. Therefore his answers are beyond the scope of philosophical assessment. Strawson's book has merit because it asks the right questions: his answers are only incidental. The style of argument, with its often frustrating exactness and concern for detail, typifies what future generations may remember about contemporary British philosophy. They will probably forget what was said whilst acknowledging the *method* of saying it. In this respect Strawson does not tower above his contemporaries as Plato did; on the contrary he typifies them. His work is not spun out of some intellectual *parti pris,* but is the product of a school which has more exacting standards than any before it – even to the point of excluding those for whom philosophical puzzlement does not express itself in this way.

DAVID LAMB,
Philosophy Department, University of Southampton

CLASS, CODES AND CONTROL, Volume I,
by BASIL BERNSTEIN.
Paladin. 75 pence, paperback.

This book is the first of 2 volumes entitled *Class, Codes and Control,* both of which are concerned with the sociology of language. Volume I contains Professor Bernstein's collected papers of the period 1958–1973 and therefore spans a good deal of the development of his theories on socialisation. To emphasise this point the papers are helpfully grouped under the headings "Beginnings", "Developments" and "Explorations", and are presented more or less in chronological order. Although previously published in hardback, this is the first paperback edition, and is complete with its own, new, "Postscript".

The forword by Professor Macrae gives an insight into the background of the book, while the introduction, by Bernstein himself, tells us as much about Bernstein the man as about Bernstein the sociologist. It is encouraging to note that he left the London School of Economics in 1951 with what, he says, is not considered to be a good degree! His interest in research developed in one of the most wholesome ways possible: by trying to communicate with a class of G.P.O. recruits on day release, who did not respond to a formal teaching situation. The results of the survey he carried out on these recruits is reproduced here and, at times, one needs to perform mental gymnastics in order to unravel the discussion of these results.

Much of Bernstein's work has a definite Durkheimian flavour, which is encouraging at a time when Durkheim tends to be underrated. Durkheim's concepts of mechanical and organic solidarity provided the starting point for the development of Bernstein's concepts of stratified (strong, hierarchical) and differentiated (weak, less hierarchical) social relationships within the schools. This led to the developments of the concepts of 'open' and 'closed' school systems and elaborate and restricted codes which provide the link with socio-linguistics.

In the postscript, he states that the aim of his research "has been to try and understand the basic social controls on the form and contents of symbolic orders transmitted initially in the family and in the process of education". There are, therefore, two strands to his research: that concerned with socio-linguistic codes, and that concerned with education as an agency of social control.

Bernstein writes in a very compact, concentrated style, so that one feels every sentence of the book is important and no word is superfluous. Obviously, in a review, it is impossible to go into his theories in detail, but a brief description would not be out of place.

He maintains that communication codes are produced by social class. The working-class code is orientated towards the concrete, the here and now, and towards positional forms of social control, while that of the middle-class is more concerned with the abstract, the exploration of motives and intentions and with personalised forms of social control. This leads to different emphases on language potential in different social classes. The middle-class have a "theoretical attitude" towards language, i.e. they emphasise the structural possibilities or sentence organisation and abstract concepts. The working-class tend to have a more limited and descriptive form of language, which does allow a range of possibilities but discourages verbal elaboration of subjective intention. For brevity, the middle-class are said to have an "elaborate" code and the working-class a "restricted" code.

It is important to note that this orientation to linguistic forms is independent of non-verbal I.Q. scores: it bears no relation to an individual's intelligence, but is a purely social phenomenon.

The main reason why working-class children tend to do less well at school than middle-class children with comparable I.Q. scores, is that the restricted, working-class code is at odds with the code of the school. Formal educational institutions favour and are oriented towards the use of the middle-class, elaborate code. Thus for middle-class children, the school confirms and helps their social and symbolic development and reinforces their social identity; while for the working-class child, school is a place of symbolic and social change and a change of social identity. The elaborate codes of the middle-class are not intended as instruments for the alienation of the working-class, but tend to act as such in industrialised societies, where they dominate the classification and frames controlling formal education. Therefore the work on socio-linguistic codes is interrelated with the work on knowledge codes, made available through public education.

Bernstein takes the opportunity of answering Labov's criticism that he says the middle-class code is 'superior' to that of the working-class. All Bernstein says, in fact, is that an elaborate code puts middle-class children at an advantage because of that code's adoption by the educational processes. The postscript also throws interesting light on the search for an adequate linguistic theory to guide the analysis of speech. Chomsky's theory was rejected as being too purely linguistic for Bernstein's purposes; the theory must go beyond the construction of the sentence to match the logical levels of sociological and linguistic analysis. Professor Halliday's theory was adopted as this allowed linguistic analysis to take account of the wider social context.

In such a volume as this there are bound to be some inconsistencies, but to criticise Bernstein for this would be irrelevant. Indeed Bernstein himself deals with any such criticisms by saying "the single most important fact of research is where it *leads*, not where it starts", although he recognises that the initial formulation of a problem has some effect on its future development.

JANICE DAVIES,
Social Services Administrator.

MEDICAL

A COLOUR ATLAS OF RHEUMATOLOGY
by A. C. BOYLE
Wolfe Medical Books £3.50

It is said that beautiful women enjoy browsing through pictures of beautiful women. Those whose interest is in diseases of joints should therefore enjoy browsing through this colour atlas of rheumatology as I did perhaps there is a brighter future for doctor's pictorials than for the prosey periodicals with their untrendy graphs and figures. Certainly this generous collection of rheumatological "What the butler saw" will provide an entertaining and instructive interlude for senior medical students and interested postgraduates – senior medical students because the explanations are inadequate without some preliminary knowledge. Those whose friends take photographs know that what is blindingly obvious to the photographer is not always visible in his photograph; a few of the illustrations have suffered from this phenomenon. Some of the X-Rays are too small to show the abnormalities and the crystals are unrecognisable. These are minor criticisms and the book is a fine exposition of the clinical art of rheumatology. There are some gems including an ochronotic ear which will be valuable for medical quizzes.

This book can be especially recommended for a painless revision of the subject before examinations and will amply repay the short time and little effort required to read it.

E. C. HUSKISSON,
Senior Registrar, Rheumatology Dept.

THE HUMAN LENS – In Relation to Cataract
CIBA Foundation Symposium 19.
Elsevier, Excerpta Medica, North Holland.
$ 16.70

This is a report of a Symposium recently held in London. The age changes and cataractous changes of the lens are described and other methods of documentation by ultrasonography and photography are shown. The protein and enzyme changes with alteration in the ionic balance are also described as are the immunological and fluorescent combined studies. Drug-induced cataracts are also mentioned.

It is clearly a book designed for the specialist reader and indeed most busy clinical ophthalmologists would find it hard to follow, although it is certainly very interesting reading. It is not recommended for under-graduates.

M. A. BEDFORD
Consultant Ophthalmologist

A GUIDE TO DRUG ERUPTIONS
by W. Bruinsma.
Elsevier, Excerpta Medica, North Holland.
£5.40, paperback

This slim volume of 103 pages is an excellent guide to the troubled waters of drug eruptions. Problems in this field are extremely common; it is estimated that 20% of those admitted to medical wards have a drug reaction during their stay.

Dr. Bruinsma is a dermatologist and Director of Public Health for Drugs (sic) in the Netherlands and has produced a lucid account of the commoner drug reactions, with a list of 190 useful references and a number of review articles. Not surprisingly there are areas where practice in this country differs from that described in the book. For example, patch tests are normally removed after 48 hours and not 24 hours as suggested here; a few of the drugs are either not used in British medicine or appear under a different name e.g. Pyrvinium.

The main snag is that the price seems excessive for a soft covered book of this size; at one-quarter the price one could recommend it unreservedly. As it is, few private purchasers would find it value for money.

MICHAEL KLABER
Senior Registrar, Skins Dept., The London Hospital

REPORTS VOLUME 16, 1971–1973.
Royal National Hospital for Rheumatic Diseases, Bath.

This volume contains the published papers of a long-famous rheumatological institution. They vary in content, language and quality as would the papers from any other rheumatological institution; most are in English but there are papers on historical aspects of Bath, joint pressures, thermography, case reports, clinical trials and even one on the design of fire escape chutes. Of particular interest for re-reading is a series of articles on synovial rupture, popliteal and claf cysts their relation to intra-articular pressure, and their proper treatment. The use of thermography in rheumatoloty has also been extensively studied in Bath but the papers are disappointing. There is a good account of the apparatus, now out-dated of course, but no evaluation of the usefulness of the technique as a measurement in arthritis. We know little more than that arthritic joints are warm. There are the very beginnings of what will surely be a valuable programme of research into back pain, useful reviews of the rheumatoid foot and heart disease in rheumatic patients, some good papers and some poor ones. The whole volume reflects the vitality and vigour of its origin and that, I imagine, was its intention.

E. C. HUSKISSON,
Senior Registrar, Rheumatology Dept.

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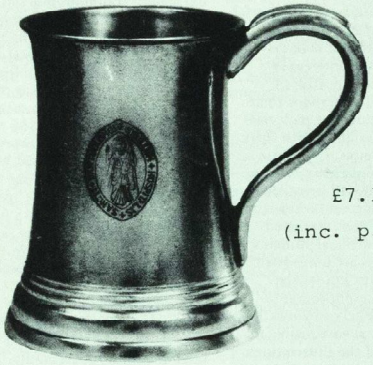

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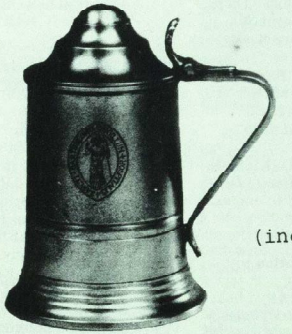

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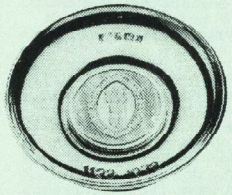

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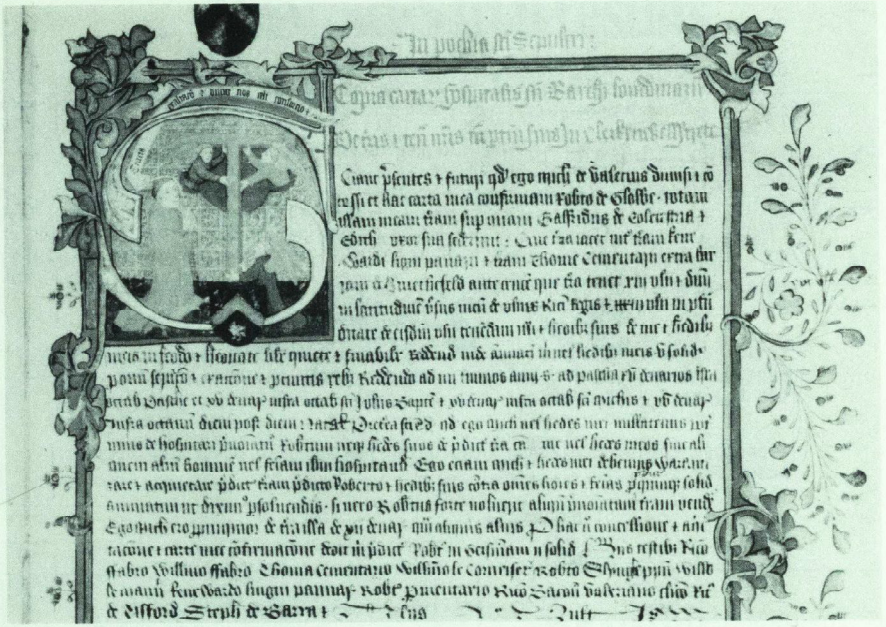

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THE BETTER PART OF VALOUR

"Doctors at the Hammersmith Hospital in London plan to carry out the first Fallopian Tube transplant in Britain early in January. The first reported transplant operation of this nature was performed last week in West Germany'... "The next stage was to transplant an ovary as well"..

Thus a prominent and 'serious' Sunday paper announced the latest advance in the remorseless tide of medical research. With a blare of press releases another milestone in the 'History of Heroic Surgery' prepared itself for acceptance into the canon of normal practice. Childless women will flock for their new tubes in wide-eyed droves, and perhaps some will conceive, and some certainly won't, and yet another ethico-legal debate will begin when they start trying to transplant the ovaries as well. But amidst all this excitement how many people will be brave enough to stand up and say, bluntly and loudly, "So what?"

Because if we are honest, we must admit that the overall lack of fertility of the species Homo Britannicus is hardly a subject for concern. In fact this overcrowded isle, and the overcrowded planet of which it is a part, could quite happily do with a prolonged plague of blocked Fallopian tubes. Already, for reasons that are hard to understand in a social context, we are using fertility drugs and artificial insemination techniques to help those unable to conceive, and since such usage is a 'fait accompli' we can only, in all conscience, continue to use them. But to develop them further, in direct contradiction to the widespread benefits that would accrue from, say, a truly comprehensive family planning policy, is nothing short of ridiculous. We are simply spending money and effort in diametrically opposite directions, and anyone who does not realise by now that solving the population problem is the key to future social harmony, must surely be classified as hopelessly deluded.

Of course, I am in no way belittling the tragic consequences for those couples who wish to have a family, yet are unable to for whatever reason. Nor am I belittling the concern and effort and good offices of those workers who have striven to assist them, whether in research or in practical expertise. Thus it would be morally wrong to refuse the assistance of already available techniques. But to go for further progress in this field, while benefiting certain individuals, will be of minimal use to the vast majority, who not only provide the bulk of moneys into the N.H.S. but who are already over-stressed in their various 'urban conglomerations'. Somewhere along the line we have to say STOP, we have to rationalise our areas of research and expenditure, (especially in the light of the economic situation) deliberately choosing those which provide the most benefit for the largest majority of the people. Otherwise 'Health' becomes an infinitely widening horizon, offering more and more complex 'cures' for ailments that our grandparents regarded as part of the human condition. Already you can get your 'bat ears' fixed on the N.H.S.; how soon will it be before 'face lifts' (oh, the misery of those crow's feet around my eyes!) or 'hair implants' or 'blue-eye transplants' will be demanded by all and sundry, as we desperately strive to look like 'Mr. (or Mrs.) Normally Handsome – 1984'.

What is happening then, as this Fallopian Tube announcement so beautifully exemplifies, is that the medical profession is falling into the traps of a consumer, demand-orientated society. The 'I want it now' ethic is all. We can't refuse anyone anything.

We seem no longer able to accept with equanimity our own personal limitations. Some of us can't look like Paul Newman or Marilyn Monroe (lucky us), some of us can't see or hear or talk to other human beings, a fate quite incomprehensible to those of us who accept our faculties without a thought; some of us, sadly, can't have children. Obviously, to do nothing at all about the various tragedies of existence is mere idleness, a Panglossian acceptance that everything is for the best in the best of all possible worlds. But there are small tragedies and there are large tragedies, and to concentrate energies on 'small-print topics' while all around the old and mentally ill and arthritic are crying out for care and attention is as immoral as doing nothing at all. Doctors are in many ways the interface between science and its application to people, and they have a real responsibility to understand and to explain the limits of their art, and to

abide by those limits. Extravagant and needless sorties into the world of heroic fantasy, and this venture into Fallopian Tube transplants clearly fits into such a category, can only create the further misery of unfulfilled expectations. The true scientist should know not only *how* to apply his knowledge or to extend his range; he should also have the courage to ascertain *where* he needs to go.

UNIONS DEFY GOVERNMENT YET AGAIN!

