

mas. Everyone was badly out of training and therefore extremely pleased that we won the Cup for the second time running.

**Bart's v. Q.E.L.** By half-time in the first match the team was feeling exhausted, but the defences continued to play well and Bart's just managed to win.

**Bart's v. Goldsmith's.** We were on top throughout this game, most of the work being done by the attacks.

**Bart's v. Westfield.** After winning two matches we only had to beat Westfield to win back the cup again. The final was a slow gruelling game. Three minutes before time Bart's led 3-2, but Westfield equalised one minute later. Determined to win, Bart's won the draw and the attacks made a final effort. Luck was with us and the winning goal was shot seconds before the whistle.

Team: B. Anderson, E. Bohn, J. Clarke, G. Darch, A. Glew, A. Grieg, D. Leyton, U. Onians, J. Pitt (capt.), R. Sutton, S. Williams.

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# ST. BARTHOLOMEW'S HOSPITAL JOURNAL



Vol. LXVII, No. 5

MAY, 1963

#### EDITORIAL

The occasion on which Gordon Watson and Frherington Smith were able to race their new cars round the Square while they were on the House must seem to many to belong to the uncluttered and nearly forgotten past, but in fact is within living memory of some Bart's men. In those days it was the custom for members of the staff, arriving in carriage and pair, to make one majestic sweep round the fountain before finally drawing up at the entrance to their wards. The introduction of parking meters round the Hospital has led to such a pressure on space within the precinct that for a while it seemed that this custom was about to be re-introduced; but, through necessity, for although the square was now filled with cars, their owners were frequently seen driving round and round—this time in search of a few square feet of parking space which, if found, was usually far from their destination. The situation was not helped by the invasion of frustrated motorists who had little connection with the Hospital—it has been known that travelling salesmen used the Hospital as an excuse for free parking while they went their rounds on foot or that a Bummarree could show a bleeding finger as an excuse for parking safely on the site, avoiding the hazardous business of paying sixpences to meters, or larger fines to the coffers of the local Borough.

A search for alternative arrangements for increasing the available space by making use of part of the redundant Smithfield Goods Depot revealed that Fleet Street had unfortunately thought of it first. Thus the only relief to the limitation of parking within the precinct to one hundred cars is the opening of the new park at Charterhouse. This will help temporarily those affected by the new arrangements who do not want an even longer walk to street-parking in an area which is so far free from meters. However, the long-term provision of facilities under the new Out-patient block and in the Cock Lane site will probably come after the present relief is made unusable by building and new parking restrictions. The problem is one which affects in one way and another all residents in Central London and which requires early solution, remembering the mistakes of the brave new L.C.C. estates which sometimes appear to have been designed without realising the gradual and inevitable approach on the universal "family-car" age—these blocks even now stand surrounded by a tightly-packed mass of motor-cars.

The posts of Assistant Editor and Assistant Manager to the Journal fall vacant in June. Applications should be sent to the Editor by 14th June. Candidates for the post of Assistant Editor should include a specimen Editorial.

**B.M.S.A.**

The Annual Dance will be held in Chislehurst Caves on Friday, 14th June, from 10 p.m. to 6 a.m., to the music of a dozen bands. Tickets (price 4s. 6d.) can be obtained from Miss J. Bond or Miss R. Fisher and must be bought in advance.

**Births**

**CUTHBERT.**—On April 9th, to Toni and Dr. Dan Cuthbert, a son (Alistair).

**HOLLAND.**—On April 21st, to Patricia (née Kielty) and Dr. James H. Holland, a son (James Patrick).

**LEWIN-SMITH.**—On April 6th, to Rosemary and Dr. Richard Lewin-Smith, a second son.

**MARSH.**—On April 4th, to Jacqueline and Dr. Brian Marsh, a daughter (Carolyn Deborah).

**Engagement**

**LEAVER—CLARKE.**—The engagement is announced between Peter K. Leaver and Jane M. Clarke.

**Marriage**

**FRANK—MARR.**—On 25th May, Alexander John Martin Frank to Anne Elizabeth Marr, at St. Mary's, Bramshott.

**Death**

**GERARD—PEARSE.**—On April 8th, Mr. J. E. Gerard-Pearse, F.R.C.S. Qualified 1914.

**Appointment***London University*

Dr. J. F. Fowler has been appointed to the newly instituted chair of medical physics at the Post-Graduate Medical School of London.

**Changes of Address**

Dr. and Mrs. G. Bourne to 61, Farley Court, Allsop Place, N.W.1. Tel.: WELbeck 2138. Consulting Room from 20, Harley House, to 73, Harley Street, W.1. Tel.: WELbeck 9942.

Dr. and Mrs. W. C. Dale to "Quendale", 4, Barton Terrace, Dawlish, Devon.

**MONDAY, 17th JUNE:** Matter for the July Journal should be sent to the Editor by this date.

**1963 SMOKING CONCERT**

The Wine Committee are sponsoring another Smoker sometime in October. Anyone with ideas, materials, scripts, sketches, quips or just jokes should see Mr. Graham Chapman. This will be the first All Bart's Smoker for over a century. Anything hilarious will be used to make it the year's whackiest event.

**Calendar****JUNE**

Sat., Sun. 1 & 2 June: Dr. E. R. Cullinan  
Mr. C. Naunton  
Morgan

Mr. Coltart  
Dr. R. A. Bowen

Tues., 4 June: 5.30 p.m. "Recent advances in Psychopharmacology" by Dr. P. Jansen in the Physiology Lecture Theatre (No. 2).

Fri., 7 June: **View Day Ball at the London Hilton.**

Sat., Sun. 8 & 9 June: Dr. G. Hayward  
Mr. A. W. Badenoch  
Mr. J. N. Aston  
Mr. G. H. Ellis

Sat., Sun. 15 & 16 June: Dr. A. W. Spence  
Mr. E. G. Tuckwell  
Mr. W. D. Coltart  
Dr. R. Ballantine

Mon., 17 June: 5.30 p.m. "The Biological Basis of Personality" by Professor H. J. Eysenck, St. George's Hospital Medical School.

Fri., 21 June: B.M.S.A. Visit to Guinness Brewery at Park Royal.

Sat., Sun. 22 & 23 June: Prof. E. F. Scowen  
Prof. G. W. Taylor  
Mr. H. Jackson  
Burrows

Sat., Sun. 29 & 30 June: Dr. Ian Jackson  
Dr. R. Bodley Scott  
Mr. Alan Hunt  
Mr. J. N. Aston  
Dr. T. B. Boulton

Wed., 3 July: 5 p.m. "Acute Tuberculosis and Granulocytic Disorders" by Dr. N. C. Oswald, Brompton Hospital. Physician Accoucheur on duty for the month of June is Mr. D. B. Fraser.

**THE N.H.S. SUPERANNUATION SCHEME****Plugging the Gaps**

**I**N THE pre-1948 age, good or bad, according to individual taste, the doctor was left to his own devices for providing for his old age and for his family. This was achieved with varying degrees of success, but there were many requests for assistance from the Medical Charities and lack of resources compelled many a doctor to "work until he dropped".

The setting up of the N.H.S. Superannuation Scheme in 1948 completely transformed the situation for most doctors by introducing compulsory contribution to a comprehensive Scheme for providing a pension and some protection for dependants. Only at the inception of the Scheme were doctors permitted to "opt out".

It is not the function of this article either to give a summary of all the provisions of the Superannuation Scheme—a detailed booklet is available—or to criticise any deficiencies. On the latter point it is sufficient to say that the doctor receives very good value for his contribution of "6 per cent. of remuneration". Moreover, tax relief is allowed on the full amount of the contribution.

In considering the measures to be taken to supplement the Scheme, it will simplify matters if we divide the benefits into three separate sections.

**1. RETIREMENT**

The following examples will give an idea of the pensions to be expected.

If a General Practitioner serves for 40 years and earns an average N.H.S. income of £3,500, before deduction of expenses, his pension will be £1,592 per annum.

A full-time Consultant who, after 40 years service, earns an average of £4,000 per annum in his last three years of service will receive a pension of £2,000 per annum.

In both cases the doctor will also receive a lump sum at retirement of one year's pension (or three years' pension if unmarried). The "gap" is revealed if, after retirement, the doctor pre-deceases his wife as the latter will then receive only one-third of the original pension. As there are far more widows than widowers, it is advisable for the married doctor to build up a capital fund to enable the widow to restore her income to a reasonable level. This can best be achieved by either:—

- (a) Endowment Assurance maturing at, say, age 65; or
- (b) Whole of Life Assurance, preferably with the premiums ceasing at age 65.

The young doctor will not be able to afford a substantial Endowment Assurance and he should, therefore, effect a cheaper form of policy which can be converted to Endowment Assurance when he is in a position to afford the higher premium required.

**2. DEATH BEFORE RETIREMENT**

If death occurs within the first ten years of service, the only benefit payable will be a lump sum, consisting of the largest figure produced by three separate formulae. Generally speaking, this "Death Grant" will be not less than "average remuneration" during the three years preceding death.

On the death of a married doctor after ten years of service, but before retirement, his widow will receive a pension of "one-third of the pension he would have obtained if he had retired the day before he died". In addition the widow would receive a lump sum of one year's pension.

It is all too apparent from the foregoing that the main deficiencies of the Superannuation Scheme arise during the early years of married life, when the children are young. The degree of extra protection required will depend upon individual circumstances, but the young family man will be well advised to take the following steps:—

- (a) Cover his house mortgage by some form of life assurance protection so that his house will pass, free of debt, to his wife.
- (b) Have a reasonable amount of Whole Life or Endowment Assurance to provide immediate capital at his death. If he survives, these policies will provide the capital, on retirement, referred to in (1) above.
- (c) Effect what is known as "Family Income Benefit" to cover the period during which his children would be a financial liability to his widow. On death within the selected period of years, the Insurance Company would pay to his widow an agreed income, free of tax, for the unexpired balance of the original term of years. Fortunately, the cost of such cover, to a healthy young man, is very modest. At around age 30, an

annual premium of approximately £10 will provide Income Benefit of £500 per annum for the unexpired balance of an original term of 20 years.

### 3. PREMATURE RETIREMENT

If this occurs after five but less than ten years of service, the doctor will receive a sum equal to his "average remuneration" during his service. In addition the Minister of Health may, at his discretion, grant a pension not exceeding two-thirds of "average remuneration" in the event of permanent incapacity resulting from causes attributable to the nature of the doctor's duties.

The only satisfactory supplement to these benefits is a permanent Sickness and Accident Insurance; that is to say, a policy to provide a weekly sum during temporary disability and also a continuous income to, say, age 65, should permanent disability occur. A "permanent" insurance cannot be cancelled or amended by the Insurance Company on the grounds of an unfavourable history of claims.

This article may read like a pessimistic review of all the ills that can befall mankind but, nevertheless, the young doctor should give some thought to the matter, particularly on marriage, as it is obvious that he cannot entirely rely on the combination of the Welfare State and his Superannuation Scheme to look after either himself or his dependants, should some disaster befall him.

It is equally obvious that he cannot afford to pay out considerable sums on insurance during the early years of his career. However, there are many schemes available for spreading the load by means of lower premiums during the initial few years of the insurances and expert advice should be sought. No single insurance company can hope to provide the cheapest and best solution to all insurance problems and it would be a laborious task for the doctor to make his own investigations.

You may prefer to consult the Medical Insurance Agency, which was founded in 1907, by members of the medical profession, to act as an unbiased advisory service. Whenever possible, the Agency allows rebate to the doctor and its entire surplus is donated each year to the Medical and Dental Charities. The Head Office of the M.I.A. is at B.M.A. House, Tavistock Square, London, W.C.1, and there are sixteen provincial offices to provide a nation-wide service.

## LAST MONTH

As usual Bart's Preclinical school contributed to the Bank Holiday chaos by getting back to work at the most convenient time for the teaching staff. Perhaps this is the ideal cure for a hangover, but most of us found that it prolonged the agony!

2nd M.B. now being over, College Hall is considerably quieter—at least we do not have to have our lunch sitting on the floor.

Those who passed appear occasionally, rather condescendingly one feels, to keep an eye on things this side of the market. We do hope that their unlucky contemporaries succeed in joining them next month. 2nd M.B. seems a drastic method of forcing students to wear ties! The standard of dress in the Preclinical school seems scandalously slack. One feels that "Charterhouse Tech." would be a more appropriate title.

Yet another "Old Faithful" of Charterhouse is leaving us. Last Summer it was Miss Law, this time it's Dave Ridley, who has been with us for seventeen years. Seeing that we can't give him his job back, we wish him a long and happy retirement. I find it hard to understand why someone who is doing an efficient job has to be retired because of his age. Talking about efficiency I would like to bring to the notice of the people who run Charterhouse Square a discovery made in 1832, namely the thermostat. This is an instrument that maintains a constant environmental temperature. During April the weather turned pleasantly warm, but the heaters at College Hall turned out heat as if we were still in the post-Christmas ice age, and everywhere, the library being worst of all, was uncomfortably hot. Then on 1st May the heating was turned off, but the weather (which it is not possible to control thermostatically) took a turn for the worse. We thus spent a fortnight shivering. Moreover, to add to our discomfort, when the library reached a reasonable temperature, great machines, rumbling in the depths of the earth, blew out torrents of cold air. Of course the weather's warmer now, and we're forgetting about the cold, but winter will soon be round again; surely there's time before then to develop a reasonable central heating system?

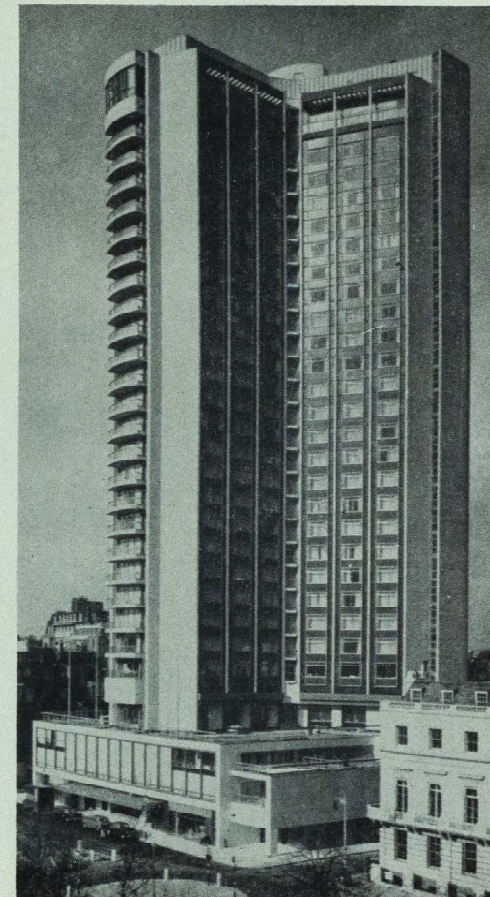
\* \* \*

## THE VIEW DAY BALL

This year the View Day Ball is to be held on 7th June at the London Hilton, under the Patronage of the Lord Mayor and the Lady Mayoress, Sir Ralph and Lady Perring. The Hilton is in many ways an ideal place for the ball, having a very large dance floor, a cocktail bar with a superb view over West London from the 34th floor and, most important, ample parking space in its subterranean regions. There is to be a four-course dinner which will certainly satisfy the disappointed gastronomes of last year. Bill Savill and his orchestra are leading the music which will also include the well-known Trinidad steel band and Joe Williams. As usual the Tom-bola will yield a quantity of liquor and other luxuries.

All the proceeds of the Ball are to be given to the London Homes for the Elderly, which is the City's charity for this year, and one which is doing much good work in the rehabilitation of old people, who, for one reason or another, cannot subsist as they did. At the present time there are two such Homes with a projected third to be built in Bermondsey, at an estimated cost of £200,000. The Charity has so far £60,000 of this sum, and we hope by our efforts to help them towards their target.

Tickets are limited this year to 350, priced at £4 10s., and in fact this is extraordinarily good value since practically no profits come from their sale. Applications must be in as soon as possible to avoid disappointment, to Richard Maw, c/o The Abernethian Room. The Tickets will be sent out after 15th May.



## FIFTY-SIX MILES

From our special correspondent

In the small hours of Saturday, 21st April, they did it. On 10th and 11th May some of us will do it too. Why do we do it? And why Brighton? Of course it is more practical than Blackpool, but why not Windsor or Canterbury? Maybe there is a Masefieldian urge that demands a coastal town as the target, although the ships at Brighton are few having no masts, certainly not tall ones. And the sea? That at Brighton is pleasant to watch and hear only in the winter when it breaks with a vengeance on rattling beaches that are bare. In the summer the same sounds, softer, waft unheeded over naked navels and burning buttocks to mingle with maddening music in the mush-minds of the bare bodies strewn about there.



Reprinted by permission of the Brighton Evening Argus

Twenty-four Smithfield porters covered the distance in twelve and a quarter hours, a market record, taking with them a 700 lbs. loaded barrow. I doubt if many of us will do it so quickly even without barrows. The porters had quite a send off. All their friends were there in large Ford cars, sporting expensive cameras

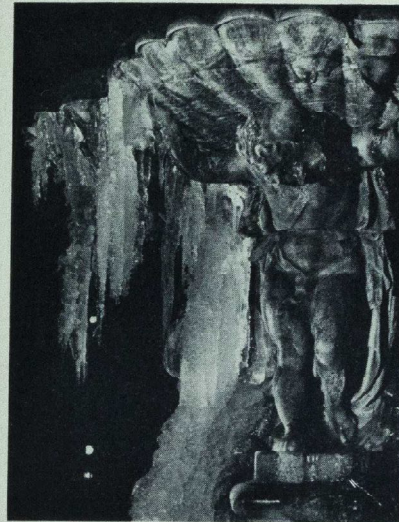
and pretty girls. Your correspondent was informed by an elderly and reliable porter that the social convenience of the Ford front bench seat was delaying the fraternity's progression into Rovers and Jaguars.

Mr. Iain Matheson, a likable Scot and veteran stroller, is organising the Bart's strollers. He tells me that he will not be walking this year. He has a sensible and practical attitude towards the Stroll, thinking it unnecessary for us to win and stating jovially that the shilling entrance fee is not an insurance for the walkers but purely a cover for third party risks. "They sign their souls away when they fill in their entry forms," he says pleasantly.

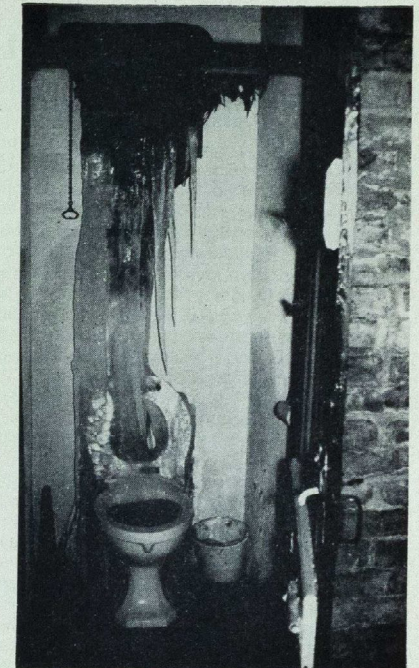
We wish all lovers of tall ships luck. Speaking from bitter experience we advise against

special shoes or boots. Take a tip and wear silk evening socks in an everyday pair of shoes. Our friend, Nicholas Loughman, used to say that a clove carnation, a walking stick, silk socks and a full flask would see the lamest duck through to the Aquarium hot salt baths. But then, he was Irish.

## THAT WAS THE WINTER THAT WAS



(Photographic Dept.)



(D. S. Tunstall-Pedoe)

### BRUSH UP YOUR (MEDICAL) GERMAN

**B**ART'S men and women get around quite a lot, so that it is quite possible that some of you who read this journal will visit a German hospital before long. International understanding and wine swilling is always improved if one speaks the lingo. So, for the benefit of those whose knowledge of German is rudimentary, the following glossary of technical terms is bound to prove helpful.

Hospital  
Bart's Hospital  
Physician  
Surgeon  
Professor of Surgery

E.N.T. Surgeon  
Anaesthetist  
Nurse  
Bart's student  
Mary's student  
Houseman  
Professor of Bacteriology  
Head Porter  
Psychiatrist

Krankenhaus  
Hauptkrankenhaus der Welt.  
Herr Poshdoktor für Krankengebettingmitpillsundphysik.  
Hauptspezialist für Slashingsunddummkopfhausemengeblitzing.  
Herr Obergruppenführer der Spezialisten für Slashingsunddummkopfhausemengeblitzing.

(This word would not pass the censor)  
Spezialist für Gassingsundalleflappingsmitdamningsundblindings.  
Schonesmädchenfürmoralegeraisingundhousemengewifing.  
Textbookgeschwottendedummkopf  
Rugbyfussballgehasenedummkopf  
Nichtschlafendeunteroffizierundgeneraldogsbody  
Direktor der Laboratoriumfüridentifikationundesglaughteringderkleinebugs.  
Spezialistfürkleinegoldfischegefeeding  
Herr Bonkersdoktorfürbonkersmännergebetteringmitlektrizität.

Robert Newill.

## GALEN AND THE THYMUS GLAND

by Professor A. J. E. Cave

MODERN anatomical nomenclature eschews eponyms, with the avowed object of providing the medical student with a uniform, readily intelligible and more informative terminology, and from the purely utilitarian viewpoint there is doubtless some justification for such a procedure. But a defect of the new nomenclature is that it deprives the student of that almost unconscious introduction to the venerable history of anatomy which the older terminology afforded. Enquiry into that history proves educatively rewarding and serves to remind the student that he is no mere technologist but a potential member of a learned profession, founded in antiquity.

Perhaps under any system of nomenclature the medical student might legitimately be expected to evince some curiosity as to the meaning of the anatomical terms he employs, if only because language is the tool of thought and anatomical nomenclature is primarily designed to be at once definitive and descriptive. It is a wholesome and profitable exercise to seek to discover why particular anatomical structures bear the names they do. Not to be acquainted, in some measure at least, with the derivation and meaning of anatomical terms is both an intellectual defect and a handicap in study. Sometimes the anatomical term is obvious or self-evident (e.g. **pancreas**, **sublingual gland**), but at other times its significance must be sought in history (e.g., **thyroid**), in metaphor (e.g., **acetabulum**, **tibia**) or elsewhere (e.g., **fabx**, **sesamoid**).

One anatomical term which seems, at first sight, singularly inappropriate is that of **thymus** for the well-known gland of that name, and this notice purports to show how such an essentially botanical term came to be applied descriptively by Galen to the solid, fleshy mammalian gland and how the very adoption of such a term constitutes intrinsic evidence of the assiduity of Galen's anatomical researches.

Since, however, the modern student is unacquainted with the **vena magna Galeni**, etc., of the Old Terminology, Galen himself may require some introduction and something may need to be said regarding his place and significance in the history of anatomical science.

The earliest people systematically to explore the interior of the human body, and thus to acquire a first-hand acquaintance with its several organs and parts, were the Ancient Egyptians, whose distinctive religious beliefs necessitated the preservation of the eviscerated corpse by an elaborate process of mummification. The technical details of this process—itsself but a part of an extensive magico-religious ceremonial—varied at different historical periods and are irrelevant here. But they involved the removal of all the thoraco-abdominal contents, save the heart, through a flank incision some 80-90 mm. long, a manipulation impossible of performance without a detailed knowledge of the position, relationships and mutual attachments of the internal organs, certain of which, after removal, were themselves embalmed for ultimate interment. Mummification was carried out continuously over a period of some 3,000 years, resulting inevitably in the establishment of a unique corpus of anatomical knowledge. The internal organs were named and were recognized to correspond to their animal counterparts: this earliest anatomical nomenclature was most likely akin to that of modern butchery, wherein the thyroid is the throat gland, the pancreas the sweetbread, and so on. It was not inherently scientific, for the ancient embalmers were concerned not to study human morphology, but to prepare the cadaver for permanent preservation. Nevertheless Egypt was the cradle of anatomical science, itself the child of Greek intellectual curiosity. For in the then civilized world Egypt alone possessed an exclusive and traditional knowledge of human morphology; she had been, for centuries, unprejudiced against manipulation of the cadaver, and offered unrivalled opportunity for a nicer exploration of man's physical structure. Hence the rise, in the 3rd century B.C., of the "Alexandrians", i.e. those early Greek anatomists who found in the Egyptian metropolis an exceptional field for enquiry and who there established the foundations of anatomy as a scientific discipline. Their endeavours were aided (perhaps even made possible) by the curious decadence which, at this relatively late period in Egyptian history, befell the embal-

mers' craft: for examination of mummies of this period demonstrates conclusively that (for whatever reason) the most cursory attention was now bestowed upon the cadaver in contradistinction to the elaborate care devoted to its wrappings, coffin and funerary equipment. Unmistakable evidence indicates that, during embalment, the cadaver might suffer partial decomposition or might disintegrate, to be re-assembled most haphazardly.

Such a state of affairs, however otherwise deplorable, provided the "Alexandrian" Greek anatomists with wholly exceptional opportunities for anatomical investigation, opportunities which they profitably seized.

[The "Athenians" of the 4th Century B.C. (Hippocrates, Diocles, Aristotle) must be dismissed from present consideration. Although their tradition doubtless reflected something of Ancient Egyptian medical knowledge, and though Diocles (d.350 B.C.) wrote works (since lost) "On Anatomy" and "On the Heart", there is no evidence that they dissected the human body and no probability that they did.]

The pioneer "Alexandrians" were Herophilus of Chalcedon (c.300 B.C.), the father of scientific anatomy, and Erasistratus of Chios (d.290 B.C.), the first experimental physiologist. Herophilus distinguished cerebrum from cerebellum, arteries from veins and motor from sensory nerves; he described and named the meninges, the cerebral aqueduct, the *confluent sinuum* (Old Terminology **torcular Herophili**), the hyoid bone, the parotid and submaxillary glands, the duodenum, the ovary, the uterine tube, the prostate, the seminal vesicles and the retina, vitreous and ciliary body.

Erasistratus named the aorta, the tricuspid, aortic and pulmonary valves, many of the principal arteries, the caval, renal, pulmonary and hepatic veins and the chordae tendineae, besides describing the superficial origin of the cerebral nerves.

Both obviously had a direct personal familiarity with human structure, but their Alexandrian successors had perforce to confine themselves to animal anatomy alone. For though during the first two centuries of our era Alexandria remained the cultural centre of the world it no longer provided the Greek anatomists, whom it still attracted, with any opportunity for exploration of the human body. Mummification had been abandoned, with the ancient religious beliefs of Egypt.

The later "Alexandrians" included Rufus of Ephesus (1st cent. A.D.), who wrote the first treatise on anatomical nomenclature, Soranus of Ephesus (2nd cent. A.D.), Marinus of Tyre, Quintus, Numisianus of Corinth, Satyrus of Pergamum, Pelops of Smyrna, and Lycus. The **Onomasticon** of Julius Pollux (134-192 A.D.) introduced such still current anatomical terms as **amnion**, **atlas**, **axis**, **cricoid**, **canthus** and **tragus**.

The great Galen was born at Pergamum (c.130 A.D.). His is the last great name in antiquity, to the medical knowledge and scientific achievements of which he remains the portal. His anatomical reputation, his physiological hypotheses and his immense authority in matters clinical, were to dominate Medicine for centuries, until, indeed, the rebirth of anatomy in the Vesalian age. He had studied anatomy under Satyrus at Pergamum, under Pelops at Smyrna and under Numisianus at Corinth and later at Alexandria. Settling in Rome in 162 A.D., he ultimately became physician to Commodus and to Marcus Aurelius, and in Rome (176 A.D.) he delivered public lectures on anatomy. Traveller, physician, physiologist and anatomist, an indefatigable worker and a prolific author, Galen was familiar with the anatomical work of his predecessors (Marinus' lost anatomical works are known only from Galen's references), which, reinforced by his own additions to knowledge, he transmitted to posterity.

In anatomy Galen excelled in neurology, myology and arthrology. He distinguished the dura from the pia mater, systematized the cerebral nerves (into seven pairs), wrote impressively upon the cerebral ventricles, corpus callosum, fornix, colliculi, hypophysis and upon the internal cerebral vasculature. His **Encheiresis** was the earliest treatise on (animal) dissection and he introduced into anatomy a host of terms which remain valid to this day. These include **epiphysis**, **diaphysis**, **apophysis**, **symphysis**, **diarthrosis**, **enarthrosis**, **gomphosis** and **suture**. Another term is that of **thymus** for the glandular organ so known, whose exact function still awaits final determination. With Galen's death (c.200 A.D.) anatomical enquiry ended, and was not to be resumed until the 16th century.

The thymus gland in the pigs and oxen dissected by Galen is, on inspection, the customary fleshy, solid, bipartite organ situate ventral to (sometimes cranial of) the pericardial sac and occasionally manifesting extensions in-

to the lower cervical region. To such an organ the term **pancreas** might seem ideally applicable, yet Galen deliberately applied to it the botanical term *thymus* (θύμος). (Taxonomically the wild thyme plant is *Thymus serpyllum*, the cultivated plant is *Thymus vulgaris*.)

At first sight there is no apparent resemblance between the homely thyme plant and the solid, compact thymus gland, and one might wonder what prompted Galen to apply the botanical term to the mammalian organ. This problem of nomenclature is not to be resolved by reference to the descriptive accounts of the thymus gland in anatomical or veterinary treatises, which confine themselves to the topography, embryology and general features of the organ as a whole and then pass to an immediate consideration of its microscopical structure.

If, however, time and labour be expended upon a meticulous dissection of the ungulate thymus, there ensues a surprising and very beautiful picture of its true constitution, and the aptness of Galen's name for the organ is shown to be fully justified. For when all the dense supportive connective tissue has been carefully removed the fully dissected thymus is seen to bear a remarkable resemblance to a plant or shrub whereof the stems are the thymic bloodvessels and the leaves are the unitary lobules of the thymic parenchyma.

The fully dissected thymus gland of a young rhinoceros (*Diceros bicornis*) is depicted in the accompanying figure, which illustrates the singular appropriateness of Galen's descriptive

term for the mammalian thymus. The fact that Galen should have selected this botanical name for the gland is indirect but positive evidence that he himself must have dissected out the ungulate thymus in the greatest possible detail—a tribute both to his scientific curiosity and to the thoroughness of his prosectorial practice.

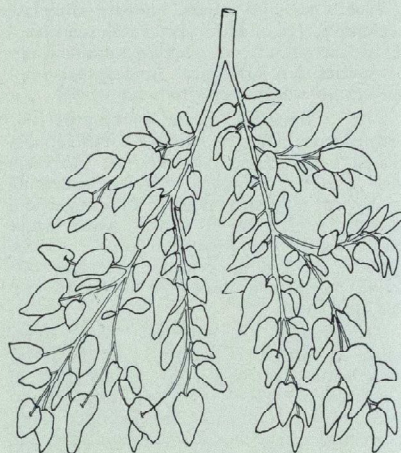


Fig. 1. Fully dissected thymus gland of young *Diceros bicornis*.

## ANCIENT EVIDENCE OF DISEASE

by R. M. Bark

Disease is obviously nearly as old as life itself. Though evidence is, on the whole, necessarily restricted to skeletal parts which are all that is preserved, it may seem trite, and not to add anything to this thesis, to list some early instances. It is, however, not without some interest, even if only for curiosity's sake.

The earliest fracture callus is in the radius of a Permian reptile. Other reptiles of the

same period show various fractures, one, in a spine with osteomyelitis. Osteo-arthritis seems to have been fairly common in Dinosaurs, first from the cretaceous period. An osteoma has been seen in a cretaceous Monosaur. Caries has been observed in the teeth and scales of Permian reptiles, and extensively in the teeth of a monosaur. Fossilised bacteria (not necessarily pathogenic, of course) have

been found in the coal measures, and in stools of various animals.

As might be expected, there is plenty of evidence of disease in human remains, from the earliest Hominids (Australopithecines) onwards.

Dental caries has often been said to be a disease of civilisation. On the contrary, it seems to be one of the oldest of man's ailments, although of course in early days not nearly so common as it is today. Several of the "ape-men" of the Australopithecus group, from Africa, have carious teeth. In the later, Rhodesia man, at least ten of the fifteen teeth present are carious. Many other instances are found in Paleolithic remains. The overall incidence, though, remained very low, probably little more than two per cent. of all teeth were carious. Through the Neolithic and Bronze ages there seems to have been a slight rise, but not above five per cent. In the Iron age and Roman period a marked increase occurred, in British and other material to around ten to fifteen per cent., but this was reduced to eight per cent. or so in Saxon times. This compares with about fifteen to twenty per cent. for a series of eighteenth- and nineteenth-century skeletons. It is also, however, interesting to note that in studies of wild apes (in captivity caries is almost invariable), five per cent. or more teeth have been found carious.

This all applies to teeth left in the jaws at death. In some cases extensively carious teeth may have fallen out, but there are also other reasons for tooth loss. Dental abscesses are in evidence in all ages, and signs of *Pyorrhoea alveolaris* are common too.

Osteo-arthritis is a disease which has left plenty of evidence. The Dinosaurs have already been mentioned, and many other fossil animals have been found with signs of osteo-arthritis. The earliest evidence in man is found in the Neanderthal men. The one found at La Chapelle-aux-Saints is extensively affected in the spine, hips and jaw joints. Several other skeletons from the Paleolithic era are affected. Many examples of osteo-arthritis, especially of the spine, have been found in Britain, from Neolithic times on. In Ancient Egypt, from the earliest remains onward, osteo-arthritis of the spine seems to have been the rule. Very few adult skeletons have been found to be free from arthritic change.

Ankylosing spondylitis is another spinal condition which has been reported a number of times, though many authors have not differentiated it from osteo-arthritis. Several cases

of ankylosis of vertebrae and of sacro-iliac joints, and one or two complete poker spines, have been found from Ancient Egypt and elsewhere.

Several other diseases of bone have been found. For instance, a case of Paget's disease has been reported from Neolithic France. Achondroplasia has been described in Egyptian remains. Of course dwarfs of various kinds have figured in ancient art. True tumours of bone have rarely been found. One of the early men from the far east, Pithecanthropus, has a curious exostosis on the upper part of the shaft of a femur which may however be traumatic in origin. Three examples of osteo-sarcoma are known from Egypt.

Several skeletons have been found with the limbs markedly unequal in size on opposite sides of the body. This is the result of muscular paralysis of a limb early in life, and in most cases almost certainly the cause was poliomyelitis. An early Egyptian skeleton buried with a walking stick has the left femur eight centimetres shorter than the right. Two Neolithic skeletons found in Britain each show one arm much smaller than the other.

Rickets and osteomalacia were very rare in prehistoric times, if they occurred at all. One or two cases have been reported from Scandinavian Neolithic, but otherwise none is seen till the historic period. No evidence of the disease has been found from Egypt or among ancient Americans.

In the great majority of human remains one can only guess at the possibility of disease in the soft parts. Mummies, however, provide a unique opportunity to probe further into the pathology of ancient populations. Classically, mummies are found in Egypt, where a great art was built up in embalming and preparing the bodies. In Peru rather cruder forms are found. The bodies seem to have been merely left out to dry in the sun before being wrapped up in a coarse cloth.

One condition which, belying its reputation as a scourge of the present scientific age, is very common in Egyptian mummies, is degenerative arterial disease. Even though in many cases the larger arteries were removed by the embalmers, very many bodies show signs of arterial disease. The Pharaoh Minpepa, of the Hebrew Exodus, had numerous calcified plaques in his aorta. In fact all gradations from simple atheromatous plaques (histologically identical to those seen today) to complete calcification are found. The calcification, incidentally, can also be seen in X-ray studies

of undisturbed mummies. In the Peruvian material arterial disease is pretty rare. Only one case has been reported. The heart itself does not seem to have been much studied, although unlike most viscera, which are usually removed, it is almost invariably left in. Lung discases are known to have occurred in Ancient Egypt. Two or three cases show the typical appearances of pneumonic consolidation, and several others have pleural adhesions. Anthracosis has been found in one case. A curious thing is that no evidence of pulmonary tuberculosis has been found. Pott's disease of the spine, however, is known to have occurred not infrequently. A priest of Amon of the 21st Dynasty (about 1000 B.C.) has marked curvature of the spine, with collapse of the last three thoracic and first lumbar vertebrae, and in addition, a classic psoas abscess. In many other cases from Egypt, Europe and America, bony remains show changes indicative of tuberculosis of the spine.

Leprosy is a disease which, from biblical evidence, would be expected to have been very common in the Middle East. However no evidence has been found of its presence in Egypt until the sixth century A.D. At this time the disease was undoubtedly fairly common all over Europe.

Urinary disease has been found in several mummies. Congenital hypertrophy of one kidney in one, multiple abscesses in the kidney with Gram-negative bacilli in another, and renal and vesical calculi in a number of cases have been found. Two mummies of the 20th Dynasty have calcified eggs of *Schistosoma* in their kidneys.

In only a few cases are the intestines preserved, but one shows extensive adhesions around the appendix, resulting presumably from past inflammation in that organ. A priestess of the 21st Dynasty has gallstones, and several cases show prolapse of the intestine, though this could be post mortem.

Various other pathological conditions have been reported from individual mummies. The Pharaoh Sipta of the 19th Dynasty (about 1200 B.C.) has a club foot (*I. equino-varus*) which could be either congenital or paralytic in origin. Rameses V (20th Dynasty) has some skin lesions which could be smallpox. A priestess of the 21st Dynasty has a pelvic abscess and extensive bedsores. Several mummies have enlarged spleens which have been interpreted as possibly indicating malaria.

In any consideration of the history of disease, of course, the question of syphilis is

bound to arise. The evidence regarding syphilis is nearly all negative. In fact the antiquity of syphilis is about as nebulous as life on other planets. This is largely because the bony lesions resulting from syphilis are rarely absolutely characteristic.

The earliest certain case is found in a female skull found near Spitalfields in London. It was dug up from what was probably the burial ground of St. Mary Spittle. This was built in the twelfth century, and was in use till the early sixteenth century, burials probably ceasing about 1537. This makes it just too late to be definitely pre-Columbian. (Columbus's first voyage was 1492-3.) [The nature of the sores on Henry VIII's leg are still a matter for hot controversy. The venereologists ascribe them to syphilis of course; but "orthopods" can claim them to be sinuses from chronic osteomyelitis, and vascular specialists will have them as varicose ulcers.] Many other early remains have been claimed as syphilitic, especially in France, from Neolithic times onwards, but none are, in fact, definitely syphilitic lesions. Virchow described lesions similar to many of these in cave bears, and modern syphilis does not affect lower animals. From ancient Egypt no evidence at all has been found among over 25,000 individuals, including mummies, examined by Elliot-Smith and Wood-Jones and others.

Unfortunately for the Columbian theory, the evidence from America is no more certain. This is partly because of difficulty in dating. Several bones with pretty certain syphilitic lesions have been found among remains of American Indians, but it is very difficult to prove that they are definitely of pre-Columbian date. In those which can be dated with more assurance the pathology is not so certain.

Serious venereal disease of some kind certainly was present in Medieval Europe, as there are several literary references. For instance, King Edward III, in 1346, wrote to the Mayor of London expressing concern over a disease communicated by "carnal intercourse with women in Stews and other secret places". Whether or not this was syphilis must be a matter for conjecture.

It can be seen that the popular idea that syphilis was brought to Europe by Columbus and his men can be neither proved nor disproved, on the solid evidence so far discovered. It may be that there has been some change in the manifestation of the disease since ancient times.