It is fairly common these days to read of one union or another making a stand against the Government and the employers over some point, usually pay. We are quite used to being brought to a standstill, blacked-out or held-to-ransom. Crises are commonplace; working-to-rule widespread. In fact the latest flare-up in union activity in search of improved pay and conditions is hardly work a mention – except that it is not the dockers who are threatening us but the *doctors*. The reason for this is the policy decision of the present government to remove all private beds from the NHS by the end of next year, thereby reducing the freedom of the individual, consultants' clinical freedom, and several pay cheques.

Only the last of these arguments has any substance: there has never been freedom of choice for the majority of individuals; clinical freedom means only the freedom to treat one person before another for no better reason than the fee involved. And that is obviously at the root of the third objection – if there are no pay beds in NHS hospitals there will be less chance to earn a fast buck on top of one's merit award. Here another point must be raised: is it necessary for doctors to be so well paid in comparison with other health workers? No doubt it can be argued that doctors comprise yet another "special case", and that they should be compared not with other health workers but with other trained professionals. That is as maybe, but it is a situation which is unlikely to change even after the removal of pay beds. The fact is that the doctors want extra money to make up for the loss of privilege within the NHS, and the right to carry on their private work outside it.

The increases in salaries requested are, perhaps, reasonable; but they can only be met with when all consultants become full-time employees of the NHS (as will be necessary with the addition of the private beds to the NHS workload). These increases should also be matched by suitable improvements in the pay and conditions of junior medical staff, and of non-medical and ancillary workers, so that the whole NHS becomes a worthwhile occupation financially as well as vocationally.

The removal of pay beds is a useful first step on the road to the provision of a universally acceptable health service. The concept at issue, that of whether health and health services constitute a right to all or a commodity on the free market obtainable only to the highest bidder, must be finally decided soon. In the meantime, there appears to be no justification for the provision of beds and facilities by the government for the exclusive use of doctors in their worst entrepreneurial rôle. Private hospitals there may be in the future, and private consultants, but there is no case for the provision of the former or the training of the latter inside the NHS. They are a separate system, and must exist as such.

Meanwhile, in the fight for *their* rights the doctors must remember that they comprise just another small, self-interested group, standing in defiance of the elected government. They might also remember the degree of support they gave to other health workers when the latter sought better conditions: they will know then how much help they can expect in return.

THE PRICE OF FATNESS

As the much prophesied 'economic crisis' comes up over the horizon, and the bankruptcy rate continues to rise at an alarming pace, out come all the hoary old phrases about austerity, tightening our belts, the Dunkirk spirit, and the most amazing one of all, 'facing up to reality'. People are hyper-sensitive about shortages; first it was the toilet-paper, then it was sugar, then the absurd salt rumour; what key article of consumerism will it be next, lollipop sticks perhaps? How will we survive the winter without them? Perhaps they will have to be rationed! And so the pampered overfed people of U.K. 1974 go tearfully about their daily tasks, hoarding mounds of toilet-paper, squabbling in queus over sugar, burning up petrol and tobacco and alcohol and anything else vaguely inflammable.

Because what is so sickening about the present mess are people's attitudes towards "austerity". For example, were sugar supplies to be virtually cut off for the next twenty years the benefits to the British people would be quite enormous. Dentists would become almost extinct, obesity would surely regress in popularity, and, according to Professor Yudkin, cardiovascular disease would decline dramatically from its present epidemic proportions. Incidentally, we might just start being able to afford a National Health Service. As for toilet-paper, it seems blatantly obvious that the first press magnate to cotton on to the idea of a "super-soft" edition is bound to make a killing. As for cigarettes, any sane government would double the tax at once; if people insist on ruining their health they might as well pay for it.

The simple truth of all this palaver is that we Europeans are fat and we consume too much, and have been doing so for far too long. Now that the near-starving "Third World" are beginning to demand fair prices for their raw materials, we start to squeal about trade distortions and imbalances; yet our so-called austerity would make any Indian peasant die of hysterical laughter. "No Spanish holiday, no colour T.V., no regular hair-do, no butter mountain, no leather shoes, no car, ..." even without these fancy goods that most people on this planet don't even dare dream about our lives would still be light-years away from the teetering existence of a Calcutta slum.

Yet while we bemoan our coming fate we are guilty not only of unjustified self-pity but also of blind stupidity in not actively welcoming the loss of some of our more piggish excesses. For the rising rates of violent crime, alcoholism, suicide, and general pill-taking are clear indicators of the false values and distorted ideas created by unlimited consuming. We have created a society that wants more and more; a society where advertising creates expectations of the 'good life' in everything you buy, whether it be cornflakes or alcohol or soap-suds. But all this frenzied consuming turns to ashes, and the brewers gloat as drink sales soar, and the drug companies gloat as sales of tranquillizers and anti-depressants climb and climb, and the criminals gloat as the law slides into disrepute. In other words, we've never had it so bad, at least in non-material terms (which are difficult for us of today to understand, I must admit) and the coming change of circumstances could well be the best thing since the invention of colour T.V. Which comparison only goes to show how deep-grained is the materialist instinct.

LETTERS

ST. BARTHOLOMEW'S HOSPITAL STUDENTS' UNION

Abernethian Room
St. Bartholomew's Hopital
London, E.C.1.

Dear Sir,

I am putting pen to paper to carry on the tradition the journal has of being a means of communication between the Chairman of the Students' Union and other students. First of all I would like to thank my predecessor, Tim Finnegan, and the other officers of last years' Union for their work. One only fully appreciates how well they did it when one takes over.

It is difficult for a new Chairman to issue a manifesto for two reasons. First, the job is essentially symptomatic. It is not possible to predict what problems will arise nor whether a preconceived opinion will be appropriate. Secondly, a Chairman is not selected according to his opinions but in the hope that when a problem does arise he will assess student opinion ans accurately represent it.

There are, however, a number of major topics which will need to be examined this year. The trend of clinical teaching in Bart's in the future is, I believe very rightly, to reduce the size of firms. This will be carried out by increasing the number of firms by bringing the Hospitals in the "Bart's Group" into a larger role in student teaching. I emphasise this fact rather than the emotive one of sending Bart's students to "other" Hospitals. The geographical separation of these Hospitals will, however, strain the every-day social unity of the clinical students. The solution of this problem is not obvious, and it would be as well for the student body to consider it, especially as in the future students will not have had the advantage of a strong social unit in Charterhouse, but rather that of the more disseminated Queen Mary's College.

It must be clear, even to the most insular of Bart's students, that the forces of inflation are insinuating into the Students' Union. The problem is not totally solved by increasing the subscriptions to £15 per annum. This year we hope to undertake a very close scrutiny of the Union expenditure, and we hope all students will co-operate in this.

An important job of the Students' Union is to keep the students informed not only of the semi-political activities of the Union, but also the social activities in Barts' and possibly in London. Two large Diaries are available for this purpose one in College Hall, and the other outside the Hospital Library. I hope that those who have occasion to publicise events use them, and thus provide other students and members of the Hospital with an incentive to look at them.

Finally, I would like to extend a personal welcome to all those new at Barts', and urge them to take part in as many as possible of the various activities. There is no necessity to become too 'paranoid' about the work. It has been known for some relatively well balanced people to pass exams at Barts'.

Yours faithfully,

Rory Shaw

Chairman - The Students' Union.

PRIVATE PRACTICE

Dear Sir,

At a recent London conference on the crisis in the NHS a group of doctors and medical students voted to set up a committee to investigate the role of Private Practice, both inside and outside the NHS. The consensus of opinion was that it was detrimental to the NHS and to the delivery of adequate health care.

The Owen Working Party will report on the whole question of Private Practice towards the end of November. We feel that since there is a great division of opinion over this issue it would be opportune to discuss/debate this contentious aspect at that time. Would anyone interested in organising a discussion/debate at your Medical College please contact me? It may be possible to arrange a speaker for such a debate.

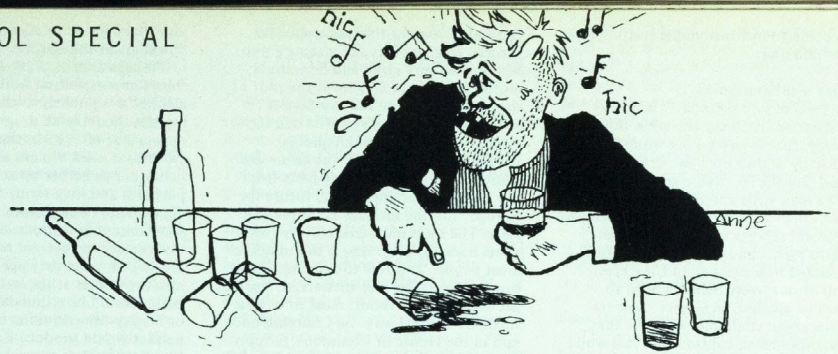
Yours faithfully,

MICHAEL MURPHY.

6, Ravenslea Road, London, S.W.12.
01-673 3853.

This letter has been abridged for reasons of space

ALCOHOL SPECIAL



It being Christmas, or thereabouts, it seemed appropriate to gather together some aspects of alcohol and its consumption, we have no doubt it will comprise a large part of people's Yuletide festivities. For your perusal then, dear readers, are three articles, two by men who know what they are talking about, one by a layman who talks about what he knows, and that isn't much. Essentially, they comprise three sides of the argument, in that those for and against alcohol have their say, whilst the Professor of Pharmacology occupies the "massy rock" of the middle ground in describing the fundamental facts. His quoted passage from Macbeth is certainly the neatest part of the whole caboodle and makes all the rest of us look like chattering fools. However, let the drums roll, and may good alcoholic cheer be with you this Christmas.

ALCOHOL – A SOCIAL NECESSITY?

by Trevor Turner

To attempt to say anything original about alcohol requires a certain pig-headed pride in one's own uniqueness. Every poet, playwright, songster, crooner and generalized hack entertainer has had his say, and a quick dip into the Oxford Book of Quotations would soon pull out a hundred references. Any standard medical student has made abundant studies on his own person of the effects of beer (or wine or spirits or what you will); these "reports", if written up, would soon out-volume even that most remorseless of weeklies, the B.M.J. Any good hostess knows that a few stiff drinks will make her party "go", for most 'parties' only justify their existence by providing a forum for some sort of group alcoholization. Our tribal feasts and rituals are sanctified in alcohol, whether they are family affairs, like weddings or Christmas, or clan gatherings like Bart's v. Guy's. Even the Church has incorporated alcohol into its daily activities. In fact, Western culture is alcohol-based, whole areas of the land and the economy being devoted to its continued production. Scotland and Burgundy, Bordeaux and the Rhine Valley, Cyprus and Algeria, are all largely dependent for their prosperity on various admixtures of 'Ethanol plus flavouring'. So that in our way of thinking jollity and a red face have become quite inseparable, like a doctor and his stethoscope, or a lawyer and his gown; we all suspect that the red face, the stethoscope and the gown are unnecessary appendages maintained purely for tradition, but there is a real need for them, especially the red face. A short survey of historical usage, present usage, and the special environment in which we live today will, I trust, show how totally NECESSARY it is that we continue to use alcohol.

Historical

Right at the murkiest beginnings of the Western cultural tradition men were setting the tone for our attitudes to alcohol. Homer, the so-called "first epic poet", has liberally spiced both the *Iliad* and the *Odyssey* with descriptions of drinking bouts and their sequelae. "...and a steward carries round the wine he has drawn from the bowl and fills the cups. This, to my way of thinking is something very like perfection" (*Odyssey* – Book IX). Excessive perhaps, but no one who has sat back in post-prandial fullness can deny the sense of happy ease that comes with seeing your glass re-filled for the umpteenth time. And Horace, the Roman version perhaps of Dylan Thomas, likewise had plenty to say, so much so that it would be relevant to quote most of his poetry verbatim. "Fill the polished goblets to the brim with memory-drowning Massic," he cries, (somewhere in the 2nd book of Odes, Massic being an excellent Roman wine and not, as it may sound, their equivalent of chewing gum cum denture powder). "Why tax the mind with plans? Better by this tall tree to sprawl, and while we may, drink wine . . . Let Bacchus dissolve those gnawing cares." (from another ode in the same book). And if we turn to that sober historian, Herodotus, another ancient Greek "first", (he is supposed to be the first "historian", but entertainment, rather than verification of facts, was his real métier) he has a most interesting tale to tell of the Persians. "If an important decision is to be made, they talk over the problem when drunk, and the next day, when sober, they reconsider the decision they have reached. If they still approve, it is adopted; if not, it is abandoned. Conversely, any decision come to in sobriety is re-examined afterwards when they are drunk" (*The Histories* Book 1–134). Critics of modern parliamentary drinking hours might like to ruminate on this, for in English life there are many examples of alcohol's benign influence. Billy Shakespeare's most engaging rogue was Falstaff, best described in the bard's own words as "that huge bombard of sack!" Dr. Sam Johnson almost lived in his local; quoth he, "a tavern chair is the throne of human felicity". Samuel Pepys was no abstainer, yet he founded the Royal Navy, and someone even named a pub after him. Out in the Wild West, they regarded the saloon and the bartender as sacred holders of the mystic flame; to serve out drinks was a calling beyond the humdrum activities of normal gun-toting life. Henry Ford's "My Darling Clementine", a film about Wyatt Earp, has this key scene, stressing the dedication of barroom life.

Earp to the barman, Joe:
"Say Joe, ever bin in love?"
Joe's reply:
"No sir, I've been a barman all my life".

There seems little doubt about it; psychiatrists are just frustrated bartenders. And if we take a quick look at recent history we find that it was only in 1914 that in Britain, "The Sacred Freedom of drinking was tampered with; licensed hours were cut down, and the beer watered, by order". (Taylor. *English History 1914-1945*, p.2). Here is the watershed maybe, the point where the need for jollity ran head on into the 20th century. Good cheer through the ages had always included wine with the women and the song, and now the time

had come to institutionalise it, to define its boundaries.

Today's circumstances

Everywhere you go today, the glossy advertisements all say the same thing – namely, that lovely young women, often in skimpy bikinis on a sun-drenched coral island, are the inevitable accompaniment to the man virile enough to drink the latest ethanolic concoction. Throughout the world reports emerge of various bizarre events and terrifying statistics, all related in some way to the exploitation of our overwhelming need to consume alcohol. In Greece they are stoical about it all, but why is it that wine production continues to rise while the grape harvest often falls? Let us just add that it has nothing to do with imports. In Italy they are far more brash about the whole business. They simply have enormous multi-billion lira scandals when some oddly honest civil servant works out that a large proportion of their much-loved Chianti has never been near a grape in its life. Chemicals make much better business sense than grapes. In America the real horrors occur. In the public hospitals, where the poorer people go, every patient admitted is at once regarded as an alcoholic, apart from anything else he may be suffering from. They also have enough alcoholics under 21 years of age to fill a fair sized town. In good old merry Britain, symbol of phlegmatic stability and orderly existence, there are now some 250,000 alcoholics (at a conservative estimate), who have a suicide rate 80 times the normal, and it is reckoned that alcohol plays a part in two-thirds of all crime. It is certainly associated with a higher proportion of crimes of violence. In Ireland, their national symbol is the Irish harp; it is also the trade-mark of Guinness. In Russia the consumption of vodka is so alarming that the government have invited in Western brewers in a desperate attempt to alleviate matters with beer's less toxic substance. Recently, Pepsi-Cola has also been signed up to provide an even "softer" alternative. In Libya and Saudi Arabia they have actually gone back to solid Islamic tradition and banned alcohol outright. To see the Western envoys based there must be a worrying sight. Either they abstain or take recourse in the local "hooch, a very dangerous expedient.