The material for this article was collected in preparation for a paper in "Paleopathology" for Part II of the Archaeological and Anthropological Tripos, Cambridge.

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## LETTERS TO THE EDITOR

Dear Sir,

Mr. Alment's excellent article on The Genetic Responsibility of The Obstetrician, who by definition "stands in the way", reminds me of a personal dabbling in eugenics some years ago.

The patient, aged 38 and obese, came into the class complaining bitterly of infertility of 12 years' standing. She placidly unfolded a dramatic story of Huntingdon's chorea as it affected the senior members of her family. She was blissfully unaware that the story had any personal significance.

Her physical signs were normal and I decided to strike a blow for eugenics. The students for once were quiet as I explained to the woman that private life in future should be confined to the few days preceding and following her period. Within the six months' span of that group of students she returned triumphant, pregnant and grateful.

As the pregnancy advanced it became obvious that she had a gross pelvic reduction and she underwent successful Caesarian section.

She returned within the year, again pregnant in the "safe" period, for a repeat section.

So much for eugenics—the tainted genes go on down into another generation. One consoles oneself in this atomic age with the knowledge that Pepys made his main contribution before the age of forty.

Yours truly,  
 Donald Fraser.

Dear Sir,

Mr. Malcolm Donaldson has raised once again the subject of a rowing tank at Bart's. In 1952, when I was Captain of the Boat Club, half a dozen keen members, including myself, carted a large number of stone blocks over to Charterhouse Square from the bombed part of the hospital and were prepared to start digging and building a tank ourselves. However the Medical College squashed this project by informing us that the proposed site had been earmarked for tennis courts. At that time we did manage to extract from the College authorities a promise that a rowing tank would be incorporated into one of the new buildings at Charterhouse Square, probably on top of the roof of one of them. Now, ten years later, there is still no sign of a rowing tank. I was convinced then, and am still convinced, that Bart's will never have a good pool of fit and well-trained oarsmen unless they can receive daily instruction within the hospital site instead of the long and costly trips to the river. So let the present Boat Club officers start pestering the Medical College again.

Yours truly,  
 Robert Newill.

## PLAY 1963 RING AROUND THE MOON, by Jean Anouilh



"My darling, my darling, I'll follow you to the foot of the Steppes of Siberia, ever your faithful squaw . . ."

It does seem a little late to review this play produced on 21st February by Janice Swallow. The journal office has been so assailed by leading and endearingly vociferous members of the production that we have given way.

Seeing the considerable space devoted to reviews of this play elsewhere, we thought it wise to waive our review rights; after all, did not J.R.S. and M.P.S. between them have the last word? I suspect that the cast of Ring Around the Moon know the value of respectability and posterity, hence their lust for a mention in an established journal. They would rather a journal panning than a Broadsheet rave.

Not that J.R.S. raved. He was cruel. I liked his review because it was positive and I like positive writing. But I knew it was grossly unfair and this was where M.P.S. scored. Writing a review in this sort of academy is purposeless because plays do not even intend to run (they are, so to speak, one night stands), and it is invidious and unenviable because one must write about people one knows, some well. Add to this the fact that the plays likely to be reviewed are amateur productions

and the task becomes almost intolerable. One thing is sure, there is no place for loftiness in this kind of parochial criticism which must avoid becoming an exercise in review. This, of course, is nearly impossible since as I have said reviews here are purposeless and therefore the critic is doing an exercise!

Simply, this play is a satire on high society marriage and family intrigue which draws largely on a comedy of situation plot for its effect. Antony Mann, playing the dual rôle of Frederick and Hugo, only occasionally confused one, and with Sue Williams playing the Cinderella part of Isabelle mostly succeeded in preserving the plausibility of the situation. This was the first time ever I have appreciated Sue Williams on the stage. She acted her part well and really did seem lost in a world that was not hers. Strangely, this was an astute piece of casting. In a quiet and meek part she was a surprising success—she was even appealing in the dilemma of her poverty on the one hand and her daydream romance on the other. There was a lot of clever casting in this production; although many of the smaller parts were not difficult to play, they were

workmanlike enough. Mary Newbold as the too-rich daughter of Messerschmann was sufficiently cold but too stiff. Vivian Onians had to play her part from a bath chair. She did it well, conveying in every word an embittered, yet amused, "I have seen and been through all this before" attitude.

The production was below recent standard.

It was poor because although, taken singly, the performances of actors were satisfactory, yet together their effects were not more than their sum. Further, in this production the comedy was allowed to bury much of the satire, but perhaps the audiences enjoyed it all the more for this, to judge from their noisy reactions.

## PHOTOGRAPHIC COMPETITION 1963



"Anne" — Frederick Leach

Winner of Portrait Section.

## FIFTY YEARS AGO

We have culled the following specimen of fatuity from the correspondence column of the *Daily Sketch* of April 19th:

### CRAZE FOR OPERATIONS.

Are Surgeons Too Fond of Using the Knife?  
Sir Victor Horsley says that modern surgery is due to vivisection. Are not his own words a strong protest against vivisection? Never in the world's history, I should think, have so many medical murders taken place as since the so-called advance of modern surgery.

Ask what your friend died of. The reply is generally: He died after an operation. Oh, he had an operation.

It has been said by a right-minded doctor that the operation for appendicitis should be catalogued among criminal operations. Doubtless the first was performed on a dog. Hundreds have died from it since.

Can any sensible person think it necessary for enormous numbers of helpless children to be operated on for a harmless thing called adenoids (which nearly all outgrow when let alone), or to have the tonsils God has given them to protect the lungs cut out wholesale, as is done today?

Sir Victor Horsley's words are true! This wicked craze for operations is due to vivisection as much as it is due to the greed for gain.

Out with that "right-minded doctor."

## PHOTOGRAPHIC COMPETITION 1963



"Beach Game" — Dan Tunstall-Pedoe

Commended in Action Section

## SPORTS DIARY

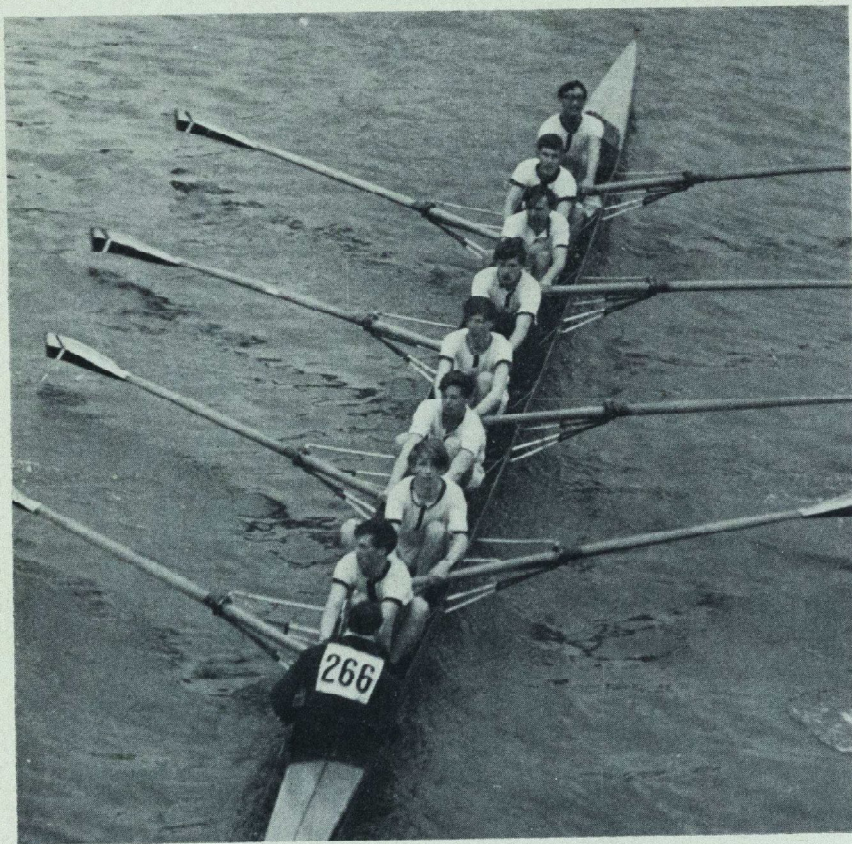
- |         |   |         |   |
|---------|---|---------|---|
| June 1  | Mixed Doubles Tournament — Chislehurst.<br>Ladies' Tennis 1st VI v. Cambridge University (A).<br>Reading Clinker Regatta.<br>Twickenham Regatta.  | June 15 | Cricket 1st XI v. Old Tauntonians (A).<br>Men's Tennis 1st VI v. St. George's Hospital (A).<br>Ladies' Tennis 1st VI v. Charing Cross Hospital (H).<br>Cambridge Regatta.<br>Reading Amateur Regatta.<br>Athletics—U.H. Championships at Motspur Park |
| June 2  | Cricket 1st XI v. Valeswood (H).<br>Mixed Doubles Tournament — Chislehurst.<br>Ladies' Tennis 1st VI v. Girton College (A).   | June 16 | Cricket 1st XI v. Horlicks (A).<br>Mixed Tournament v. Horlicks (A).  |
| June 5  | Cricket 1st XI v. University of Sussex (H).<br>Mens' Tennis 1st VI v. Mct. Police (A).<br>2nd VI v. St. Mary's (H).<br>Athletics v. The London and Middlesex Hospitals (H).<br>Ladies' Tennis 1st VI v. U.C.II (H). | June 19 | Golf v. King's College Hospital (H).<br>Ladies' Tennis 1st VI v. St. Thomas's Hospital (H).   |
| June 8  | Cricket 1st XI v. Queen's College, Cambridge (H).<br>Men's Tennis 1st VI v. Imperial College (H).<br>Walton Regatta (B.C.).<br>Oxford City Regatta (B.C.).<br>Ladies' Tennis 1st VI v. Middlesex Hospital (H).      | June 22 | Cricket 6-a-side Tournament (H).<br>Men's Tennis 1st VI v. Middlesex Hospital (A).<br>Horseferry Regatta.<br>Marlow Regatta.  |
| June 9  | Mixed Doubles v. St. Mary's Hospital.<br>Cricket 1st XI v. Parkfield (H).   | June 23 | Cricket 1st XI v. St. George's Hospital (A).  |
| June 12 | Ladies' Tennis 1st VI v. Bedford College (A).<br>2nd VI v. Bedford College (H).<br>Athletics — U.H. Championship (A).<br>Golf v. U.C.H. (H).  | June 26 | Athletics v. Westminster Bank (A).<br>Ladies' Tennis 1st VI v. Guy's Hospital (H).<br>2nd VI v. Guy's Hospital (A).<br>Golf v. Middlesex Hospital at Hendon.  |
| June 13 | Men's Tennis 1st VI v. Cumberland Club (H).   | June 29 | Cricket 1st XI v. Jesters (H).<br>Men's Tennis 1st VI v. West Heath Club (H).<br>Ladies' Tennis 1st VI v. King's College Hospital (A).  |
|         |   | June 30 | Cricket 1st XI v. Old Roans (H).<br>Mixed Tournament v. Middlesex Hospital (A).   |

### BOAT CLUB REPORT

Oarsmen are often described by the uninitiated as "all-weather masochists", but at the beginning of the year even rowing was cancelled twice on the Tideway when wind, snow, floodwater and icebergs proved too much even for the most oblivious "heavy". It was not surprising, therefore, that people were reluctant to row in January, but by the end of that month we had two crews who were prepared to train regularly for the Putney Head of the River Race.

The 1st VIII rowed twice a week from Chiswick, regularly coached by David Dunn, and each Thursday John Curry coached us on the Tank at the London Rowing Club. In addition we did weight training twice a week in the gymnasium at Charterhouse, and it was hoped that this programme would enable us to both improve our technique and get fit. At the end of February M. Stewardson replaced A. B. Ayers, who was preoccupied with the 2nd M.B.

### The 2nd VIII Shooting Hammersmith Bridge during the Putney Head of the River Race



B. Lee, Bow; J. Merrill, 2; D. Robins, 3; P. McArthur, 4; C. Sykes, 5; J. Silverton, 6; G. Libby, 7; P. Needham, Stroke R. Gleadle, Cox.

Our 2nd VIII has become a well-established boat thanks largely to the enthusiasm of the crew. They were coached regularly twice a week by A. J. Robertson and their rowing has improved remarkably. This has been very good for the 1st VIII, who were hard pushed to beat the 2nd Boat early in the term.

Four novices and a new cox persevered during the winter and were coached by E. Hoare. Their efforts have not been in vain and will stand them in good stead this Summer.

Bedford "Head of the Ouse" Race, in which the 1st and 2nd Boats had hoped to compete, was unfortunately cancelled as the river was frozen. On 16th March the 1st VIII rowed in the Reading Head of the River Race where we started No. 162, the last crew. We had a three-hour wait in the boat before coming under starter's orders, by which time we had sat through two showers of rain and exhausted our singing repertoire—but the final insult was the heavy hailstorm which hit us

in the third minute of the race. We covered the course rating 30 at a firm though perhaps too comfortable rhythm, for we found difficulty working up to the fast finish we had planned. Bart's finished 48th in 11 mins. 45 secs., as compared with U.C.H., 34th in 11 mins. 35 secs., and St. Mary's and Guy's, both 64th in 11 mins. 52 secs. This was not a bad result but we felt that it should have been better.

The Tideway Head of the River race was on 23rd March, and we entered three crews. The first eight, No. 255, got off to a good start, soon disposed of the crew ahead, and settled to a hard-working rhythm at a rating of about 30. From Barnes Bridge we tried to liven up the rating a bit, but it soon fell back again. At Chiswick Steps we overtook a crew on the outside of the bend and unfortunately from then on had a clear river ahead and no competition in front or behind. The loud ovation from Hammersmith Bridge spurred us on and we began to gain on a crew several lengths ahead, but again we were slow in working up to our final spurt which was not very impressive. However, we felt we had rowed a good course and were most disappointed to find that we had come 102nd, a drop of ten places on last year.

The second boat started at No. 266 and finished thirty places higher. They started off at a good pace, and at Chiswick Steps put in a fine spurt to overtake the crew ahead. Towards Hammersmith Pier they were threatened by a crew from behind but held them off until Harrods, where the light weight of our 2nd VIII and their relative unfitness began to tell. The crew picked up again after the mile post and came home in grand style.

Nine gentlemen turned up at Putney to chastise themselves in the 3rd VIII, only to find that the London Hospital had taken their boat. This was most unfortunate, but the crew's relieved expressions belied their disappointed complaints—in any case, the bar was open!

The results of the Putney Head of the River Race were:—

	mins.	secs.
U.C. & H.	51st	19 45
Mary's	93rd	20 4
BART'S	102nd	20 7
Westminster	154th	20 31
Guys I	168th	20 38
BART'S II	236th	21 27
Royal Dental	255th	21 59
Guys II	262nd	22 9
London Hospital	269th	22 35

These results bear out the fact that the 1st VIII is still well below the standard it must reach if it is to go to Henley this year. Two of our men have unfortunately fallen under the 2nd M.B. axe, and the crew which starts training after Easter will have to put in a tremendous amount of work to get the boat moving fast. The bumps are our first major event, and it is then that we will decide whether to take an eight or a four to Henley.

We are very grateful to our coaches, who braved the elements and the bicycles to battle along the towpath. Both crews had regular coaches last term which made it possible to work constructively to a prescribed programme.

R. G. Nicholson has had a most successful term in the London University Crew who won the Head of the River races at Reading and at Putney, and who later won the "Brussels Treaty Cup" at Amsterdam. M. McKenzie rowed for the U.L. 2nd VIII who came up from 270th to 18th in the Putney Head.

The crews for the Putney Head of the River Race were:—

**1st VIII:** D. Lloyd, Bow; R. Anderson, 2; D. Parr, 3; M. Stewardson, 4; W. Garson, 5; M. Kettlewell, 6; H. Coleridge, 7; D. Macfarlane, Stroke; I. Cole, Cox.

**2nd VIII:** B. Lee, Bow; J. Merrill, 2; D. Robins, 3; P. McArthur, 4; C. Sykes, 5; J. Silverton, 6; G. Libby, 7; P. Needham, Stroke; R. Gleadle, Cox.

**Gentlemen's VIII:** J. Tricker, Bow; P. Scriven, 2; J. Gilkes, 3; R. Bark, 4; T. Buckwill, 5; B. Bennett, 6; R. Husband, 7; K. Stephens, Stroke.

D.A.L.

### RUGBY CLUB REPORT

**Bart's v. Streatham. 2nd March. Lost 15 pts.-5.**

Bart's began their game against Streatham in the usual post-Cup match manner and the strong running visitors scored four tries and a penalty very early on in the game. This sudden onslaught shook the Bart's pack out of its depression, which had resulted from the narrow defeat by St. Thomas's and it settled to the task of holding the heavy Streatham forwards. In muddy conditions and showers of rain the two sets of forwards fought a dour struggle, with B. Gurry hooking magnificently in front of a retreating pack.

At half-time Bart's were 0-15 points down, but had the wind and slope in their favour for the second half. Almost immediately they lost P. Savage with a knee injury and C. Cripps went on to the wing. The Bart's seven forwards then proceeded to give their opposite numbers a lesson in forward play, while the threes, and especially A. T. Letchworth and E. D. Dorrell, played as if this were a Cup match. The depleted side received just reward when M. M. Orr crashed over for a try which J. Gibson converted.

The last few minutes of the game saw Bart's with twelve fit men, D. C. Pope injured an elbow and D. Goodall his chest; and despite this the final whistle went with Bart's firmly camped inside the Streatham "25".

**Aldershot Services v. Bart's. 9th March. Won 9 pts.-6.**

Bart's travelled to Aldershot and arrived in the middle of a hailstorm; the pitch was virtually under water. These conditions did not encourage good rugby and the two spectators who braved the cold certainly did not see any. The Bart's pack tried to open the ball out to their threes, but conditions were so bad that the halves, Ross and Letchworth, were unable to open the game up. So tactics were changed and with a series of first-foot rushes Bart's almost scored several tries. Their efforts were rewarded by Gibson kicking two penalties to put them 6 pts. up at half time.

The second half saw the same pattern develop without exception. Aldershot also began to use their feet instead of their hands. Due to a relaxation in the defence a heavy Army forward crashed over for an unconverted try and then an infringement under the posts gave them a further 3 points. At 6 points all and three-quarters of the way through the second half a series of fine handling movements took place, the result of which was that Gibson completed a fine display by going over for a try but failed fractionally to convert.

The game ended, much to the players' relief, with Bart's worthy winners by 9 pts.-6.

Team: E. D. Dorrell, D. Goodall, D. Browne, R. M. Phillips, E. Sidebottom, A. T. Letchworth, A. P. Ross, J. Hamilton, B. Gurry, A. J. S. Knox, D. Delany, B. Doran, J. C. MacKenzie, C. J. Smart, J. A. Gibson.

**Bart's v. Public School Wanderers. 13th March. Won 20 pts.-8.**

Public School Wanderers opened the scoring with a grand try by their left winger; then

Bart's replied with a try by Gibson who crashed over from a short penalty. Bart's then took the lead through two penalties by Gibson, but the Wanderers were not to be dispirited by these set-backs after their encouraging start and they scored and converted another try. Just on half-time Gibson landed another penalty to make the scores 12 pts.-8 to Bart's.

In the second half Bart's attacked continuously until Sidebottom cut through the very sound Wanderers' defence to score a magnificent try near the posts; Gibson added the extra points. At the close Bart's were attacking all the time and the last score came just before the final whistle, when Goodall collected a kick ahead and put Smart over in the corner.

Bart's won a very enjoyable game by 20 pts.-8.

Team: E. D. Dorrell, D. Goodall, E. Sidebottom, D. Browne, P. Bradley Watson, A. T. Letchworth, A. P. Ross, K. Stephens, B. Gurry, A. J. S. Knox, B. Doran, M. M. Orr, C. Cripps, C. J. Smart, J. A. Gibson.

**Oxford v. Bart's. 23rd March. Won 17 pts.-3.**

Leading at half-time Oxford R.F.C. were well beaten by 17 points to three in their match with St. Bartholomew's at the Southern By-pass Ground. But this was the third successive week they have begun over 20 minutes late and this plus injury to scrum half Bagnall spoilt an otherwise enjoyable game.

Oxford began spiritedly in conditions ideal for open Rugby but fumbled passes spoilt their early attacks. St. Bartholomew's came nearest to scoring in the opening exchanges. First wing forward Gibson charged down Lloyd's clearance and was only just beaten for the touch-down. Then Gibson again was only just short with a 40-yard penalty. But Oxford soon swung play back and their pack, heeling quickly in the tight, gave the backs plenty of openings. Bagnall was close with a long penalty for Oxford in the 15th minute and two minutes later put his side ahead by charging down a kick five yards out.

Though less closely knit than their opponents, St. Bartholomew's came close to scoring on several occasions. First when Gibson took another penalty and Kilgour held the kick but was caught in possession.

But for all the narrow escapes Oxford were

the better side. They looked much more together than the visitors, who were relying heavily on individual efforts and penalty kicks.

Half-time: Oxford R.F.C. 3 pts.; St. Bartholomew's Hospital nil.

But their individualism won the visitors the match in the second half. Gibson, who had found his range at last, kicked two towering penalties and converted a brilliant solo try by Sidebottom. Picking up a wild pass, the Bart's centre ran from near his own 25 through the entire Oxford defence. So, with only 20 minutes left, Oxford suddenly found themselves 11-3 down and had lost their first half cohesion completely. David Bagnall's injured

leg, which forced him off, was simply the last straw.

Though Oxford never gave up trying they had to accept defeat and a try by Phillips and another penalty by Gibson sealed their fate.

Oxford R.F.C.: R. Salter, D. Kilgour, R. Tapper, N. Thomas, M. Phipps, D. Lloyd, D. Bagnall, R. Hance, C. Ede, J. Pemberton, O. Oatley, P. Redsell, D. Barratt, D. Howard, I. Paterson.

St. Bart's: E. D. Dorrell, I. Smith, M. Phillips, E. Sidebottom, D. Goodall, A. T. Letchworth, D. C. Pope, J. Hamilton, C. J. A. Gilmore, A. Knox, B. Doran, D. Delany, J. C. McKenzie, C. J. Smart, J. Gibson.

**INTERFIRM SEVEN-A-SIDE COMPETITION, 6th APRIL, 1963**

Preliminary Round	1st Round	Semi-final	Final
	1st time Clerks & Dressers II	} 2nd time Clerks & Dressers	} Finalists
	2nd time Clerks & Dressers II		
Finalists	} Finalists	} Finalists	} House
Kids & Specials II	} 3rd year Preclinical		
1st time Clerks & Dressers I	} House	} House	} House
2nd time Clerks & Dressers I	} 1st time Clerks & Dressers		
1st year Preclinical	} 1st year Preclinical	} Midder & Gynac.	} House
Kids and Specials	} Midder & Gynac.		

**HOCKEY CLUB**

This year it was the happy lot of Bart's to obtain a bye through to the second round of the Hospitals' Cup, and we duly met St. George's Hospital (now combined with the Dental College) at Chislehurst in December.

As fate would have it the weather robbed us of a probable victory, for we were clearly the better side before a minor blizzard stopped the match prematurely. The long spell of snow forced the replay to take place some twelve weeks later, this time at Wimbledon, and the long inactivity together with an improved St. George's side saw us beaten 7-1.

Even Thomas, playing as hard as ever, could not pull the side together. Once again lack of punch in the forward line (even with Glover's welcome return) and some misjudged tackles in defence, let us down, enabling a larger score to be assembled against us than was perhaps justifiable.

The Second Eleven, however, provided some hope for next season. Having won their first

round match after twenty minutes extra time and the toss of a coin, they inflicted a heavy defeat on the London Hospital (5-1). In the Final, against Guy's, played in pouring rain and on a sodden pitch, the forwards were unable to recapture their previous form and only capable play by a hard-worked defence prevented the half-time score of 1-1 from being greater. Alas, the last fifteen minutes saw our downfall, and at the end we had lost 4-1.

Certainly the season has not brought us an excess of victories. We have missed those one or two players of distinction who make a mediocre side into a good one, and we therefore all hope that Thomas will be able to spend more time with the Hospital next season.

A hopeful note to end on is that there are now more people playing hockey than in the past few years, and it is quite probable that if this trend is maintained the club may re-assume its previous high position in Hospital sport.

**WOMEN'S HOCKEY CLUB****U.II. Cup Semi-final v. Royal Free Hospital, Chislehurst, 16th March. Won 4-1.**

After several postponements and one abandoned attempt we eventually succeeded in playing this match. Royal Free, although one player short, did not prove the strong opposition expected. Bart's played well, and combined as a team remarkably successfully considering that we had not played since December. Scorers: S. Minns (2); J. Spring; M. Newbold.

Team: C. Lloyd, T. Tennent, E. Evans (Capt.), M. Ironside, M. Newbold, A. Coates, V. Nash, J. Spring, W. Smith, S. Minns, P. Knight.

**U.H. Cup Final v. St. Mary's Hospital, Enfield, 20th March. Lost 3-5.**

The Bart's team, unchanged from the semi-final, once more played extremely well. This was against a strong St. Mary's team and was probably one of our best matches. It made a tense and exciting final, the outcome of which was not certain until the final few minutes. Both teams were determined to win, Mary's to retain the shield, and Bart's to regain it after two years.

Bart's opened the scoring with a beautiful goal scored by S. Minns from a superb pass by V. Nash. Encouraged, Bart's attacked determinedly, but Mary's levelled and went ahead. Bart's retaliated, and both sides fought desperately, the score being 3-3 for much of the game. In spite of many attempts, some of which should have resulted in goals, the forwards could not score again. Within the last few minutes of the game, our defence cracked, and Mary's scored twice, urged on by their ardent supporters, to secure victory.

The shield was presented to the Mary's captain by Miss Melvyn Hickey, the England player. Who knows? The shield may have been ours if we had had but one supporter to cheer us on. Scorers: S. Minns; J. Spring; W. Smith.

Team: C. Lloyd, T. Tennent, E. Evans (Capt.), M. Ironside, M. Newbold, A. Coates, V. Nash, J. Spring, W. Smith, S. Minns, P. Knight.

**SWIMMING REPORT**

As was mentioned in the March Journal the Water Polo Team has been suffering during

the last term from a lack of adequately competent players. This is exemplified by the fact that the team has failed to win any, bar one notable exception, of its games in the last three months in Division I of the University League. We have been soundly beaten by teams better than ourselves on every occasion. When we finally managed to field one of our best teams we beat Imperial College 1st Team in a very convincing manner. Within 3 minutes of the start we were 3 goals up and attacking for more. This fired the previously lagging enthusiasm of the team and although I.C. retrieved 2 of these goals we entered the second half determined that this game should not elude us. So it turned out for we soon made it 6-2 and despite losing a further 2 goals we held on to our slender lead. This match was recognised as having been one of the highlights of the season and really convincingly demonstrated the power and skill of our team when at full strength.

The past season has therefore been rather depressing for the club, and further setbacks are to come as more senior and skilful players qualify and leave. There is also a disappointing lack of potential in the junior members of the Hospital and next year—at the moment—promises to be very bleak.

**MOTOR CLUB (MOTOR RACING)**

Due to mechanical trouble with his Lotus XI, Jim Robinson was unable to race last month.

However, Ted Carden's Turner Ford had two outings. The first was at Brands Hatch on Easter Monday and, after the gear lever broke off during practice on the Saturday, a front wheel bearing collapsed on the ninth lap of the ten-lap John Davy trophy race when the car was lying in third position in its class. After a rather hair-raising tenth lap during which the brakes also failed the car finished in fourth position. The second outing was on 27th April at Silverstone at a "National British" meeting. Having eliminated the bugs from the previous meeting the car went very well and proceeded to win the class for 1600 c.c. to 2500 c.c. Grand Touring cars, also (according to existing information) setting a new lap record for the class.

**BOOK REVIEWS**

**Aids to Anatomy, 12th Edition**, by R. J. Last. 408 pages. 12s. 6d., and **Aids to Embryology, 6th Edition**, by M. B. L. Craigmyle. 200 pages. 8s. 6d. Baillière, Tindall and Cox.

Books of the "Aids" type will always arouse suspicions in the mind of an averagely intelligent reader who knows that a readable style and clear presentation go a considerable way towards making the contents of a book readable and consequently enjoyable. Whatever one's ability, learning is turned from business into pleasure given an element of enjoyment. Who has enjoyed reading an Aids book?

*Aids to Anatomy* has a few black and white diagrams and those are not always helpful. The chapter on joints is better than most, providing two different classifications of joints and a concise account of each. These explain joint movements sensibly, but are thin indeed in description of joint relations. The whole matter of relations is important and yet suffers badly for brevity's sake. "Posterior diaphragm" purports to be an adequate description of the posterior relations of the suprarenal glands. And then there are frank errors, statements suggesting the lacuna magna to be in the floor of the terminal spongy urethra and the inferior vena cava to be a frank anterior relation of the right suprarenal are unforgivable. The oesophagus is omitted as a posterior relation of the heart. In fact that vital organ would appear to have no particular relative position in the thorax at all. Maybe a remark such as—"The heart is between the lungs on either side which overlap it anteriorly and lies with its left atrium, being its base, on the oesophagus and descending aorta"—would be too banal a comment for such a book.

The sensible medical student will accumulate adequate anatomical knowledge with knife, cadaver and Cunningham's dissecting manual in addition to perusals of a good atlas with occasional dabbings into Gray or one of the other Good Books.

*Aids to Embryology*, being less cramped, is less dangerous than its big brother. In fact it is often recommended amongst students here, both for revision purposes and as a basic text. There are more, simpler and better diagrams. Important chapters, such as the one about implantation and placental formation, are written right up to date.

One criticism—a rough calculation shows that the text is no shorter than the large print contained in the Embryology section of Gray (naturally accompanied by vastly superior drawings). However, another calculation shows that both in cost/weight and cost/space this little book is cheaper than the better known volume. S.C.-S.

**Principles of Medicine and Medical Nursing**, by J. C. Houston and Marion Stockdale. Published by E.U.P. Price 7s. 6d.

This is not a new edition of this well known textbook from Guy's Hospital, but its first appearance as a paperback, in an attractive format, at 7s. 6d. W.E.H.

**Hewer's Textbook of Histology for Medical Students**, by C. L. Foster, M.Sc., Ph.D. 476 pp. William Heinemann. Price 32s. 6d.

Unpretentious, this book is not large and has neither the spectacle nor the readability of Ham. It is sensibly set out, sensibly and often concisely written and contains many two-tone photographs which are carefully explained within and beneath as well as in the text. The complementary diagrams are always helpful. Many chapters have additional electron micrographs and new information elucidated from modern histochemical studies. Hewer's book makes an honest attempt to make itself attractive to medical students by trying hard to correlate histological information with that gleaned from other related subjects. The sensibility of the book is summed up by an introductory remark: "It should be remembered always that cells are living structures existing in a labile, semi-fluid condition and continually undergoing modification in response to a changing environment: the appearance of a fixed and stained preparation when seen under the microscope must always be interpreted with this in mind." In other words the study of histology, which is succinctly described in the first chapter with mention of modern techniques such as autoradiography and high speed centrifugation, still has limitations which should be born in mind.

Most of the extra space is devoted to tissues rather than organs. The chapter on cell ultrastructure is well expanded and illustrated with many E/M plates, and that on blood is so complete as to provide a fair basis of blood physiology. The chapter on muscle is very good, including minute details which help to elucidate the physiology of muscle contraction, or the function of those weird lines and bands we used to stare at ignorantly. With the exceptions of the thyroid and the liver there is not much that is new on the histology of the organs. However, the new information on the liver is worth waiting for; written up to the moment and illustrated with several E/Ms and an elaborate colour plate it abolishes the old liver-plate bog which never quite made sense anyway.

A.S.W.

**Nurses' Manual of Laboratory Tests**, by S. Garb, M.D., and P. Sporne, S.T.D., S.R.N. Published by Heinemann. Price 10s.

No nurse can carry in her mind the details of all the laboratory tests that are performed on her patients. She does, however, often want to know what are the normal values to be expected and sometimes how to perform a test that is new to her. A book like this would be much used in any ward where it is kept. The changes from the American edition are adequate, and a wide range of information is given.

The most important omission is that of milliequivalents for the normal range of values, which are all given in mg %.

W.E.H.

**Human Physiology**, by F. R. Winton, M.D., and L. E. Bayliss, 649 pp. J. & A. Churchill, Ltd. Price 42s.

There are many improvements in this edition of a standard text book. They should help the book to hold its own against similar books from across the Atlantic which are rarely superior in content or language—slang English being as sad as stilted English—but so much better laid out. They have style—something that Winton and Bayliss lacks; a most annoying feature of the latter being its continual recourse to small print which could well go into an appendix.

The chapters on circulation, digestion and ductless glands are hardly altered. That on the circulation, while still inadequate on the subject of venous return, makes a better effort to describe in some detail the blood flow through individual organs. The chapter on digestion is still very thin indeed, there being hardly any space developed to large bowel physiology. One sometimes wonders just how much work has been done since Pavlov's dogs obeyed that gong.

The chapters about urine, reproduction and the special senses are improved. That on respiration has been helpfully expanded on several topics such as diffusion capacity and artificial respiration. At last the mouth to mouth method has become respectable! Nerve and muscle physiology is now worth reading about in this book. They have been allotted more space for the inclusion of up to date ideas. The result is less confusion. It is good to see the physiology of the cerebellum based on sound clinical observations in preference to some of the esoteric theories relating its functions to  $\gamma$ -efferent activity, as the result of animal experiments.

This book is staid and solid, but at 42s. its value is fair, considering that fourteen of its twenty-one chapters are written by men of considerable distinction within their subjects. Yes, Winton and Bayliss is with us yet a while. A.S.W.

**Nurses' Guide to Surgery**, by Peter Childs. Published by John Wright and Sons, Ltd. Price 10s.

The appearance of a new book in a paperback is a sign of the times, and the price of 10s. is a remarkable one.

All aspects of surgery except gynaecology have been considered, though naturally some of the specialities are not treated at any length. The book has been written both for student and pupil nurses (Mr. Childs should know that "assistant" has now been removed from the title of the enrolled nurse and pupil), and since the needs of these two groups are disparate, the student may sometimes find the information given slight, while the pupil may feel that parts are too heavy for her. More line drawings would have made parts of the text easier to follow, but would, of course, have raised the price.

There are some very good sections in this book; the one on fluid balance is excellent. It is full, comprehensible, and original. There are good accounts of inflammation and of tumours of the skin. The "story of middle meningeal haemorrhage" is very well told indeed.

W.E.H.

**Towards a Measure of Medical Care, Operational Research in the National Health Service.**

This little book can be recommended to anyone working in the National Health Service who is interested in trying to understand some of the administrative and organisational problems which the operation of the service as a whole involves. Operational Research, in the words of Professor M. G. Kendall, "endeavours to make the best use of limited resources in complex organisations involving man and machine"; anyway it is meant to help us take an objective view of a given situation! The contributors pose questions which vary from being mildly controversial to being down right thorny, but which warrant frank and objective discussion even if a few sacred cows get shot in the process. Perhaps operational research will prove to be a suitable shot-gun.

K.W.E.W.

**Midwifery. (Principles and practise for pupil midwives.)** 573 pp. R. Christie Brown, Donald Fraser and Richard H. Dobbs. Published by Edward Arnold, Ltd.

In this, the fifth edition, the text has been completely revised since the last edition six years ago. The result is undoubtedly a very attractive book, easy to read and profusely illustrated with diagrams, line drawings and a few photographs.

The book may be roughly divided into five parts, dealing respectively with anatomy and physiology; the management of normal pregnancy, labour and puerperium; abnormalities and emergencies; the care of the newborn; obstetric operations. Since the book is intended primarily for pupil midwives, no previous knowledge of anatomy or physiology is assumed and the first hundred or so pages will serve as not unnecessary revision for most medical students. The diagrams are excellent throughout and clearly labelled, though one or two would be improved by being larger. Sub-headings and the arrangement of facts in tabulated form are used extensively, points most people will find aids to learning.

The type is large, clear, and easily legible and the paper has a matt finish. This last is an important point apparently not realised by some publishers.

This is a book which will be found useful by medical students as well as by the pupil midwives for whom it was intended. R.G.F.

**Growth and Development in Childhood** by Andrew Bogdan. Price 3s. 6d.

As with the previous publications in this series a deal of information is incorporated in this booklet. The material, however, is essentially in note form and, as such, makes dreary reading not helped by such statements as . . . certain milestones provide a yard stick of progress. Were the readers able to attend the author's tutorials on the subject the booklet might be worth having. Other instructors in the field are unlikely to follow the author's suggestion of basing their teaching programme on his.

S.M.

**Recent Advances in Neurology and Neuropsychiatry** by Lord Brain and Dr. Benjamin Strauss. 7th Edition, 1962. Price £2.

Here is an intoxicating mixture which will provide many a delightful hour for anyone interested in the nervous system and the mind. Each stimulating chapter blows fresh air into those rather stale ideas which vegetate for years in the pages of textbooks.

We read that consciousness is now determined by activation of the central reticular formation in the brain stem. Descending impulses reach this system from the frontal, parietal and temporal regions of the cerebral cortex; ascending impulses travel in the sensory pathways of the spinal cord. The latter cause desynchronization of the E.E.G. such as occurs in the change from drowsiness to wakefulness. Destruction of the reticular formation causes coma and hypersynchronization of the E.E.G.

Barbiturates appear to act in a selective way on the reticular formation so that anaesthesia may be produced though ordinary sensory stimuli still reach the cerebral cortex via the lemniscal pathways.

The student attending lectures will be interested to know that the central position of the reticular formation in the homeostatic mechanism of arousal plays a preponderant role in the cumulative defacilitation which at its height is called "sleep". "Attention" is at the other end of the scale. The cortex keeps signalling back to the diencephalon.

Coma in man is related to disturbances of the mid-brain, hypothalamus and arcus near the 3rd ventricle—possibly all affecting the reticular activating system.

The idea of "levels" of function in the nervous system (higher and lower) has been gradually replaced by more holistic views with increasing knowledge of the inter-relationship of cortex, thalamus and reticular system. The concept of "centres" and "localization" of many cerebral functions has also been discarded. There is now considerable evidence that the hippocampal gyrus, fornix and mamillary bodies play an important part in the neurological basis of memory—probably acting as stations in the passage of memories to those parts of the brain concerned with storage. Recall of a single memory may require the activity of millions of neurones. Psychopharmacology has indicated that the action of Lysergic acid, an hallucinogenic drug, produces symptoms more like schizophrenia than a confusional state. It is believed to stimulate ergotropic activity in the middle and posterior parts of the hypothalamus and may block serotonin. The actions of mescaline, phenothiazine and ipromazole are of similar interest.

Drug-induced Parkinsonism with akathisia, dyskinesia and oculogyric crisis offers a new approach to the physiology of diseases of the basal ganglia. Tremor and rigidity in Parkinsonism can be relieved by ventro-lateral thalamotomy and so can hemiballismus, dystonia and acquired chorea.

Assessment of the use of anticoagulants in carotico-vertebral and cerebral vascular diseases is still in doubt, and so is the value of the surgical manoeuvre of thrombo-endarterectomy, but knowledge and experience accumulate.