And as the data piles up, as the world becomes more and more a world of "masses", more and more frenetic attempts have been made to control alcoholic usage. The ultimate bungle was Prohibition in America, which simply created big money and a secure base in society for the Mafia and their associated hoodlums. This organization is now reckoned, by some quite sane economists, to be taking a 5% tax out of every US citizen's purse. In Britain we have licensing laws and breath tests, and now there are demands that the police be allowed to check anyone leaving a pub. Which is all very good and honourably motivated but hardly gets at the root of the matter. Because the key fact of today, as any brewer's profits will show, is that consumption of alcohol is RISING fast, and with it the crime and addiction rates. The scaring facts from the USA are warnings of the future for Europe, and the message is simple and clear. The mass industrial society, with all its material comforts, is too much for most people. It offers too few satisfactions and too few real answers, so people get off the roundabout, most of us in a small, occasional way. As Churchill once said in the House of Commons, in reply to the exalamation of a shocked lady member that he was drunk; "Madam, you are ugly, and I shall be sober in the morning". Likewise, most of us will be fine in the morning. The ugly permanence of alcoholism is something outside, on the edges of our world.

Modern Approaches

However shocked we may be by all these unpalatable problems, there is little use in moralizing, saying that it is bad or unclean or degrading. It is a fact, another symptom of 20th century life. We must simply learn to adapt to an artificial environment, consisting largely of concrete, tar macadam, brick, steel and glass; and with these materials of course there are the fumes and the crowds and modern range of noises. How can man be natural amongst all this? The short answer is that he cannot; there is just too much movement, too much pressure, too much change. So to match this environment he needs all the weapons that modern technology can offer him, and among these alcohol, the well-tested friend of history, is of prime importance. How long this will be so is less sure, for other "substances" are coming to the surface. Pot, cocaine, L.S.D. and other agents of variable effect and potency are increasing in both quantity and quality, and there seems little doubt that Aldous Huxley's *Brave New World* fantasy, where people take drug "holidays" as rewards for work, is well on the way to becoming a solid reality. However, the law, and custom, still regard alcohol as quite enough for the moment, (with tobacco as well, of course) so how can we in some way fuse the "jolly times" concept of alcohol with the hard demands made upon it by 20th century factors? Because there is no shirking the issue: alcohol is here; modern industrial life is here; how to "take some time off from reality", without turning it into a hell for oneself or other people, is the problem we have to come to terms with. As such, we cannot "solve" it, so much as learn to see it for what it really is, and by fully understanding it perhaps we can gain some insight into the much more important problem of surviving intact as "dwellers of the Earth".

Perhaps a medical model will put things in perspective, in that if we regard alcohol as a publicly available drug, like aspirin, then like all drugs we must expect side-effects. In this case there are two major ones, violent antisocial behaviour (whether by accident or on purpose) and long-term, debilitating, dependency. The former we can limit to some extent by various legal measures. In this respect the present licensing laws are misjudged, since they spew people out into the streets at the wrong times. Much better would be either day-long drinking or no day-time drinking at all, for neither would produce a mass "closing-time" exit. Also, extension of evening hours till say 1 o'clock when roads are virtually empty, could only lower the risks of accidents. For example in Australia the bars used to close at 6 pm. Thus an evening's drinking was crammed into one crazy hour at the most, and mayhem followed on the still busy roads. Extending hours to 10.30 or 11.00 reduced road casualties immensely. Concomitant with this type of approach, breathalyzer bags should be readily available at any bar, so enabling a potentially drunken driver either to test himself or be tested by the landlord. The deterrent of disapproval by his fellow drinkers seems far more effective than the random stopping of weaving vehicles by bored policemen.

As for alcoholism, we can only accept these social inadequates as misfits, the small percentage on the edges of the normal distribution curves. Some people react badly to halothane or penicillin, but no-one seriously suggests we should therefore remove them. For, like alcohol, they do an awful lot of good for the vast majority of people who use them.

Clearly, we must go on looking for better drugs with less possible side-effects, but for now we have to accept the bad with the good. Warnings, à la cigarette packets, and an acceptance by people as a whole that alcoholism is a standard disease entity, can all be indulged in, but in some ways the alcoholic is anyway a victim of social pressures, so to pound him further with "warnings" and "attitudes" can only increase his sense of isolation. Like homes for the mentally and physically handicapped, organized care facilities will just have to be the price we so-called "normals" have to pay.

Addiction, then, and violence are the two big side-effects and they seem to be increasing, and the natural fear-response of many people is to demand bigger and more comprehensive controls. But as Prohibition so starkly displayed, things get worse if you remove alcohol, just as if you were to treat someone by suppressing his immune-defence mechanisms. What really needs adjusting, to bring consumption back into line with history, is the speed and change of modern life, and, some would argue, especially needed is radical social reform. But these anti-prohibition, liberal reformers are just as wide of the mark, for they are missing the blaring evidence of the past few years. For people are drinking more and more in spite of massive changes in society. Social security systems, Welfare States, overseas aid and many radical political upheavals have largely produced, in Europe at least, an increased need to take in alcohol. The real point is that man has reached a stage where external tools, like wheels and levers, boats and planes, cars and washing-machines, guns and atomic bombs, are not enough. He needs, and is devising as part of his new knowledge, internal tools, to assist him in an increasingly mechanized environment. When the South American Indians sailed to Polynesia they chewed coca leaf to help them survive the journey, just as Inca messengers chewed it to increase their long-distance ability. As we start to "lift off" towards the planets, the stars, the nether regions of the various sciences, and the ultrastructure of our own cellular organization, we need more than simply food and water to live off. Alcohol has thus been deliberately taken up as a new-found, rather crude, weapon in our search to adjust to our present environment. It has well-known defects, but is safer than anything else as yet known. Some would say other drugs are better; some would say vegetables are all you need. The fact is that most people, now, are accepting alcohol.

Conclusion

The rising tides of alcoholism and alcohol usage are simply then a phenomenon of urban, industrial man. We must see this as an evolutionary step, as important as our emergence from the trees or our acceptance of a static, farming way of life. Just as the lame lost out in the hunting world, so those unable to adapt to the urban world are bound to lose out in some way. Which is not to say we should ride roughshod over these "flotsam", or ignore them, or put no effort into rehabilitating them. It is just that most people are deliberately using alcohol as a means of communicating, beneficially, with others and with that part of themselves normally inhibited by the many internal and external pressures of living in a high-density society. "There's truth in wine", said a wise philosopher, and it is as a "happy truth drug" that alcohol long has been and long will continue as central to society. History, our present situation, and the fact that we are entering a whole new "Science Age" of evolution, all point to a coherent philosophy of alcohol. So drink on, brothers of the 20th century, we have nothing to lose but our inhibitions.

T.H.T.

THE CAUSE OF ALCOHOLISM

by Bernhard Kinman

Written large on many alcohol education folders and repeated in conferences, articles and journals, are the words, "The Cause of Alcoholism Is Not Yet Known" or "We Do Not Yet Know the Cause of Alcoholism."

Thousands of pounds are spent annually in research – following the alcoholic around, checking his whims and fancies, and yearnings, studying his environment, watching the process of alcohol upon his cells and statistically tabulating the growing army of millions of alcoholics as they increase in number, and then as they drop out by the wayside.

So much of this study is centred on the effects of alcohol consumption. Other major studies are focused on rehabilitation methods in order to make an attempt at halting the avalanche of human suffering. It would seem that the investigators have long forgotten to seek for the cause. The result is that we have an overwhelming array of confirmed data on alcohol as a narcotic, showing it to be a depressant drug bringing about an addiction of dependence.

Both the drinker and non-drinker will be better off if he can know the *cause* of alcoholism. This knowledge will hold the certainty of better living. Medically we are told that alcoholism is an incurable disease. I am convinced, however, that alcoholism can be solved. Naturally, it must be dealt with humanly, objectively and realistically. Once we know the cause, we shall knwothe answers to questions which have been asked for centuries. We shall also be able to set up a successful programme of prevention and rehabilitation.

Temperance advocates are in the main an unpopular breed, principally because (1) They project a Victorian image and (2) They are considered kill-joys. They have, however, been sincere in their desire to help humanity and have co-operated with physiologists and pharmacologists and with them have declared the nature of alcohol, and its impact upon society. They have concentrated, however, generally on alcohol – the drink.

Many national and local health departments and related organizations on the other hand, fearful of the image of being labelled total abstainers, have placed their focus on the person. In this way they have continued in the favour of the moderate or social drinker and of course the brewers.

We are told that theories about the causes of problem drinking are various and complex. It was stated in a recent magazine article that "Alcoholic makes alcoholics."

Dr. Niel Kersel and Dr. Henry Walton in their book "Alcoholism" page 179, say: "Two things are required to produce an alcoholic 'The drink and the person'. Surely this is the crux of the problem and both are part of the solution. It is only when the temperance advocates, whether they be doctors or laymen, and the Government and Health Organizations co-operate, honestly desiring the elimination of this international scourge that together they can work toward the prevention of alcoholism and rehabilitating the alcoholic."

It would be good, therefore, to think of man in terms of Four Dimensions and to consider the Four Dimensional key to the cause of alcoholism.

First Dimension – Physical

The power and wonder of the human body has over the centuries captured the thoughts of artists, sculptors, churchmen, medical scientists, and many other students of life and health.

These natural powers functioning with growth; repair and development, plus all the ability of operation makes the body a beauty in design and purpose.

As man has searched out the secrets of this power and wonder he has discovered its source of efficient operation is hidden in obedience to amazing inherent laws.

These basic laws of life, though considered elementary, are the source of life and happiness. They are pure air, sunshine, pure water, proper nutrition, rest, exercise and abstemiousness.

Failure to heed these vital needs may create abnormal or unnatural physical cravings and distort our mental attitudes, our ambitions, goals and efficiency.

Our bodies are like houses. Some take longer than others to break down under neglect and impairment.

The recent copy of American Medical Association Manual on Alcoholism says: "Physical disabilities and impaired life adjustment certainly may precede or contribute to the development of the illness." (Page 6). "The role of physiological factors in progression of the disease is quite well established." (Page 16).

The truth is, therefore, that our physical appetites and desires will minister to our happiness when brought under self-control.

Three pointers to first dimension

1. Our physical powers will reward us according to our use of these powers.
2. The control of these powers is available to us through obedience to the laws of our being.
3. Alcoholism does have a relationship to the physical powers.

Second Dimension – Mental

Man's mental capacity is the core of his governing powers. This dimension has a vital relationship to his conduct. The mind like the body will develop according

to the way it is fed.

The will is the spring of all mental actions. It is the control mechanism over impulses and emotions. The mental powers can be strengthened by a conscious exercise of wholesome decision making.

"In the specific defense against anxiety the alcoholic patient does not use logical thinking, does not respect the demands of reality and cannot delay immediate gratification of his impulses." Dr. Chador Koff, Quarterly Studies, 25. 292.

Third Dimension – Social

Social relationships are essential to happiness and man's development. Man does not find genuine contentment if ostracized or isolated from society. Paul the apostle stated a well demonstrated truth when he said: "For none of us liveth unto himself, and no man dieth to himself." John Donne: "No man is an island."

The American Medical Association Manual on Alcoholism, page 28: "It is apparent that sociological factors are of great significants in origin and development of alcohol use and abuse."

Fourth Dimension – Spiritual

Man is more than a Physical, Mental and Social Being. He is not fully living until he recognises and gives place to the extra dimension.

William Jewett Tucker puts it in perspective when he says: "Do not expect that you will make any lasting or very strong impression on the world for good through intellectual power without the use of an equal amount of conscience and heart." – 'Think' I.B.M. Magazine, Dec. 1968.

Destroy the spirit of man and you destroy the fact of life physical, mental and social. We are living in a world that is destroying the things of the spirit.

Modern education ignores it.
Philosophy side-steps it.
Religion often doubts it.
Business has limited use for it.
Mysticism attempts to counterfeit it.
Pleasure spurns it.
Politicians often only consider it to receive votes.

Impair the spirit of man and you destroy his hope. The philosophy of the Epicurians comes into its own. "Let us eat, and drink, and be merry for tomorrow we die."

The reason Alcoholics Anonymous has been so successful in rehabilitating alcoholics is the programme's recognition of the need for spiritual restoration.

Step two of its twelve step programme says: "We came to believe that a power greater than ourselves could restore us to sanity."

Step eleven: "We sought through prayer and meditation to improve our conscious contact with God as we understood Him, praying only for knowledge of His will for us and the power to carry this out."

To summarize: alcoholism is a dependence on alcohol brought about by the conscious or unconscious neglect or impairment of either the physical, mental, social or spiritual faculties of the individual.

So the same principles apply to prevention and rehabilitation.

Prevention Foster a development of the physical, mental, social and spiritual life, so that a person can find satisfying rewards in the functions of life's powers without the need for the use of alcohol.

Rehabilitation Remove alcohol from the patient and work to restore the physical, mental, social and spiritual well-being of the patient until he can find life rewarding and is able to function without dependency on alcohol.

Bernard Kinman
LMRSH., LLCM

The Pharmacology of Alcohol

by Professor J.P. Quilliam

Beverages containing alcohol (ethyl alcohol, ethanol, C_2H_5OH) have been prepared since ancient times from natural products available in one form or another to the various races and tribes which inhabit the face of this planet. It is remarkable that the varieties of the brewing processes, conducted so widely, in geographically disparate places, and presumably which had developed quite independently, should all lead to drinks containing ethanol, sometimes in substantial concentrations. It is an interesting reflexion that ethanol drinks have been in such wide use and demand through the ages, presumably providing a facility to "escape" from the realities of life whether in primitive dwellings, "tower blocks" or within the "rabbit hutch" constraints of modern suburbia.

In 2347 BC, "the sone of Noah that went forth of the Ark were Shem and Japheth and Ham." (The last named had 4 sons one of whom was named Phut of whom little or nothing is recorded!) "Noah began to be an husbandman, and he planted a vine-yard. And he drank of the wine and was drunken; he was uncovered within his tent. Ham ... saw the nakedness of his father and told his two brethren without. And Shem and Japheth took a garment and laid it upon their shoulders, and went backwards and covered the nakedness of their father; and their faces were backwards, and they saw not their father's nakedness". The two brothers were suitably rewarded "....and Noah lived after the flood 350 years" and died at 950 years of age, so that neither his naked shame nor his home-brewed alcohol seems to have interfered with his longevity.

Local Actions

Alcohol precipitates proteins from solution and thus can injure cells by precipitating and dessicating cell protoplasm. This action found favour at one time in the prevention of bedsores for its application was believed to harden the skin over pressure points. Now regular turning of bed-ridden patients and the washing of the skin at risk with soap and water has replaced alcohol. Alcohol applied to the skin (e.g. as eau de cologne) evaporates and cools. It can also form a vehicle for perfume or for medicines.

Mucous membrances can be irritated by alcohol. The chronic irritation of the alimentary tract of the alcoholic may not only impair the absorption of food and vitamins, but also of the alcohol consumed.

Permanent damage to nerve fibres by alcohol may be exploited occasionally in intractable trigeminal neuralgia by the giving of a local alcohol injection around the nerve trunk concerned.

Ethanol can cause peripheral vasodilation by decreasing the activity of the vasomotor centre. The warm feeling is pleasant; as alcohol bleeds heat from the body, its use in a cold environment can be dangerous. Tramps who have spent their last few pence on drink instead of a bed in a "dosshouse" have died of exposure when sleeping "rough" in freezing weather. Polar expeditions and other exposed activities demand abstinence from alcohol prior to exposure.

A solution containing 70% by weight (or 76% by volume) of ethanol is more effective as a skin antiseptic than stronger or weaker ethanol solutions.

Absorption, Fate and Excretion

By mouth, alcohol is readily absorbed from the stomach and small intestine. It can gain entry to the circulation from the colon and by inhalation of the vapour. Rare, occasional fatal results from inhalation of alcohol vapour have occurred.

The rate of absorption from the stomach is at first high and alcohol appears in the breath and urine within a few minutes. Absorption then slows greatly even if high concentrations are maintained in the stomach. Food retards absorption as does the sugar content of beer. Closure of the pyloric sphincter will delay transit into the small intestine and thus the major part of the absorption of alcohol. The "shorts" on an empty stomach at a cocktail party induce effects rapidly whereas high alcohol-content liqueurs consumed at the end of a banquet are slower and more benign in action. Experienced drinkers recommend taking alcohol with food. The pharmacologist might prepare himself for a "blind" by swallowing 30 ml of olive oil or a pint of milk together with the judicious use of "post-pituitary snuff", thus maximizing his bar hours uninterrupted by inebriation and diuresis!

Ethanol is metabolized at the rate of about 10 ml/hour yielding about 56 calories/hour which represents a contribution to, but (alas) not a complete substitute for food requirements. Among the ingredients in solutions prepared to provide for the nourishment of patients by intravenous infusions, ethanol often appears but in so low a concentration that its action cannot be detected by the recipient to their grave disappointment!

Ethyl alcohol is oxidised by zinc-containing alcohol dehydrogenase to acetaldehyde which in turn is converted into acetylcoenzyme A (CoA) and shares the fate with the other acetyl CoA. Alcohol can also be metabolized to acetaldehyde by another route involving the drug detoxifying enzymes of the hepatic smooth endoplasmic reticulum and eventually increases (induces) the activity of these enzymes.

Only about 2% of ingested ethanol escapes oxidation. Of this, most is excreted unchanged in the breath and in the urine while some escapes in tears, sweat, bile, saliva etc. Thus the use of diuretic drugs or of hyperpnoeic agents have no place in hastening recovery from alcoholic intoxication.

Pharmacological Actions

Once absorbed, alcohol is distributed by the blood stream to, and is soon detectable in, all tissues. As the agent falls into the general classification of drugs which depress the central nervous system and as its action on the brain overshadows all other effects, changes in central function, and thus of behaviour, take pride of place. The widespread social use and availability ensures that all may observe and many may savour first hand the spectrum of behavioural effects of ethyl alcohol.

The layman regards alcohol as a stimulant which is at variance with its pharmacological classification but he may be pardoned for this misinterpretation for the actions of the compound arise from alterations in a behavioural pattern which has been instilled into us since a very early age. These alterations take effect first upon our higher mental processes and attitudes which enable us to show self-restraint, exhibit modesty, exercise self-criticism and adjust our conduct in the light of previous training and experience. As these features of the perfect gentleman or gentlewoman are erased by alcohol, the removal of "inhibition" produces "uninhibited" behaviour which the layman interprets as a progressive "stimulation", at any rate in its earliest stages.

As the blood alcohol concentration rises, first there is a dulling and then the loss of the finer grades of mental discrimination and critical judgement, of memory, of powers of concentration, of insight and of "inhibitions" controlling social behaviour. The person becomes impulsive of speech and action, confidence markedly increases (Dutch courage or, as the Dutch call it and returning the compliment, English courage), the personality changes to become expansive and vivacious. Speech becomes very free, eloquent and occasionally brilliant to characterize the successful "after-dinner" speaker although group alcoholization provides a sympathetic audience in tune with the occasion.

Characteristically the performance of work in which the person is skilled shows proportionately less deterioration than other functions. Thus the tipsy typist and the p...ed piano player can continue tolerably well with their personal skills. Most are familiar with the chap who can play the piano at a rugger binge yet requires assistance to stand or walk because of inebriation.

Depending on circumstance, the mood under alcohol may be vivacious at the Bar among friends or sleepy and morose at one's quiet fireside.

For many people the use of alcoholic beverages is not habitual and only rarely does indulgence lead to overt drunkenness. For others, and they may number about 250,000 in the U.K., regular alcoholic ingestion is compelling and chronic alcoholism develops with a train of medico-socio-legal sequelae especially when the family budget is depleted to provide alcohol for the father or mother. The alcoholic shows a tolerance to the effects probably related, at least in part, to enzyme induction. Reliability, ability to work and truthfulness diminish in spite of "covering up" by the alcoholic, his or her workmates or professional colleagues, and family. The careless, untidy, unkept and unclean appearance of the advanced alcoholic, who might be a medical or nursing colleague, is as unforgettable as it is pitiful.

Treatment of chronic alcoholism is difficult and often unrewarding. The alcoholic should recognize and accept that he needs treatment for if he does not then all efforts to help him are doomed.

Withdrawal of alcohol, where the degree of physical dependence of the chronic alcoholic has developed, requires care. As abrup stoppage can provoke dramatic symptoms, the unpleasant withdrawal phase may be mitigated by sedation with chlorpromazine, chlordiazepoxide, paraldehyde or chlormethiazole. There must follow a long period of psycho-sociological therapy in which not only the doctor but "cured" alcoholics, as do Alcoholics Anonymous, support those being treated in their moments of crisis.

Aversion to ethyl alcohol can be induced by disulphiram (Antabus) which blocks the breakdown of ethanol beyond acetaldehyde. When the patient receives disulphiram regularly (but no alcohol) no symptoms occur. Either alcohol administered medically as a demonstration or by the patient in a moment of weakness yields a large accumulation of acetaldehyde which gives a severe reaction within 5 minutes comprising of a vasodilation and fall in blood pressure, nausea, vomiting, sweating, breathlessness, headache and chest pain and rarely convulsions or circulatory collapse. As this treatment relies on regular self-medication by the patient with disulphiram, its limitations are obvious when the psychological make-up of the chronic alcoholic is considered.

Acute alcoholic poisoning or drunkenness carries grave risks if the sufferer drives a car, train, bus or aircraft where the safety of others relies on speedy and correct mental judgements of many factors. When drunk, critical assessment is slow, confused and often incorrect with a spurious confidence which can lead to disaster. Until 1967 in the UK, a person suspected of being intoxicated to a degree to impair driving was submitted to a doctor for a clinical examination. As drunkenness can simulate or be associated with illnesses producing not dissimilar effects, the clinical examination called for great skill and even then might be non-definitive. Since 1967, a police officer can submit a person in charge of a motor car to a breath test which can detect ethanol. Should the breath test be positive, the motorist is detailed for a compulsory blood or urine sample for GLC deter mination of alcoholic concentration. A blood alcohol in excess of 80 mg/100 ml of blood is legal evidence required for a conviction. A blood alcohol level of 80 mg/100 ml is considered to double the liability to accidents.

The increased liability to accidents was dramatically demonstrated by the performance of experienced Manchester bus drivers before and after 4 small whiskeys. After the whiskeys, 50% of the drivers estimated that they could drive an 8 feet wide bus between poles separated by less than 8 feet whereas they needed a separation of at least 9 feet or more. Clearly confidence had been enhanced and performance diminished by alcohol in a manner quite unrecognized by the driver who had consumed 4 whiskeys.

The impact of alcohol upon urine flow and sexual function was described by William Shakespeare in "Macbeth" in classical terms which have defied betterment.

MACBETH

Enter Macduff and Lenox

Macduff: "Was it so late, friend, ere you went to bed,
That you do lie so late?"

Porter: "Faith Sir, we were carousing until the second cock: and drink, Sir, is a great provoker of three things."

Macduff: "What three things does drink especially provoke?"

Porter: "Marry, Sir, nose-painting, sleep and urine. Lechery, Sir, it provokes, and unprovokes; it provokes the desire, but it takes away the performance: therefore, much drink may be said to be an equivocator with lechery; it makes him, and it mars him; it sets him on, nad it takes him off, it persuades him, and disheartens him; makes him stand to, and not stand to; in conclusion, equivocates him in a sleep, and, giving him the lie, leaves him."

Ethyl alcohol was, is and will remain the universally available western tranquillizer, which in modest dose, induces a pleasant physical feeling of warmth and well-being, a welcome obtunding of the pressures of life and sound sleep where otherwise worry might promote wakefulness. Like any drug which changes the mental outlook, it can, especially in the susceptible, lead to habitual consumption and dependence so severe as to undermine the moral and physical fibre of the individual so defeating the beneficial actions of this interesting compound.

INTERACTIONS WITH ALCOHOL

All drugs with cerebral depressant effects (e.g. hypnotics, tranquillizers, anti-epileptics and anti-histamines) can summate with the action of ethanol, particularly with heavy drinking and this has led to fatalities. While the enzyme induction in alcohol dependent persons may make them relatively tolerant of barbiturate drugs, this does not provide much protection from the dangers of alcohol/barbiturate synergy.

The sulphonylurea anti-diabetic drugs and metronidazole can give a disulphiram-like action. Anticoagulant therapy may be upset by enhanced destruction by induced enzymes or reduced liver metabolism of the anticoagulant. However, modest drinking appears unlikely to cause serious trouble.

APPROXIMATE ALCOHOLIC CONTENT OF BEVERAGES

Beer	3–6%
Cider	6–12%
Claret	10–17%
Sherry	20%
Distilled Spirits, Whiskey, Gin, Vodka, etc.	50%

Industrial methylated spirits contains 95% ethanol with 5% v/v of "wood naphtha" which contains methanol, pyridine, mineral naphtha and methyl violet. The "wood naphtha" makes "meths" visually recognizable and very unpalatable

METHYL ALCOHOL

Methyl alcohol (methanol, CH_3OH) has effects similar to those of ethanol but these effects arise more slowly and last for several days because it is metabolized five times as slowly as ethanol. The formation of formate in the metabolism of methanol is the basis for the long and dangerous methanol intaxication. As little as 15ml of methanol can lead to non-reversible damage to the optic nerve and as little as 50ml of methanol may have proved fatal.

Treatment of methanol poisoning is aimed to reverse the acidosis arising by the intravenous infusion of 5% sodium bicarbonate or one sixth molar sodium lactate with monitoring of plasma bicarbonate and blood pH. As ethanol and methanol are metabolized by a common ensyme system, the administration of ethanol can slow the breakdown of methanol which could be beneficial. This appears to be the sole therapeutic action of ethanol.

P. QUILLIAM

BOOK REVIEWS

LITERATURE AND GENERAL

Tools for Conviviality
Ivan Illich
Calder and Boyars 110 pp. 95p

Ivan Illich is now one of the leading lights in the American intellectual onslaught upon industrialised society. In books like *Celebration of Awareness* and *Deschooling Society* he has focussed attention on the way in which the basic institutions of our mass world have become mere service agencies imposing upon the user. In this long essay he expands further on the theme, analysing the difference between 'convivial' tools, which expand man's awareness, and those tools that are today turning him into a frustrated consumer. And without doubt it is an exciting experience to read such a penetrating analysis of our modern world. Much of the emptiness and absurdity seems at once less inevitable; given the human willpower and energy to act on these fundamental ideas, there IS light at the end of the tunnel. We *can* do something about this mad, humdrum, hypertensive asylum of a world. But in spite of this definite sense of optimism, there are still large areas of Illich's ideas and methodology that are porrly expressed or poorly thought out. In particular, some aspects of his approach to medicine clearly lack the insights of day-to-day experience.

However, allowing for this tendency to bland generalisation, his broad analysis is often tightly logical and offers so much food for imaginative thought. His basic criterion, conviviality, he defines as "the opposite of industrial productivity", as "individual freedom realised in personal interdependence, and, as such, an intrinsic ethical value". In other words, he regards people's relations with each other as being the centre of any true, moral, way of life. He goes on to show, using as examples the institutions of modern (American, I fear) medicine, education, industry, etc., how and why 'Convivial Reconstruction' can and should take place; a key theme is the clear exposition of how "the individual's autonomy is intolerably reduced by a society that defines the maximum satisfaction of the maximum number as the largest consumption of industrial goods." He shows how one's 'Knowledge-stock', high speed, and levels of income have all become indicators of a so-called "well-being"; how societies are called 'advanced' when "living has been transformed into a process of ordering from an all-encompassing store catalogue." On the other hand, where people "depend for most of their goods and services on the personal whim, kindness or skill of another," we use the term underdeveloped. Using a series of eye-catching phrases, such as 'the modernisation of poverty' and analogies, such as the way both time AND money can be had, spent, saved, wasted, afforded, and 'be worth', he goes far beyond the narrow confines of political ideology. As he forthrightly points out, "Certain tools are destructive no matter who owns them, whether it be the Mafia, stockholders, a foreign company, the state, or even a workers' commune". Two further points of attack are "the spreading empire of international professions" and the gross imbalance of global wealth. This latter factor he portrays in the telling figures of American expenditure on transport; the U.S.A. spends one quarter of its energy resources simply in getting from place to place.

In a further chapter entitled 'Multiple Balance', he shows how monopoly, obsolescence, and 'overefficiency' lead merely to frustration; how education "becomes necessary not only to grade people for jobs but to upgrade them for consumption." In fact education is now merely a means of social control, defining each person's failure level and thus his degree of consumerism". And having analysed these structures of imbalance and non-convivial tools, he finally goes on, in two short closing chapters, to point the way to "Recovery" and "Political Inversion" of the industrialist system. Major aspects of this include the demythologisation of science, the use of language in its uncorrupted forms, and the use of the legal model. For to Illich there is little wrong with the fundamental methods of social interplay; it is simply that they have been distorted by consumerist ideas. He is no anarchist, wanting to blow it all up and start again, but a respecter of the use of traditional ways in solving our present conflicts. And a prime theme behind his whole essay is the ne d to accept limits, a "joyful austerity". Such an attitude of self-sacrifice is hardly to be wondered at considering his Roman Catholic background.

In describing these aspects of Illich's thought, however (while apologising for an excessive use of quotes, which I deemed necessary since so often the writing defies anything else) I have largely avoided several hair-raising statements. These include such oddities as:– "Most curable sickness can now be diagnosed and treated by laymen." "90% of all medical care for patients with terminal diseases is unrelated to their health." There is also a typically Catholic/masochistic comment about helping people to bear their suffering rather than using nasty modern drugs. Which is not to say that all his attacks on medicine are ill-judged, but he is largely aiming at American 'hyper-money' modes of practice and he rather misfires when applied to the more human systems elsewhere. It is disturbing though that such simplistic generalisations are being used, and one is led to wonder how far this permeates other aspects of his approach.

For despite his intended aim, Illich has written a book such as only could be produced in a world of scientific methodology and specialised jargon. He has a dense noun-rich style, ranging from the clarity of the best English to the vulgarities of, "a dimensional analysis to obtaim information about the major variables which can upset the balance..." etc. Much as he may rail against over-education, only a small minority of academically-trained people will be able to get to grips with this book, since only they have had the time (like his, created by industrial excess) to synthesise all the economic, social and psychological concepts of the present problems of existence. It is a book for a small élite, based largely on American experience and American attitudes, much of which is heartily despised by many Asians and Europeans even though they are pressured by 'Yankee propaganda' and sales techniques into trying to emulate the American way of life, and, as an inevitable result, the American way of mental disruption. It is easy for the very rich to call for austerity, but no attempt is made to explain HOW

this message can be passed on to the very poor who, quite rightly, will start to wonder whether they are yet again being conned out of their birthright. To say, as Illich does, that it is still possible for pre-industrial societies to pass directly into a post-industrial phase is mere wishful thinking, as well as being illogical; a post-industrial society must, by definition be a society that has actually been through the industrial experience.