Myasthenia gravis has received attention—the hypothesis that it might be an auto-immune response concerning antibody to end-plate protein is interesting.

Serum Aldolase, and Transaminase levels have been studied in myopathies.

Central core disease of muscle is a new disease since 1956 and amyotonia congenita has been the subject of much study in which benign congenital hypotonia and congenital muscular dystrophy are of importance. Knowledge concerning degeneration in nerve, posterior root ganglia, spinal cord, muscles and cerebellum in association with carcinoma, particularly of the bronchus, has increased since 1948, but the nature of the association remains unknown.

The carpal tunnel syndrome has blossomed whilst the neurological syndromes of the cervical rib, scaleni and thoracic inlet have correspondingly shrivelled in recent years. Benign myalgic encephalomyelitis is a puzzling condition first described in 1957. Electroencephalography has indeed been thriving in the normal, in biochemical diseases, during drug action, in endocrine disorders, in psychiatric disturbances, dementia and many brain diseases, organic and functional.

Neuroradiology has made great strides in technique and interpretation especially in myelography, in vertebral angiography and myodil ventriculography. The neuro-radiologist now plays a princely rôle on the stage where once the neurologist was king. Even a simple skull X-ray is much more revealing than it used to be.

These are mere notes about a book which is a mine of information for both graduate and student. F.L.

**Royal National Hospital for Rheumatic Diseases, Bath Reports, Volume 11. 1959-1962.**

This is a volume of reprints of many of the papers published by members of the staff of the Royal National Hospital for Rheumatic Diseases and the Research Unit attached to it. It is in no sense either a text book or a reference book, but it gives a very clean account of the research activities of this group, headed by Dr. G. D. Kersley, himself an old Bart's man. The publications vary from articles in *The Practitioner*, giving practical advice on such things as analgesics and uricosuric agents in gout on the one hand, to publications in *Nature* on the coenzyme I content of spleen after freezing, and the synovial proliferation induced by polysaccharides. Perhaps the most valuable reprint is one published originally in the *Annals of the Rheumatic Diseases*, of the gold therapy trial in rheumatoid arthritis as arranged by the Research Subcommittee of the Empire Rheumatism Council. This work, now a classic, deserves the widest recognition.

It is nice to find that these reports are still being issued, and we look forward to Volume III in due course. H.W.B.

#### PRESS RELEASE

**LIGHT LABORATORIES**, Ship Street Gardens, Brighton 1, Sussex, will shortly be announcing their new **LIGHT UNIGRADE** which ensures immediate visual indications of variations in temperature speed, pressure strain, voltage and many more.

**The Journal of James Yonge (1647-1721), Plymouth Surgeon.** Edited by F. N. L. Poynter. Longmans, 1963. 247 pp. Price 35s.

The October, 1946, issue of this *Journal* contained an item entitled "James Yonge's 'Oleum terebinthinae', 1679", describing a small book contained in our Library. The book attracted attention as having been written by one of our outstanding ship's surgeons, who, together with military surgeons, contributed so much to the development of modern surgery. Yonge suggested the use of turpentine in arresting haemorrhage, described the flap operating in amputation, and also a contrivance similar to the tourniquet.

James Yonge was born in Plymouth in 1647, and before the age of eleven was sent to sea as apprentice to a ship's surgeon. His travels abroad, his experiences as a captive of the Dutch, and his later settling down as a surgeon and a family man, have previously been briefly recorded. He became Mayor of Plymouth, a Fellow of the Royal Society, and died in 1721. These brief details can now be considerably embellished by the publication of his *Journal*, a most fascinating document furnished with fifty-seven maps and sketches by the author, a selection of which is reproduced in this volume edited by Dr. Poynter, Librarian of the Wellcome Historical Medical Library. One point which might have been clarified is the present location of the original *Journal*, and some information provided regarding its history. Dr. Poynter thanks the Puslinch Estate (representing the Yonge family) for permission to reproduce the *Journal*, but does not state if they are the present custodians.

The seventeenth century is of vital significance in the history of medicine and science, and Yonge provides information not only upon the state of surgery, but upon social conditions, the countries he visited, his companions and his family. He also records meetings with contemporary scientists and medical men in London. Yonge is outspoken, critical and truthful. He probably wrote without expecting his words to be printed and made public, although the maps and sketches clarifying the text suggest that he did anticipate others seeing the *Journal*. He provides "A list of famous men and women I have seen in my travels", and "A catalogue of the books I have writ and published", and obviously spent many hours during his imprisonment in Rotterdam penning the story of his life. It is a success story, simply told, exciting, and illuminating the events of the seventeenth century. James Yonge's *Journal* was worthy of reproduction in printed form, and has been unobtrusively edited by Dr. Poynter. Some readers, including the reviewer, might have welcomed more extensive annotation, but who can quibble with those responsible for making generally available this most fascinating document?

J.L.T.

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**The Foundations of Surgery**, by George Perkins. 2nd Edition. E. & S. Livingstone, Ltd. Price 12s. 6d. 236 pages.

This little book provides an excellent introduction to surgery for those just beginning the clinical course. It is concise and lucid. Some readers, however, may be put off by the absence of illustrations: they will be missing something. J.H.P.

**Molecular Genetics and Human Disease.** Editor: L. I. Gaidycz, M.D., Professor of Paediatrics, State University of New York, Springfield, Ill.; C. C. Thomas, Oxford. Blackwell Scientific Publications, 1961. Pp. 297. Price 92s.

Of the many advances in genetics of the last few years, much has been of the type which can be described as molecular genetics and molecular diseases. It has now become possible to discover carriers of abnormal genes and to predict the outcome of marriages between two apparently symptomless partners. This book describes a Symposium of fourteen leading research workers, and we are allowed a glimpse at these important events—rather like having a still of a race which has gone along at a rapid pace but which allows us to realize what has happened before, and perhaps to have a guess at some of the future developments.

The Editor contributes an historical essay, and Barton Childs of Johns Hopkins University Medical School continues this into present times. Readers of this *Journal* might be interested in the following sentence: It has become pretty nearly a cliché to refer to the observations of Sir Archibald Garrod on the affinity between genes and enzymes, but such a revelation at a time when genetics was a new science is evidence not only of his special insight, but is also a reminder of the usefulness of human material as an object for the study of gene action.

One of the prize contributions is from F. H. C. Crick from Cambridge, England, on the structure of D.N.A. There is a coloured frontispiece to illustrate the important concept of two long polynucleotide chains wound together round a common axis. Another very important chapter is contributed by V. M. Ingram, formerly Cambridge, England, and now of Cambridge, Massachusetts, who showed how in the case of abnormal haemoglobins, the action of a gene can be related to the replacement of a single amino-acid amongst about 300 forming the two polypeptide chains of human haemoglobin. There are chapters by leading workers on galactosaemia, on the genetical determination of sensitivity to quinoline drugs, and there are clear expositions of the work on human chromosomes and their abnormalities which result in diseases such as Turner's syndrome, Klinefelter's syndrome and Mongolism. Indeed, the last name is now being replaced by the word "Trisomy 21", to indicate that the abnormality consists in having three instead of the usual two No. 21 chromosomes. Records of discussions are included, and one wonders how much of this is superfluous:

Dr. X: "I don't know—the air gets pretty blue in some of these meetings. I'm a non-smoker."

Dr. Y: "I thought so."

Dr. Z: "Are there any other comments? At this time we will close our panel with many thanks to the participants."

I do not think that many medical students will be able to afford to buy this book, but all should attempt to obtain it one way or another. Human genetics are developing at such a pace that it would be wise to begin now to make oneself familiar with these new traits, because it will only become more difficult to do so as time goes on.

I.L.L.

\* \* \*

"Cardiovascular Disease is now the leading cause of death, with coronary heart disease accounting for two thirds of all heart disease deaths."

*Ann. Int. Med.* (1961), 55, 33

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Over 1,500 patients have now been treated for periods from a few weeks to two years. In the great majority of cases, serum triglycerides, serum cholesterol and serum uric acid levels return to normal or near normal.

REFERENCES: *J. Clin. Invest.*, (1962), 41, 1364 *Lancet*, (1962), i, 1321. Proceedings, IV World Cardiology Congress 1962 (in Press) *Lancet*, (1963), i, 148 *Lancet*, (1963), i, 1320 *Nature*, (1962), 194, 942

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**Obstetrics and Gynaecology Combined for Students,**  
by Elliot E. Philipp. H. K. Lewis and Co.,  
Ltd.

This book is the result of a really ambitious attempt to provide a satisfactory textbook in both Obstetrics and Gynaecology for the medical student. The author has set himself a hard task for this is one of the most difficult things to achieve. The two subjects are so inter-related, because often the one is the cause of or the result of the other and *vice versa*, that in theory they should be described in one volume. All divisions of the two subjects are dealt with by means of the same rigid classification whenever possible and this is good.

Mr. Philipp has taken the trouble to ask the advice of many of the more senior students attending at his hospital and their criticisms and encouragement must have helped a good deal in the final result.

The fact that the two subjects are described within 571 pages must mean that sometimes the information is a little scanty, but then the student, having learned the first principles, will have to refer to a larger volume if he is interested enough to do so.

J.R.

**Modern Surgery for Nurses.** Edited by F. Wilson Harlow, M.B., F.R.C.S. (Eng.). Published by William Heinemann Medical Books, Ltd. Price 35s.

"Modern Surgery for Nurses", in its scarlet cover, is recognised at sight by all student nurses. Every two or three years a new edition appears to testify to its continued popularity. Clear type, good paper and excellent photographs are among its obvious merits, while regular users know that information can be found in it on literally all common surgical conditions, and on many that are uncommon.

The amount of hard detailed work that goes into the production of a book of this size and comprehensiveness is very great. The book retains its familiar look, but has much new material, including many good photographs. External cardiac massage now appears in the treatment of cardiac arrest, and there are new sections, such as that on radiation hazards.

The subject to which attention should be paid in the next edition is perhaps sterilization techniques, including the use of chemicals. Kangaroo tendon and horseshair are surely little used now, and there are each year fewer theatres which have to depend on boiling for "sterilizing" sutures. The disinfectant list on page 482 might receive attention, and lysol (page 675) is a dangerous substance to recommend for vaginal douches.

W.E.H.

**Textbook of Medicine for Nurses (3rd Edition),** by J. W. Joule, M.D., M.R.C.P. Published by H. K. Lewis and Co., Ltd. Price 35s.

This new edition has been completely revised and some rearranging of subject matter done. The very effective headings in each section have been retained and the style of the entire book is clear and concise. A long-standing error is the confusion of papaveretum ("Omnopon") and papaverine on page 448.

This is a book which the young student nurse should buy and keep beside her. It will give her a clear understanding and lead to a natural desire for wider reading later on.

M.N.

**Faber's Anatomical Atlas—A. K. Maxwell, I. M. Burdon, S. Macdonald.** Revised by Dr. John McKenzie of the Anatomy Department of the University of Aberdeen. Price 10s. 6d.

This Atlas has always proved a useful reference book for Nurses and Students of elementary anatomy. Now in its 4th edition and revised by Dr. John McKenzie, it cannot fail to be of value when used in conjunction with a more detailed book on Anatomy and Physiology; and indeed may be most useful to future nurses in their first year of training, studying under the proposed new syllabus, when they will only be required to have a general overall picture of each system of the human body.

The text, especially the section on elementary histology and on the skeleton has been revised and improved. The illustrations, as usual, are excellent. That of the skin has been revised showing some difference between the epidermis of the palm and that of the trunk; this should be of interest to nurses. The addition of the diagram of the breast is welcomed and it is hoped that in the next edition it will be possible to include more illustrations of the text dealing with the nervous and digestive systems. This might then be more truly described as a "volume of maps".

M.M.E.

**An Introduction to Diagnostic Neurology,** by Stewart Renfrew. Livingstone, 1962. Pp. 404. 2 vols. 25s.

These two paper-back volumes are intended for students at the beginning of their clinical work. One of the chief difficulties facing the student at this period is that textbooks describe diseases and the signs which accompany them, yet give little help in how to diagnose the condition from a knowledge of the signs. The book describes in detail the technique of neurological examination in an orderly and logical manner. The aim is to make the student think carefully while he is eliciting every sign and so proceed in a logical manner, rather than performing the examination in a stereotyped fashion and only considering the significance of what he has found when he has completed the whole examination.

Each section begins with a chapter on the use of language in medicine and the principles of inductive reasoning. The nature of evidence and the inferences and probabilities which can be derived from this evidence are discussed. The object of examining a patient is to find evidence which increases the probability of one diagnosis to almost a certainty while the probability of other diagnoses falls to almost zero.

Individual diseases are discussed as examples, illustrating points found in the history and examination. The descriptions of the diseases are not intended to be comprehensive although most neurological conditions are covered. Any remarks on treatment have also been deliberately excluded. The classification of epilepsy is probably too elaborate for most students. There is a good short chapter on the E.E.G. showing in what conditions it can prove useful and which also helps to clear up some of the mystery surrounding this investigation.

This is an interesting book, not only with regard to Neurology, but to the whole of clinical medicine, since the author stresses the approach to the subject rather than the subject matter itself. The neurology involved is only really used as examples of how to apply the technique of inductive reasoning to the examination of the patient.

# ST. BARTHOLOMEW'S HOSPITAL JOURNAL



Vol. LXVII, No. 6

JUNE, 1963

## EDITORIAL

There is a new Klondyke on the horizon for the drug firms today and there is a healthy competitive rush, becoming more intense every day, for the gold of "the pill". Beyond the immediate material interest of the companies there stand the humanitarian and social implications which are discussed elsewhere in this issue. Few Western Governments have so far shown themselves capable of taking this moral issue on their shoulders—for it is a moral issue, and although we may not agree that apathy of the civilised communities to the rising tide of human misery in overpopulated countries is necessarily a sin, we in the scientifically advanced countries are alone responsible for finding ways of controlling the problem. We cannot support the theory of the Chinese Communists that their population is allowed to increase unchecked for a military advantage over the countries on their borders.

It is therefore fortunate that a company was prepared to invest £500,000 in research to produce a new type of oral contraceptive, and that the Governments of India and Japan were prepared to sponsor large-scale trials. The new drug combination is the most potent of its type yet found and trials in this country have shown it to be remarkably free from side-effects. This has enabled the progesterone-like part of the mixture to be used safely in large doses for the symptomatic alleviation of endometriosis and Endometrial carcinoma; for the latter the side-effect of mild euphoria with large doses is a useful property. This is an important and relatively new application of progesterone-like steroids which is undergoing active research at the present time. This product is remarkably free from measurable androgenic and mineralocorticoid activity. As with all compounds of this type there is the vitally important question of long-term effects which will remain waiting for a definitive answer for several generations. Against this uncertainty must be balanced the benefit to individuals in overpopulated and underfed areas. In this case the potency of the compound has led to great difficulty in discovering the metabolic fate of the substance in the body, of which little is yet known except that it is not via the destroyed pathway. It is surely of prime importance that the fate of any drug should be known before releasing it for use, and especially if it is intended for long-term use. Administration of the Tritium-labelled compound to a volunteer is now delayed pending the decision of the Medical Research Council, but results may shed new light on the pathways of steroid metabolism.

The family doctor is ultimately responsible for much of the advice on the use of these compounds given to patients in the Surgery or in the Clinic. For many the uncertainty of long-term effects will cause them to advise against the use of oral contraceptives, but the doctor must remain aware of changes in moral climate which may affect the advice he gives, now or in the future, and as always be free from emotional or religious influences. The latter affect the problem in different ways and at present hold a stultifying grip on various aspects of the practical application of birth control—in America the question was dropped before reaching Congress; in this country a drug firm has sold its product to another for marketing due to pressure from the board of directors; and W.H.O. tactfully keeps quiet whatever help it may give in field trials. Hope for a more liberal attitude now centres on the results of an election in the eternal city.

**The George Aylwen Research Bursaries**  
These bursaries for full-time research work in the Hospital are awarded annually by the Executive Committee on recommendation by

the Standing Bursary Committee. No more than six may be held at one time, and they last for one year with opportunities for re-election. The bursaries are available for former Bart's students and also to medical practitioners who have been on the Hospital staff for more than a year. Congratulations to Dr. M. W. Chiloe, Dr. M. J. L. Patterson, and to Dr. J. H. Pennington, who have recently received this appointment.

#### Literary Competition

Dr. Geoffrey Bourne has judged that the prize of £5 should be equally divided between

### Engagements

**CHRISTIAN—DAWES.**—The engagement is announced between Dr. Brian Christian and Margaret Dawes.

**TOOTH—STEEER.**—The engagement is announced between John Storrs Howard Tooth and Barbara Dorothy Steere.

### Marriages

**BLAKE—CUTHBERT.**—On 11th May, Dr. Henry Valentine Blake to Dr. Katharine Elizabeth Cuthbert.

**GORDON—SARGENT.**—On 23rd April, Dr. Edward F. S. Gordon to Mrs. Margaret Joan Sargent.

### Births

**COOK.**—On 1st May, to Ann (née Watford) and Dr. Richard Cook, a son (Nicholas James), brother for John.

**DUNKLEY.**—On 23rd April, to Susan (née Gardner) and Dr. Alan Dunkley, a daughter (Helen), sister for Janet and Sally Ann.

**GOODWIN.**—On 25th April, in Hong Kong, to Jean (née Bruce) and Dr. Stewart Goodwin, a son (Timothy Stewart), a brother for Ruth and Caroline.

**HADFIELD.**—On 23rd April, to Beryl and John Hadfield, M.S., F.R.C.S., a daughter.

**MAKSH.**—On 4th April, to Jacky and Dr. Brian Marsh, a daughter (Carolyn Deborah).

**NORBURY.**—On 29th April, to Jennifer (née Wheatley) and Dr. Keith Norbury, a daughter (Elizabeth Claire).

### Death

**COLTART.**—On 5th June, William Derrick Coltart, F.R.C.S. Qualified 1930.

### Changes of Address:

Dr. Hugh P. H. Ivens, McKell Place, Goulburn, N.S.W., Australia.

Mr. Douglas Robertson, Tylecote, 7, Gladstone Road, Sheffield 10.

Dr. P. W. Rowland, Feldy, The Lane, West Mersea, Colchester.

Mr. Bezly Thorne Thorne, Sherwood, 4, Tongdean Road, Hove 4, Sussex.

### Appointments

#### College of Pathologists

The following office-bearers have been elected:

John Guillebaud and Derek Browne, whose essays appear in this issue.

Dr. E. K. Matthews, who obtained a Ph.D. in Pharmacology at Bart's, has now been awarded a Beit fellowship for work to be carried out in Cambridge.

The first volume of a new series of St. Bartholomew's Hospital Reports has just been published by E. & S. Livingstone. These occasional publications replace the redundant Statistical Reports and the present issue deals with cases of malignant disease seen in the hospital from 1948-1952.

Members of council—Dr. E. N. Allott, Prof. G. J. Cunningham, and Dr. E. M. Darmady.

#### Royal College of Physicians of London

The following have been elected to the fellowship: O. Garrod, C. N. Evans, Felix Post, R. A. Kemp Harper, P. J. Lawther.

The following was elected to the membership: John Martin.

The following diploma was conferred jointly with the Royal College of Surgeons: D. I. H. John Barnes and D. M. Stainton-Ellis.

#### University of Edinburgh

Mr. F. Jolin Gillingham has been appointed to the chair of neurological surgery.

Mr. Donald Winstock has been appointed consultant dental surgeon to the Middlesex Hospital, London, as from 1st October, 1963.

#### Royal Photographic Society, Medical Group

Awards for medical photography were presented as follows: British Medical Journal award to Miss Diana Cross; Chairman's Award to Mr. Peter Cull, Medical Artist; and the Association of British Pharmaceutical Industries' Colour Trophy, to the Department of Medical Photography.

### Calendar

Sunday, 1st July: Art Exhibition, Great Hall.

Sat., Sun. 6 & 7 July: Dr. E. R. Cullinan

Mr. C. Naunton

Morgan

Dr. R. A. Bower

Sat., Sun. 13 & 14 July: Dr. Graham

Hayward

Mr. A. W. Badenoch

Mr. J. N. Aston

Mr. G. H. Ellis

Sat., Sun. 20 & 21 July: Dr. A. W. Spence

Mr. E. G. Tuckwell

Dr. R. Ballantine

Sat., Sun. 27 & 28 July: Prof. Scowen

Prof. G. W. Taylor

Mr. H. Jackson

Burrows

Dr. Ian Jackson

Physician Accoucheur on duty for the month of July is Mr. J. Howkins.

### University of London Final M.B., B.S. Examination April, 1963

#### Honours

Coates, O. A. (Distinguished in Surgery.)

Minns, S. A. (Distinguished in Surgery.)

Shinebourne, E. A. (Distinguished in Medicine.)

#### Pass

Gleadle, R. I.  
Guest, A. D. L.  
Gurry, B. H.  
Hadley, D. A.  
Hardy, J. D.  
Healey, J.  
Howells, D. B. M.  
Knight, A. H.  
Layton, D. C.  
Leaver, P. K.  
Lettington, W. C.  
Lewis, A. A. M.  
Lopez, J. T.  
Loth, D.  
Maw, A. R.  
Pain, V. M.

Perriss, B. W.  
Phillips, J. D.  
Pusey, J. H.  
Rolfe, M.  
Russell, A. L.  
Salole, R. M.  
Stanley, P.  
Stephens, A. D.  
Waller, J. O.  
Ware, E. A. S.  
Whyatt, N. D.  
Wilson, R. G.  
Wise, K. S.  
Williams, C. R.

#### Supplementary Pass List

##### Part I

Jennings, M. C.  
Latham, D.  
Littlewood, P.  
Lloyd, C. M.  
McPhail, L. M.  
Miller, A. J.  
Nash, A. V.  
Newstead, F. R.

##### Part II

Ratcliffe, R. M. II.  
Richards, C. J.  
Robertson, A.

##### Part III

Jennings, M. C.

##### Part IV

Jennings, M. C.  
Phaure, T. A. J.  
Ratcliffe, R. M. H.  
Richards, C. J.

#### Conjoint Board Final Examination

#### April, 1963

#### Pass

Birch, A.  
Dupré, P. C.  
Leaver, P. K.  
Ruoss, C. F.  
Shinebourne, E. A.  
Whyatt, N. D.  
Rolfe, M.  
Layton, D. C.  
Hardy, J. D.  
Aldis, P. W.  
Gurry, B. J.

Dudley, N. E.  
Austin, A. J.  
Ware, E. A. S.  
Tam, Y. D.  
Minns, S. A.  
Loth, D.  
Bootes, J. A. H.  
Hilton, A. M. B.  
Waller, J. O. de W.  
Davies, N. M.

**Supplementary Pass List**  
**Pathology**

Bousfield, J. D.  
Carter, T. R. G.  
Ying, I. A.  
Lloyd, C. M.

Miller, A. J.  
McPhail, L. M.  
Newstead, F. B.  
Nash, A. V.

Sibunruang, S.  
Sewell, J. B.

**Medicine**

Davies, R. K.  
Wilson, R. G.

Phillips, J. D. Lopez, J. T.

**Surgery**

Wilson, R. G.

**Midwifery**

Phillips, J. D.

Wilson, R. G. Wise, K. S.

## OBITUARY

### Mr. W. D. COLTART, M.B., B.S. Lond., F.R.C.S.

1907-1963



The sudden death of Derrick Coltart, on 5th June, at the age of 55 at the height of his powers, is as devastating as it was unexpected.

The son of a doctor, he came to Bart's with a scholarship from Epsom, to which he remained most loyal. He took his conjoint diploma and his London M.B. in 1930, and his F.R.C.S. in 1933. He was House Surgeon

to Sir Girling Ball and Mr. J. B. Hume, and to the Orthopaedic Department under Mr. R. C. Elmslie and Mr. S. L. Higgs. At that time the Orthopaedic House Surgeon also acted for the Plastic Department under Sir Harold Gillies. Like Elmslie, who followed Paget in bringing pathology into bone and joint surgery, Coltart served an apprenticeship as Demonstrator of Pathology. Later he became a Chief Assistant in the Orthopaedic Department, and, as fracture officer, might be considered the lineal descendant of John Izard, the first bonesetter to the Hospital, appointed in 1596. At various times, Coltart held the posts of Resident Medical Officer in King Edward VII Hospital for Officers (in the day of "Sister Agnes"), Registrar at the Royal National Orthopaedic Hospital, Honorary Orthopaedic Surgeon to the East Ham Memorial Hospital, and Visiting Surgeon to the Red Cross Clinics in Hertfordshire (at the time a valuable source of teaching material for the Hospital).

A member of the Auxiliary Air Force before the war, he served with the R.A.F. as orthopaedic specialist from 1939 to 1945, reaching the rank of Wing Commander and taking charge of the Surgical Division of the R.A.F. Hospital at Church Village. In 1942 he was given special research duties directed to the early restoration of airmen to duty, which led to the publication of two classic

papers, the first, with Sir Reginald Watson-Jones, on "Slow Union of Fractures" and the second on "Aviator's astragalus". After the war he returned to Bart's in the post of Assistant Orthopaedic Surgeon, and he was Hunterian Professor at the Royal College of Surgeons in 1946. Other appointments included those of Orthopaedic Surgeon to the British Red Cross Clinic for Rheumatism (later the Arthur Stanley Institute of the Middlesex Hospital), Orthopaedic Surgeon at Chase Farm Hospital and—posts that he still held when he died—orthopaedic surgeon to Chailey Heritage, St. Andrew's (Dollis Hill) and the Royal Masonic Hospital. He was a keen mason and held high office.

His orthopaedic interests were not cramped or confined, but nevertheless he had perhaps special leanings towards some subjects, notably fractures, rehabilitation and rheumatology. He rendered outstanding service to Bart's and elsewhere, in all three. Himself a clear and accomplished teacher, he was full of ideas for undergraduate education, and, at the time of his death, was working with others to develop this and to further the collaboration between the orthopaedic department and other departments of the Hospital.

Coltart loved organizing, and he did it well. He had the gifts of decision and precision. He knew what he wanted and his instructions were unambiguous. These qualities served him well in the operating theatre and outside it. He was in demand for committee work, both at Bart's, where he had been Secretary of the Medical Council, and elsewhere. He was a Director of the Medical Defence Union, and he did notable work for the Empire Rheumatism Council and especially for the Journal of Bone and Joint Surgery of which he was British Secretary and Treasurer, and which, alone in medical journalism, has a separate home in each hemisphere. He was Vice-President of the Orthopaedic Section of the British Medical Association in 1956.

Extremely handsome, a delightful companion, fond of his fellows, Coltart led a gregarious life. He had a host of friends and many interests both inside and outside the Hospital. He never seemed to tire, whether at work or play. At Bart's he was not only devoted to his work and his patients, but also much concerned in student affairs, taking an active interest in the athletic and dramatic clubs, and joining in many social occasions. Fond of travel, he was an excellent ambassador. That he could find contentment in

solitude as well as company was shown by a fondness for fishing that seized him in later years.

We have said farewell all too soon to a good companion. Our sympathy goes out to his wife, Mary, and to his step-children, one a Bart's student.

H.J.B.

H. B. Lee writes: Derrick Coltart came to Bart's in 1925, and his association with the Hospital from that time was unbroken except for the 1939-45 war. He was appointed Assistant Orthopaedic Surgeon to Bart's in 1946, and continued the great traditions of the department founded by Elmslie. He made many valuable contributions to the advancement of the speciality, and was well known throughout the orthopaedic world, where his pithy contributions to learned but diffuse discussions seemed to let in a breath of common sense and fresh air. A fine craftsman, he never let the sheer joy of using his hands over-rule his judgment.

His sudden end on 5th June came as a shock to us all. He had just come home from a meeting of the Medical Council, where he had been in his best and most sparkling form. At Sports Day the week before he had worked as hard as ever, and obviously enjoyed himself as much as we enjoyed his company. His "Come on . . . let's . . ." held the old infectious spell it always did when he was a student, a competent and enthusiastic sprinter and quarter-miler, and a useful hurdler. A distant memory of him as the handsome and civilised hero in a production by the Amateur Dramatic Society seems to symbolise his enduring charm of personality.

As joint Secretary of the 12th Decennial Club he was largely responsible for the success of that cheerful institution, and he was also a member of the 11th. Both before and after the war he was an enthusiastic member of the R.A.F. Volunteer Reserve, and during the war was a Wing Commander as Orthopaedic Specialist.

The Orthopaedic Department will miss him badly, and a great many at Bart's will feel poorer for the loss of a warm-hearted and loyal friend.

The tragic loss of the man whom all his colleagues would have described as the fittest member of the Staff must come to all his friends as an inexplicable disaster. There had been no premonitory whisper of the sudden

catastrophy. Only the day before, we had talked and laughed with him as he stood in the Square, tall, handsome, beautifully dressed, the very personification of a fit and healthy consultant in his surgical prime.

I first met Derrick Coltart in 1938 when his foot was firmly on the ladder which he was with seeming ease and unchecked success destined to climb to the very top. When many of us were wondering where our duty lay at the ominous time of Munich, Derrick Coltart was already established in the City of London Auxiliary Air Squadron as their Medical Officer. He brought to the humble rank of Flight Lieutenant a distinguishing grace which endeared him to the pilots he was devotedly serving, so many of whom were to give their lives in the fierce battles which saved the western civilisation in 1940 and broke the back and heart of the Luftwaffe. It was characteristic of him that, at the beginning of the war when the various medical specialists were busy building their empires, he did not promote his claims by virtue of his qualifications and experience to become a specialist, but remained with his Squadron until winkled out by higher authority. Probably the most successful specialty in the Royal Air Force was orthopaedics and Derrick Coltart's work, under Sir Reginald Watson-Jones and Henry Osmond-Clarke, pro-

vided for him a vast experience of traumatic military surgery that was to serve him so well when peace came. His distinguished R.A.F. career naturally and deservedly earned him a Consultancy at his old teaching Hospital.

Of his skill as a carpenter, I can personally testify, having entrusted my right hand to his care. There was no doubt in my mind for one minute about the result of his operation and I can attest that the standard of his bed-side manner was exactly as one would have expected. The nursing staff, however, naturally paid more attention to the surgeon than the patient.

As a man and a friend, Derrick Coltart was the most delightful of companions and it would be difficult to find a better man to sit next to in committee or at a dinner. His great hobby was fly-fishing at which he was something of an artist. Many a memorable and happy day have we spent together on the banks of the Dovey or Lambourne and I think it was by the river-side that he was most contented. It is a happy thought that the last time he fished, he killed three salmon and this was the apogee of his angling career. It is a comfort to those of us who mourn him that our friend had reached the zenith of his surgical and his piscatorial career.

John Howkins.

## "STANDING ROOM ONLY" — AN EXPLORATORY DISCUSSION OF THE FUTURE OF MAN

by John Guillebaud



(photo—Freedom from Hunger)

**W**HY bring children into an already overcrowded world? Is it to increase the total mass of co-existent human flesh? Is it to furnish an ever-increasing market for cars and cosmetics? Do we want more perambulating culture media for human pathogenic organisms? Do we see some obscure virtue in widespread hunger and malnutrition—or in the provision of cannon fodder? One has little difficulty in obtaining the impression that these are not the reasons why any couple decide to reproduce themselves. And yet, whatever the reason, it remains a cruel, inescapable biological fact that every new birth without a "compensatory" death somewhere is hastening our planet towards an epoch of human misery like no previous turn of world history.

Such a remark should not be dismissed out of hand as cheap sensationalism, without first considering the facts, which are as plain as their potential consequences are profoundly disturbing. The population of the world stands at three thousand million; of those who have ever peopled the earth, half are

alive today. By the year 2000, unless something appallingly bad or miraculously good should happen in the interval, six thousand million of us will be sitting down to breakfast every morning. It is not difficult to calculate that if this aptly-styled "explosion" were allowed to continue at the same rate indefinitely, there might be as many as 2,000,000,000,000,000 representatives of our species in a mere three or four hundred years' time. This represents less than one square yard of dry land per head—standing room only, and no seats upstairs (at least, not in the foreseeable future, and it is to be hoped that *Homo sapiens* will attempt to solve this problem with more wisdom and realism than by seeking space in space!).

And we of the medical profession, though impelled in most cases by the very highest motives of love and compassion, must bear much of the responsibility for this situation. Public Health measures and epoch-making advances in therapy have together halved the infant and adult mortality rates, but the total

world birth-rate remains as high as ever. Quite rightly, on the face of it, doctors have set themselves to relieve the present suffering of ones and twos, but in doing so have unwittingly set in motion a process which seems destined to lead to the misery of millions yet unborn. This example of the fact that even the good man does frequently turns sour on him is more grist for the twentieth century cynic's mill.

Two-thirds of the world is even now undernourished by accepted standards and twenty-five million people die annually solely through malnutrition. Now it is true that many of the remaining one-third suffer from "surfeit syndromes"; there is a scandalous amount of wastage—surplus milk poured down mines, oranges dumped in the Atlantic, wheat burned for power, and the like; and many likely food sources remain untapped. Yet it must also be true that the most scientific and philanthropic husbanding and distribution of the resources available, actual and potential, cannot suffice for ever to feed a population that is increasing *ad infinitum*. How naïve then are those opponents of population control who maintain with "Arthur Fallowfield" that "the anserri loys in the Soil", and only there; increasing food supplies alone delays and may in fact aggravate the eventual crisis. For example, it was found in India that if a well be built in an arid area, initially the neighbouring villagers are better fed and apparently healthier; but reduced mortality frequently causes them to return to bare subsistence level in a few years, and then for every one half-starved urchin before the experiment there may be ten afterwards. This is no argument against the work of Oxfam, FAO, War on Want and similar worthy organisations; it is, however, an argument for supplementary measures to prevent the benefits of increased production being swallowed up by an undiminished rate of reproduction.

This reproductive mania has repercussions not only in the realm of nutrition, but in the fields of medicine, psychology, biology, education, economics and politics; indeed, its effects are so far-reaching that it can legitimately be styled "the greatest single problem of the day", notwithstanding the ludicrously small amount of publicity it receives. Presumably "Ban the Bomb" sounds better than "Ban the Baby"!

From a medical view-point, it is clear that overcrowding and undernourishment increase greatly the hazards of infectious disease: with

ever more rapid transportation, local epidemics may now become world-wide pandemics in a matter of days, and doubtless these are the means that Nature will increasingly employ to restore her balance—that balance of nature which man is so busily disturbing. The mighty metropolises mushrooming on every hand show, in Asia and Africa as well as in the West, an ever-increasing incidence of psychosomatic and affective disorders, and these psychiatric conditions can be closely related to the stressful and impersonal way of life their denizens are compelled to lead. Social and domestic instability, aggravated by acute housing shortages, follow from lack of family planning at the personal level—quite apart from the global effects.

It is a sobering thought that there are literally millions of individuals throughout the world who have never been more than a hundred yards away from all their fellows, have never been really alone for a quiet think. . . . Indeed, *H. sapiens* is rapidly becoming the only animal species on earth, apart from those he domesticates or attempts to perpetuate in zoos or National Parks. To many this ecological effect is one of the most distressing:—whether or not man is in reality superior to the beasts, is it being sentimental to question that he should express his domination by their gradual extinction?

Then in the field of education, in spite of heroic efforts by all concerned, the absolute number of illiterates in the world is now greater than it has ever been. The proportion may fall—in Brazil the illiteracy rate is now said to be 50.6 per cent. compared with 65.3 per cent. fifty years ago—but this figure actually represents two and a half times as many illiterates as there were then.

What of the political and economic future of our world? This was the chief question at issue at the Santa Barbara, California, conference in December, 1962—which attracted far less attention than it merited. It was shown, by Aldous Huxley and others, that the differential rates of population growth are such that the gap between the "haves" and the "have-nots" is ever widening, and the latter must use all their resources to meet the primary needs of their new members. In a world where the industrialised nations are pre-occupied by measures to increase their own affluence and by an increasingly expensive armaments race, there will never be enough foreign aid to prevent the remainder from plunging into worse poverty than they have

ever known. And, through radio and the cinema, they have gained the taunting knowledge of something that they would not otherwise have known they were missing: the affluence of the affluent world. This can only breed envy and frustration, and from there to widespread social unrest and to the tyranny of either Right or Left Wing dictatorship, the road is short. In the past the spirit of tyranny was always willing, but its technical and organisational flesh was weak; today, however, the flesh is as strong as the spirit, and in the context of modern or future weaponry a popular uprising will be foredoomed. And this fateful trend must absorb those democratic nations which seem at present immune to it—sooner, or later; unless, that is, any land-hungry parties decide to take short-cuts, such as might precipitate thermonuclear war. Earl Russell believes that "Nothing is more likely to lead to an H-bomb war than the threat of universal destitution through over-population" ("The Human Sum"). Indeed, it has been suggested that a brutally efficient means of keeping the world's population static would be to have an annual war; but each year there would have to be more deaths in such a war than the total number of casualties in any country between 1939 and 1945.

Thus spake the Santa Barbara Conference; ironically enough, a few days later, Mr. Edmund Brown, Governor of California, was proclaiming four days of celebration starting with the sounding of hooters "by every car-driver in the state". The reason: California on 28th December overtook New York as America's most populous state.

If modern medicine, by controlling death, has in large measure created this problem of the "conquest by cradle", with its seemingly endless complications, then surely we as present or future doctors should be far more concerned than we manifestly are to find and to implement its solution. Apart from infanticide and abortion, methods with many practitioners but few sane advocates, the widespread and effective practice of contraception must provide the answer.

"The basis of every real success here must be the development of a cheap and satisfying oral contraceptive, and the pre-requisite of this is research. If one-tenth of one per cent. of what is spent on atomic missiles or space satellites were available for research on the control of human reproduction we should undoubtedly have an answer within a decade." (Julian Huxley, New Delhi, 1959.) However,

even if this "pill of the Brave New World"—cheap, effective, reversible, acceptable, and without untoward side effects—were to emerge from the laboratories tomorrow, the social impediments to its widespread use would remain identical to those already experienced with the methods and drugs already available. And they are a formidable list: ignorance, apathy, social organisation, religion and emotion.

Ignorance, of both the "why?" and the "how?" of birth control, is astounding even in communities where literacy is the rule, so it is not surprising that the majority of the world's population remains quite untouched by this kind of propaganda. The problem of communication here is enormous; by its very nature the importance of reducing birth-rate requires a minimum of intelligence and knowledge, and as already indicated the number of people without this minimum is steadily increasing. The vicious circle set up in this way can readily be appreciated.

Apathy is the sin of the "civilised", who know and yet act not. There is much that could and must be done for the safety and happiness of the world even by those communities whose own population is under control. But modern apathy is a cancer of the highest grade of malignancy.

Social and religious pressures, unlike the above, offer positive antagonism to the use of contraception on a large scale. The anachronistic and distressing position of a certain very influential Christian community, though showing signs of partial and belated revision, needs no further comment. Greater yet are the effects on birth-rate if, as in most societies of Asia, Africa and South America, the number of children is an important index of social status. Among the Swazi of South Africa, for instance, typical of the commonest variety of kinship system in which descent is patrilineal, "the production of legitimate children is considered a social obligation of adult men and women" (Hilda Kuper). Sons are valued because they work for the father and protect the interests of their mother, especially if it is a polygynous household; and daughters bring in bride wealth. So, "the more, the merrier". Even in matrilineal societies, such as the tribes of Rhodesia and Nyasaland, or the Nayars of South India, "it is the duty of all women to produce as many children as possible for their brothers . . . as future workers and as making for more stable marriages" (A. I. Richards, of the Mayombe). This social ideal, persisting in precisely those areas which are already most

overcrowded, in combination with the reduced infant mortality rate under modern conditions, must daunt the most optimistic protagonist of population control.

It has been stated that progressive industrialisation alone leads to an adequate reduction in birth-rate, and if true this would be a hopeful fact for the future. The case of Japan, cited in this context, is clearly exceptional; her strikingly low Net Reproduction Rate\* must be due far more to the practice for many years of legalised abortion than to her economic expansion. And elsewhere such evidence as is available suggests that, after a preliminary fall, when a certain level of affluence and social security has been reached the rate begins to rise again. Among the countries of the "civilised West" the most highly industrialised, the U.S.A., has practically the highest N.P.R., and in Britain, where until recently this had been very little in excess of unity (the rate for replacement) a distinct upward trend is now apparent. Thus even in the more informed communities the situation is not under control; it seems that fear, emotion, religion, plain prejudice and, above all, apathy, are more than enough to triumph over reason and common sense.

Where reason does conquer, under prevailing conditions the consequences may not be wholly beneficial. In a given social setting it is generally the more intelligent who limit the size of their families, and the others who by their unthinking fecundity are increasing the proportion of those with less than ideal heredity, for intelligence and related traits. Here this discussion crosses the frontier into the controversial field of eugenics: in order to produce the "ideal" population for our planet, in terms of quality, there must necessarily be considerable limitation of freedom—and that in a realm which from Adam and Eve onwards has rightly been held most sacred and immune from outside interference.

And yet the preceding arguments make it difficult to avoid the unpalatable conclusion that even in terms of sheer quantity of human existence, no truly effective solution can be found which does not involve the loss of much individual liberty. What is at present being

\* The Net Reproduction Rate estimates the average number of daughters that would be produced by the women of a country throughout their lifetime, and allows for varying fertility and mortality rates at each age. A Net Reproduction Rate of 1 indicates that on the basis of current fertility and female mortality, the present female generation is exactly maintaining itself.

done on a voluntary basis can only be described as "too little, and too late", like baling out the ocean with teaspoons. A few organisations (notably the International Planned Parenthood Federation) and individuals are making super-human efforts against the overwhelming odds, and one hears from time to time of heroic characters, in India and elsewhere, coming forward in ones and twos for voluntary sterilisation. But true control of population involves each and every adult and demands forthright and directed will-power. At this late stage it is thus unlikely, even if the money available were to be increased a thousandfold, that birth control will ever be successfully carried out in the countries that need it most urgently, if it remains on an entirely voluntary basis.

Does any ray of hope penetrate this dark and gloomy prospect? The best answer must be to find "the pill", or something equally efficacious, and then somehow to ensure its universal use in such a manner as to bring all birth-rates down to replacement levels. This can only be achieved, one fears, by legislation, which must apply to every class of society and every nation of the world, and be backed up by appropriate sanctions on the parents if the statutory number of offspring be exceeded. The nature of these sanctions should as far as possible be positive rather than punitive, and they should never jeopardise the well-being of children. As a token, in this country, fiscal pressure might be applied by such measures as the reduction of Family Allowances after (say) the third child.

Even these suggestions seem to clash with our most cherished concepts of freedom and democracy. It seems that "birth control—effective and voluntary" is a contradiction in terms; indeed, all measures diminish in efficacy in proportion as the element of compulsion is reduced. Truly effective population control begins to appear impossible in any but a totalitarian state, especially if the "thin end of the wedge" argument be applied, and in that case may not the treatment be worse than the disease? Those who have such thoughts should remind themselves again of the appalling prognosis without treatment. For this is another context in which the issues are not black and white, where the lesser of two evils must be chosen. Edmund Burke's "Liberty must be limited in order to be possessed" was never so true as in this connection; the human race must lose some of its freedom to procreate, or lose that and all else besides.

So we are left with little on which to pin our hopes, and yet hope we must for that is human nature. Let us therefore both work and hope that the means of population control may be perfected and applied, everywhere, effectively, with a minimum of compulsion, and in time to prevent the Dark Age of social unrest, tyranny, famine, pestilence and war, with which otherwise we appear to be confronted. Meanwhile, it appears that not one of our political leaders, fiddling with school and housing plans while the planet chokes, has done more than shudder at the prospect and turn back to his professional obsession with the

old alliance, the new rocket and the next election. The cynic—patronisingly declaring that, as throughout his history, man will follow any course but the only sane and responsible one open to him—has a point.

#### Acknowledgements

The International Planned Parenthood Federation.  
The Manchester Guardian (Report by Alistair Cooke on the Santa Barbara Conference).  
African Systems of Kinship and Marriage (Edited by Radcliffe-Brown and Daryll Forde).  
Introduction to Health Statistics (Satya Swaroop).  
Other sources acknowledged in text.

## LAST MONTH

As the months slip by, "Last Month" becomes increasingly more difficult to write. It seems that as the summer approaches the amount of time spent by students actually studying in Charterhouse Square decreases as the weather improves. I am assured by the most work-conscious students among us that this is far from the truth! Frankly, I find it difficult to think of a good reason why anyone would wish to spend more time than necessary away from Charterhouse Square, away from the most aesthetically exciting buildings in London built since 1960! It is a constant source of amazement to me why so few architectural students come to visit this example of the new approach to medical college building—one wonders whether it is because they are too shy or that they simply cannot find it.

The new car park at Charterhouse really is

proving most useful and makes one wonder how we ever managed without it. Whilst on the subject of motor cars, a colleague remarked the other day that there was little similarity between the species of motor car parked outside the Anatomy department and those parked outside the Biochemistry department—no comment!

Dr. Coulson, the students' Medical Officer, is in the midst of a massive campaign against tuberculosis and is furiously giving Heaf tests and Mantoux tests, with the result that many students have to have a B.C.G. injection. I found it a trifle amusing that Dr. Coulson took the trouble to wear a face mask, while we students were busily breathing our potentially dangerous breaths over each other's arms and any fascinating pieces of equipment nearby.

# ICONOCLASTOMA

by Colin Brewer

**I**CONOCLASTOMA is a disease as old as mankind and the history books give many examples. It appears to have been a generally fatal disease, but today death is not (in Britain at any rate) a common sequel. When it occurs, death usually results from over-energetic therapeutic measures and for this reason methods such as pyrotherapy, prolonged carotid sinus pressure, and craniectomy (with or without post-operative canonisation), have been largely discarded. Physiotherapy has long been used with some success (Torquemada *et. al.*) and a selection of the many ingenious instruments designed for the purpose may be seen in the basement of Madame Tussaud's.

One time honoured remedy—still widely employed, especially in Russia and Spain—is known appropriately as “blunderbuss therapy”. Practitioners in these countries claim to have almost eradicated the disease, but the expense and inconvenience of the N.K.V.D. clinics, where prophylactic screening tests are carried out, are viewed with disfavour by patient and profession alike in this country. However, there are signs (Vassall, Blake *et. al.*) that opinion may be changing.

Iconoclastoma is a common condition in Britain, where it afflicts mainly adolescents and young adults, but no age is immune. Most cases regress before the age of 30, but some may persist into senescence (Russell's syndrome).

The disease may attack any part of the body politic. It often manifests itself by metabolic and hormonal effects, notably a proliferation of all bodily hair, and pseudohermaphroditism, so that sexual differentiation is frequently very difficult. Patients are subject to attacks of myasthenia, during which they assume a characteristic squatting posture. In cases of long standing (or rather, sitting), gluteal scarring is a common finding.

The diagnosis is confirmed by examination of a blood film. This reveals *Aldermast* cells, with their characteristic *nuclear fission* (Fig. 1). It is believed to be due to the presence of an *anti-nuclear factor*. Infiltration with eosinophilic (Latin: red-loving) sickle cells is common, and occasionally these may completely replace the Aldermast cells (Fig. 2).

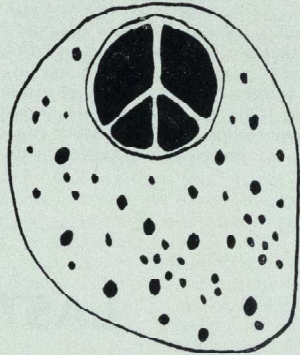


Fig. 1. Aldermast cell showing Nuclear Fission.

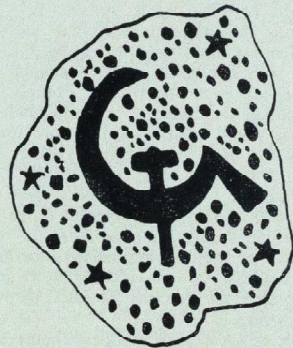


Fig. 2. Polymorphonuclear eosinophilic sickle-cell.

Sufferers are prone to infections, because the blood contains only feeble, non-nuclear phagocytes. In a few cases, there is *no phagocytosis at all*. Only modern antibiotics ensure the survival of such cases.

The well-known canoncollins metastases often occur in the lungs. Multiple sessile tumours (Redgrave bodies) may be found, and must be picked off one by one. They usually recur.

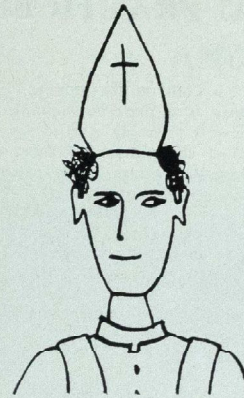


Fig. 3. A case of Mitral Stenosis. Compare with Fig. IV.

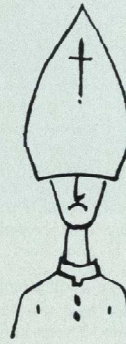


Fig. IV. Mitral incompetence.

**TREATMENT:** (a) **Group Therapy.** In this method, the patient is placed in a small dark room for one night, along with several hundred fellow-sufferers. Patients are charged a variable fee for the treatment, but it is uniformly unsuccessful.

(b) **Drugs.** Theomycin has been held by some to have a specific action in this complaint (and indeed, in many others). Its administration has been criticised by Marx *et. al.* on the grounds that it is merely an opiate, and he recommends instead *Lenicillin*. This however frequently causes severe side effects, the worst of which is *Leninismus*, in which the patient assumes a fixed ideological attitude from which no deviation is possible. Furthermore, *Lenicillin* is itself a very powerful hypnotic.

I will conclude with a report of a rather unusual case. The patient, a middle-aged clergyman from Woolwich, developed an iconoclastoma of the skull. This would normally have expanded harmlessly on the surface, but because of the constricting headwear favoured by the patient, the tumour was forced to grow inwards, thus compressing the brain and causing delusions. Chief among these was a belief that God was *inside him*. This syndrome is known as *mitral stenosis* (Figs. 3 and 4).

Treatment so far has been largely oral (Latin: *orare*—to pray), but little improvement has resulted. Attempts have been made to relieve the cerebral compression by removing the patient's hat, but he alleges that this will cause a loss of status and has resisted such attempts with almost religious fervour. It has been suggested, on sound surgical principles, that only excision of the affected organ can be relied upon for a permanent cure.

## FIFTY YEARS AGO

### CORRESPONDENCE

To the Editor of "The St. Bartholomew's Hospital Journal".

Dear Sir,—There are many old Bart's men among your readers who will regret the statements made in your recent editorial note with regard to the ethics of those undertaking work in connection with the National Health Insurance Act. Several, at any rate, of us have consistently from the beginning of the movement been strongly in favour of the Act, not

only on account of its constructive work for curative medicine, but also for the benefits it ensures for preventative medicine; we feel that it is unnecessary for an editor or editorial committee to endeavour to influence not only the present but also the coming generation of medical men against an institution which is considered by many to be a forward step to secure the welfare of the nation.

I am, yours truly,

Audí Alteram Partem.

## DIAGNOSIS IN GENERAL PRACTICE

On 28th May, 1963, Dr. L. V. Gimson came up from Canterbury to lecture to final year students, choosing this as his thesis. After quoting Dr. Chandler "General Practice is 90 per cent. medicine", and the late Dr. Geoffrey Evans, "What yer want to do is to find out what yer patients know, and then if yer know anything at all yer know more than they do," he said that diagnosis, in general practice as in hospital practice, is based on history taking, clinical examination and special investigations; of these by far the most important is the history. It is often difficult to get to grips with this, and to concentrate on the main issue. Many patients have multiple complaints and are liable to keep the vital one until the last moment, so that as they reach the door "While I'm here, doctor, ought I to be passing blood?" Migraine, epilepsy, angina may, sometimes must, all be diagnosed from the history alone, and a cerebral tumour, absolutely without physical signs, was inferred from the patient's statement that for the last few days she had had difficulty in giving change over the counter in her shop, and had also been incontinent of urine. It takes time to get a good history, but in the end time is saved.

A physical examination must be made. Patients may think this unnecessary. . . . "Just something for me cough, Doctor" . . . but must be trained to accept it and to expect it. Often an examination has to be made from the wrong side of the bed and in a bad light. One gets used to that, but there is no need to do without special investigations which, in spite of all that one reads nowadays, can be laid on in most places with very little trouble. Some investigations must never be omitted, e.g., an X-ray of chest, no matter how trivial the haemoptysis may seem, and a blood count before treatment of pernicious anaemia, or indeed of any other variety of anaemia, is begun. In many infections, too, bacteriological investigation of swab or specimen should be put in hand before any antibiotic is taken.

The general practitioner is very much on his own; no one supervises or criticises his methods. If he does not strive to make his diagnosis as precise as possible, he is likely to become slack and woolly-minded, and may before long find himself unthinkingly using the patient's diagnosis . . . "a chill on the

liver", or "a chill on the kidneys", and so on. Influenza is a perfectly definite clinical entity, and it is probably true to say that in the absence of an epidemic, a short fever is not influenza. "Frankly, I don't know what 'rheumatism' is. I know about acute rheumatic fever and rheumatoid arthritis, but 'rheumatism' means nothing to me."

The acute abdomen is relatively rare. A busy man is unlikely to see more than one such case a month, and 80 per cent. of them will be acute appendicitis. Very seldom indeed will the patient present the full collection of classical signs.

### SOME DON'TS

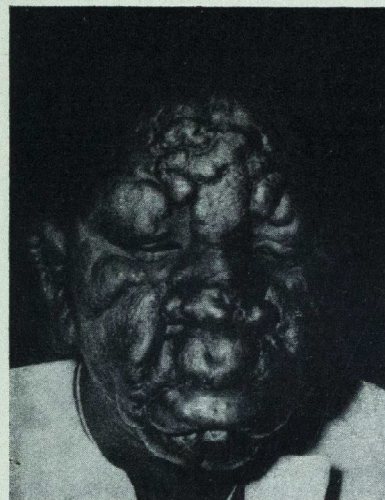
Don't diagnose neurosis by exclusion. An anxiety neurosis should be a firm diagnosis, based on definite symptoms and signs. Don't disregard positive physical signs, errors in diagnosis are usually due to the omission of something in the history or examination, or to the faulty interpretation of clinical findings. Don't frighten the patient unnecessarily by suggesting he has a weak heart or malignant disease, and don't invent a diagnosis simply to satisfy a patient. The patient probably doesn't want a diagnosis; he only wants relief of symptoms. "If you can't make a diagnosis, it is best to say, 'I don't know, but I'll come tomorrow and we'll see how things develop'." This may lose you a few patients at first, but as they get to know you, they'll accept this as your carefully considered policy." And don't necessarily believe all you are told!

Dr. Gimson doubts very much whether it is an advantage to know patients well. Seeing them frequently and over many years makes their story too familiar and may allow new conditions — myxoedema and Parkinson's disease, for instance—to develop insidiously and unnoticed, whereas a new look would spot them at once.

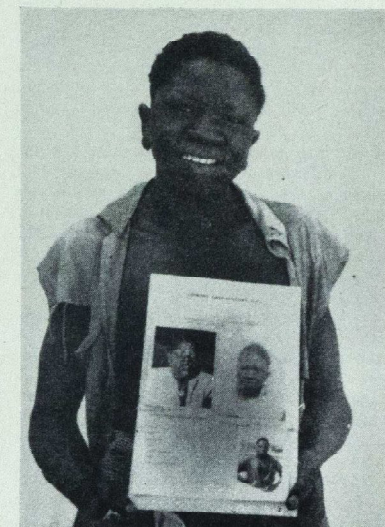
How good they are, these men who have been in general practice for fifteen or twenty years! We left him talking to a knot of students in the Square, and after that, characteristically, he was going up to the wards, to see one of his own patients, "Oh, Doctor, I'm so glad to see you".

## THE STIGMA OF LEPROSY — A REPROACH AND A CHALLENGE

by Derek Browne



*Lepromatous Leprosy, aged 17.*



*After treatment, aged 21.*

*(Photo, "Mission to Lepers".)*

A FRIGHTENED young man slid furtively into the doctor's consulting room.

"Doctor," he said in a whisper, "I am worried about a small patch that I've had on my arm for some weeks. Can you tell me what it is?"

After asking a few questions and examining the arm, the doctor gave his verdict. "I am very sorry to have to tell you that you have leprosy."

Leprosy? *Leprosy*. Was it possible?

That dread word meant something more terrible than cancer, than tuberculosis, than venereal disease. In fact, to many people it is even more terrible than a diagnosis of cancer-tuberculosis-venereal-disease, for in addition to the name of the disease there is the *stigma*. And added to the stigma, is the feeling of guilt. "This man has sinned", or his parents have, and now the divine punishment has descended inexorably.

"But this patch—can it really be leprosy, doctor? After all, it is so small, and it doesn't hurt at all."

"I'm afraid there's no doubt," replied the doctor, as sympathetically as he could.

What does it feel like to be branded as suffering from this disease? And why should this disease seem to be singled out from all other diseases? Why should ten million people in the world be considered as outside the pale?

I have recently lived for some months in a leprosy settlement in Africa, and have spoken to many of the patients. I have worked in the laboratory, and have helped in the diagnostic clinic and the treatment clinics. From the experience gained in that settlement, I will try to describe this fear of leprosy, and the stigma attached to the disease.

One day, I was walking down the settlement road to the men's town, passing on the way several old women seated on benches

peeling oranges while waiting for the nurse to inspect their ulcerated feet. As I approached the first house, a young man of about twenty-three appeared from behind a curtain screening off the front door of a hut. I recognized him as Nwachuku. He was dressed in a spotlessly clean Ibo costume and carried a decorated walking stick in his right hand. Without thinking, I put out my own hand to greet him, but he kept his hand firmly gripped around the handle, and, looking me straight in the eye, said, "Sorry, Derck, but we do not touch anybody who hasn't the disease." I had forgotten, for the moment.

From then onwards, and throughout my stay in the settlement, I could sense this feeling of separation, this fear that kept the patients at arm's-length as it were. They were fearful of giving leprosy to healthy people, and healthy people on their part were fearful that a single contact with someone suffering from leprosy might give them the disease.

The truth is that leprosy is only very slightly contagious. The fear of catching leprosy by chance contact is baseless, for leprosy is almost always contracted by "prolonged and intimate contact" (according to the standard text-books). Probably such factors as inherited susceptibility, undernutrition and lack of personal hygiene may also play a part.

"Why does everybody dread leprosy so?" I asked Nwachuku as we walked along the road towards the rehabilitation centre.

"Many people still think that leprosy is incurable," he replied. "I know that if left untreated, leprosy does indeed cause mutilations and deformities, but it does not necessarily do so. When people see the ulcerated extremities, the nodular faces, the claw hands and feet, they are terrified, and imagine that everybody who gets leprosy will eventually end up by losing his fingers and toes. Many of us have been thrown out of our villages and left to fend for ourselves because our fellow-villagers were scared of catching the disease from us. This feeling of revulsion is so strong among the Ibos that we try to hide these patches as long as we can." Nwachuku lifted up his costume and bared his arm. I could see several ill-defined hypopigmented haloes surrounding some scar tissue.

"Yes," he went on, "I tried at first to cut out these patches with a knife—it didn't hurt—but they continued to spread. Other patients try to hide the patches under their clothing, but they cannot keep this up for long because we wear little clothing when working in the

fields in this hot climate. Many visit the local witch-doctors and pay large sums of money for useless treatments. I have known some who have even tried burning the patches with gunpowder sprinkled on and set alight. You can picture what these people look like after such treatment—huge ugly scars, wrinkled skin, fearful deformities, blindness. The disfigurement caused by gunpowder is often worse than the disease itself. But nothing does any good. Once the patches begin to spread, nothing can stop them spreading."

I had already spent some weeks in the settlement and had seen patients in all stages of the disease, but comparatively few of them were grossly deformed. I remembered some of the misconceptions about leprosy prevalent in England. "Leprosy is no longer a problem in the world—the new drugs have virtually abolished leprosy." "Leprosy is incurable." "Everybody who gets leprosy is doomed to a living death; the fingers and toes drop off; and progressive deformity is the rule."

It has not been sufficiently stressed that deformity in leprosy is only secondary to nerve involvement and that all leprosy patients can be taught to look after their hands and feet even though the peripheral nerves have been attacked. The onset of deformity can thus be stayed.

I had for long been interested in leprosy, and in the first two years of my life I must have seen some thousands of people suffering from leprosy, although I don't remember anything about that now. My father used to tell me of an old cannibal chief, who had leprosy, rubbing his hands together ghoulishly as he looked at me in my travelling cot one day, and saying, "What a nice little baby!"

Since becoming a medical student, I have been intrigued by the fact that a tiny rod-shaped organism could be responsible for such a disease. I had of course read about *Mycobacterium leprae*, described by Hansen in 1874. Though it was the first bacillus to be associated with a human disease, it remains the last to yield its major secrets. Leprosy is said to be "a chronic infectious granuloma affecting mainly the peripheral nerves and the skin", but this bald statement fails to do justice to the far-reaching consequences of anaesthesia and paralysis of the extremities. I had also read of the many different diseases with which leprosy is likely to be confused, and had seen for myself some of these diagnostic pitfalls.

There are three main types of leprosy, and

a bewildering variety of intermediate forms. Tuberculoïd leprosy, which is non-infectious and often self-healing, is characterized by well-defined, raised, hypopigmented patches on the skin; lepromatous leprosy, "malignant" and contagious, is shown by ill-defined hypopigmented macules, and sometimes by nodules or diffuse infiltration; borderline leprosy has characteristics of both the lepromatous and the tuberculoïd forms. It is this latter type which is the most difficult to treat and which shows the greatest tendency to relapse. The different kinds of hypopigmentation in leprosy are often mistaken by the inexperienced for syphilis, psoriasis, yaws, onchocerciasis, or one of a host of other diseases.

"There's another reason why leprosy is feared", said Nwachuku, as we crossed a small bridge over an open drainage gutter. "People who get leprosy often imagine that they have somehow incurred the wrath of God. Either they, or their ancestors, have committed some terrible sin, and this is the punishment. In the Old Testament, there are many references to leprosy, and in the Book of Leviticus (Chapters 13 and 14), you can read that leprosy is an unclean disease and that it is the result of sin. This idea makes some people with leprosy spend their lives brooding as they try to put their finger on something they have done in the past that might have offended God. I myself used to think this when I first knew I had leprosy, but now I don't think so any longer."

"What made you change?" I asked him.

"Your father told me that many leprosy experts and biblical scholars now think that the 'leprosy' of the Old Testament is not the disease we know today as leprosy. He said that the word used in the Bible means any kind of scaly disease of the skin and that this word was wrongly translated when the Old Testament was put into Greek. For instance, you never see leprosy 'white as snow', and yet in the Bible I think it was Naaman and Gehazi who were supposed to have leprosy which was 'white as snow'. Therefore it couldn't have been leprosy."

I rather marvelled that this young African man could be speaking to me in this fashion, and teaching me things I did not then know.

I had read somewhere that because of its connotation of "unclean" and "stricken of God", the word "leper" is no longer used by such bodies as the World Health Organization. Some people would go further, and seek another name for the disease itself, and call it

"Hansen's disease".

As we walked along together, I recalled the long history of leprosy, from the early hints in Egyptian records to the detailed account given by Aristotle in about 345 B.C. It was he who recognized the anaesthesia that is associated with leprosy. I remembered reading about the so-called leprosy epidemic in the thirteenth century, which was attributed by many to the returning Crusaders. And nearer our own time, came Father Damien, who spent most of his life on Molakai, a South-Sea island set apart for leprosy sufferers. For many years he tried in vain to get help from the Government for food and water and clothing for these unfortunate people, and it was only when he himself contracted the disease that officialdom was moved to action. I thought again of the thousands of people who had been banished from home and friends under a mistaken diagnosis of leprosy.

"But, surely," I remarked to my companion, "the old ideas about leprosy must have disappeared completely from a district like Eastern Nigeria, where the problem of leprosy is almost under control?"

"Well, you might think so," he replied, "but it is still true that many people when they find that they have leprosy, just cannot face their fellows. They go into hiding. They do not believe that leprosy can be cured, despite the thousands of folk now cured and well, walking about the villages and working on the farms. And they do not want to enter a segregation village because they imagine that they might remain there for life."

Every morning for some days past I had been busying myself in the laboratory of the Leprosy Research Unit, helping the technicians. Afterwards, I had watched the clinical assistants as they distributed the drugs to the patients. It was these drugs that had transformed the treatment of leprosy during the last fifteen years or so. Dapsone, a sulphone—often known familiarly as "D.D.S"—is still the drug of choice. It is cheap and relatively non-toxic. Chaulmoogra oil, which was the standard treatment in the past, was only effective in a few cases with established disease, and many patients used to complain of the pain of the weekly injections. Today, new remedies are being tried out: e.g., Etisol (ditophal, a mercaptan derivative), and a saf-ranin dye, "B.663". Both these drugs are inexpensive; Etisol has an objectionable odour—it is given by inunction—and B.663 causes a ruddy pigmentation of the skin.



Fingerless leper due to severe lepromatous leprosy which could have been prevented.  
(photo—S. G. Browne)

I asked Nwachuku what he thought of the new drugs being used at the settlement.

"Wonderful!" he replied, with that curious high-pitched tone on each of the syllables of the word "won-der-ful", that seems to be characteristic of West African English. "But we have to be the guinea-pigs—the doctor says that no animals can be used to test the drugs on, since no animal can be given human leprosy. We all want to be cured in less than four years, and we keep hoping that one of the new drugs will prove to be much speedier than the standard treatment."

"What dose of dapsone are you taking now?" I asked him.

"I myself am taking three small tablets twice a week," he said. "But the doctor thinks that even smaller doses may still be effective and not lead to severe reaction with high fever, headache and nerve pain. Several patients are being given these smaller doses . . . but they don't like it."

"Why not?" I asked.

"They think that one small tablet every week, or even twice a week, cannot possibly cure such a severe disease as leprosy. You should see the disappointment on their faces when they receive such a small dose. But when the patches begin to disappear, then they really think that the medicine must be powerful.

Still, they cannot imagine why they cannot get bigger doses that will cure them more rapidly."

"Yes, it must be very difficult for them to know the reasons for all that is done for them. And I suppose that they cannot see what a great benefit they would receive if they were never to have a reaction—since they have never experienced such a condition themselves."

We went into one of the rooms in the laboratory where a technician spends all his time examining stained smears from various parts of the skin of leprosy patients. He stains them as for tubercle bacilli, and records his findings according to a set notation. I had watched some of these charts for a few weeks, and had seen the gradual fall in the Bacterial Index, as it is called. Then some of the patients who were receiving one of the new experimental drugs, showed a rise in the Bacterial Index. Resistance to the drug was beginning to develop. This is one of the disadvantages of a drug that shows some degree of bactericidal activity. I was told that sometimes a combination of drugs seems to avert, or at least to postpone, this resistance.

Nwachuku was most interested in the progress chart of a child friend of his, now receiving one of the new drugs.

"If children get leprosy more easily than adults," he said, "they have a better chance of permanent cure if they come here, and usually do not become deformed."

"Why is that?" I asked.

"Well, for one thing they are admitted to the settlement more easily—even if they have tuberculoid leprosy. And, for another, they do not have to feed themselves while they are here: some foreign organizations like the Mission to Lepers and BLRA help to pay for their food and clothing and their fees at the settlement school. Look at me," he added. "I have but little weakness of my fingers, but if I turn sideways you can see that I have a slight depression in my nose."

I could just see the beginnings of a saddle-back nose.

We left the laboratory after saying "Good-bye" to the technician in charge of the smear reading, and made our way to the Rehabilitation Centre. Here many patients were at work—some were weaving rugs, others making cane baskets and chairs, others were carving small animals from blocks of balsa wood. I knew the man in charge. He was still a patient, and I had seen him in the treatment clinic.

"Does everybody have a job in this settle-

ment?" I asked Nwachuku as we left the Rehabilitation Centre.

"No," he replied with a sad shake of the head. "I am one of the lucky ones, and so is the man in the Centre. The Settlement and the Welfare Department employ as many patients as they can, but their funds will not permit them to employ all those who want work. Most of us are here for at least four years, and we want to earn our living as well as occupy our time. You've seen the manioc and yam plantations, and the maize farm. And the oil palm industry is a very thriving concern just now. The food is sold to the hospital for feeding the bed-ridden patients, and some of it goes to the feeding centre for the children, who all get two meals a day, regularly."

"Keep up the good work," we shouted as we waved back to the patients, and made our way towards the Physiotherapy Department. As we drew nearer, we heard the sound of singing. A tuneful melody, with a thumping rhythm. A group of a dozen or so patients were sitting round a small table, singing with great gusto and squeezing "silicone bouncing putty" between their fingers in time with the beat of the music. At first I thought this quite amusing, but when I saw a young lad struggling to close his fingers around the putty I realized how terrible must be the loss of power and sensation. Some of these younger patients had been attending for months to have hand and foot exercises. Part of the treatment was to educate them to watch what their fingers were doing. When sensation has gone completely, it is pathetic to see a small child looking at his burnt finger—he felt nothing, and noticed nothing until the smell of burning flesh attracted his attention.

Nwachuku himself had been coming to the Physiotherapy Department for some months, but he had now been told that he need attend no longer.

"Why?" I asked him.

"Because I am going on discharge in a fortnight's time," he replied, rather sadly I thought.

"But why so sad?" I asked.

"Well, I am still young, and I have been here for five whole years—and that's a big chunk out of your life, isn't it? I was good at my classwork at school, but where am I now? Several of my classmates have got scholarships, and are now training in U.K. It was after passing G.C.E. at Advanced Level that I detected the first sign of leprosy. I tried cutting the patches, then I tried burning

them with powerful herb extracts. I feel that I have wasted these five years as far as my education is concerned. My pay here has been very little compared with that of casual labour outside, and I have missed my chance in the competition for good jobs."

"But you will get a discharge certificate when you leave," I said.

"True," he conceded. "But when competition is so severe for the few jobs available to educated boys, what chance has a person like me of getting a job? We get a certificate, saying that we may now live among healthy people. But can we? And can we get a job and work among healthy people? Many foremen and managers of big firms think they know better than the doctors, and tear up a certificate when they have read what it says. Sometimes an ex-patient will tear up the certificate himself rather than present it when he applies for a job."

"That seems to be going a bit too far," I said.

"And not only that," Nwachuku continued, "but many patients fear that they will be recognized by their friends, and once again go through all the suffering that was theirs before they came for treatment. No, you can never make up the time and the opportunity lost while you are in here. You can't."

I listened as sympathetically as I could while Nwachuku recounted the forebodings and the fears of those who would in a few short weeks be facing again the world outside the settlement.

"You see," he went on, "we are a friendly crowd here. We have running water, and film shows. We are treated well when we get ill from other diseases. We have a Literary Society for those of us who speak English—we feel our disease more than others do, I suspect. At some of our meetings we learn about progress in leprosy from the doctor, and what is being done in other lands for people like us."

It was now midday, and the fierce sun was striking our uncovered heads. I thought it was time for lunch. We left each other, Nwachuku to go to his simple plate of gari (roasted grains of manioc, somewhat like our tapioca), and I to my more sophisticated meal.

A fortnight later, on a Sunday, I attended the Discharge Service in the Settlement Church. It is called a "Grateful Samaritan" Service, after the one patient who, alone out of ten leprosy patients healed by our Lord (Luke, Chapter 17), returned and said

"Thank you". During the Service, the prize-winning settlement choir, conducted by the ex-patient composer Harcourt Whyte, sang anthems and lyrics in Ibo, whose words and music had been written by their choir-master. "Won-der-ful," as they say in West Africa. It was

Then we made our way to the Community Centre, and to the green lawn just outside. What noise! What commotion! What joy! The women, dressed in their most colourful costumes, sang negro spirituals to the rhythm of the "pot" drums. Some of the men danced and pranced to their heart's content. Others banged the drums, great and small, until the sweat just poured down their bodies. Others fired dane-guns into the air.

Names were called one by one, and one by one the fortunate patients went forward to receive their precious discharge certificates. Then Nwachuku's name was called. I watched him as he danced up to receive his certificate. He then shook hands with all those who had helped him—the doctors, the nurses, the physiotherapist, the Welfare Officer—everybody. As he returned "to the ranks" he received a tremendous ovation from his friends, for he too had been of great help to many.

What was he facing? What would the future hold for him? Would he get a job? Would he be able to continue his studies somewhere, somehow?

The crowds cheered. The guns fired. Nwachuku waved his certificate in the air, and came towards me.

"Yes," he shouted gaily, "I'll be all right. I'll make it."

A lump came in my throat. Would he? I could not help wondering. He was facing a big question-mark.

At last, the proceedings came to an end. The crowds dispersed. Those who remained looked forward to the day when their turn would come, when they would get a scrap of paper that would mean all the difference to them. Many visitors had come for the ceremony. Some had come to welcome relatives and friends back home again. But other discharged patients had no one to welcome them. Their relatives still thought of leprosy as more than a disease—it was a curse, a punishment,

a sign of God's anger. And, of course, leprosy was never really *cured*, was it?—it would relapse. And so they did not come to welcome their banished friend and they would not welcome him when he returned to his own village. For it was there that he might have to face all over again the slights, the sneers, the avoidings, the poisoned drink, the stolen farm, the hate and the fear, and the terrible stigma. Not a human being suffering from a curable disease, but someone branded, cursed, till the day of his death.

I left the Community Centre in very thoughtful mood. What a tremendous challenge leprosy offers to physicians and surgeons, to physiotherapists, to geneticists, to sociologists, neurologists, bacteriologists, and the rest! This world-wide problem could be controlled and eradicated if we really did something about it. Governments, and WHO and UNICEF, are doing a lot, continuing where missionaries began. For the cost of two bombers, virtually all patients with leprosy in the world could be treated . . . but the funds are not forthcoming, neither are the dedicated men and women in sufficient numbers.

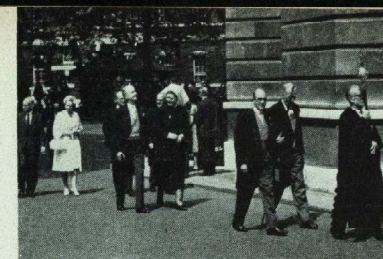
Where leprosy is endemic, few local doctors or technicians will enter the leprosy service. They are really frightened of catching the disease, and incurring the stigma. A laboratory assistant told me how scared he was when told he was being transferred to a leprosy settlement. He dreaded his first encounter with a patient. But when he saw the doctor actually touch the skin of a patient, the fear left him. He realized with a shock that his old ideas about contagion must have been wide of the mark.

Many of us will come up against this problem sooner or later. People suffering from leprosy are said to be entering Britain every month. One overseas nurse after finishing her training in this country, was found on her return home to have widespread and severe lepromatous leprosy. She had been here for several years, working in hospitals, and nobody had diagnosed leprosy. Strange, but true.

I am hoping to learn more about leprosy, and perhaps do something to take out the stigma and the sting from this age-old and much-dreaded scourge.



Then . . .



. . . and now

## VIEW DAY 1963

From a social correspondent

It was on 8th May this year. It was a sunny and well attended View Day which was doubtless enjoyed by most people in spite of a degree of carping from a Broadsheet correspondent.

The origins of this day are buried beneath four centuries of parochial history. In 1559 the Governors viewed in order to castigate the abundant abuses and take notice of complaints. To-day it would be as surprising to hear a patient stop the passing dignitaries with a derogatory comment on his View Day lunch as it would be to remark the senior surgeon reproaching a ward sister for the untidiness of her ward. So it is that May's second Wednesday has become an empty annual event; just another symptom of an institution that is riddled with the disease of traditionalism. However, all the symptoms of this disease are mild and this correspondent is reactionary enough to think it not a bad disease at all to suffer from. If it has the complication of decadence then St. Bartholomew's has so far been spared that.

View Day is best organised for the Hospital Governors. They have a leisurely lunch and an early tea sandwiched between a comprehensive conducted tour. Giving and taking most of the pomp they can not get lost. But what of the hoi-polloi? The families of students and nurses as well as old Bart's men, what should they do, or more precisely, see?

For the benefit of future visitors to the academy I did a swift tour with a stop-watch. Speed becomes important when visitors realise that they have a bare half-hour to view between the Governors' departure and the serving of tea. So it is a question, as they say, of doing Bart's in twenty minutes in order to head off the vanguard in the undignified rush for tea. It is well known that Parisien tourists can do the Louvre in under three minutes by taking scant notice of all but the Venus de

Milo, the Winged Victory and the painting of the Last Supper. Similarly it is possible to visit St. Bartholomew's the Less, see the Hogarth frescoes (without mounting the stairs) and view London from the sun-lounge of Gloucester House in something under five minutes. Being a devoted member of the Royal and Ancient myself, the following suggested tour is slightly less rushed.

3.30 p.m. Park outside the Henry VIII gate. "Take it in" on entering. Built in 1702, Sir Norman Moore said, "It is a good piece of architecture". The statue between the arch and the clock is Harry himself.

3.31 p.m. Have a quick look in the 12th-century church on your left.

3.32 p.m. Stride on to the second arch which is placed beneath the Great Hall. This building also contains offices for the Clerk to the Governors and the Steward.

3.33 p.m. After this arch turn left through a large blue door. As you mount the stairs (two at a time if you want tea), cast a glance at the two large frescoes on the wall. "The pictures are appropriate to their place and are fine examples of the art of Hogarth" (Sir Norman Moore). The Pool of Bethesda and the Good Samaritan are depicted. The former, which is easier to see on climbing the stairs, includes a man with an ulcer, a woman with mastitis, a girl with Cushing's and a man with gout. This picture is more appropriate than cheerful.

3.34 p.m. The Great Hall is large. It is very cold in the winter and often serves as an examination hall for embryo doctors during that season. You will notice many paintings of famous old Bart's Men. On this tour there is time only to stare briefly at that of Percival Pott by Sir Joshua Reynolds before dashing down stairs back to the quadrangle.

3.36 p.m. Remark the quadrangle, one administrative and three medical blocks built

by James Gibbs between 1730 and 1759. Think on the fact that this extensive 18th-century rebuilding scheme cost Bart's very little since James Gibbs made no charge and all those names (you may have noticed them engraved in gold on the walls of the Great Hall) paid a minimum of 50 guineas each towards the cost in return for a small space in the annals of posterity.

3.38 p.m. Enter the north block which contains orthopaedic and children's wards. Turn right in order to have a swift look round Henry. It is typical of all Bart's wards, indeed of any hospital ward, but has the advantage—important to View Day visitors—of sheltering patients who are not as a rule in any way diseased.