Illich is fascinating and provides a rich source of ideas for those of a reformist persuasion; also his analysis of the present malaise in modernised society strikes home on many tender points. But his excessive use of jargon and generalisation only serves to display the paradox of his own position. He lives in and is a product of what he is criticizing; his ability to criticize so keenly is entirely due to the freedoms that industrial society has created for the intelligent few, and those freedoms must be tasted by the great majority before we can hope to eliminate the concomitant horrors. This latest essey is largely an exercise in academic insight. What is needed is a coherent and popular ideal, expressed in ordinary language, designed for pass appeal. Preaching to the converted is just so much back-scratching. T.T.

About a Marriage
Giles Gordon Penguin 35p

The back-cover blurb describes this rather simple little novel as telling "of the very basic emotions which afflict a young husband as he struggles to understand the incomprehensible". More revealing is the flesh-coloured substance of the cover, which, erotically blurred, depicts two bodies in embrace, the woman's hand at the base of the man's back, while her breast lies crooked in his angled right arm. And, this *is* a book about the sex-life of a young sixties' couple, a writer-cum-businessman down from the north, and his partner-wife whom he met in London. They have trouble conceiving, but two kids emerge in time, despite experimentation with boots, positions, and sexy apparel. The whole thing is really rather mawkish, a thinly disguised autobiography which never goes beyond the more obvious scenes and attitudes. For example: "I don't want everything, every bloody thing, to be ghastly"; or: "When I first set eyes on you I wanted your child". The husband (who tells the story) never examines the relationship between his work and home life, while references to events of the time are limited to occasional comments about the classically popular cult films, such as 'Jules et Jim'. It is this shallowness that pervades a readable but obvious piece of writing. The last scene, so tritely, has our hero commit, yes, you guessed it, adultery! T.T.

Lusitania
Colin Simpson Penguin 50p

This is a readable piece of historical research mixing the plausibility of good documentation with the gift of the journalist for spinning a plot, and bringing to the reader the sense of participation in an unfolding drama.

All I could remember from my 'O' level history was that the 'Lusitania', sunk by a German U-boat in 1915 with the loss of over 1200 lives, somehow led to the decision by the United States to join the war on the side of the Allies. It seemed to me a bit daft of the Hun to niggle the Yanks in this way (though it was all part of the fun to portray Fritz as a 'dummkopf'). This account makes the incident more intelligible. Basically, Simpson amasses the evidence to show that: (a) the passenger liner was being used to transport vast quantities of armaments from the US to Britain and it was the detonation of these and not simply the impact of the usually ineffectual torpedo which caused the ship to sink; and, more tenuously, (b) the Admiralty deliberately left the ship unprotected to increase its chances of being sunk in order to bring the US into the war. A neat piece of Churchill-bashing here.

I was left with the impression that in such wars, as in most things, there's more to be said for the other's case (and less to be said for one's own) than the blinkering effect of patriotic partisanship might lead one to suppose.

Meanwhile, ('O' level history lives on.
D.W.

THE SOCIOLOGY OF LITERATURE
by DIANA LAURENSON & ALAN SWINGEWOOD
Paladin 50 pence.

Written from a structuralist viewpoint this book provides a good introduction to a rapidly expanding field within sociology and is of interest to students of literature as well as of sociology. The authors consider various theories of literature, examining the social situation of the writer and the relationship between specific economic, social and political influences and the structure of particular literary works. Writers such as Camus and Sartre are analysed in terms of categories such as alienation and reification in an effort to explain the structure of their novels.

But Swingewood emphasises that the sociology of literature must concern itself primarily with literature as *literature* rather than as a reflection of the social structure. While socio-economic factors need to be analysed in close conjunction with actual literary texts, he argues, on no account should the texts themselves be dissolved into the surrounding environment. So this study is an important contribution to the sociology of literature because it moves away from the usual 'reductionist' account of literature which sees an author's text either as a crude reflection of the social structure or as a reflection of the author's personal psychological history. One of the problems associated with the reductionist account is accounting for creativity: if literature is seen as an uncontrollable reflex of the social structure then there can be no room for creativity and originality. This problem is faced in the section of Lucien Goldmann who attempts to overcome it by arguing that great literary works are those which transcend the limitations of their immediate social situation. A structuralist account of literature such as Goldmann's is concerned only with 'great' works of literature, that is, literature which strives constantly to understand and go beyond the obvious transient features of its culture. For literature which finds itself in conflict with accepted norms and values and which strives to overcome them will be significant beyond its own time and will help man to understand his society. Godmann argues that all great literary and philosophical works have a total coherence and embody 'world visions'. A world vision is defined here as a total conception of the world which attempts to grasp its meaning in all its complexity and wholeness. The importance of the concept of world vision, which embraces social groups, social classes and social structures, is that it enables literature to be discussed sociologically without denying its status as literature. In relation to this question, Swingewood then discusses briefly, in my opinion too briefly, Goldmann's peculiar brand of structuralism: genetic structuralism. Swingewood also looks at Goldmann's study of Pascal and Racine in *The Hidden God* where he attempts to apply the principles of his sociology of literature, using the idea of the 'tragic vision'. The discussion of Goldmann is valuable in so far as many of Goldmann's untranslated works such as *Pour une Sociologie du Roman* and *Recherches Dialectiques* are referred to in the course of the study. However Swingewood is not sufficiently critical of Goldmann's approach particularly as far as Goldmann's misleading definition of tragedy is concerned.

Another interesting aspect of this essay is the discussion of the work of the widely-revered D. H. Lawrence where it is argued that certain themes in his work suggest a "fascist mentality". Swingewood emphasises that Lawrence is a reactionary thinker who depicts social relationships in non-social terms : " ...There is no totality within his novels: the foreground is wholly taken up with the basic problem of the blood and sexual polarity; human relationships develop within this field." (p.86) Swingewood claims that Lawrence defines human relations solely "in terms of sexuality; and a sexuality which is sociologically absurd, for men and women live within a society which defines their range of interests as well as their sexuality; a genuine human relation is one of equals and this Lawrence never depicts." (p.86) Swingewood points to these factors as limitations on Lawrence being a great novelist. But given these limitations, Lawrence's popularity still needs to be explained but Swingewood does not attempt to do this. Rather he is concerned to point to guidelines that may be used in giving a sociological account of literature.

Apart from these minor points the book is a good introduction to the subject with an excellent use of footnotes and an extensive bibliography.

S. EASTON,
Sociology Department, University of Southampton.

MEDICAL

Neurology for Physiotherapists
Joan Cash Faber & Faber £2.95

This is a most welcome and much needed book on physiotherapy covering subject ranging from cerebral palsy to geriatrics. The underlying principles of the specialized techniques used in this branch of physiotherpy are discussed in the first section. The following chapters are written by a number of physiotherapists experienced in the treatment of specific conditions including hemiplegia, peripheral nerve lesions and spina bifida.

There are three very interesting chapters on the treatment and general management of lesions of the spinal cord dealing with the special problems of lesions at each level of the cord. This book aims to give a general outline of treatment and although designed for student physiotherapists it will be of interest to all those involved in the management of patients suffering from neurological disorders.

ELIZABETH RODGER

Human Reproduction and Society
Derek Llewellyn-Jones.
Faber and Faber, London, 1974.
547pp, 67 figs, tables 116. £5.25

'The exponential growth rate of human population, together with ecologically faulty productive technology, poses a major threat to mankind's survival in the next half century'. With this broadside, fired in World Population Year 1974, the author opens this comprehensive work and with his first-hand experience both in developed and developing countries his writing has both depth and authority.

The book is divided into three sections – Population Dynamics, Birth Control and Social Obstetrics. In the first section there is a clear introduction and exposition of the science of demography, tracing its development from Graunt's original work in the London of 1662 to the present fulminating world population predictions. The largely iatrogenic 'disease' which causes world population to double every 35-40 years at the present time is investigated and possible 'treatments' are discussed.

The second section on Birth Control investigates one such 'treatment'. The history, development and use-effectiveness of all the presently available contraceptice methods is detailed together with a critical assessment of the newer medical methods, steroidal contraception and the I.U.C.D. It is a pity that the Saf-T-Coil was ignored, it has a much wider use than many of the devices mentioned (incidentally the illustration labelled the M-device is in fact the French designed 'Omega'). The techniques, legality and effectiveness of abortion and sterilisation in the medical armamentarium and an assessment of the effectiveness of birth control campaigns ends this section.

The final part of the book is concerned with social factors influencing obstetrics. That the outcome of any given pregnancy will vary with the age of the prospective mother, her parity, her marital status and her social class is clearly demonstrated, and there are two good chapters on Perinatal Mortality and Maternal Mortality.

The text of each of the 19 chapters is well referenced, although the figures and tables are not invariably so, and the use of some source material from the 1950's in the final section should have been avoided. At £5.25 this is not a cheap book for students, but regarded as a compendium of three books it offers enormous value, being of use not only for exams, but during one's future practice within society. PATRICIA LAST

Cancer Medicine
James F. Holland and Emil Frei III.
Lea and Febiger, Philadelphia/Henry Kimpton, London. £40.50

I wonder what the first reviewer of *War and Peace* felt like? I rather suspect that the hugeness of the task daunted him, and doubtless he scratched his head and wondered what on earth he could say. Size isn't everything but it sure is difficult not to be overawed by the sheer scope (and weight) of this book. It scales in at about twelve pounds and the most obvious error by the publisher is that it should have been in two volumes. Nobody, however conscientious, reads this big a book in bed.

It's hard to fault it on grounds of omission. the 2000 pages are mostly written by the most authoritative authors in their particular areas of interest – methotrexate by Bertino, adriamycin by di Marco, lymphomas by Carbone and DeVita, and so on. It really is a pity that the whole work took so long to produce, though; from the lists of references, it's clear that the bulk of the writing was done in 1970/1971, and a good deal has happened since then.

There are some sections I particularly like. On the whole, the important drugs are well described, and the major ones get over ten pages each, with sections on pharmacology, biochemistry and a revue of the clinical data. The chapter on alkylating agents, however, is rather dull – and in some places inaccurate; for example the statement that chlorambucil is the agent of choice in remission maintenance of Hodgkin's Disease should never have passed the sub-editor's desk; we know better than that at Bart's.

Some of the best and most thoughtfully written parts are in fact those which deal with general principles. Epidemiology is a good example; how interesting to learn that in 1844, Rigoni Stern published a report on cancers of the breast and uterus for the city of Verona, and was able to draw conclusions regarding incidence and fertility which are still relevant today. In the same chapter you will learn that male mammary cancer is unknown in Hawaii, and a few pages earlier (in the fascinating section on Comparative Neoplasia) you can read about malignant melanoma in platyfish-swordtails and lymphosarcoma in Irish pike, leukaemia in lizards, hypernephromas in frogs, the list is endless.

In summary, there is little doubt that this work will become a classic; no single book on cancer has ever attempted so much. Its most serious drawback is the old problem of being out of date so quickly, and Drs Holland and Frei ought perhaps to be persuaded to bring out an annual addendum based on a review of the year's most significant work. At £40, this book will appeal only to libraries or friends of Mr Rockefeller; but there is no doubt that Bart's library should invest in a copy. JEFFREY TOBIAS

People Not Psychiatry
Michael Barnett
Allen & Unwin £1.95

At the beginning of the book the author writes 'Watch out for me. I can be a fast convincing talker. *Caveat lector.* Beware reader.' He is wrong; his book is badly written, tedious and at times unreadable. He uses psychiatric terminology with abandoned inaccuracy, but one gathers that his general argument is that psychiatrists exist only to satisfy their own power-crezed desires to manipulate others. And that he could do better.

Of course, Barnett would expect no more of me than that – 'magnifying my own mystique and the helplessness of the patients' – so I was interested to read the favourable review the book received in *Sennet.* The reviewer remarked that

schizophrenics account for 95% of mental patients in this country, and could find no better way to describe R. D. Laing than as 'the psychiatrist who prescribes L.S.D.'. If I couldn't convince anybody more knowledgable in my subject than that I think I'd give up.

If Michael Barnett seriously believes that no orthodox psychiatrist cares about the sufferings of the mentally ill he really must be made. If he doesn't, he ought to be more intellectually honest in his attempts to help the enormous problems that both patients and doctors face.

ALAN HOUSE

Lung Function Tests: An Introduction
B. H. Bass
H.K. Lewis Ltd. 4th edition.

This book cannot be recommended. The short text is clearly printed but it fails to convey the value and limitations of tests of lung function. This failure is compounded of inadequate explanations of normal physiology and the tests available, and wrong emphasis. There are two few illustrations and I suspect that the text has not been adequately revised. The explanations of whole-body plethysmography, compliance measurements and gaseous exchange are likely to confuse the uninitiated reader. Space is wasted on a detailed description of differential bronchospirometry, a technique which is now little used, and 10% of the text is devoted to an exposition of the value of x-ray fluoroscopy as a means of evaluating lung function.

There is a brief section on tests which are believed to measure small airway function but no attempt is made to show why these tests were developed and it is unlikely that anyone unfamiliar with the subject will understand even the fundamentals of these tests after reading this book.

Potential readers are advised to seek the excellent accounts of pulmonary physiology contained in several textbooks on Respiratory Medicine written by British and American authors.

JOHN COLLINS

New Perspectives in Child Development
Ed. Brian Foss Penguin Books £1

This collection contains six essays on various aspects of the psychology of child development, *viz.* visual perception, conditioning and learning, ethology, exploratory behaviour, attachments, and language and cognition. They were all written especially for the volume and give very much a contemporary view of their topics.

What they collectively offer is firm evidence of the increasing tendency of development within psychology of a reflexive and critical attitude toward its output and in particular toward the latent theories and assumptions which necessarily underlie that output. The need for such a critical stance is especially acute given the historical dominance of the various behaviourist approaches which have frequently shared a reverence for natural science's epistomology and methodologies or, put another way, a belief that empirical data can be generated and the "objective truth" tapped independently of any preconceptions on the part of the investigator. Now that this has been brought more into question it no longer suffices to collect empires of empirical data and worry about theory construction later, if ever.

Accordingly, the authors of the chapters offer her mere than a summary of the accumulated findings in their specialist areas. They attempt also accounts of the theoretical traditions which have animated the various researches. This is perhaps best demonstrated in Cromer's contribution on "The Development of Language and Cognition".

One of the results is to show the limitations on the growth of knowledge imposed by working within one discipline in ignorance of relevant work in other disciplines.

DAVE WEBSTER,
Lecturer in Sociology, Alsager College.

The EEG in Acute Cerebral Anoxia
Pamela Prior
317 pp

The improvements over the past decade in techniques for resuscitation after cardiac arrest have saved many lives but have also regrettably led to increasing numbers of patients surviving the acute episode with severe brain damage incompatible with recovery of consciousness. With the passage of time the prognosis becomes only too obvious but it is often difficult to predict the outcome within the first few days. Neurological signs of decerebration following acute cerebral anoxia are notoriously unreliable and a variety of special investigations have therefore been employed to detect gross anoxic brain damage. Of these the most widely used is electroencephalography and as yet no other method of assessment has been shown to be of greater reliability. Understandably this topic has generated a very extensive literature and there has long been a need for an authoritative review suitable for the non-specialist.