3.40 p.m. Now the more energetic of your party might visit the Museum, founded in 1726 and vastly improved by Sir James Paget who was curator in 1834. It is at the top of three flights of stairs in the Pathology block. The less energetic would be well advised to sit down by the famous fountain for a few moments. There, films may be changed and

## NOISE ABATEMENT IN HOSPITALS

by Dr. G. F. PETTY

### A Random Sample

While spending a fortnight in hospital, following cholecystectomy, I made my personal observations of disturbing noises and also had the opportunity of finding out what disturbed other patients in this ward of 30 males.

In investigating the causes of reducible noise, there are certain criteria which should be accepted:—

1. It is impossible to produce a soundless ward with whispering night nurses.
2. Noise should be classified broadly into two groups:—
  - (a) Disturbing.
  - (b) Non-disturbing

Of these some may be considered inevitable, others reducible and a few capable of elimination.

To decide what is a disturbing noise one has to consider the conditioned reflexes of the average individual. It is well known that many of us have slept through a barrage of shelling, heavy bombing, when exhausted, and in conditions of a minor degree of safety, e.g., in a bomb shelter, dugout or trench. It is also common knowledge that many people go to sleep in the rattle and clanging of a moving

breath recovered for the final lap.

3.43 p.m. Walk briskly to the east gate by the Queen Mary's Home for Nurses, turn right up Little Britain past the Queen Elizabeth block, the new radiotherapy building (mostly underground) and some unsightly slums that pay rent to Bart's.

3.44 p.m. You should have arrived at the multi-storey Gloucester House, a nurses' home, opened together with the Q.E. block in 1961 by Her Majesty the Queen. It is alleged that both were financed from just one year's income. A lift will take you to the sun lounge at the top of Gloucester House.

3.45 p.m. Notice locally, St. Paul's, the Old Bailey and the Hand and Shears. Ignore the Daily Mirror building and notice further afield, Westminster Cathedral, the Monument and Nelson on his column (an unfortunate profile).

3.49 p.m. You are wilting by now. Take the lift to "G", stagger across the foyer to the doors on the left of the porter's desk in order to be in good time for tea in the ill-designed hall of Gloucester House.

train—only to wake up when it stops and the noise ceases. Animals in their natural habitat will wake at the least crack of a broken twig. This is a conditioned reflex indicating approaching danger from a falling foot.

The average inpatient on his first admission is anxious and will not sleep well in the first night in any case. Observation on the first night is therefore omitted. The table of disturbing sounds which wake patients or prevent them sleeping is not necessarily confined to observations at night because most sick people sleep by day as well as by night and need to. Patients can, however, sleep through the chatter of conversation and the patter of feet as this is a constantly recurring and reassuring noise.

Wards in this hospital have a quiet hour after lunch. On questioning, only one out of thirty slept during this period and the patient was one who claimed that he had not slept at all during the night since his admission three weeks before. Most patients tend to sleep after breakfast when washing is completed and the beds have been made. The ward maids and the vacuum cleaners have gone and there is an automatic lull, waiting for the hospital rounds.

### TABLE OF DIFFERENT TYPES OF NOISES FOUND DISTURBING TO PATIENTS

Clanging swing doors	6
High-pitched squeaks from trolleys and squeaking pulleys from limbs under traction	11
Slamming of bedpans in the sluices	4
Kitchen noises	8
Nurses	Nil
Snoring and groaning	4
Telephone	1
Not woken by any noise at all	10

#### Notes

Of these not woken, 8 were at the farther end of the ward, away from close proximity to the source of most of the noises.

From the table it will be seen that disturbing noises can be divided into:—

- (i) The staccato noise, e.g., swing doors banging, clatter of crockery in the kitchen, the banging of bed pans in the sluices, the clanging of the refuse bin lids.
- (ii) The high pitched sounds, e.g., squeaking trolleys and squeaking pulleys.
- (iii) Lower pitched sounds such as snoring and groaning are only noticed by the four patients in close proximity to the individual.
- (iv) Noises made by nurses are not disturbing, except as in (i) and (ii). The nurses wear soft flat-heeled shoes and the ward has a wooden floor.

Acoustics considerably aggravate the problem. The furnishings of wards are essentially devoid of soft, sound absorbing material, e.g., carpets, curtains, etc., and therefore the echo is prolonged and sounds accentuated. For example; in the Dean's Hall at Berkhamsted School there was an echo of 7 seconds and even the loudest speaker was inaudible at the back of the hall. The problem was overcome by covering the wall at the far end completely with a layer of canvas containing three inches of dried seaweed. This reduced the echo to 2 seconds and any speech could easily be heard.

The passages outside the ward are almost soundless, the floor being of a rubberised substance, which produces no noise and reflects no sound. However, in contrast the kitchen has a stone mosaic floor, and to make matters

The telephone ring waking the patient is typical of the conditioned reflex. This was true for myself alone, because after a lifetime of being jerked awake by the demanding ring, I subconsciously responded. A business man in another ward complained of the same thing. He suggested, "Why not a switch, for a night buzzer and a blue lamp in the ward?"

The following types of trolley are in use in the ward:—

Dressing trolleys
Medicine trolleys
Flower vase trolleys
Washing and linen trolleys
Food trolleys

In the above table there is no observation on the admission of new patients at night. This is because a side ward is kept for this purpose and the main ward is therefore undisturbed.

worse, the maid stacks the tin trays against a wall behind a water pipe three inches off the floor, making a phenomenal clatter. Any movement of a metal refuse container likewise produces a high pitched noise. Unbreakable china which never cracks (but does chip) leads to careless handling while washing-up and the clatter of cups cracking together in sink and on draining board makes a cacophony of sound, like the crash of broken china in a shooting gallery.

#### Conclusions

The problem resolves itself into the fact that two out of three patients agreed that noise either tends to keep them awake or actually wakes them up.

The disturbing noise is high pitched or staccato in type. This type of noise is the most easily curable.

Hospital flooring should be of the same type that exists in the passages, i.e. soft, rubberised and noise absorbent. Effective sound-proof doors to the kitchen and bedpan sluice room are required.

Bigger wheels should be used on trolleys and routine mechanical inspection made of these wheels. (Those in use had wheel diameters varying from three inches to nine inches.)

A different type of door to the swing-to could be considered, or, failing this, a reduction in the strength of the returning spring should be carried out by the hospital engineer.

This is a simple survey of a straightforward problem, and is a random sample. Could other doctors, placed in a similar predicament, take advantage of this and compare results with mine?

## MISS ORMISTON

In the week or so before Christmas, coffee-break in Sick Rooms was always an impressive affair. This was the time of day when, with the first rush of work dealt with, Miss Ormiston would pause to deal with her morning mail. As Christmas drew near, the flood of cards and letters would begin to pour in from all over the world, a massive and spontaneous annual demonstration of the lasting affection in which Miss Ormiston is held by generation after generation of St. Bartholomew's nurses.

Frances Ormiston started her training at this Hospital on 1st March, 1922, and, apart from her secondment to Queen Charlotte's for Midwifery training in 1926, she spent all her professional life in the service of this hospital. She was appointed Pink, assistant to the House Sister, Miss Irvin, in 1929, was promoted to 2nd office Sister after 6 years, and in 1939 to Day Superintendent. During the war, this post carried the responsibility of office Sister's duties in addition to the care of sick Nursing and Domestic Staff, Sick Parade being held in the ground floor office (now Assistant Matron's office). With the changing pattern in the Health Service and increased staffs the volume of work grew steadily, and Sick Rooms with its own office was transferred to its present position on the 3rd floor. Miss Ormiston continued as Superintendent of Nursing and Domestic Staff Health and Sick Rooms from 1950 up till her retirement on 30th September, 1962.

She was Alloway born-and-bred, and Sick Rooms bear the indelible imprint of her firm but gentle Scottish personality. Her hospitality was boundless, so that her department has become known for its homeliness and welcome. Over the years, Sick Rooms became a haven for waifs and strays from all corners of the Hospital; not only nursing staff, but their parents, fiancés and boyfriends would receive the same charming welcome; and from time to time, students, housemen (and even on occasions professional Staff!) have been taken

under her wing.

Her natural kindness and sympathy made her ideal for her work. Her deep insight into the needs of her patients is partly due, of course, to the understanding brought by years of experience in handling human problems, but partly this too was innate. She has that Gaelic gift of intuition which at times, to a mere earth-bound English colleague, seemed to be positively "fey". Her lovely Scottish vernacular occasionally peeped through too, with such terms as "peasie-weepee" and "peely-waulie" (or how should they be spelt?) to describe the minor psychiatric afflictions of the student nurse more vividly than by any scientific jargon.

She set a high standard, but her firmness is that of true strength of character, so that one rarely glimpsed the fibre behind the gentle charm. The strongest condemnation one ever heard her use of anything or anybody was that it was "not S.B.H.!"

Her achievement is not to be measured simply in morbidity statistics or health records, but is a sum total of human happiness—of young people helped through dark times, of trainings completed and careers salvaged. The affection in which she is held needs no written statement. The way old Bart's nurses would not dream of visiting their old hospital without including a call to see Miss Ormiston, knowing that even if they arrived complete with their young family to show, they would be sure of a welcome in the middle of the busiest of mornings; the endless correspondence bringing news from all over the globe; the many Bart's weddings throughout the year to which she was invited as a specially honoured guest (in fact it seemed that she should have been provided with special expenses because of her occupational hazard of having to give so many wedding gifts!)—all these, coming from so vast a company, and coming from the heart, are a far more eloquent testimony.

J.M.C.

## DERBY DAY

From A Racing Correspondent

I was mad. They had cancelled the trip to the Epsom mental place and there was I, a regular hard-working, five-day-week, nine-to-five man, left stranded. During Outpatients coffee break I perused the sports page of a newspaper in a study of the Big Race form. I fancied the favourite, but discarded it on grounds of nationality. A true patriot, it was impossible for me to support a French horse—a foreigner!

See the Derby? Visit Epsom race course? These were the questions that swirled from the white china cup before me in indolent coffee-pot-fresh eddies. There was poetry in the idea. They had stopped my Epsom visit. Why should I not still go, but to a racecourse rather than a mental hospital? Then I remembered the legion advertisements we had seen about the place for weeks. They told us to go to Chislehurst and contribute—(nebulous, wretched word)—to Sports Day. There was talk of strawberries and cream.

It was during lunch that I decided that the Athletics Club is insane. They have a flair for arranging their annual event on the day after the View Day Ball, during the Head of the River or on the afternoon of some outstanding Bart's society wedding. Last year, skilfully, they fixed it to clash with *all* these. And now this year they had to choose Derby Day! So it was that this correspondent had compassion and went to Chislehurst having at the same time wagered half a dollar each way on a fancied British colt.

Curse the vagaries of our climate. It was a miserable day. The Athletics Club would have been better off with one of those cool, crisp and sunny days in late February. 29th May was a grey day. It was not cold. It was bitterly and unpleasantly cold. No one there had known such a cold day in May since. . . . Scense, humour or both had prompted Laurie White into lighting a good fire in the pavilion.

There were as many spectators as I have seen on any Sports Day, and bearing the ridiculous weather in mind, this reflected considerable credit on the Club's publicity campaign. Spectators soon realised that simply watching was right out; their contribution must take the form of huddling round the fire, drinking at Laurie's bar, tackling tea or pitching for the pig. The police had closed the bar until five o'clock, the teas were less exciting than strawberries and cream but none the less welcome and the pig, or rather the winning of it, became the pastime of choice.

He was a small, ugly and exceedingly frightened pig. This correspondent reflected mildly on the paradox of grown men and women spending shilling after shilling to knock down skittles for something they could not possibly want. Messrs. Castleton and Cannon, who won the animal, proved this point by at once selling it back to the farmer at a loss.

What was worth noting of the sporting events? (Certainly not the Derby result in this correspondent's case.) The Dean took on and beat all comers in the hundred yards. As is usual on these occasions a handful of professionals, Messrs. Tunstall-Pedoe, Herbert, Foxton and Niven, carried off sixty per cent. of the more serious sporting events. Later, when Mrs. Cope presented the prizes, Mr. Tunstall-Pedoe won the prize for athlete of the year, Kids and Specials won a fair amount of beer, Mr. Cope won a pint ticket which he cashed and drank in considerably less time than it took him to win his race and Mrs. Cope was given a bouquet as is the custom.

After a buffet salad supper, also admirably organised by Miss Susan Williams, nurses began to arrive, smiling and bright for the final Sports Day ritual—the dance. This year it was delayed, firstly by the numerous 'Jug o' Wars, in which the antics of the S.B.H. R.U.F.C. are best left unreported, and secondly by a surfeit of schooner racing organised by Mr. MacElwain, who succeeded in pitting each club there against every other club. An hour or more was left in which to twist the night away to Ted Carden's Five, until the 11.30 coach took us home.

The organisers had done a fair job. They lent solid hard work more than imagination to Sports Day which is a simple more than a sophisticated social occasion. But curse the climate!

Reluctant Pig.



## SPORTS NEWS

### JULY SPORTS DIARY

- July 3 Men's Tennis v. Royal Dental Hospital (A).  
Golf v. St. Mary's Hospital (A).  
July 6 Cricket 1st XI v. U.C.S. Old Boys (H).  
Men's Tennis 2nd VI v Westminster Hospital (A).  
July 7 Cricket 1st XI v. Past (H).  
July 10 Men's Tennis 1st VI v. Westminster Hospital (H).  
2nd VI v. King's College Hospital (A).  
Ladies' Tennis 1st VI v. St. George's Hospital (H).  
Golf v. Guy's Hospital (H).

- July 13 Cricket 1st XI v. Incogniti (H).  
Men's Tennis 1st VI v. Rochampton (A).  
July 14 Cricket 1st XI v. Hampstead (H).  
July 17 Men's Tennis 1st VI v. U.C.H. (A).  
Golf v. U.C.H. (H).  
July 20 Cricket 1st XI v. Nomads (H).  
Men's Tennis 1st VI v. Epsom College (A).  
2nd VI v. London Hospital (H).  
July 21 Cricket 1st XI v. Dartford (A).  
July 27 Cricket 1st XI v. Old Cholmeleians (H).  
Men's Tennis 1st VI v. Staff (H).  
July 28 Cricket 1st XI v. R.N.V.R. (H).

### EDITORIAL

For the majority of people at Bart's, tennis means an occasional outing to the Charterhouse courts. However, there may be some more athletic students and nurses who wish to play more serious, and to some extent, competitive tennis. These very people are well catered for by the Bart's Tennis Clubs.

This year some twenty people are playing in matches for the Men's Club. The team Secretary is at last able to pick two teams, instead of the more usual practice of begging for players. Over the past seasons, in addition to a shortage of members, there has been a considerable difference in standard between the 1st VI and the 2nd VI, with the result that the same people were called upon week after week irrespective of how well they had been playing.

Each season some forty matches are arranged, including mixed doubles. As a rule the season begins in May and lasts well into August. Early season fixtures tend to serve as practices for the majority of the team and also experimental pairings. The Club now hopes to have regular winter play so that they can begin the match season with permanent and well-practised pairs.

The Club is very fortunate in having some of the finest quality grass courts to play on at Chislehurst. A number of the team have played in tournaments at Wimbledon, and it is their considered opinion that our courts certainly match up to the outside courts at the Wimbledon Club—praise indeed for our groundsman, Laurie White.

More recently the Club has done well in the Hospitals' Cup. For the last two seasons Bart's were narrowly defeated in the semi-final. This year the Club has been fortunate in being able to renew fixtures against Rochampton Club and the Cumberland L.T.C. In addition to the Wednesday and Saturday matches a tour is arranged early in the season against several Cambridge Colleges. It is hoped that in future seasons the Cambridge tour might be extended over a week, and a tour of Oxford is now being considered.

We congratulate Charles Evans and Bernard Watkins who have been invited to form part of the long distance canoe team to represent Great Britain in Spain on 4th August for the International Sella River Race.

G.H.

### CRICKET CLUB REPORT

#### v. U.C.H. 27th April. Lost by 5 wkts.

On the first fine Saturday of April the 1st XI disappointingly lost to University College Hospital. Bart's batted first and after preliminary instability Delany and Cannon added sixty runs for the fourth wicket. The batting after allowed a final total of 148 for nine to be attained before tea, at which the Hospital declared.

In the two hours remaining on the usual placid Chislehurst pitch U.C.H. scored 150 runs for the loss of five wickets.

Bart's 148 for 9 wkts. declared (D. J. Delany, 56; J. Cannon, 17).  
U.C.H. 150 for 5 wkts.

#### v. London House. 28th April. Won by 158 runs.

Bart's batted first on a wet wicket, and R. S. A. Thomas and N. Offen batted to 57 for the first wicket. Thomas nonchalantly scored yet another century in partnerships with R. Higgs, Lloyd and Griffiths, so that the Hospital declared at 248 for four.

London House were quickly dismissed by some fine slow left arm bowling from Lloyd—and were all out for 90.

Bart's 248 for 4 wkts. declared (R. S. A. Thomas, 117; R. Higgs, 43; Lloyd, 31).  
London House 90 (Lloyd 4 for 8).

#### v. Royal Veterinary College. 4th May. Won by 3 wkts.

The Royal Veterinary College batted first and were well contained by a good opening spell of bowling by Vartan and Rawlinson. Their scoring rate progressed with the slow bowling of Delany and they finally declared at 175 for five wickets.

Bart's were quickly in trouble and at one stage were 25 for four wickets. D. J. Delany and D. Goldie then came to the rescue and hit 110 runs in thirty-five minutes, scoring 79 and 41 respectively in true six-a-side style. Their total was reached with 3 minutes to spare for the loss of seven wickets.

Royal Veterinary College 172 for 5 wkts. declared.

Bart's 173 for 7 (D. J. Delany, 79; D. Goldie, 41).

#### v. Putney Eccentrics. 5th May. Won by 6 wkts.

Quick wickets by Smart and Savage soon had the Putney Eccentrics in trouble and at

lunch they were 77 for six. After lunch their remaining four wickets fell for twenty runs.

Bart's opened well with Thomas and Griffiths in fine form, and the total was reached comfortably with the loss of 4 wickets.

Putney Eccentrics 97.  
Bart's 98 for 4 (Griffiths 48).

#### v. Wimbledon. 11th May. Draw.

Thomas and Offen opened well for Bart's against the Wimbledon bowlers. As the pitch started to take spin, the wickets tumbled and the Hospital were finally all out for 150. H. Walker batted well for the Hospital.

After losing 3 quick wickets, Wimbledon contained the bowling and batted for a draw for the loss of six wickets.

Bart's 150 (R. S. A. Thomas, 40; H. Walker, 43; C. Smart, 23).  
Wimbledon 107 for 6 wkts.

#### v. Hampstead. 12th May. Lost by 206 runs.

Hampstead opened the batting on a wet pitch and scored rapidly before lunch. They further increased their score after lunch and declared for 233 runs.

Against an inspired bowling spell by Millar and Kenny, Bart's distinguished themselves by being bowled out for 25 runs in thirteen overs. Hampstead 233 for 5 declared.  
Bart's 25 (D. J. Delany, 14).

#### Oxford Tour

#### v. University College. 16th May. Match Drawn.

On a fine afternoon at Oxford, the Hospital batted conservatively against a strong bowling side. R. S. A. Thomas was in fine form, and was well supported by I. Peek and R. Higgs. At tea the Hospital declared at 129 for six wickets.

University College were unable to score rapidly against the Hospital fast bowlers, and so our captain put on the slow bowlers. However, a defeat was prevented by a fine last over by P. Savage.

Bart's 129 for six wkts (R. S. A. Thomas, 43).  
University College 126 for 6 wkts.

#### v. Brasenose College, Oxford. 17th May. Match Drawn.

Bart's laboured in the field, against a strong Brasenose side, and the hosts declared at 226 for 6 wkts.

After an attempt to go for the runs by I. Peek and R. Higgs the Hospital lost three

quick wickets and the game was "closed up" by Phillips and Lloyd, who batted out for a draw.

University College 226 for 6 wickets.  
Bart's 132 for 8 (I. Peek, 31; R. Higgs, 36).

#### v. Romany. 19th May. Lost by 68 runs.

Romany scored freely against the Bart's attack and finally declared for 233 runs.

N. Offen and N. Griffiths batted well for a first-wicket partnership of 61, after which the familiar "collapse" occurred, and the Hospital were all out for 165 runs. Romany 233 for 6 wickets declared.  
Bart's 165 (N. Offen, 39; Pagan, 26).

#### Cup Match

#### v. London Hospital. 21st May. Lost by 86 runs.

The London Hospital batted first on an easily paced wicket and lost quick wickets to Vartan and Savage, and at lunch were 107 for 4. After lunch they scored rapidly, until an inspired spell of bowling by P. Savage and C. Vartan capitulated the "tail end" of the London.

Bart's started well against a mediocre London attack, but then slowly collapsed and were finally all out for 101.

#### Cup Match: Result

#### London Hospital

C. Smith b. Vartan .....	8
T. Lawson ct. Thomas b. Savage .....	21
A. Rugg-Gunn b. Savage .....	8
D. Dunn ct. Thomas b. Savage .....	12
M. Wilkinson ct. Thomas b. Savage .....	85
J. Cosgrove ct. Peek b. Griffiths .....	40
J. Bourke b. Savage .....	9
L. Newson-Smith Not Out .....	3
A. Wilkinson b. Savage .....	0
B. Leatherdale ct. Thomas b. Vartan .....	0
P. McClure ct. Stoodley b. Vartan .....	0
Extras .....	0
Total .....	186

Dowling	O.	M.	W.	R.
Harrison .....	7	2	0	15
Vartan .....	17.2	5	3	39
Savage .....	14	7	6	26
Smart .....	11	0	0	61
Stoodley .....	3	0	0	17
Griffiths .....	4	0	1	20

#### St. Bartholomew's Hospital

R. S. A. Thomas b. Wilkinson .....	24
D. N. Offen ct. Wilkinson b. Cosgrove .....	12
N. Griffiths b. Smith .....	8
I. Peek b. Smith .....	13

B. J. Stoodley ct. Newson Smith b. Smith .....	17
D. J. Delany ct. Wilkinson b. McClure .....	18
W. H. Pagan ct. and b. McClure .....	2
C. P. Vartan b. McClure .....	4
C. J. Smart ct. Newson Smith b. McClure .....	3
P. C. Savage b. McClure .....	0
J. R. Harrison Not Out .....	0
Extras .....	0
Total .....	101

#### ATHLETIC CLUB REPORT

#### Wednesday, 8th May, at Cobham.

v. Westminster Hospital.  
St. Mary's Hospital.  
Royal Veterinary College.  
London Hospital.

Due to the bad weather at the start of the season this was the first match. The lack of match competition and the strong wind blowing across the track meant that some performances were below form. Nevertheless the new members of the club gave a good account of themselves.

As usual Bart's were very strong in the long distance events with Foxton in fine form winning the mile and two miles. In the shorter distances the lack of match fitness was evident but Scott, Coltart and Davies show obvious potential.

The field events presented a pleasant surprise with Bates, recruited that lunchtime from a couch in the A.R., doing well in the shot and discus. Pope, making a return to athletics after a long lay off, showed that with more effort he is going to do well this season with the javelin.

In the final results Bart's were second (with 62 points) to the Royal Veterinary College (with 71 points), London 3rd, Westminster 4th, Mary's 5th.

#### Individual Results

100 yds. P. Davies	4th	10.6 secs.
220 yds. B. Scott	3rd	24.6 secs.
440 yds. J. Coltart	3rd	57.4 secs.
880 yds. R. Thompson	1st	2 min. 12 secs.
1 mile T. Foxton	1st	4 mins. 39.6 secs.
2 miles T. Foxton	1st	10 mins. 18 secs.
Shot T. Bates	3rd	31 feet.
Discus T. Bates	1st	94 feet.
Javelin D. C. Pope	2nd	145 feet.
High Jump B. B. Kasteliz	5th	4 ft. 8 ins.
Long Jump D. Goodall	2nd	19 ft. 9 3/4 ins.
Hop, Skip, Jump D. Goodall	3rd	39 ft. 0 in.
Relay 110 x 4 P. Davies	J. Coltart	
	B. Scott	D. Goodall

#### Friday, 17th May, at Dog Kennel Hill.

v. King's College Hospital A.C.  
Charing Cross Hospital A.C.  
University College Hospital A.C.

This was a disappointing evening in many respects. The turnout of Bart's was poor due to blistered feet as a result of the Brighton walk and also to bad liaison between Charterhouse and the Hospital. The organisation of the match was also poor and with the amalgamation of Charing Cross and U.C.H., Bart's were forced to enter two people per event. This produced the amusing spectacle of Foxton throwing the javelin 10 feet to qualify for points and Goodall just clearing 4 feet in the high jump.

Nevertheless, those taking part had some valuable training and competition though the results were naturally poor.

In the events with regular performers Bart's did well. Foxton and Littlewood ran well in the mile and Thompson in the half-mile. B. Scott did well in the quarter and furlong. J. Niven, a welcome addition to the Bart's team, ran well in his first 100 yards this season. Though Goodall jumped well the effect of doubling up in four other events was apparent. Kasteliz picked up valuable points in many unfamiliar field events.

The result was an inevitable win for K.C.H. with Bart's close behind Charing Cross and U.C.H. in third place. The outlook, however, is not gloomy and Bart's should beat all these hospitals at the Inter-Hospital Championships in June.

#### Results

100 yds.—Niven, 3rd; Goodall, 4th.
220 yds.—Scott, 3rd; Niven, 4th.
440 yds.—Scott, 4th; Thompson, 5th.
880 yds.—Thompson, 2nd; Hardy, 4th.
Mile—Foxton, 1st; P. Littlewood, 2nd.
L.J.—Goodall, 3rd; Niven, 4th.
H.S.J.—Goodall, 3rd; Foxton, 6th.
Discus—Scott, 4th; Goodall, 6th.
Shot—Kasteliz, 4th; Goodall, 5th.
Javelin—Kasteliz, 5th; Foxton, 6th.
High Jump—Kasteliz, 5th; Foxton, 6th.
Relay—3rd Scott Thompson
Goodall Foxton

#### MEN'S TENNIS CLUB

**Trials.** Bad weather prevented full team trials being held on the grass courts at Chislehurst. However, a Freshers' Trial was held on Saturday, 27th April at Charterhouse. No outstanding players were discovered, but M. Bowen and M. Fryer should make regular 1st

team appearances this season. A number of other players, namely, Wainwright, Chandler, McGeachie and Farrow were also quite good.

#### Sat., 4th May. 1st VI v. St. Mary's.

A result was not possible for this match. We had to loan one of our players to the St. Mary's team. However, this first match of the season made it clear that the Bart's team will need much practice, concentration, and an ability to fight when losing, if any worthwhile results are to be obtained in the U.H. Cup. Team: P. Mitchener, A. Edelstone, P. Kingsley, M. Fryer, J. Barretto, M. Nightingale.

#### 14th-18th May. Cambridge Tour.

Five days were spent in Cambridge, but in fact only three matches were played. We were unable to arrange matches on two days because the Cambridge people were involved in their own league fixtures and examinations. For most people in the team the tour represented the first stretch of regular tennis this season, and consequently performances by all members of the team were rather more erratic than they might otherwise have been. However, the occasional flashes of inspiration that were in evidence may hold out some hope of more reliable performances later in the season.

#### Tues., 14th May. 1st VI v. Caius College.

It was unfortunate after a promising start which put us ahead two matches to one, that rain should cause cancellation of the remaining matches.

Team: A. Edelstone, Mitchener, Kohli, Frank, Barretto, Nightingale.

#### Thurs., 16th May. 1st VI v. Clare College.

Although beaten 7-2 by a fairly strong Clare team, this result was not entirely indicative of their strength, but rather of our inconsistency. A notable performance was put up by our 2nd pair, Kohli and Fryer, who did well to beat Clare's 1st pair. An enjoyable match was rounded off with a visit to the only consecrated bar in England—that under Clare College Chapel!

Team: Mitchener, Edelstone, Kohli, Fryer, Barretto, Nightingale.

#### Sat., 18th May. 1st VI v. Queens' College.

We were pleased to record a 5-4 win, but a higher score might have been expected in view of the strength of the Bart's team. Carden and Edelstone played well for Bart's.

Team: Edelstone, Carden, Mitchener, Kohli, Latham, Fryer.

**LADIES' SQUASH**

The 1962-63 season produced much the same results in the Ladies' Squash as it did last year, mainly due to the fact that only six people availed themselves of the excellent coaching provided on several Wednesday afternoons in the Autumn term. Everyone who was coached was very much helped by it, and the results showed in the following matches. However, good intentions were not followed up, and we hope that this will be remedied next year.

In the autumn term we played six matches in the U.H. Tournament, of which two, against St. Thomas' and against King's College Hospital, we won, those against St. Mary's, Middlesex, and Royal Free were lost after a good fight, but Guys, in our last match before Christmas, completely outclassed us.

However, when we met Guy's in the Spring term we were able to reverse the result and we also won our match against King's. Of the remaining four matches, we lost three and one was cancelled.

Our team throughout varied greatly. The people who played during the season included: J. Sykes (capt.), C. Foot, P. Aldis, D. Layton, T. Lopez, J. Clarke, E. Bohn, W. Rostron, A. Grieg, S. James, M. Newbold, P. Kumar, E. Sykes, V. Onians, S. Hereward, S. Macdonald.

**BOOK REVIEW**

**Materia Medica for Nurses (5th Edition)**, by W. Gordon Sears, M.D.(Lond.), M.R.C.P. (Lond.) Published by E. Arnold, Ltd. Price 13s.

This well-known book contains an extraordinary amount of important and useful information in a small space. Compared with the 1959 edition a few additions have been made and several older and outdated materia have been omitted.

Nurses should find this book valuable and within the price range of their pockets. Perhaps the index is not as helpful as it might be. Tranquillisers and Steroids come to mind as being words which nurses might want to find but which do not appear in the index.

A. E. Davis.

From the day you qualify . . .



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**EDITORIAL****People's Responsibility**

As we go to press the National Health Service enters its sixteenth year. In this orange juice, sperm to worm, welfare age what is to be said about Lord Beveridge's baby?

In fifteen years it has grown into a gawky and awkward adolescent costing a thousand million pounds a year. To-day it is late and not a little condescending to trot out the time-worn platitudes about teething troubles. In six years this expensive child will have its wisdoms as well as a man's estate. Its problems are more acute than painful gums, they are those of puberty. And this in an age when adolescence rides high—its problems stretched over a muddled decade of neurotic teenagia.

Coming as it did with all the other trappings

of a welfare state the N.H.S. has contributed to a distressing fall in the responsibility of the people. (As is so often the case a people's responsibility is inversely proportional to that of its Government.) The Service, attended by the clumsy ineptitude common in civil service departments, finds itself dangerously dependent on colonial and foreign doctors and chronically short of General Practitioners who are overworked and underpaid, especially in less fashionable areas. Such men have been debased financially, socially and, most tragic, medically. Small wonder that each year five hundred of their colleagues escape to the dominions where a house and often a car is guaranteed, where salaries are two or three times higher, taxes lower and where they may be practitioners of medicine.

What of the patient—the lone chap in our molly-coddled masses? He is more health-conscious but no healthier, although there is a marked improvement in the health of his environment and the community at large. This is little credit to doctors, medicine or even the N.H.S. It is the result of higher and more realistic wages which in turn increase standards of nutrition, sanitation and housing.

#### Insurance or B.U.P.A.

What of that weather-vane of all political and social movements, the middle classes? Do they accept the N.H.S.? Does it give them, the spine of any nation, that feeling of security which is so important a facet of fixed income respectability? A firm negative reply to these questions coupled with the suggestion that these people are positively flocking back to the old ways would be a hyperbole. Exaggeration is unnecessary, the indications are clear enough, a movement has begun in a country where movements are notoriously orderly.

At the inception of the N.I.L.S. there were 400 full-time private practitioners who opted out. Now there are 500. In other words 200,000 extra people have preferred to pay directly for their medical treatment and waive the N.H.S. benefits. (Such people are still bound to contribute to the Scheme.) If the patients of the many part-time private practitioners are included, it is possible to estimate that there are at least two million who have turned their backs on the National Health Service. True, more than half these become "private" only when they require hospital treatment. However, this merely broadens the spectrum of dissatisfaction to include hospitals as well as G.P.s.

How is it that a middle-class, less monied than ever before, can afford a return to private treatment? The answer is insurance or B.U.P.A.

in a word. In sixteen years the coverage provided by the British United Provident Association has increased more than fifteen fold, so that it now insures the health of more than a million people. There are others in this field, such as the smaller Hospital Service Plan, which has multiplied its coverage no less than fifty times in twenty years. This is clear evidence of the value set on private treatment by a large number of people in modern society. It may be that treatment is no better. No matter, it should not be so. An ill man sets a higher price on service and that is what money buys. It is unnecessary to predict a trend, the staggering increase in the demand for private beds speaks for itself. It was because hospital private wings and nursing homes were unable to meet this demand that the Nuffield Nursing Homes Trust was launched in 1957.

#### Too Reactionary

A return to the old system of slate-clubs and the panel might be a little too reactionary; but clearly the presentation to the British public of the N.H.S. on top of all the other welfare gadgets has diminished its responsibilities and its sense of values as well as degraded its doctors. One must insure a motor car and it is advisable to do the same for one's house. One's health is no less important. While maintaining a measure of responsibility for old age pensioners, mental patients and hard-up pregnant mothers, the Government would do well to rescind the scheme. Now is the time for the State to ask the public to look after itself. Since it has the means it should be encouraged to value a fifteen-guinea annual subscription to B.U.P.A. or some other firm more than the television licence—more than the set if necessary. No longer lackies of the State, many doctors would also gain immeasurably from such a move, and again experience a pride in their work. G.P.s. especially would regain a pre-war stature, that of a true doctor rather than a Government clerk cum local hospital sorting officer.

Of late there has been talk of moral stupor and the rot of affluence. We know that before the war, too, many men went hungry, many of whom were disgracefully poor. The picture has changed. It is a mistake of welfare society to assume too many responsibilities, to give too much away. It should give sufficient and leave the rest to free enterprise which is so often more efficient than nationalisation. It is reasonable to assist a lame man up stairs by giving him a stick, but ridiculous to provide him with an escalator for the purpose and at the top to offer him a glass of orangeade.

## AN ANNOUNCEMENT

Quite recently the Journal had to raise its subscription rate. This applies to new subscribers only and there will still be special concessions for recently qualified Bart's men and retired Bart's nursing staff.

Every effort is made to publish the journal in the current month. This has not always been possible. It is sad to admit that this issue is only the second this year to be published in its own month, sadder still that we have lost nearly two-hundred old Bart's subscribers over the past eighteen months. Rightly, they are unamused to read a July Journal in September—and have to pay for it. Regaining such a number of subscribers will be an uphill task. We hope that in the near future many old Bart's men will show their appreciation of an up-to-date Journal by becoming subscribers.

Editors are often faced with protracted struggles in the extraction of material from unwilling and unpaid contributors. This can, and frequently does, cause delay in publication.

The Journal is free to all medical students of the Hospital and Medical College. This will continue to be so although the numbers distributed in the students' cloakrooms will no longer be so ridiculously unlimited.

The price of the Journal to nurses will be reduced to 9d. a copy. We do hope that this particular section of our readers will show considerably more interest in writing for us. The publications committee is always glad to consider contributions. They should be addressed to the Editor, c/o Abernethian Room, and sent in for publication by the copy date announced in the previous issue.

## Correspondence

Dear Sir,

I do not wish to renew my subscription to your Journal, the reason being that they arrive to me some six weeks or two months late. The interest matter in them is then so out of date as to be useless. As an example of this, I have so far not yet received the May Journal.

When you can assure me that the Journal will arrive on time I shall be delighted to renew the subscription.

Yours faithfully,

F. F. Croft.

[Of course you are quite right. I am sorry that you and other subscribers are consistently let down. This should not be the case. The problem of late

publication is a perennial one which is commonly blamed on our printers—in the opinion of this editor, unfairly. Of late we have made up some time and over the next six months each Journal is expected to be published within the current month.—Editor.]

## Births

APTHORP.—On May 21st, to Marion (née Anderson) and George Hugh Apthorp, a son.  
FABER.—On May 30th, to Susan (née Barrett) and Dr. Vernon Faber, a son, a brother for Ruth.

## Engagements

SEWELL—WATERS.—The engagement is announced between J. Barratt Sewell and M. Fiona Waters.  
SIDEBOTTOM—BENSON.—The engagement is announced between Eric Sidebottom and Margaret Benson.  
SMITH—SAXBY WILLIS.—The engagement is announced between Ian Rea Smith and Angela Saxby Willis.

## Marriage

KNILL JONES—SYKES.—On 22nd June, at St. Giles, Ashted, Robin Knill Jones to Jennifer Sykes.

## Deaths

BELL.—On April 26th, Dr. J. A. Bell, aged 84. Qualified 1904.  
MARSHALL.—On February 26th, Dr. Eric Marshall, aged 88. Qualified 1906.  
REES.—On June 2nd, Thomas Percy Rees, O.B.E., M.D., F.R.C.P., aged 64. Qualified 1925.

## Changes of Address

Prof. Bryan N. Brooke,  
Department of Surgery,  
St. George's Hospital,  
London, S.W.1.

Mr. F. C. M. Capps,  
16, Park Square East,  
London, N.W.1.

Mr. Norman F. Smith,  
14, Furnival Mansions,  
43, Wells Street,  
London, W.1.

## A SERVICE OF REMEMBRANCE

for the late

WILLIAM DERRICK COLTART

M.B., B.S., F.R.C.S.

will be held in the

CHURCH OF ST. BARTHOLOMEW-THE-GREAT

West Smithfield, E.C.1

WEDNESDAY, 17th JULY, 1963

at 12.15 p.m.

## CALENDAR

15th July Copy Date for August Journal.

## July

Sat., Sun. 20 & 21 July: Dr. A. W. Spence  
Mr. E. G. Tuckwell  
Dr. R. A. Bower

Sat., Sun. 27 & 28 July: Prof. Scowen  
Prof. G. W. Taylor  
Mr. H. Jackson  
Burrows  
Mr. G. H. Ellis

Physician Accoucheur on duty for the month of July is Mr. J. Howkins.

## August

Sat., Sun. 10 & 11 Aug.: Dr. R. Bodley Scott  
Mr. Alan Hunt  
Mr. J. N. Aston  
Dr. T. B. Boulton

Sat., Sun. 17 & 18 Aug.: Dr. E. R. Cullinan  
Mr. C. Naunton  
Morgan  
Dr. Ian Jackson

Physician Accoucheur on duty for the month of August is Mr. G. Bourne.

19th August Copy Date for September Journal.

## LAST MONTH

From our Charterhouse  
Representative

Having decided that I needed a few days' break, I arrived the other day at Paddington Station to catch the Cheltenham Spa Express.

The first thing that strikes one is that the train has eight coaches, four of which are first class and one a dining car. That leaves three for the "hoi polloi" like myself. Thus it is on Paddington Station that one obtains the first glimpse of Cheltenham, which was my destination. A town with higher rates than Kensington—that has had a Tory M.P. since time immemorial—it is

the last resting place of retired colonels and rich old ladies. Perhaps I caught a glimpse of the waters and the gardens as I passed the first class coaches on my way to the second class. Here the compartments are full of school children, returning from a day in London, the air full of the Gloucestershire accent.

The foundations of the Great Western Railway were laid by I. K. Brunel, and Paddington Station designed by him. As the train gathers speed one wonders how much things have changed since his time. As every schoolboy knows, the number of "de-de-de's" in 41 seconds gives the speed in m.p.h., and thus it is simple to compare the speed of the train now with its speed a century ago (assuming, of course, that the Cheltenham Spa Express of a century ago was preceded by a horse). But I found the calculation difficult for two reasons. The first was that the noise of the wheels was unlike anything I had heard before, which was disconcerting, and secondly, when I had counted twenty they ceased altogether. Immediately the reason occurred to me, we had become derailed. Luckily I was sitting with my back to the engine, and fighting to remain cool I braced myself against the seat. After a short time in this uncomfortable position I found myself sweating slightly, and I wondered if I ought to warn my fellow passengers of their impending doom. They seemed quite cool, however, and the two men next to me were even talking. I took a hasty glance out of the window; we were approaching a large junction, and danger of capsizing seemed imminent. I listened to the fellows talking, something about welded track, meaningless engineer's conversation, and then a most extraordinary thing happened, the wheel noise started again. I think I may have fainted. And what is most ironic of all is that not one of my six companions know how near to death he had come.

I dismounted at Cheltenham very much in need of a few days' break.

## UP TO THE MINUTE, IN A MOMENT

A pretty traumatic month from a Party point of view—Miss Keeler and Co. will have a tale or two to tell their grand-children. Doubtless then, after the elapse of time—that universal leveller, the whole issue will be viewed in correct perspective in the pages of History. It is a pity that we live in a society which must make so much of so little. Values topsy-turvy, it has to sell the trivial and the commonplace. Presumably it is the price we pay for democracy, or more precisely, the freedom of the press which, we are told, is its prop.

The amusing foot-note to this saga of salacity is the Establishment snobbery à la the Keeler girl. Poor wench, she does not match up to the courtesans of history. No doubt Mr. Profumo rated her sex appeal higher than her breeding. Anyway, what did breeding ever have to do with sex?

The political wires have been humming a bit on the parochial front too. On 20th June there was a meeting of the Students' Union Council which discussed a progressive idea of its Chairman; namely the possibility of setting up an Education or Teaching Committee. A smart idea that can only do good to the teaching at Bart's—we hope that there will be some sort of close staff liaison to lend such a committee authority. We were told that the new hospital A.R. will be built by October. Work has yet to begin and the plans have spent the last nine months oscillating between various committees. This October?

On 7th June a good many Bart's men visited the new London Hilton in some style and at considerable expense. (Our social correspondent reports on page 171.)

On 21st June anyone who was anybody went either to a Bart's society twenty-first party in the West End or to the Cricket Club dinner locally. This was the last of the annual club dinner parties—perhaps there was a trace of nostalgia about the fine singing heard in College Hall later. Sadly, for the men, the last stag D.J. affair until '64.

More recently, on 1st July, the Bart's Art Exhibition opened in the Great Hall. In places the standard was high; outstanding were Messrs.

Brett, Duff and Ballantine, the last using colour in a child-like but fascinating way. (An art critic will report in our August issue, published August 12th.)

The weather has been fair for cricket and on 22nd June many besides bona-fide cricketers enjoyed taking part in the six-a-sides at Chislehurst. Ham cricket has an attraction all of its own. This season the Cricket Club are beating good sides, losing to poor ones and giving no quarter in the bar to any side—writes our sporting correspondent. Mr. Hugh Phillips was thinking of retirement (after a long and not unexpected series of duties), until a recent double half-century and 5 wickets—that in a 2nd XI team. (This team convincingly beat the Royal Free (men!) in a return match, in spite of the wild antics of Mr. Christopher Frears. Bowling his variable medium-fast, down-slope, wind-backed surprises, he had to bowl 11 to qualify for an over. The Present XI were surprised to lose to the Past XI under the meticulous captaincy of Dr. Oswald, by 5 wickets.

In the rowing world Messrs. Dai Lloyd, William Garson, Hugh Coleridge and Mike McKenzie were chosen for Henley. They were unfortunate in just losing to St. Catherine's, Cambridge, in the eliminating heats for the Visitors' Challenge Four. Their time was the third fastest and several slower crews qualified. These gentlemen consoled themselves on Saturday, 6th July, by going to Huntingdon Regatta, where the weather was rather less tropical, to win the Senior Coxed Fours. Their time was a course record. Meanwhile, at Henley, Mr. W. Howkins, the son of Mr. John Howkins, rowed for Christ's Cambridge, who won the Visitors' Challenge Fours. No one here can fail to know that Mr. Roger Nicholson rowed at No. 3 in the London University boat which won the Grand. They have been chosen to represent G.B. in the European Championships.

We go to press in the season of examinations and new Housemen. Most recently all but 15 per cent of the candidates passed 2nd M.B. An unusually high pass rate; fair proof of the vagaries of examinations—or examiners?

(In future, Club Secretaries wishing late news to be included in this page should contact the Assistant Editor not later than twenty days after the copy date.)

## FIVE MINUTES FROM BART'S

by our Drinking Correspondent.

(Photographs by B. C. P. Lee)

"From the White Hart to the Magpie  
Down Smithfield as I stagger by,  
For the last pint of the evening  
At the Old Hand and Shears."

So goes the song. This series will try to describe some of the pubs in and around Smithfield, all of them five minutes from Bart's. Bad ones as well as good ones will be considered so that the novice pubman may avoid wasting his time and money in them.

This month's selection are all good ones, where the backbone of the Bart's drinking fraternity can usually be found at some time or other.

On walking out of the casualty gate you are confronted by the White Hart. The Hart turns its back on the class system and has only one bar, a notable feature of which is that a bleep can be heard at the end nearest to the Hospital. The decor is a cross between British Railways' Western Region chocolate with a hint of the Palm Court added in the form of some potted ferns. But there are plenty of seats and tables and the beer (Charrington's) is well kept and the service quick and friendly.



"The Hart turns its back on the class system."

The bulk of the trade is a lunch-time one and this is not surprising for the Hart offers a menu ranging from veal and ham pie to various sorts of grill and roast, all good and reasonably priced. A half of bitter with a cooked lunch eaten at the bar need not cost more than 4s.

Walk up Cloth Fair and you will come to the Hand and Shears. This is one of the very few pubs in the area which opens on Sunday and, above all others, qualifies as the Bart's local. Until recently it had fallen from favour because its last landlord unfortunately believed that medical students should always behave like little ladies and gentlemen and not sing, or be drunken or put their feet on the table. Things changed when he departed for the



"Walk up Cloth Fair."

genteel South Coast and the present landlord, a cheerful Czech called George Kruml, took over. In fact all The Hand lacks now is a darts board. It has four bars, a piano, very good beer and snacks, and above all it has George and his wife Muriel. George did mysterious things in the Foreign Office during the war but to look at him now you would think he'd been born in a pub.

If you have not been to the Hand go now and you will keep going back.

Come out of the Hand and Shears and the Old Red Cow is in front of you. Inside you will find Dick and Pat O'Shea, a darts board and the best beer in Smithfield. Dick is a large Irishman who is as good at handling meat porters as medical



"George and his wife Muriel."



"Dick and Pat O'Shea and the best beer in Smithfield."

students. It is worth going to the Cow just to meet him although he has been known to wield a shillelagh when roused.

The Cow opens early in the morning for the Market workers, so if you badly need a hair of the dog, this is the place to go. Dick is usually closed in the evenings although you will find him open on Friday nights. He provides cheese and pickles, sandwiches and sausages at lunchtime at very low prices.

## FIFTY YEARS AGO

### CLINICAL JOTTINGS

by Samuel West, M.D.

**When Arterial Tension is High, it is Not Always Well to Lower It.**

High blood-pressure is often spoken of as if it were a disease of itself requiring urgent treatment, whereas it is but a single symptom, and is often best left untreated.

Its value in diagnosis and its call for treatment varies with the causes upon which it depends. A patient would be best without granular kid-

neys, but having that disease he should have a high arterial tension. If the tension be low he is not so well, and will not be better until the tension rises again to the adequate super-normal level. This explains why digitalis may do harm as well as good in granular kidney. If the tension be low, it will raise it and do good; if the tension be already high, it will do harm.

When arterial pressure is measured it is usually the systolic pressure which is determined. This depends chiefly upon the force of the ventricular contraction, and is held to be but little affected by the thickening of the wall of the artery. What

it is far more important to know is the diastolic pressure—i.e. the more or less constant pressure maintained in the artery between the pulse-beats—and this must necessarily depend greatly upon the condition of the arterial walls.

In estimating these different conditions in the arteries and pulse, there is no apparatus yet invented which is in any way equal to the educated finger.

When the high tension occurs in the course of some general disease, such as granular kidney, the treatment will be in great measure that of the associated disease.

But high arterial tension may occur where there is no granular kidney nor any other obvious cause. The condition is not infrequent, and is met with for the most part in busy, over-busy, energetic, bustling men with much to do, and who do too much—men who work at high pressure. This common metaphor does, indeed, express the fact, for their blood-pressure is actually high. It is probably just because it is high that they are capable of so much, and to reduce it means reduction in their capacity for work.

I have met with patients in whom some casual ailment, which brought them to the doctor, has been referred to this high tension. The high tension has been treated at first by mild drugs and measures, and, when these failed, by more drastic measures, stronger drugs, under-feeding or semi-starvation, and even free bleedings, with disastrous effect upon the general health and little or no effect upon the tension. In fact, the high tension in these cases, though no doubt in itself undesirable, seems to be the normal condition for that individual which alone enables him to retain his mental and physical vigour, for he loses both as soon as the pressure is reduced.

Thus it follows that there are cases of high arterial tension which are best left untreated. This statement is contrary to much of the generally accepted teaching of the day, but it is a statement of fact which has been brought home to me forcibly and not infrequently.

#### MENTAL HEALTH RESEARCH FUND Student Prizes and Travelling Fellowship in Psychiatry

The Mental Health Research Fund awards annually to Medical Students and Doctors in their Pre-Registration Year three Monetary Prizes and a Travelling Fellowship as the result of an essay competition on a subject relating to mental health, and a subsequent interview.

Applicants gaining the top three places in the

essay competition will be given prizes of £100, £50 and £25 respectively.

The Travelling Fellowship, tenable in a Psychiatric or other Department abroad for up to six months, will be awarded as the result of an interview combined with consideration of the candidate's undergraduate record. Persons interviewed will be chosen from the top ten in the essay competition. The travelling fellowship will normally be taken up at the end of the pre-registration year or, in the event of it being awarded to a medical student, may be taken up after qualification.

The subject for the essay this year is: "What objectively verified contributions to the understanding and treatment of psychiatric disorder have been made by (a) learning theory and (b) psychoanalysis?"

The Panel of Examiners consists of two members of the Research Committee of the Mental Health Research Fund and one member of the Association of Teachers of Psychiatry in Undergraduate Medical Schools.

Essays should be sent, before 1st March, 1964, to the Secretary, Research Committee, Mental Health Research Fund, 38 Wigmore Street, London, W.1 (Tel. WELbeck 4103), from whom further details may be obtained.

#### ARTHUR WESTERMAN M.D. Aberd.

Dr. Arthur Westerman, who died on 8th January at the age of 84, lived as well as practised for over fifty-five years in the City of London, and he was an authority on its history and traditions.

Born at Wakefield, Yorkshire, he qualified at Aberdeen in 1900, proceeding to the degree of M.D. in 1904. After studying ear, nose and throat work in Germany, he settled at Snow Hill in the City of London in 1906, and he continued in active practice there until 1962, principally as adviser to companies and institutions.

He was a member of the Common Council of the City of London, and for some years he was chairman of its public-health committee and one of H.M. Lieutenants for the City. He was a past president of the Hunterian Society and a past master of the Plumbers' Company.

T. W. P. writes:

"Twenty-five years ago Dr. Westerman took up residence in the Charterhouse as medical officer to Sutton's Hospital. There he would entertain friends in what was virtually an oasis in the heart of London. His hospitality usually included a tour of this little-known historic building—on the history of which he was an authority.

"A man of many interests, he retained his vigour and vitality to the end. He will be missed by a wide circle as a wise physician and an esteemed colleague and friend."

Dr. Westerman's wife died last year. He is survived by a son and three daughters, one of whom is a doctor.

## THE CLINICAL USE OF THE ORAL HYPOGLYCAEMIC AGENTS

Derrick Dunlop, B.A., M.D., F.R.C.P.E., F.R.C.P.

OUR diabetic clinic in Edinburgh, where I have worked since its foundation, was started in 1924 with the discovery of insulin and since then, owing to a variety of circumstances, it has become traditional for nearly all the known diabetics in the South East of Scotland—actually 86 per cent. of them—to attend it for the supervision of their disorder. We are thus fortunate in having an almost unique cross section of the diabetic population to observe—nearly 5,000 of them—old and young, rich and poor, rural and urban. Diabetes is, of course, mainly a disease of middle and old age for 50 per cent. of our patients develop the disorder between the ages of 50 and 70, and only 20 per cent. under the age of 40. The preponderance of women over male diabetics in the older age groups is due to the greater incidence of obesity in post-menopausal women; obesity is an important aetiological factor in diabetes and women seem to dig their graves with their teeth more than men.

With rare exceptions the lives of the 20 per cent. of patients who develop diabetes under the age of 40 depend on the constant use of insulin. A small proportion of our middle-aged and elderly patients—some 15 per cent. of our total diabetic population—are also insulin dependent. Thus some 35 per cent. of our diabetics require insulin to live. This leaves 65 per cent. who develop the disease usually after the age of 40 and who are not insulin dependent. The majority of these—some 45 per cent. of all our diabetics—are treated without drugs by diet alone, either because they are obese or their disorder is so mild as to require no more for its control than a reduction in calorie and carbohydrate intake. This leaves not more than 20 per cent. who are not completely insulin dependent but require something more than dietary restriction for their satisfactory control and who used to be given a small or moderate dose of insulin. For these latter the oral hypoglycaemic agents provide a very welcome alternative.

It may well be asked why it is that in many other clinics some 40 to 50 per cent. of their diabetic patients are given oral hypoglycaemic agents, whereas we control not more than 20 per cent. of them in this way. The reason is that, in Germany particularly, food has an overwhelming

attraction for people—an attraction which is not stimulated by the deplorably low culinary art of the United Kingdom, and the attitude to obesity is thus quite different in the two countries. In Germany they seem to regard obesity as a socially acceptable and even noble attribute whereas we regard it as ugly and lethal. Thus subcaloric diets are unpopular in Germany and the majority of their obese diabetics, whom we would treat by diet alone, are given sulphonylureas, just as they gave them insulin in the days before the oral agents were discovered, and so they go on from day to day getting a little fatter.

#### History of Oral Hypoglycaemic Agents

The history of the search for oral hypoglycaemic agents goes back for many years. In 1877 Müller reported that large doses of sodium salicylate reduced the blood glucose concentration—a fact rediscovered by Reid in 1957 in the case of aspirin. In 1918 Watanabe showed that guanidine had hypoglycaemic properties but its use was not continued owing to its neurotoxicity in animals. Nevertheless, in 1926 Frank altered the molecule to eliminate its neurotoxic effect while preserving its hypoglycaemic action and decamethylene diguanidine (Synthalin A) had a limited and transient popularity. Its subsequent disuse was due to its supposed hepatotoxic action but it must be confessed that the reports of hepatic necrosis ascribed to its use did not prove incontrovertibly a causal relationship. Nevertheless, its toxicity to animals, the frequency with which it caused gastro-intestinal symptoms in patients and its inconstant hypoglycaemic action justified its abandonment. Interest in this group of drugs has been revived during the last five years by the introduction of the diguanidines, phenformin and metformin (DBI and Glucophage) to which reference will be made later.

As a result of the disappointing experience with synthalin, research on oral hypoglycaemic agents received a setback for a number of years and it was not until 1942 that Jambon noted the hypoglycaemic effect of a sulphonamide derivative being investigated as a chemotherapeutic agent; and in 1944 Loubatières in Montpellier, studying

the hypoglycaemic action of another sulphonamide, concluded that it must stimulate the  $\beta$  cells of the pancreas since it was ineffective in pancrea-rectomised animals. As some of the induced hypoglycaemic reactions proved fatal, further investigation of these compounds was delayed until 1954 when Frank and Fuchs in Germany, again testing yet another sulphonamide derivative—carbutamide—for its antibacterial effects made a similar fortuitous discovery of its hypoglycaemic action and appreciated its possible value in the treatment of diabetes. Though its hypoglycaemic action in certain diabetics was undoubted further clinical studies, principally in other countries, demonstrated that carbutamide was by no means free from toxic effects. It was extensively investigated in our clinic and some degree of neutropenia and particularly thrombocytopenia—occasionally with purpura—occurred fairly commonly as the result of its use. There were also a few cases of toxic sensitisation similar to those produced by sulphonamides, including drug fever, rashes and increased capillary fragility. Other side effects—a few of them fatal—were noted by many workers in different countries. Thus the use of carbutamide has been abandoned in most (but not all) centres in favour of tolbutamide, which has now been used by about a million and a half patients with remarkable freedom from toxic effects; and chlorpropamide, a more potent compound with a longer action but accompanied by occasional side effects.

## THE SULPHONYLUREAS

### Mode of Action

Loubatière's original view about the stimulation of insulin release by the sulphonylureas was at first greeted with some scepticism despite supporting evidence from animal experiments in which, after the administration of sulphonylureas, many workers showed that degranulation of the  $\beta$  cells occurred together with a decrease in extractable pancreatic insulin and an increase of insulin-like activity in the plasma. There is now indeed almost complete proof that the sulphonylureas cause  $\beta$  cell stimulation in animals and in man. Nevertheless, the initial hypoglycaemic effect which they provoke is due entirely to a reduction in the amount of glucose released from the liver; it seems probable that this reduction in the release of hepatic glucose is due to the action of the extra insulin stimulated from the  $\beta$  cells but this has not yet been entirely established.

It is only some time after the administration of a sulphonylurea that evidence of increased insulin-like activity can be demonstrated on the peripheral tissues such as muscle and fat. It can be shown that the sulphonylureas reduce the concentration

of glucose required in the arterial blood to enable the tissues to take up glucose; that is, their use reduces the glucose threshold of the peripheral tissues in a manner similar to that of insulin. Nevertheless, the uptake of glucose remains directly related to the degree to which the blood glucose level is in excess of the threshold despite the lowering of the absolute values. This would seem to indicate that the capacity of the  $\beta$  cells to increase insulin release in response to rises in the blood glucose concentration is not improved by the administration of sulphonylureas. Such an explanation would account for the fact that the shape, if not the absolute values, of the glucose tolerance curve is not materially altered by daily treatment with a sulphonylurea for long periods of time. This is not of mere academic importance as the peaks of glycaemia which occur during the day after meals containing carbohydrate are analogous to glucose tolerance curves and, like them, their profile is not materially altered by treatment though they rise from a lower fasting base line.

### Preparations

In Europe three sulphonylureas are at present in general use—tolbutamide, chlorpropamide and, to a much less extent, carbutamide. They all contain the sulphone grouping which seems essential for their hypoglycaemic activity but the extent and duration of their hypoglycaemic effect is determined specifically by the nature of the first and last radicles. Weight for weight chlorpropamide has a greater hypoglycaemic action than carbutamide which in turn is more potent than tolbutamide.

When given by mouth the compounds are rapidly absorbed, maximum blood concentrations usually being reached within four hours, though there is considerable variation in the plasma levels which result from the administration of the same dose to different patients. The active free and inactive conjugated forms are excreted by the kidney, tolbutamide rapidly, and chlorpropamide and carbutamide slowly.

The half-life of tolbutamide is about eight hours and the rate of fall of its concentration in the blood after the administration of 1.5g. is such that in eight hours it has fallen below the effective therapeutic range of 6 to 10 mg./100 ml., and only negligible amounts can be detected in twenty-four hours. In contrast the half-life of chlorpropamide and carbutamide is from one to two days and small quantities of the drugs can still be detected in the blood five days after a single dose has been given. Thus the daily administration of chlorpropamide leads to a steady rise in its con-

centration in the blood until a state of equilibrium is reached so that ultimately there is little variation in its level throughout the twenty-four hours. In contrast, a single dose of tolbutamide each morning causes a rapid rise in its concentration in the blood which, however, declines so quickly that it is hardly detectable twenty-four hours later, and this pattern persists no matter for how long the drug is given. In order, therefore, to maintain its therapeutic blood level over the twenty-four hours it must be given twice and sometimes thrice a day.

The different rates of removal of chlorpropamide and tolbutamide from the blood results in daily patterns of hypoglycaemic response to single doses of the two drugs which are strikingly dissimilar. When chlorpropamide is given once daily to a responsive diabetic patient an immediate and sustained reduction occurs in the fasting blood glucose value. The absolute fall in blood glucose concentration for each of the daily determinations is, moreover, virtually the same in any one patient. Thus, the hypoglycaemic response to a single daily dose of chlorpropamide is characterised by the reproduction of the untreated daily profile of glycaemia at a lower level. The character of this response can be directly related to the fact that, since chlorpropamide is slowly excreted, adequate therapeutic levels are evenly maintained over the whole twenty-four hour period by the administration of a single daily dose.

When, on the other hand, single doses of tolbutamide are given daily before breakfast, the fasting blood glucose levels are virtually unaffected but considerable alterations occur in the daily pattern of glycaemia. The initial profound fall in blood glucose concentration is clearly associated with the rapid rise in the concentration of the drug which occurs in the morning, by evening its concentration has fallen below the effective therapeutic level and the blood glucose rises once more to pre-treatment heights; by next day negligible amounts of the drug remain in the blood and the fasting blood glucose value is quite unaffected. Nevertheless, the maintenance of adequate therapeutic levels of tolbutamide throughout the twenty-four hours, which can usually be achieved by its administration at 8 a.m. with another dose eight hours later, results in a hypoglycaemic response similar to that produced by chlorpropamide. A few patients who excrete the drug unusually quickly require three doses daily. It appears that neither the magnitude nor the duration of the response is materially increased by the administration of single doses in excess of 1.5 g. which is the maximum one which should ever be given.

Because of the lack of effect on the daily profile of glycaemia the most suitable patients for treatment with sulphonylureas are those who combine moderately high fasting glucose values with a relatively good glucose tolerance. Although the pattern of glycaemia is unaffected by treatment the peaks do not exceed the renal threshold so that urines tested first thing in the morning and after meals remain free of glucose. The most unsatisfactory diabetics for this form of therapy, on the other hand, are those with poor glucose tolerance. In such cases, despite the reduction of an initially fairly low fasting blood glucose level, control is inadequate in the latter half of the day. This emphasises the importance of not being satisfied with testing a single overnight urine specimen which in those cases would be free of glucose whereas those passed later in the day would be loaded with it. Urine tests alone, no matter how well timed they may be, constitute an inadequate assessment of diabetic control in many patients in whom the renal threshold for glucose may be very high as it so often is in long standing, ill-controlled diabetics. In such cases treatment by sulphonylureas may virtually abolish glycosuria despite the persistence of hyperglycaemia. Had the threshold been normal a marked glycosuria would have continued. In such cases occasional estimations of the blood glucose are, therefore, essential in addition to urine tests.

### Patients Suitable for Treatment

The type of patient who should initially be chosen for a clinical trial with the sulphonylureas are: (1) those who develop clinical diabetes after the age of 40; (2) those who, in the absence of infection or other stress, do not develop keto-acidosis, on withdrawal of insulin; (3) those whose fasting untreated blood glucose values are not much higher than 300 mg./100ml.; (4) those who do not require a total daily dose of insulin in excess of 40 units daily; (5) those who are not obese. Even when all these criteria are satisfied some patients are completely insensitive to the drugs. It is thus necessary to undertake with the greatest circumspection the transference to a sulphonylurea of any diabetic taking insulin, as some patients, if they happen to be insensitive to the oral agent, may develop ketosis with alarming rapidity when even a small dose of insulin is withdrawn.

### Primary and Secondary Failures

Patients who fail to show a satisfactory reduction of hyperglycaemia in the first few days of treatment are regarded as "primary failures"; "secondary failures" refer to those who, after a

period of satisfactory treatment of at least a month, subsequently lose responsiveness to the drug. A proportion of apparent secondary failures are doubtless due to disregard of the prescribed diet, to intercurrent infections, to emotional stresses or to a spontaneous worsening of their diabetes. Nevertheless, some secondary failures are certainly due to the development of true drug resistance which is not necessarily associated with a deterioration in glucose tolerance, as such patients can often be controlled by the same dose of insulin which they may have been taking prior to the start of oral treatment. In our clinic secondary resistance develops each year in about 15 per cent. of patients receiving the drugs.

#### Toxic Effects

Theoretically all sulphonylureas are potentially toxic drugs but of the three which have been widely used clinically only carbutamide has caused a significant incidence of serious side effects to which I have already referred. Tolbutamide and chlorpropamide are very much less toxic. We have treated many hundreds of patients with tolbutamide and apart from rare and slight gastrointestinal disturbances and very occasional rashes, have observed no side effects. Derangement of the hepatic, renal, endocrine or cardiac functions do not occur with it, nor do significant hypoglycaemic reactions result from its use. Indeed its remarkable freedom from toxic effects renders tolbutamide unique among drugs of therapeutic importance.

Chlorpropamide when properly prescribed is also a safe drug but, when given in large doses of 500 mg. or more daily, may in a few cases cause jaundice due to an intracanalicular biliary stasis, and when given in excessive doses will certainly cause hypoglycaemic reactions. Because chlorpropamide is excreted so slowly such reactions may be prolonged and sufficiently intractable to require the administration of glucose over a period of time up to thirty-six or even forty hours. When the daily dose does not exceed 250 mg. such toxic and hypoglycaemic reactions are extremely rare.

#### THE DIGUANIDES

The mechanism of action of phenformin (DBI) and metformin (Glucophage) differs from that of the sulphonylureas since they lower the blood glucose levels of pancreatectomised or fully alloxanised animals and of insulin dependent diabetics provided they are receiving a minimal dose of exogenous insulin. It is probable that they act directly in some unknown way on the peripheral tissues to facilitate their uptake of glucose. Their therapeutic use in man is severely limited by the

high incidence of side effects which they cause if given in doses sufficient to have a significant hypoglycaemic action. Phenformin causes particularly anorexia, nausea and vomiting; while metformin may also cause these symptoms its main side effect is diarrhoea. Side effects occur even when the drugs are given by rectal suppository and are due to the fact that phenformin is excreted into the stomach and metformin into the small intestine. As the diarrhoea is usually less intolerable than nausea and vomiting and easier to control we have found metformin to be preferable to phenformin. Nevertheless, 50 per cent. of our patients are quite intolerant to it. The effective dose varies from 1 to 3 g. daily.

In our opinion these drugs have a limited clinical use. In most insulin-dependent diabetics the dose of insulin can be reduced somewhat by combined treatment with a diguanidine but this rarely leads to improvement in the ease of their control, and the reduction in insulin dosage seldom justifies the risk of side effects. In insulin-dependent diabetics the diguanidines are unnecessary if the patient can be controlled by diet alone or with the relatively non-toxic sulphonylureas. Thirty per cent. of patients primarily resistant to a sulphonylurea are also resistant to diguanidines, even when given in maximal doses. In the remaining 70 per cent. some effect is produced but in one-third of them the response is inadequate and in another third effective doses cause intolerable side effects. Thus perhaps only one in five of these patients, primarily resistant to a sulphonylurea, can be satisfactorily controlled by a diguanidine.

The diguanidines also have a very limited use in patients who become secondarily resistant to sulphonylureas: in 30 per cent. of such cases they are ineffective; in about 50 per cent. they have a hypoglycaemic action when given either alone or in combination with the sulphonylurea but are unsuccessful, either because the response is inadequate or because of the severity of the side effects produced. Thus, again only about one in five of patients secondarily resistant to sulphonylureas are successfully controlled with metformin alone or in combination with a sulphonylurea.

#### ORAL AGENTS AND LATE DIABETIC COMPLICATIONS

There are few medical disorders about which we know so much and yet so little as diabetes mellitus. We understand how the metabolic disturbance conflicts with physiological integrity and how with a little trouble and circumspection the diabetic can avoid the immediate lethal effects of the disease which were so formidable in the pre-

insulin era. Nevertheless, the diabetic state is so far incurable and we are largely ignorant of its aetiology and of the cause of most of its complications. Today the problem is not so much that of the acute disease as exemplified by diabetic coma for we know, or ought to know, how to avoid that catastrophe, as it is of a chronic disorder with a considerable expectation of life, which involves a prolonged effort to avoid the chronic complications which so commonly ensue—neuropathy, retinopathy, nephropathy and cardiovascular disease. Their greater incidence in patients who have had diabetes for a long time is undoubted, but there is much debate as to whether they can be prevented or postponed by careful control of the disease. On the one hand there is the profound pessimism and fatalism of those who believe that there is no relationship between the control of the condition by treatment and the presence or absence of complications—that it makes little difference how a diabetic is treated: if he lives long enough he is bound to develop one or other of them. Opposed to this point of view are those who believe that every effort should be made to restore physiological conditions, including freedom from glycosuria and a normal blood glucose concentration throughout the twenty-four hours in so far as this is possible, and that this will favourably affect the incidence of complications. The late Dr. Joslin with his vast experience thundered against the *laissez faire* heresy in diabetic treatment with a puritanical evangelistic fervour and,

after a short period of agnosticism I have come again to agree with him. Some years ago I personally examined a large group of diabetics who had attended our department for periods of time varying from 15 to 31 years and who had all required at least 20 units of insulin a day during the many years of their attendance, and attempted to correlate the degree of control of their diabetes during that time with the incidence and severity of complications. I am aware that the results were open to many of the statistical objections inseparable from retrospective studies of this nature: but the clinical experience of carrying out this survey convinced me, at any rate, that the careful control and aggressive treatment of diabetes over the years is a most important factor in the prevention or postponement of its complications. It is probable that these are due to some aspect of the metabolic disturbance which is itself complex and not confined to carbohydrates. Alterations in plasma lipids, lipoproteins, glycoproteins and mucopoly-saccharides may be related to their development and there are a few somewhat contradictory reports of the effect of oral hypoglycaemic agents on these constituents of the plasma. It is too early to say whether such drugs will be as effective as insulin in the prevention of these complications, which is the outstanding clinical problem in diabetes today. Should the new agents turn out to be less effective than insulin in this respect, the convenience of their oral administration will be dearly bought.

## BEHIND THE SCENES: I

### ALMONERS' DEPARTMENT

by Joan Floyd

"The apprentices to the three surgeons show pressing importunity and bould saucy carriage to the almoners to enforce such persons to be admitted [to hospital] as they recommend for the remedy thereof". Such was a complaint voiced by the St. Bartholomew's Hospital Board of Governors in 1664. Today, roles would be reversed and it might be the almoner who would be accused of importuning the Surgeon's apprentice for early admission for a patient. The almoners referred to in the quotation, however, were members of the Board to whom the Governors at that time delegated the responsibility of interviewing

all applicants for admission and of deciding whether to admit or reject them. The first Lady Almoner did not come on the scene in this country until 1895 when a trained social worker was appointed to the Out-patient Department of the Royal Free Hospital. At that time the word "lady" did not carry the same overtones that it does today and was used merely to denote her sex, thus distinguishing her from the almoners on certain Boards of Governors. We know that the Lady Almoner's duties in 1895 were in part those of her 17th century predecessors, although we have no record of the behaviour of the surgeon's

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International Conference of Social Workers in Toronto.  
—Vintage 1924.

apprentices of the day to her. In addition to selecting suitable patients for outpatient treatment and for admission to the wards, she was also charged with helping those in treatment to make full use of the facilities offered. It is this latter part of her duties that persisted and developed.

With the change in the climate of the times the emphasis has shifted somewhat even in this latter field. The early Lady Almoners seem to us in retrospect tall Amazonian creatures secure in the conviction that they knew what was best for their patients. The patients were poor and usually anxious for guidance, in which case they were deserving. There was, however, a stubborn type of patient known as undeserving and from such a patient help had to be withheld on grounds of lack of merit. Today in our egalitarian society the decision as to whether help of any kind should be offered to a patient is made, not according to some moral yardstick, but according to the almoner's assessment as to how far the patient can use it constructively. We study intensively in our training the dynamics of human behaviour and what happens to human beings in their social

relationships. We practise under supervision using the professional relationship with the aim of helping patients to tackle their own problems more realistically and more successfully.

Through training and experience we gain, too, a wide knowledge of the sources of practical help for human beings in adversity. Not only can we call on the statutory social services and the voluntary organisations, but often we can ask and receive help from the other great institutions which are part of the framework of our society such as the educational system, the law and commerce. Helping just one patient may lead the almoner into many fields.

Often she is called in to help a patient with a permanent and crippling condition. A man who has had a double leg amputation will have very many adjustments to make and battles to fight. Emotionally he must gradually adapt to the loss of part of himself and with it the loss of some at least of the independence he has been used to. He may need a course of rehabilitation to give him confidence. He may need to learn new skills and be trained for another job. Ideally he may need

rehousing, but if that is impossible his local authority, may be willing to carry out quite radical architectural alterations to his present house so that he may be as independent as possible. Lastly his changed condition may have far-reaching repercussions on his family, both financial and emotional. It will be the almoner's job to provide supportive relationship to the patient and his family, perhaps for months, perhaps for years, and where necessary to give him practical guidance.

So far the welfare state has not legislated for all the accidents of this life. There is no provision laid down for the care of a budgerigar when its owner is admitted to hospital, and an almoner's day might include making plans for a budgerigar as well as for a large family of children in such a crisis. A Ward Sister might, of course, agree to admit the budgerigar as well as the patient, but no almoner to my knowledge has yet made the suggestion. More difficult and challenging for an almoner would be the task of helping a patient who has spent years chasing round from one doctor and hospital to another in a fruitless search for a cure for his condition. Such a patient may have been told the facts clearly and sympathetically many times, but he has refused to accept them. Merely to tell him once more will do no good. If an almoner is to help him to come to terms with reality she will provide an accepting

and unhurried relationship in the security of which he can move at his own pace and work through some of his anger and fear and resentment.

Our focus is social—the patient's family circle, his job, what the world can offer him as well as his expectations of the world. In the course of our contact with a family we may meet one or more of our opposite numbers—child welfare officers, family caseworkers, probation officers and so on. These may have been in the same university with us, and may even have shared part of our professional training. The usual pattern today for an almoner's training is a degree in Sociology or a similar subject, followed by a year's training in an Almoner's Department in a hospital. Sometimes, however, the year's post-graduate training is done under the aegis of a university and the student may then spend only half of the year in a medical setting, the other half perhaps being spent in a Children's Department. The newly-trained almoner usually starts off in hospital, but later may move for instance to the Welfare Department of a local authority. Some of us, however, will continue to find it difficult to tear ourselves away from the hospital environment and the stimulus of continuing contact with the ancient and highly disciplined profession of medicine, however much easier it may become in the future to step sideways into other branches of social work.

Some of the Hospital's present-day Almoners.

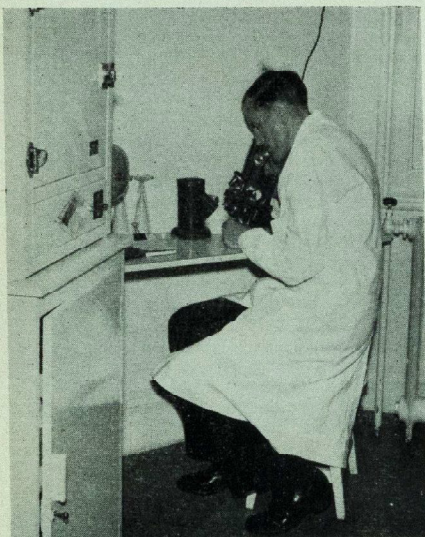


## SPECIAL DEPARTMENTS. I.

(In this Series the Journal will give space to the various Departments which students see less of during their clinical course. The series will give an indication of the work done in these Departments. It will also outline opportunities for those especially interested in a particular speciality.)

## DEPARTMENT FOR VENEREAL DISEASES

by C. S. Nicol, T.D., M.D.(Lond.), F.R.C.P.



Dr. Wilson in the new Department Laboratory.

During 1962 1,535 new patients attended the Special Treatment Centre (S.T.C.) at St. Bartholomew's Hospital and there were 8,995 attendances during the year. The S.T.C. is a medical Out-Patient Department dealing with patients suspected of having sexually transmitted diseases either of long standing or of recent origin. It is perhaps unfortunate that the term "venereal diseases" is used to identify the Department and that the Consultant in charge is termed a venereologist. In the legal sense (defined by Act of Parliament of 1917) the only venereal diseases are syphilis, gonorrhoea and chancroid. However, 75 per cent. of the patients attending the S.T.C. do not suffer from these diseases. Many of the patients suffer from diseases commonly transmitted by sex contact such as non-gonococcal genital infection (including trichomonosis), lymphogranuloma venereum, granuloma inguinale, pediculosis pubis, genital scabies and genital warts; others come for a check up following a sex risk and after

a 3 month follow up are found to have no disease.

There is no appointment system for new patients who often attend of their own accord because they are unwilling to report to their general practitioner; many patients are, however, sent by a G.P. while some are referred from other out-patient departments. Some patients attend as a result of contact tracing; the original infected patient is given contact slips for his infecting contact and for other sex contacts whom he may have infected. Two beds are available in the general medical wards for In-Patient treatment, and requests (yellow boards) are received for an opinion on other in-patients.

After history taking all new patients receive a full physical examination with recording of weight and blood pressure, urinalysis for albumin and sugar and blood tests for syphilis are also routinely taken. The Almoner to the department interviews all female patients and all male patients with disease. As can be imagined there are few patients without serious home problems to solve. In married people it is paramount to avoid separation or divorce, particularly if there is a family of children.

There is a system of follow-up and if necessary defaulters letters are sent. Patients who have not completed treatment may receive a visit from a Welfare Officer. Transfer Cards are given to patients who are leaving the area for other clinics in Great Britain or abroad.

The physician dealing with these conditions should have a training based on general medicine with some special knowledge of dermatology, urology, cardiology and genito-urinary diseases. He may also have to give opinions on psychiatric and orthopaedic cases.

Students attend the Department once weekly over a three month period for lecture demonstrations and each summer three formal lectures with coloured slides are given completing a course of six lectures over two years.

A house physician is shared with the Skin Department.

The present non-medical staff are as follows:—

**Nursing:** Miss N. Sinclair, Sister-in-Charge.

Mr. C. Dyett.

Mr. I. A. Wilson.

**Almoner:** Miss S. Bird.

**Receptionist/Secretary:** Mrs. M. A. Tod.

## WHO WANTS A 22 YEAR-OLD DOCTOR?

## By a Consultant

A 20-or-so-year-old nurse might well be considered to want a 22-year-old doctor, although she would be unlikely to specify 22 as the one and only suitable age.

On the other hand, a 99-year-old patient is most unlikely to specify 22 as the necessary age of his medical adviser. With increasing age, the patient is likely to look for experience as well as mere qualification in his doctor; and experience is not to be found in its ripeness in the doctor of 22.

But suppose that someone did insist on 22 as the age of his doctor. What then? Is he next year to have another doctor because the previous one is now 23, and so ineligible?