Dr Prior's book provides this, and much more besides. The bibliography of some 450 references appears to omit no important contribution in any language and, if her review is somewhat uncritical, it has a balance and freedom from domatism which is lacking in some writings on this emotive subject.

The monograph also presents a detailed account of Dr Prior's own studies of various aspects of electroencephalography in acute anoxia. These include a statistical approach to the prediction of outcome after cardiac arrest and the evaluation of techniques for continuous EEC monitoring in the intensive care unit.

The structure is complex and this is not a book for casual skimming. However half of its 250 pages (excluding appendices) are made up of illustrations and the presentation is generally attractive. It deserves a wide readership both among doctors and students, not only as an excellent survey of an important subject but also as an interesting demonstration of the application of a laboratory investigation and of statistical techniques to a clinical problem.

C. D. BINNIE, MD

Fluoridation and Truth Decay
Gladys Caldwell and Phillip Zanfagna
Top-Ecol Press $3.50

Because dental decay is a serious problem, especially among children, many dentists consider that it should be tackled by fluoridating the public drinking-water, which they are convinced in a marvellously effective and perfectly safe way of gaining a spectacular reduction in the incidence. There are plenty of papers which support this view, and a great deal of publicity has been given to the project. On the other hand there is also a strong body of equally well-informed people who oppose fluoridation many eminent scientists among them.

A new book from America, *Fluoridation and Truth Decay* by Gladys Caldwell and Dr Sanfagna, comes in this category, and the authors present a well documented case against fluoridation. They say that there is no moral or legal basis for adding a fluoride, which is a cumulative poison, to the drinking water, and that fluoridation was officially adopted by the United States Public Health Service before adequate tests of its safety had been carried out, and without the normal impartial 'blind' testing which is essential for objective results. They allege that fluoridation was advanced by intimidation, by denigrating the professional competence of its opponents, and by promotional propaganda instead of by scientific appraisal, that it is an extremely serious environmental pollutant (far from being safe, there is convincing evidence that it is harmful to some people), and that its supposed benefits have been greatly exaggerated. This is a formidable list of indictments, so it is desirable to give a few quotations to show on what they are founded. Regarding premature adoption, one of the early and most ardent promoters of fluoridation, Dr Bull of the U.S. P.H.S., in a blueprint for fluoridation promotion said 'Now why should we do a prefluoridation survey? Is it to find out if fluoridation works? No. We have told the public that it works, so we cannot go back on that. Then why do a prefluoridation survey?'

The denigration of opponents is illustrated by Dr Robert Felix who gave it as a 'fact' that all opponents of fluoridation are mentally deranged, and by Dr Stare, who called critics of fluoridation 'Compulsive critics, characterised as neurotics, driven by mystic primitive subconscious fears', and, again, that opponents are 'Food faddists, health charlatans, and quacks'. Yet Dr Zanfagna refers to a list of over a hundred eminent scientists who oppose fluoridation, which, he says, reads like a *Who's Who* of the scientific community. Certainly it is impossible to accept that men like Professor Carlsson, Sir Arthur Amies, Professor Steyn or Dr Burgstahler are mentally deranged because they oppose fluoridation. However, the authors point out that such tactics have done a lot to promote fluoridation because they have intimidated many doctors and dentists and so have led them to keep quiet about their own doubts about fluoridation for fear of losing their jobs or government grants if they were to produce work or opinions unfavourable to fluoridation. Cases of this kind, the authors say, have been documented and are available to Congress.

Actual promotional techniques are illustrated by a quote from Edward Bernays, of the U.S. P.H.S., who in discussing fluoridation and the 'C. scious and intelligent manipulation of the organised habits and opinions of the masses' said 'Indoctrination must be subtle. It should be worked into the everyday life of the people ... a redefinition of ethics is necessary ... the subject matter of the propaganda need not be true'. This sounds like the horrors of George Orwell's *Nineteen Eighty Four* prophecy.

Fluorine is an extremely active element, widely distributed throughout nature where it is closely bound in compound salts, but many modern industrial processes either use it, because of its activity, or release it as a by-product. As a result there are very large and intractable amounts of poisonous fluoride wastes which pose a difficult problem for the industrialists. Much damage is done by these wastes, and a great deal of money has had to be spent in compensation. Dr Exner, one of the world's leading radiologists, says 'If American industry had to stop polluting our air, water, and our countryside with fluoride fumes and fallout, it would cost not millions, but countless billions of dollars. And herein lies the explanation for the utterly relentless drive to fluoridate our water supplies, by any means fair or fould, and many other, otherwise puzzling aspects of the drive to fluoridate'. Fluorides are known to be dangerous environmental pollutants, being 1000 times more toxic than sulphur dioxide, but though both sulphur dioxide and fluorides are present in smog, the sulphur dioxide alone gets the blame.

So far as safety is concerned, the authors say 'The top promoters of fluoridation admit that no research has been done by them on the effects of fluoridation on individuals with chronic diseases such as arthritis, kidney and heart disturbances, diabetes, and on known allergic individuals', yet Dr Stare has repeatedly said 'Fluoridation is safe — absolutely and unequivocally safe. There are no ifs, ands, or buts about its safety'. Could *any* drug fulfill such a claim? Cases of definite harm from drinking fluoridated water *are* quoted: for example, Dr Rapaport's investigation on mongols. He found a causal relationship between the number of babies born as mongols and the amount of fluoride in the drinking water, but because of the U.S. P.H.S. policy of suppressing research unfavourable to fluoridation this work was not published in any U.S. Journal. It was eventually published in France. Evidence is also given showing that a proportion of expectant mothers experience adverse effects from taking fluoridated water, or fluoride tablets. The work of Dr Taylor, who found an increased susceptibility to cencer in mice that had fluoridated water, is also quoted.

With regard to the effectiveness of fluoridation, evidence is quoted to show that fluoridation does not reduce dental decay by 60%–70%, but that it just *delays* the onset of decay for one or two years. They quote Dr Pamela Hobson, senior lecturer in preventive dentistry at Manchester University, as saying 'The only answer to this widespread dental decay in children in a balanced diet with good protein content, and the continued education of mothers from pregnancy onwards'.

Of course most dentists and doctors really do not want to know the truth, as far as it has been ascertained. It is the questioning mind, and not the attitude of "Ours not to reason why", which is needed from the rising generation of dentists, scientists and doctors if the health of the community is to be built up.

MARGARET BRADY

Surgery
R. H. Kirk, J. D. Maynard, A. N. Henry *et al.*
Pitman Medical 1974 pp.384
Price. £5.50 (cased edition) £3.50 (Paperback)

The publication of a new undergraduate surgical text is an interesting and important occasion, especially if it can fill that gap between Bailey and Love's ever-expanding classic and the short-cut lecture notes. The attractive external appearance of the work under review adds to this expectation.

The text as a whole however is less exciting than the cover, it being standard non-controversial material. The style of some of the authors is rather abrupt, lacking the explanation necessary for the beginner and not necessarily following a logical flow of ideas. Headings are often inconsistent within as well as between sections.

A number of sections are good, and these include those on chronic renal failure and traumatology, while a few are outdated, such as that on cardiac arrest, or incomplete, such as that on the problems of blood transfusion.

The book starts with a short interesting historical review of surgical development. It is disappointing however that the senior author then finds it necessary to emphasize the view that ordering an investigation is only undertaken to spare the mental effort of making a positive diagnosis and is performed in the vain hope of sparing or deferring thought. Surely these views should be reserved for a post-graduate audience and that the advantages as well as the limitations of the investigation should be presented to the undergraduate. The art rather than the science of surgery is further displayed in the extensive Greek and Latin definition of terms throughout the text. Here again one feels that this laudable endeavour is over-emphasized.

The advisability of including large chunks of bacteriology and immunology is debatable since this material is better covered elsewhere and the space could have been given over to a more extensive cover of pathology.

The ragged right hand margin gives a slightly untidy appearance to the double column organization of the text, particularly when this is not broken up by diagrams. The line diagrams are generally unattractive and sparse, 112 of the 168 present being in the orthopaedic section, this adding to the lack of balance in the text.

In the preface to the text the authors state that they have tried to provide a comprehensive introduction, an accessible reference and a revision book for the student. In their efforts to achieve these widely divergent goals the authors have produced a dictionary rather than an encyclopaedia but, with some of the limitations already referred to, the undergraduate will still find this a text worth considering. Certainly the paper-back edition gives him one of the best facts-for-'ackers ratios on the market.

JOHN LUMLEY

Concepts and Mechanisms of Perception
Richard L. Gregory
Duckworth £18.00

I find it difficult to decide who will be attracted to this book and for what

reasons. Perhaps those who have previously encountered Gregory's exciting and ingenious experiments into the way we see, interpret, and respond to our environment. Perhaps those who have enjoyed Gregory's lucid almost charismatic authority when he lectures on the established facts of perception. Perhaps those seeking fruitful hypotheses to research or those trying to avoid the time-consuming effort of combing the mammoth literature on perception for themselves. Perhaps those whose views differ from Gregory's in one of the many disputed areas of perceptual theory, and who hope to find petards by which he might be hoist.

All of these however are likely to be psychologists and most will know that Gregory is an outstanding example of the older tradition in academic psychology – a distinguished career in Cambridge, researching the safe respectable area of perception whilst having no truck with latter day vulgarities such as "personality"

Who then without the pale of professional psychology might be attracted to *Concepts and Mechanisms of Perception*? Certainly not students, medical or otherwise, because they will obtain simpler but above all cheaper introductions to the 'givens' of perception. Certainly not those with an interest in people because this is essentially a book about abstractions.

Perhaps psychologists and anatomists at graduate level, who welcome the re-emerging awareness in psychology that the brain is an organ of adaptive behaviour and not just a curious epiphenomena of unconscious motivation. Those who realise, in the words of Foster Kennedy, that only in Wonderland do we find the grin without the cat. Perhaps electronics and apparatus engineers who must surely find a wealth of technical ingenuity worthy of plagiary.

But, perhaps sadly, I must after all conclude that it is a psychologists' psychology book, however scholarly and intellectually inspiring.

J. E. DRINKWATER

CHRISTMAS COMPETITIONS

JOURNAL MATHEMATICAL PROBLEM No.12 by R. Treharne Jones

£2 Prize.

Christmas Extravaganza

What five-letter word connects the following words?

(a) Courage
(b) Uncle
(c) Treat

Now, from the values A = 1, B = 2 etc, evaluate each letter in the 5-letter word. Total these values. Add this total to the number of lunar months in one year. Square the answer. Add the year in which the Journal was founded. Subtract the year in which Barts was founded by Rahere. Remember the number you are left with.

Take any 3-digit number, and reverse the digits to form another 3-digit number. Subtract the smaller from the larger of these numbers, to leave another 3-digit number as the difference. Reverse the digits of this final number, to form a number which you then add to the result of the previous subtraction. You now have a 4 figure total.

Add the figures that you have been left with from the last two paragraphs, and send the resultant total, on a postcard to the Barts Journal office, to arrive not later than 10th January 1975. A prize of £2 will be sent to the sender of the first correct entry drawn out of the hat on that date.

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There are 464 different ways of spelling the word MADAM from the diagram. Those who require the full proof may contact me via the Journal office.

Important notice

It is now one year since the Maths column first made its appearance in the pages of the Journal, and I now have to admit that, of the twelve puzzles featured so far, I have only devised ten myself. Nevertheless, it has now been decided to publish those puzzles devised by readers, in the hope of lending greater variety to the column. If *you* have thought of one, and it has not been published in any form before, why not send it in to the Journal office, and we will do our best to make you famous?

CHRISTMAS MUSIC COMPETITION 1974

Monumental prizes to be won.

£2?

'Vere de Composers hidin' then ...'

(Our music correspondent has just returned from the Dittersdorf Opera House with the following programme notes about the new production of 'The Don' by Viola Pomposa.)

The Christmas Day marriage of the Spanish Nobleman Don Iani and the beautiful Princess Carlatti has taken place. The opera opens as the guests arrive at the reception, after Mass in a local church, to feat on traditional fare, comprising the usual seasonal birds (cooked on their backs), well garnished gibbon steaks, bull-burgers and soup Ecosse. The Princess' father sings boisterously of his wedding gifts: 'With this I you endow land and half my wealth'. At this the Don borrows a dagger from his best man, the Duke Reisler, and the happy pair cut the wedding cake before leaving for their honeymoon on the very bare Brittany coast.

Act II begins as their honeymoon nears its end; they are walking in a field by a brook with the Don explaining frankly to the Princess why he must leave her: 'List, my love' he sings 'I know this is a blow to our newfound bliss, but the German threat is great and I must embark on a war.'

At the start of Act III, the Don's ram-shackle army of barbers (mostly from Seville), carpenters, tailors, quilters, shoe-men (cobblers to you lot) and mercenaries from all corners of the earth have put the Kaiser Avel's castle under siege. The Don, seeing the moats are too deep to cross, orders his men to ram open the main gate. In the ensuing foray the Don, with the dagger he borrowed in the first Act, stabs the Kaiser: 'Cor 'ell 'e's dead" howls Dragoon O'Sullivan (the Don's bat-man from Ireland).

This marks the end of the battle and all becomes still as the Don and his army march home to Vittoria, singing the sedate hymn to victory (marked in the score *Mancando ma legato*).

Allegro ma non troppo
con scherzo

Ed's note. On closer examination it can be seen that these notes conceal numerous composers' names. 38 of these are printed on page 344 in the order they appear. If you can find the remaining half dozen not listed, then apply to the Journal office for the prize of – wait for it ... £2.

In the event of more than one correct entry the contestants will be asked to:

i) Complete in less than 5 words either of the following sentences
   a) I hate ballet music because...
   or b) I like Sugar Puffs because....
ii) Expound in not less than 7000 words the virtues of the first chord of Stockhausen's 'Der ConcertomitzwolfshortwaveradiosetselfelectrictriangleszehndummykeyboardsneunJosephCoopersachtDerEnglandersiebenclockworktypewritersmitsexsexytottiesfünfgoldenRingsmitviervormidableBrunhildesleavingneinonderstageforanythingbuteinpartridgeineinpeartree' (Known to afficionados as Der Iplayit.)
iii) Rate in order of preference the following conductors:
   André Preview; E. Heath; Jane Birkin; Pierre Boulez; Ivor Batten.
iv) Pick the winner's name out of a hat.

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Paragraph 4 – Vittoria; Mahler.
Total – 38

The Sad Tale of the Lonely Shower

Some while ago, with much eager banging and scraping, a brand new shower cubicle was installed as a replacement for one of the toilets in the men's cloakroom. At last, thought we all, mayhap the vast and gloomy loo section is to be up-graded to a clean and gentle washing and changing room. Very good. But such hopes have been proved false. There sits the lonely little shower surrounded on all sides by loos of both the standing and sitting variety, doing no good to anyone at all. And were you to be so foolish as to try and take a shower, the chances of emerging unscathed by the experience are minimal. First, where to put your clothes? Second, how to avoid becoming a public spectacle to all those dubious characters coming down the stairs? Third, the floor around the urinals being in perfect alignment with the rest of the floor, how to avoid getting all sorts of horrible urinary tract nasties all over your delicate tootsies? Perhaps, in the course of time, 'Bartsfoot' will become a recognised clinical entity, combining all the most problematical aspects of urethritis, athlete's foot, corns and alcoholism. Fame maybe for the earnest young student who lights upon such a rich

RUGBY REPORT

The Rugby Club started with most of a side that has played together over the previous two seasons, and has the potential this season of doing very well. There is no lack of keenness in the club as can be seen by the fact that on 11th October five sides were playing, as well as a team playing on the Sunday. If the available talent can be channelled in the appropriate direction the club will have a better season both socially and playing than it has had for some time.

Training started back in July and was pursued with relish by several of the senior medical staff, and unfortunately not enough of the students to out-

EXAM NEWS

Big Con Joint

With all the spritely zest of a large hippo' emerging from the mud of the 'grey, green, greasy Limpopo River', the collective body of Bart's students recently gathered in vociferous fury to repel the latest assault on their sacred freedoms. Fired by the melodic oratory of 'Red Terry' Keeley they voted to maintain their traditional right to take the final Conjoint examination. And as a display of 'Sub-Dean rejection' it was most impressive. 'Here, here', you may say,'Freedom lives!' But why all the kerfuffle? Was there anyone in the A.G.M. who wanted to take the Conjoint version of 2nd M.B.? And who is more free, the student with one exam to revise, or he with two? The student with [illegible] to attack as often as they did was a tribute to the excellent way he cleared up and used bad ball to get the backs moving. In the backs, G. Brain, playing probably his only game of the season, showed attacking qualities but decided that kicking was less hazardous than running. There were occasional attacking moves which showed that if the pack had been quicker and had played together better the backs could have opened holes in Beckenham's back line.

In fact, Beckenham kicked several penalty goals from around 40 yds and kept themselves well ahead the whole game. They scored two tries eventually against weak defensive work.

The following Wednesday was the day of the freshers' trial. Several players coming back, took advantage of this to lay claim to places in the 1st XV. From the point of view of the freshers the trial was disappointing. Half a dozen freshers showed promise, John Benyon, Peter Burrell and Jeff fines being the most outstanding.

The next game against Southend saw a completely different team take the field. H. Maurice; J. Goddard; N. Dunn; S. Bonn; J. Chapman; J. Frame; C. Milford; D. Badenoch; M. Marien; S. Sullivan; G. Aiken; R. Holtby; J. Frappell; J. Capper; P. Davis.

Facing a heavier pack than us, as it appears will happen throughout the season, the Bart's forwards got down low in the set-pieces and more than held their own. In the line-out, Rick Holtby has shown himself to be a player of some promise at the front of the line-out and

APPOINTMENTS

Dr. T. Chard has been appointed to the Joint Bart's/London Chair of Reproductive Physiology as from 1st October 1974.

The title of 'Professor of Radiotherapy' has been conferred on Dr. Arthur Jones as from 1st October 1974.

Mr J. S. P. Lumley, Senior Lecturer in Surgery, has been appointed Assistant Director of the Surgical Unit as from 1st October 1974.

Dr R. B. Tattersall has taken up the post of Senior Lecturer in Medicine/Consultant Physician (St. Leonard's Hospital) as from 1st October 1974.

Professor Patricia Lindop has been appointed to sit on the Royal Commission on Environmental Pollution.

Mr John Page, gate porter at Charterhouse

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Perhaps psychologists and anatomists at graduate level, who welcome the re-emerging awareness in psychology that the brain is an organ of adaptive behaviour and not just a curious epiphenomena of unconscious motivation. Those who realise, in the words of Foster Kennedy, that only in Wonderland do we find the grin without the car. Perhaps electronics and apparatus engineers who must surely find a wealth of technical ingenuity worthy of plagiary.

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BOAT CLUB

The annual General Meeting of the Boat Club was held in the Hospital Abernethian Room, on Wednesday 16th October. The following officers of the club were nominated and duly elected: Captain, John Down; Vice-Captain, Ted Stannard; Secretary, Robert Treharne Jones; Treasurer, Dave Swithenbank. Mr. Hudson, who has been our President for the last two years, tendered his resignation, because he felt that his absence from the hospital in the forthcoming year would not allow him to fulfil his Presidential duties in the way that he would have liked. Mr. Currie, who has been our Vice-President for a number of years, was nominated and elected as the new President.

It is gratifying to see that interest in rowing is returning to the students of Barts after an absence of nearly two years. Many Novice crews are now going out on regular outings, these crews consist of both freshers, who will be forming the nucleus of the club in years to come, and also clinical students, who make up in interest what they lack in experience. We are hoping to enter all crews, no matter what their standard, for at least two regattas this winter.

It is as well to add, at this point, a Kanere. Remember the Children's from the left with.

Take any 3-digit number, and reverse the digits to form another 3-digit number. Subtract the smaller from the larger of these numbers, to leave another 3-digit number as the difference. Reverse the digits of this final number, to form a number which you then add to the result of the previous subtraction. You now have a 4 figure total.

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accessories needed to pursue the activities of the club form one of the largest bills of any club at Barts. We hope that the increasing membership will allow our critics to view the club grant in the right perspective.

FOURS HEAD OF THE RIVER

This event was held on October 26th along a course from Chiswick steps to Putney pier, a total distance of 2¾ miles. Each of the 237 crews in the event is timed over the course, so that the fastest crew takes about 11 minutes, and the slowest crew 16 minutes, each boat being released from the start at 15 second intervals.

The Barts crew featured in the notorious sterm IV from the Bumps 2nd VIII. George Evans (Str), Tony Douglas-Jones (3), Oliver Dearlove (2), and Robert Treharne Jones (Bow), together with their cox, Clare Vernon, had been attempting to row together in a regatta since May, but individual vagaries of the crew at weekends had not allowed them the opportunity. Nevertheless, regular Wednesday outings had formed them into a reasonably efficient crew, composed of some of the most experienced Novices on the river. They faced the race with some trepidation, having been advised by Dave Swithenbank, who grudgingly provided usual seasonal birds (cooked on their backs), well garnished gibbon steaks, bull-burgers and soup Ecosse. The Princess' father sings boisterously of his wedding gifts: 'With this I you endow land and half my wealth'. At this the Don borrows a dagger from his best man, the Duke Reisler, and the happy pair cut the wedding cake before leaving for their honeymoon on the very bare Brittany coast.

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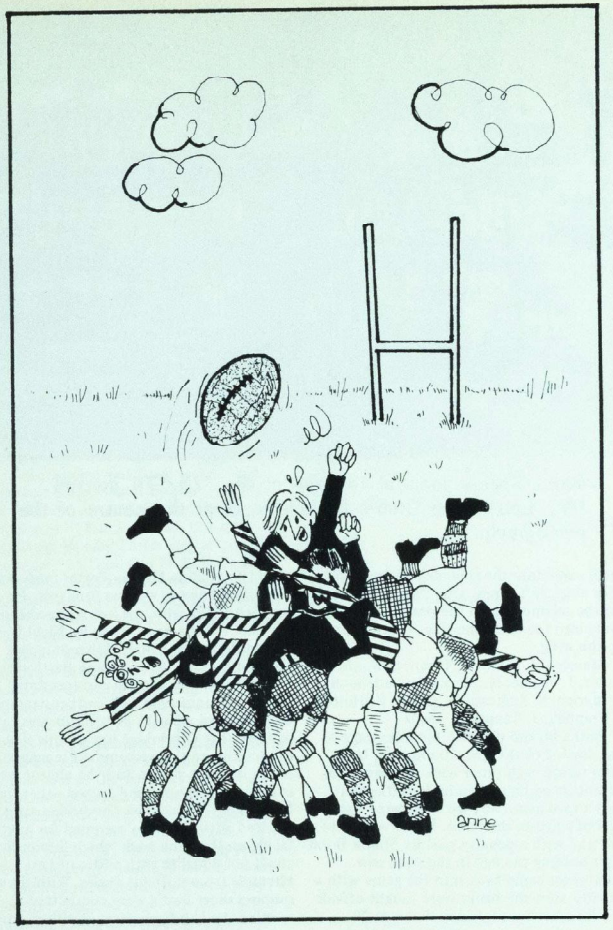
Allegro ma non troppo
con scherzo



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Training started back in July and was pursued with relish by several of the senior medical staff, and unfortunately not enough of the students to outnumber the 'vets'. Pre season training has, as in previous years, been affected by the tendency of most students to be "away" in August and September. Next year, with the main nucleus of players entering their second clinical year, training could and should be run far more efficiently and with greater numbers attending.

Notwithstanding all this the team entered the first game at Beckenham with a great deal of enthusiasm. Tim Fenton and Nick Packer made a comeback to the first fifteen as deputies for unavailable players, having already had the benefit of playing twice for the 'vets'. Unfortunately the rest of the team had not had this experience and soon realised that one can very easily overrate personal fitness.

Team:
N. Packer; R. Adley; G. Brain; N. Dunn; I. Chapman; J. Mann; M. Porter; M. Debenham; B. Marien; S. Sullivan; G. Aiken; D. Burton; J. Allen; J. Capper; T. Fenton.

Beckenham had a heavy pack and made full use of this in ruining our possession at the set pieces. The pack played exactly as if it was their first game of the season and Murray Porter, at scrum-half, had a lot of untidy possession to deal with. The fact that Bart's were able to attack as often as they did was a tribute to the excellent way he cleared up and used bad ball to get the backs moving. In the backs, G. Brain, playing probably his only game of the season, showed attacking qualities but decided that kicking was less hazardous than running. There were occasional attacking moves which showed that if the pack had been quicker and had played together better the backs could have opened holes in Beckenham's back line.

In fact, Beckenham kicked several penalty goals from around 40 yds and kept themselves well ahead the whole game. They scored two tries eventually against weak defensive work.

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The next game against Southend saw a completely different team take the field. H. Maurice; J. Goddard; N. Dunn; S. Bonn; J. Chapman; J. Frame; C. Milford; D. Badenoch; M. Marien; S. Sullivan; G. Aiken; R. Holtby, J. Frappell; J. Capper; P. Davis.

Facing a heavier pack than us, as it appears will happen throughout the season, the Bart's forwards got down low in the set-pieces and more than held their own. In the line-out, Rick Holtby has shown himself to be a player of some promise at the front of the line-out and

with a lot of possession from the back of the line-out Bart's had the set-ball from which to attack. Southend have been one of the top sides in Essex over the last four years and are a very difficult side to beat especially at home. Once again they restricted our backs by their sound tackling, and our forwards, although showing much improved form over the previous week, never dominated the game. They led by one penalty goal to nil at half-time with our side having missed two shots at goal from fairly easy distances. In the second half with Southend kicking much of their possession into the capable hands of our full back, Hugh Maurice, they were fortunate to score after a lucky bounce had hit the posts with our defenders overrunning the ball. For virtually the whole of the second half we were without our winger John Goddard who left the field with a bad cut over his left eye.

Bart's were unfortunate not to have played both these opening games at a later stage of the season. Both Beckenham and Southend are not our easiest of fixtures by any means and two slightly easier games would suit us better.

For the third game of the season we were playing Old Blues once again. Two years ago we lost against them for the first time for some considerable period, after which their club stopped their playing activities for some time! With Richard Miller coming in on the wing for the injured John Goddard we looked set to avenge that defeat. The forwards totally dominated set and loose in the first half with backs given ample opportunity to attack. But, with the lack of slickness in the centre and no real pace on the wings, Old Blues managed to spoil our attacking efforts. After some good loose work by the forwards and a thrusting run by Chris Milford, Pete Davis squeezed over in the corner for our first try of the season. Another try had been missed when, after some good support work for the wing, a final pass went astray with no-one to beat.

In the second half Chris Milford and the back row attacked more round the base of the scrum and the side began to look more confident. The forwards began to find each other more and there were several spirited rushed down field. After good work in the loose and a fine break by Jim Frame, Simon Bonn forced his way over the line, and a few minutes later Chris Milford dispossessed their scrum-half under the posts to score. Jim Frame missed this conversion but kicked two penalties to our opponents' one for a final score of 18 3 in our favour. Chris Milford without doubt looked the most outstanding player on the field, making some telling breaks and should develop into one of the best scrum-halves Bart's have had for some time.

Milford was injured for the game against the Cambridge LX club and Murray Porter

Barts Soccer team at the end of the '73/'74 season. Mr. Lettin, the Club's President, is at the centre of the photograph.

again came into the side, deputising more than ably. Jeff Fines, after scoring five tries for the second fifteen the previous Saturday, came into the side replacing John Chapman on the wing.

H. Maurice; J. Fines; N. Dunn; S. Bonn; R. Miller; J. Frame; M. Porter; D. Badenoch; B. Marien; S. Sullivan; G. Aiken; K. Holtby; J. Frappell; J. Capper; P. Davis.

Bart's kicked off with the advantage of the slope. For the first 20 minutes, both sides tested each other with the territorial advantage going to Cambridge although Bart's gave away very little showing a great deal of spirit in the loose. Bart's went into the lead with a penalty goal by Simon Bonn after holding the ball in the back row. Cambridge came back into the game with a penalty after the backs were caught offside at a lineout. Twice during the next 20 minutes Bart's were scrummaging on the Cambridge line but both times Cambridge won the ball against the head. During this period the Cambridge prop had to leave the field for the rest of the game with a head injury. Bart's started to look as if they could score several tries but the only scores were one penalty each with the teams coming over at 6 6.

In the second half Bart's looked a much better side. The forwards won good ball in the set and the loose with the backs making some good initial breaks, but too often the moves broke down due to a lack of finishing power or by stupid mistakes and Cambridge too easily gained up to 40 yards with their clearances. However, Bart's threw the ball around a great deal and did a lot of attacking. There were several good forward movements with Holtby and Sullivan showing up well. On one blindside move from a ruck in our own 10 yard line Murray Porter made a good break handing on, via two forwards, to Richard Miller who was just stopped short of the line. After a good break by Nigel Dunn, Simon Bonn was hauled down only just short of the line. At this stage Bart's were suffering from an inability to translate superiority into points. A further example of this occurred when at a set scrum the ball was over the Cambridge line on our side of the scrum and their scrum-half managed to touch it down. Shane Sullivan almost went over from a line-out and several other times Bart's went close. Then Cambridge went into the lead with a penalty awarded for a late tackle on their full-back which Simon Bonn could not equalise with either of two attempts from difficult angles. With time running short Bart's were committed to running the ball from every position, and it was from this that eventually Richard Miller squeezed over in the corner after good work from Porter, Frame and Maurice, with Simon Bonn converting to make the score 12-9 in Bart's favour.

Hugh Maurice had an excellent game at full-back as did Richard Miller on the wing. Nigel Dunn, Simon Bonn and Jim Frame all made telling breaks, and with more directness should soon start scoring tries. The forwards all played well with Dave Badenoch, as usual, playing a major part in winning loose possession, the back row and Murray Porter also combining well in attack.

Against Old Millhillians on the Saturday, Gerry McNicholas came into the side in place of Pete Davis; otherwise this was the same,as the midweek side. Old Millhillians had been playing some good rugby in the previous weeks and turned out to be a competent side. Playing at home in the usual excellent conditions that Chislehurst provides Bart's played the first half with real determination. The forwards gave an excellent display and starved the Millhillian backs of the ball they needed. Unfortunately, our support never had quite the same initial pace and quick thinking that their opposite numbers possessed, and any opportunities were stopped by a competent defence.

Millhillians scored two tries in the first half with Bart's reply being two penalty goals kicked by Simon Bonn who was in excellent kicking form. The two tries came from slack marking by Bart's and slick backing-up by the opposition. The first came from an outside break by their very competent scrum-half from a penalty with their centre touching down in the corner. The second came after we were pushed off our own ball with the ball quickly passed down their line. This second try was converted so the sides changed over with Bart's 8-6 down.