The sufferer from a perforated gastric ulcer, a wound of an artery, a dislocated shoulder, or acute angina is unlikely to ask to see the birth certificate of the available doctor, and reject him if not 22. He will not care if the doctor is 22, 23, 42, or 60! He will not even care if he has been struck off the register, provided his knowledge and kindness have not been simultaneously struck off.

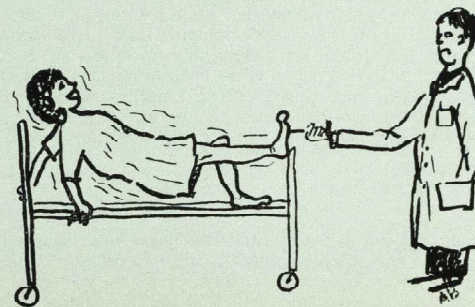
A special class of the community not keen on 22-year-old doctors is that of examiners, busy as they are ploughing aspirants to qualification.

But if by 22 is merely meant young as opposed to old, then doubtless a better case could be made out on behalf of the energy and up-to-date knowledge of youth. On the other hand, in medicine experience counts, although perhaps it is not so much experience as the capacity to profit from it that matters. But if this is what is meant by 22-year-old, then this is merely loose talk, and to be discouraged.

If, however, the question is to be taken literally, then its unusual nature is revealed by the fact that one does not remember ever seeing an advertisement reading "Doctor required—must be aged 22"!—or hearing the appeal "Is there a doctor in the house—of course aged 22?" This proviso is so obviously ridiculous that anyone requiring, or thinking that he requires, a doctor of 22 would be in danger of being considered eccentric and even in need of a psychiatric overhaul by a doctor of any age!

But is it possible that the question has been misunderstood, and that it really refers to a suggestion of earlier qualification, i.e. at 22, instead of 23 or 24? This could be achieved either by shortening the period of pre-medical education, or by shortening the medical course, or both. With new subjects clamouring for inclusion in that course, it is difficult to see how it could usefully be shortened; and, with regard to the medical education, the broader based the doctor, the better for him and his patient. In this sense, therefore, the question "Who wants a 22-year-old doctor?" may be answered "No one who has the true good of the doctor, and thus of his patient, at heart."

A.E.R.



### A Patient

"Is that Dr. A's surgery? This is Mrs. X. speaking. I wondered whether the doctor could call to see me at 'The Grange'? My palpitations are troubling me. I do not wish to trouble Dr. A., but perhaps that new nice young Doctor B. could call." "I will put you down for a visit," replies Miss C., the attractive receptionist, and promptly adds Mrs. X's name to Dr. A's list, knowing full well that as Mr. X. spends a great amount of time in the City and away at business conferences Mrs. X's. most serious complaints are loneliness and boredom, and that a visit at this stage by Dr. B. might well endanger both her palpitations and Dr. B's. unblemished reputation. She certainly wants a doctor of twenty-two!

Then, of course, there is Miss C. herself. She has been with Dr. A. since she was seventeen, and whilst she greatly admires him, he is married with four children whereas Dr. B. is in the market and available for immediate possession. She was a little interested in a traveller for one of the drug firms, but he only calls every three months, whereas the new young doctor is on the spot, and opportunities to press a closer association ever present. With her experience of the practice there is no doubt that she would make a good wife for a doctor. She wants a doctor of twenty-two!

Dr. A. wants a doctor of twenty-two, otherwise he would never have taken Dr. B. as an assistant. He has been single-handed up to now and he feels it is time for someone else to take on the chores of the practice, for someone else to do the chasing round at the most inconvenient times, while he sits back and accepts that occasional cup of coffee or tea he has always refused in the past. He will also have more time to cultivate his private practice—a valuable addition to the calculated emoluments of the National Health Service. He will definitely see more of his wife and children, and finds it difficult to think when he had the time to have four children and assumes they were attributable to the disturbances of night visits. Now Dr. B. can take over three, four or five nights a week! He certainly wants a doctor of twenty-two.

The teenage element on Dr. A's. list welcome Dr. B's. arrival. His comings and goings are a subject of conversation in factory, office and showroom throughout the town. There is an increased incidence of illness amongst this group who consider it a mark of distinction to be able to announce to their friends in the morning—"He examined me last night". Then the large number of mothers in the town have also perked up at Dr. B's. arrival for they have eligible daughters who have been eligible too long, and the invitations flow freely for lunch and dinner, as well as tennis, cocktail, sherry and other contrived parties designed for the ensnarement of a single G.P. They all want a doctor of twenty-two.

Lastly there are the patients; the sick; those awkward elements in a G.P's. life who fill surgeries or whose relations appear to spend the greater part of their lives on the telephone. Now that Dr. B. has arrived there is not such a long wait in that dreary surgery waiting room, and a doctor seems to arrive much quicker when he is commanded to appear. Also the new chap is bright and breezy whereas Dr. A. seems to have been rather testy and irritable of late, though they cannot think why, for all they wanted was a certificate! Most certainly they want a doctor of twenty-two.

Most of this has been written on the assumption that the doctor of twenty-two will be a cross between Kildare and Ben Casey, but suppose that Dr. B. turns out to be Miss B. Well, I have just spent a period in the finest of teaching Hospitals in London, which, for the sake of anonymity, we will call St. Lionel's, and if Dr. B. should turn out to be the Miss B., who was the student in my case, then I shall be the first to transfer to her list, for I definitely would like and want a doctor of twenty-two!

P. Neighbour.

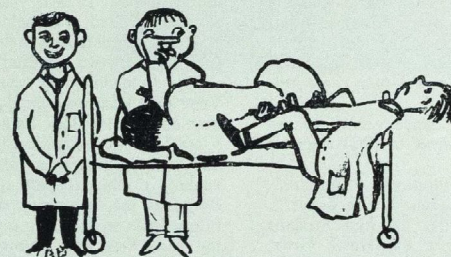
### A Sister

Does sister want a doctor of twenty-two—that junior sister who is just appointed and finding her feet in a new sphere of authority and responsibility? Does she want a youngster, also finding his professional feet, qualified but even less experienced than she is? I doubt it, she needs someone who can help as well as commiserate, someone who

at least knows his own job; she won't ask him to know hers. Does she hope for a fellow-enthusiast on the subject of fast cars or the best place to eat? This young man still will not do.

And what of the senior sister—does she see in the fledgling doctor the son she never had? Does she see him as clay in her hands, to be transformed from a student to a man of gentleness and understanding in his dealings with patients and their relatives, a graduate of the finishing school for medical men which is part of every teaching hospital and is staffed as much by the nurses as the consultants? Does she hope to transform him as she has helped to transform countless others over the years, following their careers, admitting their patients to "her" beds, and hearing praise of the G.P. who "walked your wards when he was a student and young doctor, Sister".

No, she does not want a doctor of twenty-two. She knows that there is too much to learn of life, both general and professional for it to be accomplished by this time. More and more must be taught as knowledge increases, but wisdom, if it comes at all, comes with experience. There is no hurry, the patients will still be there when the young man is a few years older, and they will then benefit from his greater maturity; they who are, after all, of supreme importance. Sister will benefit, too, for less will have been added to the sheer weight of the people who lean on her.



### A Student

Youth it seems, from the Staff viewpoint, is a doubtful advantage at the bedside, but for the patient it is a positive asset. For charm and sympathy a young man, for advice and treatment the old man, these might be the feelings of many. But are the patients feelings towards his doctor determined by age? In any case unless this young man arrives in the ward with a noticeably downy chin, he has probably passed into a period of indeterminate age. So, though sister and consultant may realise—from one source or another—the relative youth of this houseman, it is not something which the patient is often aware of, unless he or she enquires for matching purposes.

At all events age is a relative thing; to the consultant "sans everything" and approaching redundancy, twenty-two is extreme youth and probably evokes in his own mind memories of pleasurable follies and indiscretions. While to a patient of middle-age twenty-two is nothing like so youthful. Even sister may be reconciled to this fledgling if he picks things up fairly smartly, and doesn't find his professional feet too large for the service boots.

Lastly and perhaps most important the patients usually delight in the young doctor, knowing full well that he has the vicarious experience of his consultant, just so long as they benefit from that experience and do not help to extend it. For alas "experience" tends often to be the sum of our mistakes.

P.C.G.S.

## THE VIEW DAY BALL

### ORIGINS—FROM OUR HISTORICAL CORRESPONDENT

Once again the View Day Ball has come and gone and, apart from the inevitable minor criticisms, it seems to have been a great success. Most students and indeed many of the younger members of the staff must have accepted the Ball as an established feature of the Bart's calendar. A few, however, may have paused for a moment to ponder on the nature of its connection with the customs and traditions of View Day itself which takes place nearly a month earlier.

The View Day Ball in its present form was ten years old this year, but it originates from a much older occasion, indeed the Ball has its roots in the very foundation of the Students' Union.

In the February of 1904 a meeting of students agreed to the adoption of a proposed constitution and in the March of that year the old "Amalgamated Clubs", which had begun in 1892, ceased to exist and the Students' Union came into being.

The first mention of a dance occurs in the November edition of the *Journal* of 1904 where it is reported that:—

"Mr. Loughborough supplied information and estimates for a Student Union dance"; and on December 6th, 1904, the first Student Union Dance took place at the Hotel Great Central. According to the editorial in the January *Journal* this "was an unqualified success", though the writer noted a regrettable absence of junior students. The cost of a single ticket was then ten shillings and sixpence.

The following year the Dance appears to have been even more popular for one contributor to the *Journal* was prompted to write: "There can be no doubt now that this annual function is an institution that has come to stay." The intervening fifty-eight years have indeed borne out this prediction.

The numbers attending these dances steadily rose from one hundred and fifty in 1905 to three hundred and fifty in 1910 and they continued to be held early in December at the Hotel Great Central until the Great War caused their cancellation in 1914.

The first dance to be held after the cessation of hostilities was on January 28th, 1920, at the Hyde Park Hotel when tickets were one guinea for gentlemen but only fifteen shillings and sixpence for the ladies. The date in subsequent years varied from November 16th to February 9th and

the place was also altered frequently, from the Prince's Galleries to the Savoy Hotel and, in the '30's, to the Grosvenor House, with a return to the Great Central in 1924.

In 1933 the Students' Union Dance became the Students' Union Ball and then, in 1939, war again put a stop to what had by now become part of Bart's tradition, and it was not until January, 1945, that the Ball could once more be held.

Four hundred and fifty guests attended in 1949 at the Dorchester Hotel where the balls continued to take place until 1953 when a major change occurred; for the first time, the Ball became a joint function for both the Medical College and the Hospital. In that year the Coronation Ball, as it was called, was held at the Royal Festival Hall and the date was moved to May when about one thousand two hundred people attended.

The following year the Ball became part of View Day and was, therefore, known for the first time as the View Day Ball. In 1956 the Ball and View Day were separated as it was felt that a mid-week ball was too disruptive to the smooth running of the Hospital. It was after the 1957 Ball that the suggestion was first made to hold future balls on the lawn outside College Hall, but the View Day Ball Committee for 1958 decided against this in view of the damage which might result to the lawn.

In 1959, when the Ball was again held at the Royal Festival Hall after an interval of three years at the Park Lane Hotel, there was a lack, not, as in 1904, of the junior members of the Hospital and Medical College, but of the senior staff who were "represented by only one reader".

The 1960 and 1961 Balls were held at Quaglino's and the Dorchester respectively and it was in 1961 that the Ball was held in June for the first time, even so, before View Day itself, a fact occasioned by the Queen's visit to the Hospital at the end of May.

The Ball last year was a gala event to mark the three hundredth anniversary of the start of teaching at the Hospital and took place in the stately surroundings of the Hurlingham Club.

And so to this year's Ball about which sufficient has been said elsewhere to prove its success.

When Mr. Loughborough supplied his information fifty-nine years ago I wonder if he guessed what he was starting.

## SEVEN HUNDRED AND EIGHTY-NINE—

### FROM OUR SOCIAL CORRESPONDENT

That was the number of people at the London Hilton for the fifty-ninth View Day Ball of the Royal Hospital of St. Bartholomew in aid of the London Homes for the Elderly. Various theories have circulated since to account for the odd one out (or in?). The most plausible being that some impoverished medic, already four and a half pounds down, took one look at the right-hand side of the wine list and fled.

The annual increment in the price of the tickets is an accepted ritual. The organisers are faced with a ticklish problem. This is London or, more explicitly, over-heads. It is unfair to compare our Ball with the Cambridge May Balls which are on quite a different wicket. There, every penny spent is returned in the form of food, champers, caterers, bands, marquees and dance floors. It is our misfortune to have to line the pockets of Messrs. Cotton, Clore and Conrad

Hilton as well.

Most of us arrived by nine o'clock for the early dinner. Your correspondent was surprised to see many of the younger generation, students and housemen, wearing white ties. More surprising was the predominance of odd-coloured carnations—was a time when it was clove for a D.J. and white for soup and fish. Those were sartorial days when a white tie would have been de rigueur on such an occasion.

The Hilton? An odd mixture of the garish and the gloomy, it was impossible for it to please. The ballroom, with its low ceiling and pseudo black beams, was variously compared with a barn, an aircraft hanger and a bus station. Needless to say, being British, many were shocked by the escalator—such an Americanism! Your correspondent shrugged and used them gratefully; after all it is an American hotel.



The Lord Mayor's arrival: Sir Ralph Perring, Mr. and Mrs. Alan Hunt, Mr. John Cope and Mr. Richard Petty.



Professor W. G. Spector, Mrs. R. Stewart, Professor N. Morris, Mrs. Spector, Mr. Roman O'Casey, Mrs. N. Morris, Dr. Willoughby, Mrs. R. O'Casey, Mr. K. Stewart and Mrs. Willoughby.

In order to dine we had to pass an attractive young woman selling programmes. She looked as if she would take nothing below a note for her wares. After a drear Dorchester dinner and a disgraceful Hurlingham dinner all were relieved to find that at the Hilton good and the service brisk, if rather familiar. For example, Le Savarin aux Fraises could so easily have been a puddeny knock-up dressed with a couple of tinned strawberries. Not so; it was light and the strawberries fresh and plentiful.

Dinner took time. One could sit back and watch Mr. and Mrs. Alan Hunt covering the large and adequate floor in a swift pre-war fashion, or reflect on the ill-luck of Mr. Borrie whose table was sited very much beyond the fringe. (Table muddles are a perennial problem; the fault being as much with the Ball-goers as the Committee). At this point the Lord Mayor and the Lady Mayoress, Sir Ralph and Lady Perring, arrived to the accompaniment of excited cat whistles as well as the accepted clapping. There is no doubt that when a little lit up some medical students resemble the exuberant and vociferous fans of a football crowd more than future practitioners in the profession of Harvey, Hunter and Sir Harold Gillies.

By now we could see, even through the



Mr. and Mrs. E. Ford, Miss G. Edwardes, Mr. G. Shaw, Miss A. Ingle, Mr. D. Reid, Miss P. Downs, Mr. R. Galloway, Mr. E. Warwicker and Miss A. Kay.



Dr. John Pusey, Dr. Pamela Aldis, Dr. Austin, Miss Tina Beard, Dr. Nick Whyatt and Miss Lawson.

euphoric contents of a champagne glass, that something was amiss. Faces; the men's were frankly sweaty and the women's often palpably moist. One imagined a Bertie Wooster, "Jeeves!"—"Sir."—"Jeeves, throw open the windows."—"Sir, there are no windows." And that was that. By the time the air cooling system was operational, well after two o'clock, many of the more energetic dancers were positively dripping.

The Tombola was out of the ballroom and was a great attraction before the cabaret. There were some very heavy investments being made by students as well as consultants: Your correspondent saw Professor Spector, Dr. and Mrs. Wykeham Balme and Mr. and Mrs. Catchpole try their luck with the rest. One young gallant invested more than cost to win a very splendid Purdey's cartridge bag worth quite £7 or £8. The tombola was well patronised in spite of there being fewer prizes than last year and nothing so grand as a fortnight's ski-ing in Switzerland.

Nearly mid night; one still had to wait for the cabaret and then, interminably, for its end, before hitting the floor in earnest. Previously the dancing had been polite and relatively spasmodic. But now after the Pipers to H.M. the Queen had gone (incidentally, ex-

cellent though they were they had a poor response from a handful of desolatory reelers), the room was partitioned into two and Joe Williams and his Jazz band played the twist and little else besides to the younger blood on the smaller floor (euphemistically referred to in the programme as "The Night Club"). He was brash, noisy and exceedingly popular. He had an easy beat, East End charm and, of course, Screaming Lord Johnson. Who will forget him? Meantime Bill Saville entertained the older generation in the larger room.

In the other room an orgy of sweaty gyrations and contortions made the last three hours race. Joe Williams never let up for a moment. Many must have linked arms for Auld Lang Syne with relief at the thought of bed just as soon as one's car was dug out of the Hilton foundations. Our verdict? The most enjoyable and best View Day Ball of the last four at least.

A FOOTNOTE. There is opinion about, which would discredit the Students' Union View Day Ball Committee for organising a charity ball. This opinion would cut charity right out and goes on to suggest that Bart's students want



Mr. Kim Stevens and Miss Sarah Clark.

entertainment only, and that at the lowest possible cost. There is certainly a place for balls such as this and the Rugger and other clubs can and do provide them.

Our annual View Day Ball must remain a charity; a Hospital Ball, for students and staff (lay and medical) alike. St. Bartholomew's Hospital can well afford to be charitable. More is the pity it does not offer to double the Ball takings. However, in some years this could have been embarrassing—doubling a loss, that is.



Mr. Christopher Smart, Miss Janet Elkington, Mr. Martin Hudson, Miss Susan Garnett, Mr. Maurus Rimmer, Miss Carolyn Pikes, Mr. Castleton, Miss Fenella Rix, Mr. John Gibson, Miss Andrea Milne, Mr. Gilmore and Miss Hilary McCrudden.

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## OCCUPATIONAL HEALTH FOR ALL ?

H. Beric Wright, M.B., F.R.C.S.,  
Director, Medical Research Unit,  
Institute of Directors.

### Introduction

FOR every day lost through strikes in 1960, fifty-six were lost through ill health, said the Minister of Labour.

In the 1850's in the Lancashire cotton trade whale oil was used as the main lubricant for the spinning jennies, but deliveries of whale oil were, not surprisingly intermittent and when "Paraffin" Young, an *entrepreneur* from the Scottish shale oil fields, looking for outlets for the oil which was a by-product in the production of the paraffin wax used for candles, offered a regular supply of mineral oil, it was accepted with alacrity by the mill owners.

By 1860 cases of scrotal cancer in mule spinners (sliding along the bar or "mule" in front of the spinning jennies) began to occur. In 1906 a Manchester doctor realised the "Occupational" nature of these cancers, but unfortunately his paper was not published until 1922. The inevitable committees were then set up, research was instigated, the carcinogenic fraction in the oil was isolated, the war intervened, and it was not until 1953—102 years later—that legislation was passed making the use of non-carcinogenic oils obligatory in this industry.

This is not, however, an isolated instance of the time lag in legislative control of dangerous trades. Professor Schilling in his Cantor Lectures to the Royal Society of Arts, to be published later this year, instances other examples—lead poisoning in pottery workers, for instance—of this prodigious delay in legislative control of diseases that can be killing.

Bladder cancer in aniline dye workers, silicosis in miners and grinders, boiler makers' deafness, chrome cancer, radiation sickness, and so on, are all examples of overt occupational disease. But what of "ordinary" sickness which contributes to lost time in workers at all levels in industry?

### Executive Stress

Not long ago I saw a very successful business man of 45. He was a Sudanese, which meant that he had an Egyptian father and Turkish mother. His father ran a village store and had a number of sons. My patient learnt English, trained in business methods, worked for a number of years in European firms and finally, when Sudanese independence was on the way, went back into the family firm.

When I saw him two years ago he was running the U.K. end of a flourishing import/export business and doing very nicely out of it, but he had had a pain in his chest for a month or two. This radiated from under the costal margin to his neck and was severe enough to make it impossible for him to eat lunch and difficult for him to speak on the telephone.

He took his pain to an eminent cardiologist, who examined him thoroughly, did an E.C.G. and screened his chest. There was, he was told, no cardiological origin for his pain. Next he went to a gastro-enterologist who, after due examination and investigation, said that in his opinion his symptoms did not arise from the alimentary canal.

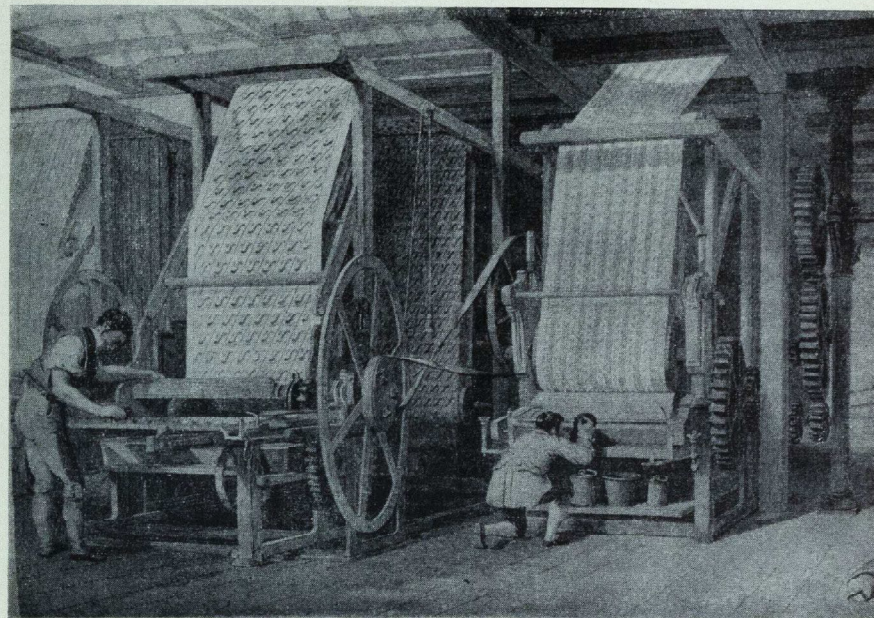
When he came to me, as someone interested in the occupational health problems of business men, I discovered three further points in his history. The first was that the pain went off when he got home in the evening and had a whisky and soda, after which he was able to eat a hearty supper. The second was that he played and thoroughly enjoyed, covered court tennis twice a week. The third and by far the most important, was that he had literally never had a proper holiday in his life. He was in fact, a thoroughly worn out citizen.

### Positive Health

These are, if you like, the two extremes of the relationship between work and health. Notice please, that I say health rather than disease. And I say this very advisedly because the medicine of the future lies in promoting health, rather than treating disease symptomatically. *Increasingly it is becoming apparent that the diseases people get are inevitably related to the lives they lead.*

At a recent meeting of the G.P. section of the Royal Society of Medicine, a doctor described a case he had just seen of a woman of 50, who came up on a Monday morning with an acute mallet finger. This she got weeding the garden. Why, the doctor wondered, should she suddenly do this after years of weeding? To cut a long story short, she was married to a successful business man, they had no children, but plenty of money. She personally was concerned about social status. On the morning of her injury her husband had refused to move to a larger house in a "better" area, and she was both angry and resentful.

If we can agree that emotional attitudes and working conditions can, and very often do, play a



By permission of Dr. Robert Murray, B.I.T.

part in determining fitness and health, it is relatively easy to see how important it is that medical coverage should include work as well as home conditions. This is why industry, to an increasing extent, is prepared to subsidise the National Health Service by employing doctors to look after people at work.

### Work of an I.M.O.

The Industrial Medical Officer (there are about 400 full time and over 1,000 part-time I.M.O.'s in this country at present) has two main functions. The first is to provide and supervise a casualty service so that people who sustain minor injuries at work can be rapidly and effectively treated and so get back to the job as soon as possible. To facilitate this it is often expedient for the works surgery also to dress non-industrial injuries and to give penicillin injections, etc., in consultation with the family doctor. This saves endless waiting in casualty departments and surgeries.

The second is more important than this and is his function, as part of the management team, to work to minimise both accidents and ill-health arising from work. Many trades are of necessity hazardous and require highly skilled medical and technical supervision. By constant attention serious lead poisoning has been reduced to a handful of cases per year. They do, however, still occur, the most recent being in a small group of workmen demolishing a steel-framed building in London. They were cutting up the old girders with oxyacetylene, seemingly a fairly safe pursuit provided anti flash goggles were worn. Unfortunately, and unknown to their employers, years of anti-rust treatment with lead paint which was vapourised by the heat, produced an appreciable hazard, not detected until several of the workmen reported with colic.

Much more esoteric was the case of an elderly man working with cobalt, who was found when he went for prostatectomy to be thoroughly plethoric. He had two pints of blood venesected before

operation. Vitamin B<sub>12</sub>, frequently and successfully used in the treatment of anaemia, contains cobalt. No cases of serious polycythaemia have been recorded from over dosage of vitamin B<sub>12</sub>, but cobalt plethora is possibly a new industrial hazard.

The increasing use of isotopes in industry and medicine gives another good example of the constant need for expert supervision to maintain safe and healthy practices. Known dangerous situations tend to be taken care of. Once a drug like thalidomide is shown to be "toxic" opinion moves rapidly to suppress its use. Thalidomide babies, lead poisoning and even silicosis may be serious and debilitating, but the numbers of cases are infinitesimal compared with the numbers who die from coronary thrombosis before retiring age, or who lose time from chronic bronchitis and rheumatism every year.

Another form of work stress which the I.M.O. has to deal with arises from pressures within the working group. Not long ago in a sausage factory where the girls worked in teams of four, the team that had the highest output also had the highest sickness rate. Watching the team in action the doctor noticed that one of the girls worked very much faster than all the others. Put at the head of the team she set too fast a pace, put at the end she frustrated the others when kept waiting. In the middle she was just as bad. The rest of the team could not stand it and broke down. She turned out to be a lonely, compulsive person who had to dominate. Although an outstandingly productive worker, she therefore had to be found a job on her own.

#### Working in the City

Readers closely associated with Bart's and the City should not need to be told about Dr. Alan Robinson's recently published report on city offices, shops and restaurants called "Working in the City". As a result of this unique piece of municipal or civic self-examination, the City Corporation is likely to set up an occupational health unit to maintain the health and efficiency of city office workers.

Dr. T. O. Garland, Director of the Occupational Health Unit based on the Central Middlesex Hospital (the only such service based on a

large general hospital, and now serving 6,000 employees of 57 small firms round the hospital), opened a weekend seminar with a talk whose title I have also taken for this article. After showing that a number of common diseases, bronchitis, rheumatism, coronary thrombosis, back strain, and so on, were often related to work, Dr. Garland went on to talk about doctors and nurses. He instanced the strain on a junior nurse left in charge of a large general ward. At one moment she was in sole charge, five minutes later Sister returned from lunch and she was back in the ranks. He once found a senior Sister near to break down on her way off duty from the geriatric wards. Not only was the nursing heavy, but she did long hours, short staffed and dealing with hopeless and demanding cases. The hospital looked after sick nurses, but did little to promote health in those who survived.

This discussion group made up of G.P.'s and industrial nurses went on to consider doctors' health problems. Why should G.P.'s have a much higher coronary thrombosis rate than consultants? The doctors present all agreed that one of their main problems was dealing with patients they disliked. From this talk it was clear that medical workers as well as executives, factory workers, office and shop workers, might well benefit from an occupational health service.

#### Factories Act

In this article I have tried to show how industrial medicine, which arose from the Factories Acts, and which represented originally the conscience of the nation against exploitation of labour particularly children, in mines and factories, has become "occupational health" dedicated to the promotion of health and efficiency in all walks of life.

I hope that I have also been able to demonstrate that this is a branch of medicine which demands good doctoring in the widest sense of the term. In return it offers close and fascinating association with all levels of productive activity. I hope, too, that Bart's will be associated with the new unit in the City and be stimulated to look more closely at the occupational health problems of its own staff—from hospital porters to Harley Street "Honoraries".

## OTHER LONDON HOSPITALS: I

### EVOLUTION OF THE VOLUNTARY HOSPITALS

THE institutional care of the sick in the British Isles has been of gradual development from the earliest times, and it was the endemicity of leprosy which was responsible for the establishment of the numerous leper houses which constituted the majority of the hospitals for so many centuries.

The popular idea that leprosy was introduced into England by the returning Crusaders in 1098 has long been demonstrated to be a fallacy. There is reason to suppose that the disease was prevalent as early as 60 B.C. Its presence in Ireland is recorded in the fifth century A.D., and in Scotland in the seventh century. Leper hospitals existed in Ireland in the ninth century. In the tenth century leprosy laws were passed, one of which made the disease a legitimate cause for divorce. Long before 1098, numerous leper or leazar houses were founded in England. It is, however, true that soon after the return of the Crusaders a great impetus was given to the establishment of these leper hospitals, and their number continually increased until the gradual decline of leprosy in the fifteenth century. Many of these leper houses shared the fate of the monasteries at the Dissolution; others, however, were converted at some stage in their history to other uses. A notable example of this conversion is St. Bartholomew's Hospital at Rochester which was founded by Gundulf in 1078, and may therefore claim to be the oldest hospital in this country.

It must not, however be supposed that no general hospitals existed in early times. Every monastery had its infirmary which was in the charge of a permanent infirmarian, and the care of the sick was by the rule of Benedict enjoined upon the superior of every religious house. This care was not always bestowed upon the sick brethren alone, but also upon the general public. In many instances there were separate establishments under the direction and administration of the monasteries.

Perhaps the earliest general hospital of which anything is known was that founded at York by Athelstan in 936, whilst Lanfranc in 1084 founded St. John's Hospital at Canterbury for the diseased of both sexes. Neither of these has survived.

The general hospital which was founded for the relief of the sick and which has continued that work for the longest period and is still in existence is St. Bartholomew's Hospital in Smithfield. This was founded in 1123 by Rahere, and was dissolved and re-founded in the reign of Henry VIII. For many centuries the hospital administered the two out-houses at Kingsland and Southwark which are illustrated.

St. Thomas's Hospital founded in Southwark by Peter de Rupibus, Bishop of Winchester, about a century after St. Bartholomew's went through the same experience at the Dissolution.

These two hospitals may be regarded as the legitimate forerunners of the voluntary hospitals of to-day; and from them has sprung the hospital system which is second to none in the world. When Sir Thomas More published his *Utopia* in the early years of the sixteenth century there can be little doubt that he was conversant with the work of these hospitals. His keen wit and satire, his powers of observation, his insight and benevolent character, his prominent advocacy of the New Learning, and the obvious reference to his own country in his *Utopia* justifies us, too, in assuming that they may not have possessed all the excellence with which he endows his Utopian hospitals. However that may be, Sir Thomas More certainly enunciates the principles which may be regarded as inseparable from a model hospital, and even prophetic of the voluntary hospitals of to-day. He says: "But first and chiefly of all, respect is had to the sick, that he cured in the hospitals. For in the circuit of the city, a little without the walls, they have four hospitals, so big, so wide, so ample, and so large that they may seem four little towns, which were devised of that bigness partly to the intent the sick, be they never so many in number, should not lie too throng or strait, and therefore uneasily and incommodiously: and partly that they which were taken and holden with contagious diseases, such as be wont by infection to creep from one to another, might be laid apart far from the company of the residue. These hospitals be so well appointed and with all things necessary to health so furnished and moreover so diligent attendance through the continual presence of cunning physicians is given, that though no man be sent thither against his will, yet notwithstanding there is no sick person in all the city, that had

not rather be there, than at home in his own house."

That such an enlightened conception of hospitals should have been advanced early in the sixteenth century is clear proof of the beneficial effect of the New Learning, and it is, therefore, not surprising that vast strides towards placing the science of Medicine on a sound basis were made during the reign of Henry VIII. The Royal College of Physicians was founded by Linacre in 1518. The Barber Surgeons were incorporated in 1540. Regius Professors of Medicine were appointed in the Universities of Cambridge and Oxford. The study of Medicine became systematised, but it was not until the eighteenth century that a really energetic movement was made in the establishment of additional hospitals.

In the first half of that century, however, there were founded the following celebrated hospitals: York (1710), Westminster (1719), Guy's (1723), St. George's (1733), London (1740) and Middlesex (1745). The provinces speedily followed suit, and hospitals began to spring up by leaps and bounds in all the chief towns of the country.

The next step in the evolution of the hospital system was the foundation of special hospitals. Of these the Lock Hospital founded in 1745, the Small Pox Hospital founded in 1746, and the Maternity hospitals founded from 1749 to 1752 were the pioneers.

## ST. THOMAS'S HOSPITAL LONDON

E. M. McINNES, Hospital Archivist.

St. Thomas's is the only hospital which has any grounds for challenging St. Bartholomew's claim to be the oldest hospital in London. Being without a foundation charter it cannot establish its exact age. About 1106 the Priory of St. Mary Overy was founded near London Bridge and between 1106 and 1212 St. Thomas's Hospital grew out of the priory infirmary. Until St. Thomas's can produce evidence that it was in existence before 1123 it must yield priority to St. Bartholomew's.

After a fire in 1212 the Priory of St. Mary Overy and St. Thomas's Hospital were separated. The Augustinian Canons rebuilt their Priory on the old site, but the Keeper and Brethren of the Hospital moved to the east of Borough High Street, then called Long Southwark. The hospital survived plague, poverty and other hazards

until 1540, when it had forty patients. Like other monastic institutions it fell to King Henry VIII, ostensibly because of the immorality of the Brothers; it was closed and staff and patients dispersed.

Edward VI was persuaded to sell the hospital to the City of London in 1551, and it was repaired and a lay staff appointed in October, 1552. The aim was to provide a hospital of 250 beds, but it was only found possible to provide for about half this number. There were six great wards and four small sweat wards, each under a sister, who had no help save that of the patients. Three surgeons were appointed, followed by a physician and apothecary. In the absence of the non-resident treasurer the senior officer was the hospitaler, who, besides acting as chaplain, was responsible for discipline and for the admission of patients. Owing to the numbers seeking admission, restrictions were placed on the type of case taken. The monastic hospital had accepted, besides the sick and injured, elderly almsmen and night-lodgers, travellers too poor to afford an inn. By 1600 both these classes were excluded to make room for more sick.

The seventeenth century saw the development of St. Thomas's as a centre for lithotomy and from the time of James Molins (Surgeon to St. Thomas's, 1605-1639) there was co-operation with St. Bartholomew's in arrangements for cutting for the stone. Towards the end of the century there was an increase in surgical work, perhaps because of the influx of wounded soldiers and sailors.

The sixteenth century saw the beginnings of an organised medical school. There had been novices in the monastic hospital and apprentices in the Elizabethan one, but about this time the first regulations for the conduct and training of "Surgeons' Cubbs" are found. Under Sir Robert Clayton (President, 1692-1707) the hospital was almost completely rebuilt, and this may have helped to attract students, but the rapid rise of the Medical School was due chiefly to the staff, of whom the most outstanding were Dr. Richard Mead (Physician, 1703-1715) and William Cheselden (Surgeon, 1718-1738). It was Dr. Mead who persuaded a Governor of St. Thomas's, Thomas Guy, to found a hospital for the long-term cases and lunatics inadmissible at St. Thomas's. The two hospitals remained closely linked until the early nineteenth century. Students were admitted to the practice at both hospitals and teaching was divided between them, lectures on surgery at St. Thomas's, medicine at Guy's. The ultimate separation of the schools arose largely out of Sir Astley Cooper's pique at



*The present St. Thomas's Hospital, Lambeth, which is being rebuilt.*

not being allowed to select his own successor.

St. Thomas's had been on the same site for over 600 years when London Bridge station was built a little to the north. When the railway line was extended to Charing Cross it passed very close to the north wing of the hospital and the hospital was forced to move to a quieter locality. No new site could be obtained in time, so temporary accommodation was found in a burnt-out music hall in Surrey Gardens, Newington, from 1862 to 1871, when the present buildings in Lambeth were opened.

The Thames-side site was not universally approved and voices raised against the muddy bank of a polluted river included that of Florence Nightingale. With money subscribed as a tribute to her work in the Crimean War she had started a school for nurses. As ill-health prevented her from taking personal charge of it, she placed it

under the Matron of St. Thomas's, Mrs. Sarah Wardroper, who had already introduced nursing reforms. The School was opened in 1860 and its earliest years were spent in difficult conditions in the temporary hospital, but it was successfully training a new type of nurse. Forced to accept the new site, Florence Nightingale concentrated on securing suitable quarters in it for her probationer nurses.

After the reopening of the hospital in 1871 financial difficulties kept a number of the new wards closed and to meet costs it was reluctantly decided to admit paying patients. Two world wars brought their own special problems. The bombing of the nineteen forties caused such serious damage that complete reconstruction proved the only feasible solution and now for the third time in its history St. Thomas's is to be entirely rebuilt.

## OTHER PROFESSIONS: I

### COULD YOU HAVE BEEN ON THE STAGE?

— IAN WALLACE

Probably not, for if you could, you almost certainly would. This is because theatrical ambition is a form of mild but chronic mental disturbance, curable only by the prospect of perpetual abject poverty. I have even known cases that failed to respond to prolonged treatment of this kind. The ailment in females can occasionally be eradicated by a financially secure offer of marriage.

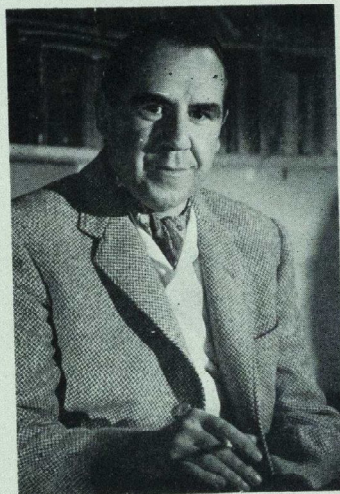
I'm using "The Stage" in its widest sense to cover acting, singing, dancing and production. Straight singing, ballet or production would have claimed you by now, because even a reasonable level of talent in these fields triggers off wild family encouragement and sacrifice. Only a superbly well adjusted family can resist the temptation to try for a Fonteyn, a Sutherland or a Bart sitting dressing-gowned at breakfast ankle-deep in fan-mail.

Acting is different. Most people believe it's an easy life and many with a strong personality can act a bit. Even more quiet, sensitive people can act very well indeed, and some of the best actors are general practitioners. They have to be good so as not to scare their patients to death. The only thing that matters is whether you are determined to act in public for money. If you are, then paragraph one applies to you, and you might as well make the best of it.

Many actors would advocate a training college, others would proudly tell you that they had no training and that talent was all. Both are right—for themselves, in the most individual profession in the world.

Assuming you decide to go to a college, what will you learn? I only know at second hand. I trained for the Bar, another branch of the acting profession. In brief, you learn to express yourself with voice and body, and to impose a discipline on each. Not the sort of restraints listed in the Boy Scouts' Handbook, but a co-ordination of movement, voice production, the portrayal of emotions as a technique, and an introduction to the rigours of a life, where 6 or 60 people land up every second of the evening precisely as they did the night before, physically, emotionally and freshly. This takes three years and the danger is that individuality may be crushed.

Then comes the hard time. All this training may yield a paltry six lines in a provincial rep. which is closing for lack of support in 2 months' time, and great persistence, courage and luck is required to hold on. But the disease is helped by courage and optimism. The facts are that for every Richard Burton there are scores of competent, interesting actors making a modest living and hoping. Out of a profession numbering about 10,000 less than a thousand regularly earn more than £2,000 a year. Many of those who do, find it an arduous and demanding life. They are the group, psychosomatically speaking, that give you chaps the most work.