In the second half Bart's in the form of Simon Bonn kicked another penalty and for most of the half were leading by 9 points to 8. But with only five minutes remaining, Murray Porter was dispossessed on our "25" and Old Milhillians drove through to score and win the game. Once again this was a spirited display by Bart's with the forwards always having the edge on the opposition.

Against Sidcup Bart's started with the same team as the previous week apart from John Goddard returning to the right wing in place of Jeff Fines. After losing the toss Bart's were playing slightly downhill at Chislehurst. Disaster struck in the first scrum. Brian Marien, the captain, was at the bottom of a set scrum and subluxed his costal cartilage. This meant that Bart's were without a hooker for virtually the whole game and with no adequate substitute being available in the scrum managed to lose more set-ball in both line-outs and set scrum than they ought to have. For all this the remaining seven forwards played with a determination that augurs well. Although, with eight forwards beating Sidcup would have been a distinct possibility, without a hooker it became an uphill struggle and so the performance put up was all the more creditable.

In the first half Sidcup managed to score only one try involving a very good move in their back line from a line-out. Our backs were unable to stop this although they had been tackling and defending very well throughout the half. Bart's looked sharper in attack than Sidcup who made little use of the possession they had, and the backs especially showed up to better advantage after their coaching by Mike Smith on the previous Wednesday.

In the second half Sidcup attacked from the kick off and from the kick off they scored a try with one of their centres running through a gap in midfield and scoring next to the posts. They managed to score two more tries during this half, one when the ball squirted out from the unguarded edge of the scrum with the wing forward following up and the other when the full-back came into the line and scored with a fine individual effort. Other than this Bart's defended well with Sidcup being kept well clear of the try-line. On one occasion a Sidcup player was pushed back five yards when already over the try-line and on another the Sidcup winger was brought down by covering tackles from the fly-half and centre covering back. The only Bart's score came when the ball was being moved from loose play into the Sidcup '25' and Jim Frame was able to drop a goal. All the Sidcup tries were converted making the score 24-3.

All the side played well and defended with a considerable vigour that has been lacking during the past two years. John Goddard especially brought off a very good tackle to stop a certain try and also it was very good to see the whole of the back line backing up their members.

JOHN CAPPER

St. Bartholomew's Hospital Journal

CONTENTS

St. Bartholomew's Hospital Journal

CONTENTS

Vol. LXXVIII No. 2 FEBRUARY 1974

St. Bartholomew's Hospital Journal

CONTENTS

Vol. LXXVIII No. 3 MARCH 1974

St. Bartholomew's Hospital Journal

CONTENTS

Vol. LXXVIII No. 4 APRIL 1974

St. Bartholomew's Hospital Journal

CONTENTS

Vol. LXXVIII No. 5 MAY 1974

St. Bartholomew's Hospital Journal

CONTENTS

Vol. LXXVIII No. 6 JUNE 1974

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first

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fast

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decisive

SEPTRIN crushes bacterial resistance with a bactericidal action which differs essentially from that of other antibacterials.

they've proved superior in bacterial infections

"....can only be considered excellent on the criteria originally specified, namely the elimination of the infecting micro-organism."[1]

Rated top oral treatment in major British survey of urinary pathogen sensitivities.[2]

In treating acute exacerbations of chronic bronchitis rated more effective on objective grounds than either ampicillin or tetracycline.[3,4]

References

1 *Med J Aust*, (1971), **1**, 526.
2 *Postgrad med J.* (1971), **47**, Supplement (September), 7.
3 *Brit med J.* (1969), **iv**, 470.
4 *Postgrad med J.* (1969), **45**, Supplement (November), 91.

SEPTRIN® Tablets, Adult Suspension, Paediatric Suspension and Paediatric Tablets contain trimethoprim and sulphamethoxazole.

Full prescribing information is available on request.
Wellcome Medical Division,
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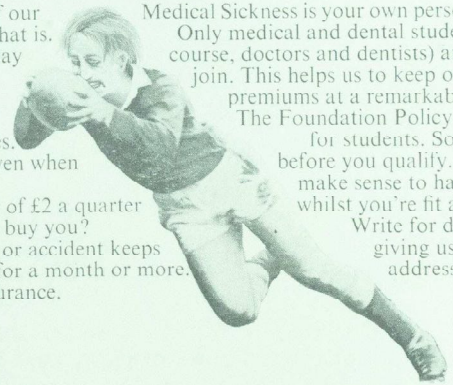

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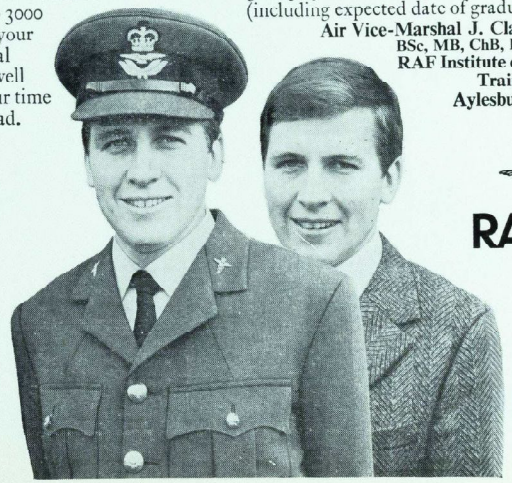

RAF officer
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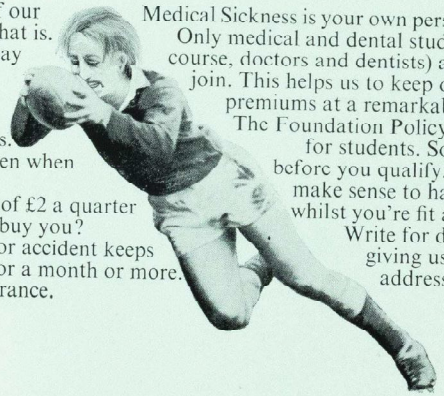

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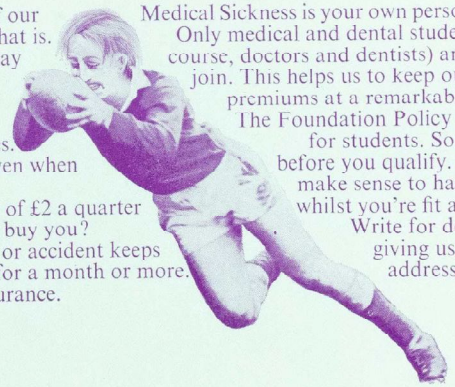

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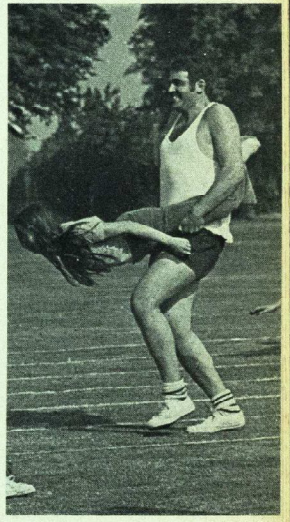
St. Bartholomew's Hospital Journal

Vol. LXXVIII No. 7 JULY 1974

CONTENTS

St. Bartholomew's Hospital Journal

CONTENTS

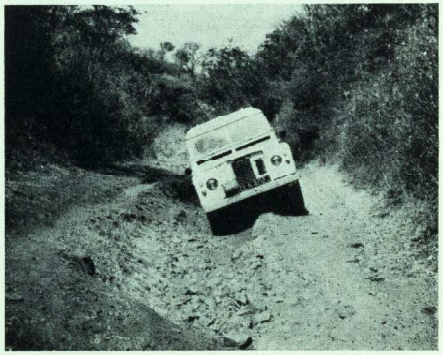


Sportsday '74—"Flying Wheelbarrow?"—See centre page spread.

St. Bartholomew's Hospital Journal

CONTENTS

Lop-Sided Lazy September Edition

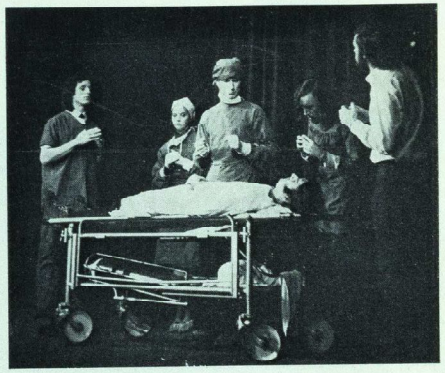


—for all those languishing in their holiday wilderness.

St. Bartholomew's Hospital Journal

CONTENTS

DO ANYTHING .....



But leave me my tie!

see page 278

ST. BARTHOLOMEW'S HOSPITAL

PRE-REGISTRATION HOUSE APPOINTMENTS — JANUARY 1975

Applications are invited for the following appointments:—

House Physicians to Dr. Hayward/Dr. Wykeham Balme	(two posts)
House Physicians to Dr. Black/Dr. Dawson	(two posts)
*House Physicians to Dr. Oswald/Professor Hamilton Fairley	(two posts)
House Physicians to Dr. Gibb/Dr. Galton	(two posts)
House Physicians to Professor Scowen/Dr. Spencer	(two posts)
*House Surgeons to Mr. Tuckwell/Mr. Birnstingl	(two posts)
House Surgeons to Mr. Ellison Nash/Mr. Griffiths	(two posts)
House Surgeons to Mr. Robinson/Mr. Shand	(two posts)
House Surgeons to Mr. Todd/Mr. Wickham	(three posts rotating)
House Surgeons to Professor Taylor/Mr. Irving	(two posts)
House Surgeon to the ENT Department	(one post)
House Surgeons to the Department of Orthopaedics	(three posts)

* Preference will usually be given to applicants applying for their second post.

REGIONAL BOARD HOSPITALS

Connaught	House Physician	(one post)
	House Surgeon	(one post)
Crawley	House Physician	(one post)
	House Surgeon	(two posts)
Hackney	House Physician	(three posts)
	House Surgeon	(three posts)
Harold Wood	House Surgeon	(one post)
Hemel Hempstead (St. Paul's Wing)	House Physician	(two posts)
Metropolitan	House Physician	(two posts)
	House Surgeon	(two posts)
North Middlesex	House Physician	(one post)
	House Surgeon	(one post)
	House Surgeon	(one post)
Orpington	House Physician	(one post)
Plymouth	House Surgeon	(one post)
	House Physician	(two posts)
Prince of Wales	House Surgeon	(two posts)
	House Physician	(three posts)
Redhill	House Surgeon	(five posts)
	House Physician	(one post)
Royal Cornwall	House Surgeon	(three posts)
Royal Berkshire	House Surgeon	(one post)
Battle	House Physician	(three posts)
St. Leonards	House Surgeon	(three posts)
	House Physician	(three posts)
Whipps Cross	House Surgeon	(two posts)
	House Physician	(one post)
Southend & Rochford Hospitals	House Surgeon	(one post)
	House Surgeon	(two posts)
Royal Sussex, Hastings		

Details of the posts at Regional Board Hospitals are available in a folder in the Library, together with any additional information on the posts at Bart's. **This File MUST NOT BE REMOVED from the Library.** Applicants should check with the Sub-Dean's Office on the number of vacancies at Regional Hospitals before listing these. *Students should contact Consultants for whose posts they are applying.*
Application forms, which must be returned by 18th October, 1974, will be available from the rack outside the Medical College Library, or by post from the Sub-Dean's Office, after 17th September, 1974.

27th August, 1974.

A. P. FULLER, F.C.S.,
Sub-Dean.

St. Bartholomew's Hospital Journal

Journal Christmas Card 1974

(See inside for details)

Vol LXXVIII No 9 11 NOVEMBER 1974

St. Bartholomew's Hospital Journal

ALCOHOL SPECIAL

A Social Necessity? by T. Turner

The Causes of Alcoholism by B. Kinman

The Pharmacology of Alcohol by Prof. J. P. Quilliam

Merry Christmas

to all our readers

Vol LXXVIII No ~~10~~ 12

DECEMBER 1974

Even if you break your neck, it needn't break you.

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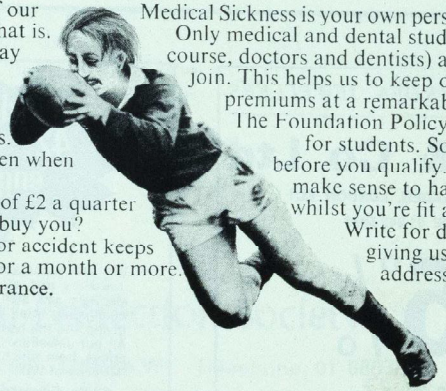

Medical Sickness is your own personal society. Only medical and dental students (and, of course, doctors and dentists) are eligible to join. This helps us to keep our costs and premiums at a remarkably low level. The Foundation Policy is especially for students. So you qualify before you qualify. Wouldn't it make sense to have one now, whilst you're fit and healthy? Write for details today, giving us your name, address and date of birth.

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Neurosis Finalis

Symptoms: Exclusive preoccupation with passing examinations without pausing to realise that now is the best time to protect the subsequent career with insurance.

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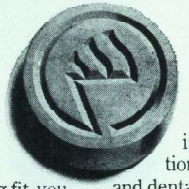

Even though passing Finals is probably your main preoccupation, you should take five minutes to think about what happens afterwards. You'll be qualified and have a career. But since it will be wholly dependent on you and your remaining fit, you should protect it with wisely-chosen insurance. And even if Finals are some years away, now is the very best time to start this protection because it will never cost less than it does at this moment.

The Medical Sickness Society offers a special Foundation Policy exclusively to medical and dental students. For a premium of less than 50p a week, you'd get £12 a week if sickness or accident keeps you away from work for a month or more, and £6000 worth of life assurance. And after five years you would have the option to double the benefits, whatever your state of health may be at that time.

The Medical Sickness Society is a mutual society providing protection for doctors, dentists and medical and dental students only. All the directors are either doctors or dentists. This means that we know your problems and have designed the Foundation Policy just for you, when spare money is tight but insurance protection is essential to safeguard your future.

You probably think that because you are young and fit now, you'll never need insurance. But remember that now is the very best time to start protecting that career you're looking forward to so much. Contact the Medical Sickness Society today and see how the Foundation Policy can help you.

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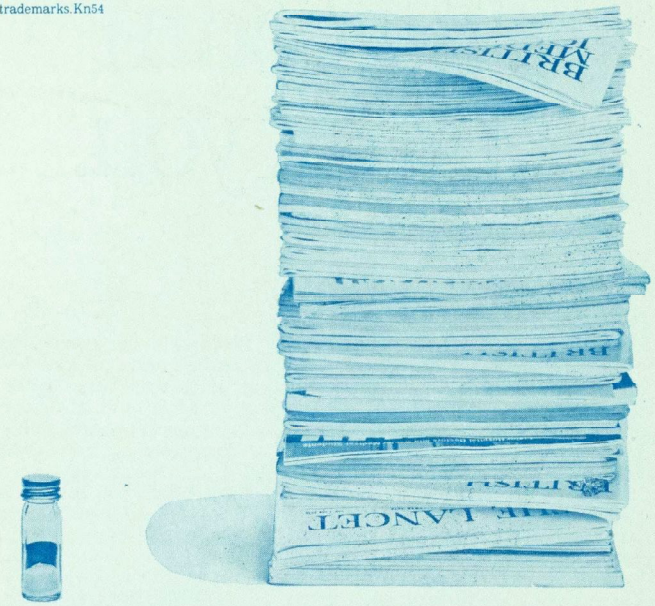

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