Ian Wallace

Nonetheless it is a happy profession. The jealousies and eccentricities are as misrepresented in popular fiction as I suspect you are by Dr. Kildare. We are good mixers among ourselves. Our great weakness is thinking that we are the only people who are really living, and that the man in the street is a dull fellow. This is a defensive attitude because we depend on the approval of the man in the street and, having revealed so much of ourselves to him in public we are unsure when we meet him face to face.

A word about my own department, singing. Here, training is essential, but not more so than the raw material of a good natural voice. An ear and a sense of rhythm are indispensable, but, as with any form of interpretative art, an individual style is the surest way to recognition. An opera singer works physically in performance as hard as a manual worker. He goes in dread of catching cold, and even being slightly out of sorts may extend his technique to conceal the fact that he is singing in phlegmish. It is a life of hotel bedrooms, stations and airports, to say nothing of sustained nervous tension. Don't believe that nonsense about it disappearing as you walk on. If you are lucky it is imperceptibly reduced.

Why do I do it? See paragraph one, added to which, I enjoy it.

St. B.H.J., July, 1963

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## CONSULTANTS' PAGE

### TWENTY YEARS AGO

by Dr. Finkelstein, L.R.C.P. (Bart's).

Twenty years ago, give or take a year or two, students at Bart's were scattered around the place more than they are now. One spent the first year at Hill End, a converted looney-bin. Structural conversion of it was minimal, but the loonies had been turfed out to make room for Bart's and had, many suggested, managed to obtain gainful occupation in the War Office.

Here, convalescing from the second M.B., one could regain one's sanity in pleasant surroundings whilst acquiring rudiments of clinical medicine from some remarkable teachers. One met Professors Ross and Christie, unsurpassable at first-year teaching, and their James Bond-approved secretary; also Christie's Chief Assistant G. W. ("Ted") Hayward; J. E. H. Roberts and his brilliant aide O. S. Tubbs; the deliberate, meticulous Irish perfectionist O'Connell; and also, already established among the great, one met young-to-youngish men like Bourne, Cullinan, Spence, Hosford, Philips, as well as the giants there—John Barris, Bedford (The Sinus) Russell and Hinds Howell.

Long grass, country lanes—quiet, in those days of few cars and rationed petrol—rural pubs, all instilled a gentle sense of leisure, helped by the thought that the next examination was two and a half years ahead. Nurses were encountered for the first time, and many beautiful friendships were formed. The "Shack", in Cell Barnes, where up to a dozen students lived all found for a pound a week, was a notable feature. Bridge most nights until 2 or 3 a.m.; the rugby team, attacking in strength, repulsed en masse; nurses, rumour had it, constrained to sign a special pledge never to enter the place; unwanted visitors stripped naked and locked outside, the ground hard with frost. Strangely, more than half the denizens then are sombre consultants now. Never peaceful, it was shatteringly woken up by the land-mine which fell only a few yards away, having mercifully neglected to open its parachute first; no casualties, but Mr. F . . . on the lavatory at the time, paused only to pull up his trousers before fleeing to Dublin.

The second year, at Bart's, was very different and largely underground. Out-Patients under the present Surgery, Casualty under the King George V Block, air raids and A.R.P. (and a

crafty guinea to be made by manning first-aid posts sometimes), Londoners sleeping in Tube stations, and some of the students sleeping in underground corridors of the Old Bailey. Also underground was the Vicarage, a bar whose memory is perpetuated by the Vicarage Club today. This bar, open to all, run by the students with élan, esprit de corps, optimism and financial ruin, was opposite the billiards room and on one's subterranean route from hospital to refectory—and vice versa—and could not have been better placed. It was used by all ranks, and at all hours. The best parties went on until the woman came to clean up in the morning, but, of course, the accuracy of payment declined as dawn approached. On one occasion one student, now a respected country practitioner, rejoined the party having been previously helped to bed, at the very moment when a sortie to a Lyons Corner House in search of food was leaving, and he got carried along just as he was, his pyjamas unnoticed. The management, the first to spot them, objected, but was successfully confused with tales, impressively told, of air raids, disasters, and personal heroism, and food was finally procured. Unfortunately, the Vicarage petered out. It was difficult to maintain the early enthusiasm, and its finances were already in serious danger when it had to close because the College started to accept women students. It closed, not because it would have been a danger to them, or they to it, but in order to be taken apart, emptied, dismantled, and transmogrified, with all the decor and decorations and accumulated extravagances of affection removed, into a women students' cloakroom.

At Bart's the students could hear Uncle Eric ("High Priest") Scowen intoning his benign and overwhelming erudition, and could witness Harold Wilson's swearing, whilst Dr. Gow perfected his embroidery, Rupert Corbett flashed his impeccable surgical technique, and Carus Wilson . . . Young Tuckwell chased in and out, the boy obviously fathering the man, Alan Hunt mastered his idiosyncrasy of not arguing but telling, Sir Girling Ball, the Dean, was seen only when he delivered his annual lecture on Bloody Water and the Sub-Dean and Warden Charles Harris wielded the whip. All this time the temporary Vice-Dean, Professor Hopwood, tried to regiment the pre-clinicals housed in Queen's Cambridge, and Jack, bless his memory, saw you signed up for all necessary lectures for half-a-crown a term.

After Bart's, students went to Friern Barnet—"Colney Hatch". A year that has final examinations looming up can hardly be as pleasant, and Friern lacked the carefree novitiate atmosphere of Hill End. But it was here that Dr. George Graham asked his question about the bleeding time; that Dr. Maxwell kept his wardful of tuberculous glamour-girls—and also, every quarter, justified his proud boast of teaching all of neurology that mattered in one and a half hours; that Reggie Vick could always tell some perfectly ghastly story to illustrate any one of his cases; that Basil Hume forcibly and avuncularly fed his flock with the basic necessities of surgery; and that Messrs. Beattie and Fraser regularly outdid the Marx Brothers in entertainment value on their enormous ward rounds.

Since those days twenty years—or so—have passed, the Charleston has returned, skirts have lengthened and shortened, and women students are marrying the men. The wards have become an annexe to administrative offices increasingly subservient to the ever ephemeral Minister of Health, and the educational habit of the royal and ancient hospital trimmed by county authorities. But these are small things, medicine is great and history long, and in twenty years, give or take a year or two, reminiscing will be as deceptive as ever.

## CHRISTIAN VIEWPOINT

### Retrospect—

#### Some great Christian doctors

Men of very differing outlooks, beliefs and background have contributed to the progress of medicine throughout the centuries; and one cannot say that Christians have had a monopoly of brains, research-ability or philanthropy. God's universal grace as Creator gives to everybody the possibility of gaining such success as his intellectual ability will allow. But Christians do claim that God as Redeemer changes their fundamental attitude of mind towards their work, brings them a radically different interpretation of life, changes the bias of their personality and brings them new moral strength to serve their fellow men. It is hoped that, in the limited space provided, the truth of this assertion will be proven by quoting examples from some great Christian doctors of the past.

**Ambroise Paré** (1510-1590) has been called the greatest surgeon of the Renaissance and one of the

greatest surgeons of all time. He was an army surgeon for thirty years and invented many instruments. He had a keen observation and insisted that surgery was learnt by the eye and by the hands. He was fearless in the pursuit of truth and quick to renounce ignorance and superstition. His humility is illustrated by the reply to congratulations on succeeding in a difficult case, "Je le pansay, Dieu le guarit" (I dressed it, God healed it).

**Thomas Sydenham** (1624-1689) shook medicine from mediaeval scholasticism. He stopped mere speculation and led men back to the bedside. He once said to a student, "Go to the bedside, there alone can you learn disease." He was deeply conscious that he would have to answer to God for the lives of the patients in his charge, that a doctor should devote all his skill to God and the human race, and that as the Son of God became man, He raised the value of man to something worth caring for.

**James Paget** (1814-1899) was a prodigious worker with a disciplined and keen observation. He cared much for students. "Your engagement in this profession," he once said, "binds you not only by consideration of your own interest, but by the weightiest responsibility to God and man, to do your duty in it with all your might. Keep this constantly in view; daily remind yourselves that you propose to take in hand the lives and welfare of your fellow men. Daily think quietly of what all this involves; and you will daily decide that not even your own lives must be much dearer to you than the duties of your profession."

**Joseph Lister** (1827-1912), a Quaker of gentle nature, imperturbable temper, and resolute will, split surgery into two eras. He was the first surgeon to experiment in the cause of progress, and have controlled experiments. His personality is well brought out by his famous remark, "There is only one rule of practice—put yourself in the patient's place." Another one is that, "success depends upon attention to detail."

**Sir James Young Simpson** (1811-1870) introduced the use of chloroform for anaesthesia, made notable advances in the use of obstetric forceps, and in the technique of ovariectomy. He prophesied the future use of X-rays. When approached at the end of his long life by a newspaper reporter and questioned as to his greatest discovery, he quietly remarked, "My greatest discovery was when I found that I was a sinner and that Jesus Christ was my Saviour."

**Howard Kelly** (1858-1948) was one of the great team of four at Johns Hopkins Hospital. Welch and Osler both admitted that Kelly did more than any of them to spread the fame of the

Johns Hopkins University. Matas wrote "his originality, initiative, and prodigious energy in developing his chosen speciality, gynaecology and abdominal surgery, is recognised the world over." He was in the habit of starting his operating list with a prayer. His views on the Bible were definite. "The Bible appeals to me strongly as a physician because it is such excellent medicine. It has never failed to cure a single patient if only he took his prescription honestly." Of his faith he commented, "One of the blessed commitments of this reasonable faith is that it places me in a new and far higher relationship to my family, my friends, and my Creator, and genders a deeper interest in, and tenderness for, all men."

All these men were brilliant in their particular sphere, but retained the virtue of humility and selflessness so enabling them to care for their patients to their uttermost. This is not a natural gift, but is a result of their faith.

## MUSIC

From our Music Critic

Bart's has never been very adventurous in its music making. In spite of being closely associated with one of the most musically active churches in London, the hospital has lagged well behind. The Gilbert and Sullivan productions seem to have collapsed and apart from sporadic chamber music concerts, carol singing at Christmas and ward show songs, listening to gramophones seems to be the main extent of most people's musical appreciation.

This is all the more irritating since Bart's contains a combined population of students, nurses and others which should be capable of doing much more. One does not have to be more than moderately competent to gain a great deal of pleasure out of performing music at a reasonably high standard. I heard the choirs of two schools singing in St. Bartholomew's-the-Great, motets and a mass by Palestrina with surprising accuracy. Surely if schools' choirs could reach such an exacting standard in their singing, it should be possible for the inhabitants of the hospital to produce something worth listening to.

A few people from Bart's sing with the University of London Musical Society which is a comparatively unknown activity of the University. On June 15th in conjunction with the Choir of the Royal College of Music it performed Beethoven's *Missa Solemnis* at the Royal College of Music. The choir achieved a comparatively high

standard with good volume and tone in a work which is reckoned to be of the most taxing choral works in the repertoire. In previous years it has sung Haydn's "Creation", Verdi's *Requiem* and Bach's *Mass in B minor*. In December it sings Christmas music in St. Paul's Cathedral which usually includes works specially commissioned by the Society. The Society is open to anyone connected with the University who wants to sing and is supported by a direct grant from the Arts Council and Senate. It is very short of singers and anybody who is mildly interested will be made most welcome at the School of Pharmacy in Brunswick Square.

## BOOK REVIEWS

### NEW PENGUIN BOOKS

Four Books by Muriel Spark

**The Comforters** and **The Bachelors**. Both priced at 3s. 6d.

*The Comforters* was Muriel Spark's first novel and was followed by five novels and three years later by *The Bachelors*. The first consists of fuss and fantasy and the second of satire and spiritualism. Both are positively stuffed with good and bad Roman Catholics; congenital, converted and lapsed alike, they all take a morbid interest in mysticism. There is plenty of this in both books, and if it does not irritate, you will enjoy them both.

I found the *Comforters* more readable because all the characters are fascinating and the story is mysterious, involved and exciting. None of the characters is quite normal; even Helena Manders is worried and confused by the unceasing misplacement of her Christian good faith. Her son is a hyper-inquisitive busybody, her husband a religious hermit, her son's fiancée a neurotic, her protegee, Mrs. Hogg, egregiously, and her grandmother, Mrs. Jepp, the incorrigible and lovable linchpin of an anaemic gang of diamond smugglers. One likes them all, and is sorry when a sudden death by drowning, a miracle and a car crash end the story bringing all the minor ramifications together and causing Mrs. Jepp to wind up her profitable business.

In *The Bachelors*, Muriel Spark shows as much or more imagination in the setting, but the book is less enjoyable because the story is less satisfactory. Perhaps it suffers for the sake of satire. Certainly more can be read into it, for it is a well observed hotch-potch of Kensington-Chelsea-Hampstead bachelor half-life. And a

horrible half-life it seems—this is where the novel scores. Its effectiveness borders on the unfair. However, the exaggeration and the caricature are legitimate and we are forced to see that bachelors are either insane, nervous, frustrated, mother-fixated, older-woman-dominated, asexual, homosexual or caught in the web of free love. This last is by no means the happiest state. The epitome of a titillating theme is the tedious *raison d'être* of a tedious plot. He is Patrick Seaton; a habitual criminal, he is evil and cruel; a first-rate medium, he is weak, vain and probably ambisexual. He is a bachelor.

Simon Campbell-Smith.

#### The Go-Away Bird and Other Stories. 3s. 6d.

This is a collection of short stories by Muriel Spark who is probably best known for the "Ballad of Peckham Rye" and her other novels. These short stories appeared earlier in various journals such as *Punch* and the *Glasgow Herald*. The book contains eleven short stories of varying length. The *Black Madonna* is a story of the self-delusion of a couple as to their tolerance of negroes and how their hypocrisy is revealed. The *Go-Away Bird* is an extended story of the hatred of two men and the effect of this on the daughter of one of them. The *Porto Bello Road* is an account by a woman of the events leading up to her murder and her subsequent activities as a ghost of the haunting variety. All these stories are stylishly written with a great deal of irony which at times veers towards sarcasm. The majority of them made me feel uncomfortable with fleeting thoughts of the fact that in the next page one of my own foibles might well be clinically exposed by Mrs. Spark's penetrating eye and elegant style.

Richard Swain.

#### "The Birds" and Other Stories by Daphne du Maurier. Price 3s. 6d.

Miss du Maurier, as we all know, is the past mistress of the macabre, whether she concerns herself with clergymen wreckers, family skeletons or mistaken identity. In this collection, which Penguin have now made available at a very attractive price, she tries her hand at a number of short stories whose common denominator is the irrational and the bizarre. The title story, which Alfred Hitchcock has expanded into a ninety-minute film, describes what happens to a man and his family living on a lonely stretch of coast when the birds stop being feathered

friends and become predators upon the population. In a few thousand words the mood shifts from mild mystification to frank horror as the hero realises that the birds have wiped out everyone in the outside world and that he is left alone without food or communication or help.

"Kiss Me Again Stranger" is a vintage creepy and "Monte Verità", the longest story in the book, is a mystery story with a startling climax. The author triumphantly succeeds in weaving a compelling eeriness into the stories in this book. Take it to bed with you if you don't want to sleep.

#### The Ballad of Peckham Rye. Price 2s. 6d.

You will not be able to stop laughing. Miss Spark tells how a firm of textile manufacturers appoint Dougal Douglas, M.A. (Edin.), to bring culture into the humdrum lives of its workers. This Dougal succeeds in doing, and he brings mayhem, fraud, blackmail and violence as well, for he is a child of the devil. He does all this with great good humour and it is the humour of the book which is its most outstanding feature. Miss Spark has an uncanny talent for observation of the suburban scene and for exact reproduction of the mood, substance and curiously genteel cadences of the South London idiom.

This is an extremely funny book and worth considerably more than the half-crown that Penguins are asking for it.

T.J.M.

#### The Country Girls by Edna O'Brien. 3s. 6d.

I am always slightly apprehensive about books which come under the title of "Memories of a . . . childhood". However charming or delightful they are, they obviously hold so much more significance for the writer than for the reader who may feel like a slightly embarrassed intruder. But when I read "Cider with Rosie" by Laurie Lee that I was convinced that this form could produce a literary masterpiece. The *Country Girls*, a novel by Edna O'Brien, comes into this category. The story of Caitheleen's growing up in Ireland, her education at a convent and subsequent life in Dublin, all with her extrovert friend Baba is told in a highly original way. All through the novel you are kept on the crest of a wave of joyous excitement, innocence and devilment, the one suddenly appearing from another. The detail is shrewdly observed with a delicious sense of oddity, "Girls with curly hair, girls with shiny black coils of it, like bunches of

elderberries, falling on to their shoulders, girls with moist blackberry eyes; smirking and talking and waiting". The only slight criticism is that the characters appear slightly conventional and are not more than superficially explored, but the story as it breezes along has little time for reflection on anything at great depth. And I certainly would not like it to slow down at all. This is the first part of a trilogy and the others, "The Lonely Girl" and "The Married Girl", will be well worth waiting for.

Richard Swain.

#### Common Sense About Smoking, Penguin Special, by Dr. C. M. Fletcher, Harvey Cole, Lena Jeger, and Dr. Christopher Wood. Price 2s. 6d.

Books written by experts for laymen often appeal to neither class of reader, but this paperback steers a fair course between the Scylla of scientific verbosity and the Charybdis of woolly sensationalism. Dr. Fletcher—Secretary of the Royal College of Physicians Committee which produced the report "Smoking and Health"—gives a convincing account of all the medical evidence. On lung cancer he includes both retrospective and prospective studies, and does not omit the other diseases in whose aetiology smoking plays a demonstrable role. After discussing alternative explanations of the uncompromising statistics, he assesses the overall risks, and considers which lines of attack on the problem have merit: from the throwing away of half-smoked cigarettes to eschewing the habit outright (as he apparently has himself).

Exhausting perhaps to any reader with the mildest fact and figure phobia, Mr. Cole's statistics on the economics of smoking—its expense to the individual in cash and to the nation in terms of lost working days or fire damage, and its importance to the tobacco industry, small shopkeepers, advertisers, and the Government—are illuminating, and emphasize the fact that the greater the vested interest the higher the standard of proof required. On the Social implications, Mrs. Jeger sketches the history of smoking and its accompanying thought-barrier (such that "non-smoker" is virtually a term of abuse), and considers measures to combat the convention that the cigarette is a natural extension of the human face. The title of the final section—"How to stop"—is self-explanatory, and Dr. Wood's very practical advice concludes a well-balanced book, in which clear reasoning is combined with im-

partiality almost to a fault. One fears, however, that it will be least read by those who would most profit from it.

John Guillebaud.

**The editor will be pleased to have the name of anyone who would like to be considered when the Journal distributes books for review.**

#### OTHER REVIEWS

Basic Nutrition by E. W. McHenry and G. H. Beaton. 2nd Edn. Pitman Medical Publishing Co. Ltd., xvii plus 409 pp. 45s. net.

This well written book can be strongly recommended to students of medicine or nursing, practicing physicians and nurses, medical officers of health, dietitians, and in fact to anyone who is concerned with the maintenance of health or its restoration to the sick or convalescent.

Professor McHenry was Professor of Nutrition in the University of Toronto, and was engaged in revising and bringing up to date the 1st Edition of his classic text at the time of his death. This task has been ably completed by Dr. Beaton.

As the title implies, the book sets out the essentials concerning nutrition and diet in so far as they are known; it deals in a very competent and balanced manner with the subjects of hunger and appetite, the requirements for an adequate and balanced diet, the composition of foods, the factors which may affect the choice of diet, criteria for judging its adequacy, and methods available for carrying out nutritional investigations.

Professor McHenry believed strongly in the importance of education in nutrition, and that the objective should be wherever possible the right choice of available foods rather than supplementation by expensive artificial additives. The aim of nutritional education should be the inculcation of good eating habits—"It is better to give orange juice to babies than to add ascorbic acid to milk."

Throughout the book the reader is continually impressed by trenchant phrases that effectively hammer home important points. "There is only one cause of over-weight: food consumption having greater energy value than the individual expends." "If increase in body weight in humans were called 'growth', as it is in animal experiments, there might be several growth periods in life." "Food provides no nutrient value unless it is eaten and good cooking is important." The statement that obesity is as much a sign of malnutrition as the deficiency diseases may also come as a salutary shock to many.

Special diets which are unnecessary or have no sound basis, such as low cholesterol diets which ignore the body's ability to synthesise cholesterol, receive short shrift from Professor McHenry. He also emphasises the limitations inherent in published data of food composition and dietary requirements, while at the same time indicating clearly their value as general guides. The inclusion of a Table of Food Composition based on average servings rather than on 100 g. units will also be found of considerable practical value.

Most of the data given in this book refer mainly to foods and eating habits in common use in Canada and the U.S.A., but the conclusions drawn are probably in most cases equally applicable to Britain, although the author is very clear that it would be a gross error to assume that they are of universal application.

There are a few instances, for example in dealing with metabolic processes which are important for a proper understanding of nutritional requirements, where over-simplification leads to statements which are not entirely in line with the latest developments in research, and since some indication of the role of the B group of vitamins as coenzymes is given, it is somewhat surprising to find no mention made of the role of folic acid in "l-carbon metabolism". The giving of molecular formulae for vitamins without giving their structure might also be regarded as somewhat inadequate, and the classification of sodium and potassium as "basic" ions is, of course, quite contrary to modern terminology.

However, these are very minor criticisms, since after all the book is not intended as an up-to-date account of biochemical metabolism, and the reader is expected to have some knowledge of biochemistry and physiology.

An adequate index and full bibliography help to make this an excellent book.

G.E.F.

**The Infected Hand** by David A. Bailey, M.A., M.Chir., F.R.C.S., London. H. K. Lewis and Co., Ltd., 1963. £1 10s. net.

The standard of treatment of hand disorders in many British hospitals is abysmal. The common infected hand, with its dire sequel, is often treated by inexperienced, though well-meaning surgeons using unsatisfactory methods in out-of-date surroundings. The present book therefore fulfils a great need. The work is based on long experience in the Infected Hand Clinic at University College Hospital, one of the pioneers in the crusade of rescuing the septic hand, and the chapter on the organisation of a hand clinic contains much good sense.

The chapters on the individual infections are concise and clear and contain many illustrations. The most common infections, such as pulp abscess, apical abscess and paronychia receive due emphasis. There are good accounts of acute suppurative tenosynovitis, pyogenic arthritis and some rare infections. However, one looks in vain for any mention of Orf, a disease more familiar in the Smithfield hospital.

The title of the book is slightly misleading, because it contains short accounts of the hand in gout, calcinosis circumscripta, Raynaud's phenomenon, cervical rib, benign tumours, malignant melanoma and Dupuytren's contracture. These chapters on non-infective conditions maintain the high standard of the rest of the book.

Few will disagree with the author's support for local analgesia for much septic finger surgery, except in children, nor with his condemnation of the lateral incision for pulp space infection and the use of Kaolin poultices and mag. sulph. paste. A more challenging stand and one which deals a final blow to the dogmatic precepts of Kanavel and Ismelin, is the intentional omission of any mention of "thear space" and "mid palmar space" infections. Their place is taken by a short account of deep palmar abscess, which itself constitutes only about 1 per cent. of all septic lesions

in the hand. This admirable sense of proportion, together with thoughtful rejection of much nonsense that has previously been copied from textbook to textbook, characterises Mr. Bailey's whole work.

This is an excellent book, beautifully produced and cheap at the price. It should be read by senior undergraduate students and read again by all surgeons, young and old, called upon to diagnose and treat the infected hand.

M.A.B.

**Modern Public Health for Medical Students** by I. G. Davies, M.D., F.R.C.P., D.P.H. Published by Edward Arnold, Ltd. Price 36s.

So many changes have taken place since "Modern Public Health" was first published in 1955, that this edition was badly needed. The Mental Health Act, 1959, has, for instance, completely altered the methods by which the psychiatric patient is brought into care.

This book only considers those aspects of public health that directly concern the practitioner, and does not cover the whole field of hygiene. It includes the structure of the Health Service, and the doctor's part in it; elementary statistical method; diseases of social importance; those services available to the handicapped, both statutory and voluntary; maternal and child welfare; and some preventive aspects of health education. Graphs, charts and figures are plentifully supplied.

Such a book is consulted for information rather than to be read for pleasure, but nevertheless the style is such that one is led from one item to another in enjoyment of the clarity of presentation.

W.E.H.

**Aids to Ear, Nose and Throat Nursing (3rd Edition)**, by Susanna Marshall, S.R.N., S.C.M., D.N. (Lond.). Published by Baillière, Tindall and Cox. Price 10s. 6d.

The 3rd edition of Aids to Ear, Nose and Throat Nursing is a great improvement on the previous one. The type is good and sections and subsections clearly indicated. New diagrams have been added and existing ones slightly altered and in many cases enlarged.

The most outstanding alteration is the distribution of the anatomy and physiology throughout the text. This adds to the clarity and makes reference to structure easier, it also brings the whole into line with the aims of the General Nursing Council's new syllabus.

The space allowed less common subjects such as scarlet fever has been reduced, while others have been expanded and new material such as the preparation of the child for tonsillectomy, and certain operative techniques has been introduced.

The whole is a worthwhile publication giving up-to-date techniques in the field of otorhinolaryngology and will be useful to both the student and post-graduate nurse.

R.E.B.

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## SPORTS NEWS

### EDITORIAL

The Athletic Club claims the distinction of being one of the oldest clubs in the Hospital. The Club originated in 1870 under the guidance of Mr. A. A. Bowlby, later to become Sir Anthony Bowlby. Since 1878, Sports Day has been run annually, apart from the interference of the two World Wars. Sports Day was comprised primarily of handicap events, the most original one being a race for Military bandmen each carrying his own instrument. Early Journals contain comments regretting the lack of patronage by students and staff, but by 1920 Sports Day had become accepted as a social occasion and no less than "five Harley Street surgeons treated an unfortunate high jumper who had broken his wrist". It was encouraging to see the greatly increased support at Sports Day this year and it is hoped that this will continue.

The honours of the Club are impressive and include Olympic Gold Medals and International successes. The Inter-Hospital Championships have been won twenty-one times—only Guy's with twenty-three have bettered this. Unfortunately the last time Bart's won was in 1950, but by taking third position this year we have improved on more recent results.

The details of the U.H. Championships are

**COPY DATES: For August, 15th July; for September, 19th August.**

### SPORTS DAY

Sports Day in previous years has been solely the Athletics Club Championships, from which the most powerful team available was selected to represent Bart's in the Inter-Hospital Championships. This year, however, emphasis was laid on the Inter-Year Competition in which points were awarded for standards achieved in each event. With the incentive of seventy-two free pints of beer for the winning year, many people not only came down to Chislehurst for the first time, but actually strove for points to help their year.

The first event, the 120 yards hurdles, started at 2.45 and each following event went off on time to the end of the long, full programme. Even the grey, threatening sky and the cold wind failed to deter the enthusiasm of Dr. Francis and his excellent team of judges, which made the smooth, efficient running of the programme possible.

recorded in this Journal, but the result is worthy of comment in that it was attained by a concerted team effort with the lesser athletes more than backing up the outstanding performers. Apart from the 100, 220 and 440 yards we had one or more athletes gaining points in each of the events. The present team spirit is very high, and with this strong foundation to build on the Club should improve next year.

In addition to Sports Day and the U.H. Championships which are the two highlights of the Bart's athletic season, a programme of matches is arranged for May and June. At the moment we tackle other Hospitals, Colleges of London University and the London Banks. This year the results of these matches have been varied. Our present lack of sprinters has let us down and often the strength of our middle and long-distance runners has not been enough to make up for it. The field events have always been closely contested at these meetings.

Plans for the future include matches further afield, possibly to the Channel Islands, and an organised team attendance of training and coaching courses run by London University. Finally, the aim of the Club is to return the U.H. Shield to its rightful place in our Library.

G.H.

In the jumping events, Niven's performances in the long and triple jumps stood out above all others. However, the winning leap of 5 ft. 6 ins. in the high jump by Rose deserves mention as it is the best we have seen at Chislehurst for some years. Both of these athletes are young and should have many successful seasons in front of them.

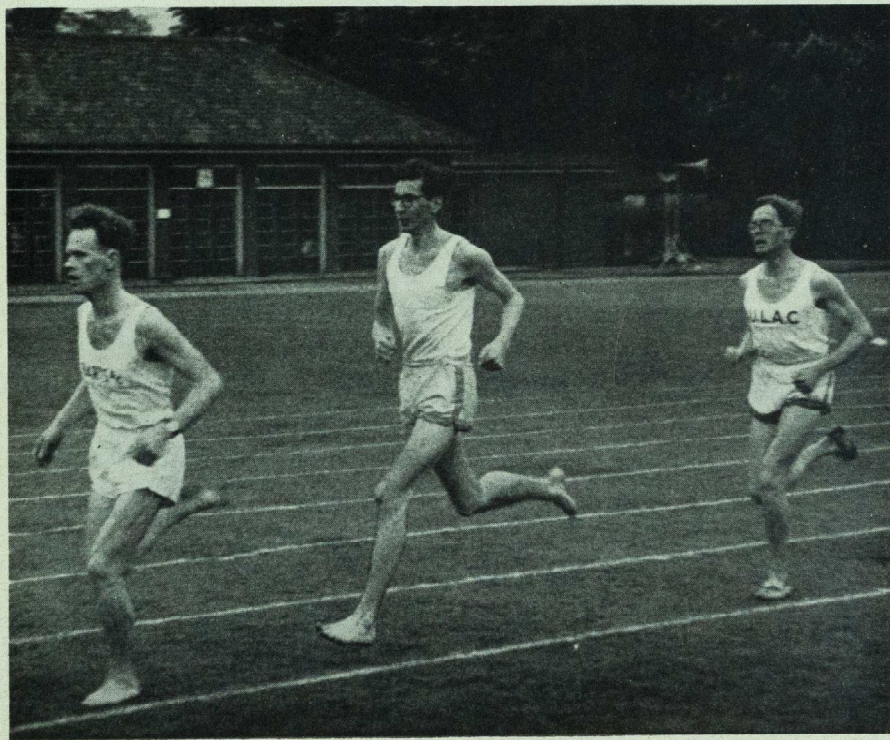
The track events provided many close and exciting finishes, especially the one hundred yards final in which all six were within a yard of each other. Once again Niven proved to be the strongest, snatching the verdict on the tape. D. Tunstall-Pedoe again demonstrated his grace and power of movement in winning both the half-mile and mile finals. Although two weeks earlier he had finished fifth in the British Universities mile with a time ten seconds inside the Bart's record, Dr. Dormer's time once again eluded him. Even so, this noble effort brought him the award

of the Treasurer Cup for the second successive year.

In the throwing events, Herbert scored a good double, taking first place in the shot and discus for the second year running. However, the best individual performance was by Rawlinson, in the javeline, with almost 150 feet; this was his first competition this year. At the end of the afternoon Mrs. Cope very kindly presented the trophies and gave away the prizes.

#### Results:

100 yards. Time 10.8 secs.  
1st J. Niven. 2nd S. Harris.  
3rd D. Goodall and I. Smith  
220 yards. Time 24.0 secs.  
1st D. Goodall. 2nd J. Niven.  
3rd B. Scott.



Peter Littlewood, Terry Foxton and Dan Tunstall-Pedoe in the three miles.

440 yards. Time 55.2 secs.  
1st B. Scott. 2nd A. Knox.  
3rd J. Coltart  
880 yards. Time 2 mins. 3.7 secs.  
1st D. Tunstall-Pedoe. 2nd T. Foxton.  
3rd N. Pott.  
1 mile. Time 4 mins. 29.4 secs.  
1st D. Tunstall-Pedoe. 2nd R. Thompson.  
3rd N. Pott.  
3 miles. Time 15 mins. 32.4 secs.  
1st T. Foxton. 2nd D. Tunstall-Pedoe.  
3rd P. Littlewood.  
Long Jump. Distance 19 ft. 6 ins.  
1st J. Niven. 2nd D. Goodall.  
3rd N. Baretto.  
High Jump. Height 5 ft. 6 ins.  
1st S. Rose. 2nd K. Rawlinson.  
3rd S. Harris.



Christopher Smart clearing the high jump.

Hop, Step & Jump. Distance 40 ft. 3 ins.  
1st J. Niven. 2nd C. Butler.  
3rd D. Goodall.  
120 yards Hurdles. Time 18.1 secs.  
1st E. Sidebottom. 2nd B. Scott.  
3rd M. Kettlewell.  
Shot. Distance 37 ft. 6 ins.  
1st T. Herbert. 2nd J. Gibson.  
3rd W. Garson.  
Discus. Distance 99 ft. 10½ ins.  
1st T. Herbert. 2nd T. Bates.  
3rd E. Carden.  
Javelin. Distance 147 ft. 2 ins.  
1st K. Rawlinson. 2nd M. Orr.  
3rd T. Powles.  
Cricket Ball. Distance 272 ft. 3 ins.  
1st D. Delany 2nd M. Orr.  
3rd J. Savage.  
Inter-Firm 4 × 220 relay. Time 1 min. 44.8 secs.  
1st 1st Year Preclinical  
2nd 2nd Year Preclinical.  
Mixed 3-Legged Race.  
1st N. Pott/E. Foster.  
2nd M. Waterworth/R. Smiley.

Egg & Spoon Race.  
1st E. Webb. 2nd V. Francis.  
3rd G. Dunn.  
Staff Handicap. 100 yds. Time 8.9 secs.  
1st J. W. Cope. 2nd B. J. Davies.  
3rd D. C. Dale

#### CRICKET CLUB REPORTS

**Sunday, 2nd June. 1st XI v. Valeswood. Won by 9 wkts.**

Valeswood opened slowly on a fine day at Chislehurst and were 45 without loss at lunch time. After lunch the wickets started to fall, with K. Rawlinson bowling well and D. Abell mopping up the "tail-enders", so that they finally declared at 142 for 9 wkts. R. S. A. Thomas and R. Wood then proceeded to slaughter the Valeswood bowlers, the latter being out 4 runs short of the total.

Valeswood 142 for 9 declared (K. Rawlinson 3-27).

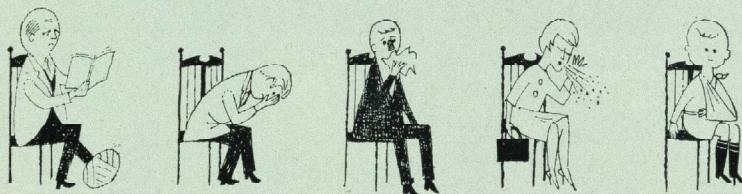
St. Bart's 144 for 1 (R. S. A. Thomas 71 n.o.; R. Wood 60).

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"The time has come the doctor said,  
 To talk of many things,  
 Of Auriscopes, and Stethoscopes,  
 Of Patients and their ills,  
 And when we all have had our say,  
 And told our tales of woe,  
 Let's sit and sup our Guinness,  
 'Cause, it's Guinness gives you go." M.B., D.Ch.

*(published by special permission)*

**GUINNESS**  
**IS GOOD FOR YOU**



**Sunday, 9th June. 1st XI v. Parkfield C.C.**  
**Match Drawn.**

Parkfield scored slowly against the Hospital on a humid hot day at Chislehurst, and finally declared at 170 for 5 wickets, leaving the Hospital just over 2 hours to score the runs.

Runs came freely with Thomas and Sidebottom in fine form, but three quick wickets slowed the run-rate, and finally a score of 144 for 8 wickets was reached.

Parkfield 170 for 5 wickets.

St. Bart's 144 for 8 wickets. (R. S. A. Thomas 45; E. Sidebottom 42 n.o.).

**Saturday, 15th June. 1st XI v. Old Tauntonians.**  
**Lost by 58 runs.**

Slow batting by Old Tauntonians in the first hour and their subsequent loss of wickets while attempting to score runs allowed them to reach a total of 184 for 9 wickets.

In the two hours remaining the Hospital gamely went for the runs, but lost wickets rapidly, despite a fine innings by H. Phillips, out of retirement. The last wicket fell in the last over to make an exciting finish.

Old Tauntonians 184 for 9 dec. (J. R. Harrison 5-49).

St. Bart's 126 (H. Phillips 40; J. Harrison 25).

**Sunday, 16th June. 1st XI v. Horlicks at Slough.**

Horlicks were quickly in trouble against the howling of Savage and Harrison on a lively green wicket at Slough, and were 60 for 5 at lunch. After lunch wickets fell to Delany and Savage and they were all out for 84.

Bart's, too, were in trouble against the Horlicks howlers, but an aggressive innings by Delany saw the Hospital safely through to a fine win.

Horlicks 84 (J. R. Harrison 4-16).

St. Bart's 85 for 5 wickets. (D. Delany 25).

**Saturday, 25th June. 1st XI v. Streatham Wanderers. Lost by 4 wickets.**

Bart's batted first on a humid afternoon at Chislehurst and were soon in trouble with the rapid dismissal of Phillips and Pagan. A collapse was prevented by a fine innings by D. Abell helped by D. Delany and N. Offen. With some stalwart batting from the "tail end" a total of 155 was finally reached. Streatham Wanderers were quickly in trouble from the Bart's attack, followed by the spin bowling of D. Abell, but a 65-run 6th wicket partnership put

them home to win by 4 wickets with 10 minutes to spare.

St. Bartholomew's Hospital 155 (D. Abell 46; N. Offen 23).

Streatham Wanderers 159 for 6.

**1st XI v. Queen's College, Cambridge. Lost by 9 wickets.**

The Hospital batted first and lost quick wickets to the Queen's bowling. Thomas and Abell then batted well for the third wicket. The score progressed well with Vartan and Delany scoring freely, but wickets were falling too frequently, and finally the Hospital were all out for 172.

Queen's lost a quick wicket, but then their No. 3 scored a rapid century against a labouring Bart's attack and the total was reached for the loss of one wicket.

St. Bart's 172 (R. S. A. Thomas 31; C. Vartan 31 n.o.).

Queen's Colege 175 for 1 wicket.

**GOLF CLUB**

Unfavourable weather at the beginning of the year, with consequent closing of the courses until late in the year, has hampered fixtures this season.

So far, three matches have been played and another fourteen are arranged.

**v. St. Mary's Hospital at Chislehurst. 1st May. Won 5-1.**

Played in pouring rain, this match proved a good victory for Bart's. Five matches were won and the remaining one was taken to the last green.

**v. Staff at Denham. 15th May. Singles—Draw 5½-5½. Foursomes—Won 5-0.**

Singles were played in the afternoon over 18 holes; the result being equal for both students and staff.

In the evening—after tea—foursomes were played over 9 holes.

**Mr. Hankey's Team v. Tandridge Golf Club. 19th May. Lost 5½-2½.**

This fixture is played over two 18-hole rounds of foursomes.

Mr. Hankey's team consisted of Mr. Robinson, Dr. Borrie, and six students; Mr. Hankey himself was regrettably unable to play. T. Stephenson and J. Miller won both rounds, and C. Richards and W. A. M. Davies halved in the afternoon.

From the day you qualify . . .



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## EDITORIAL

### Florence Nightingales

Certainly you are not overpaid, not even you Bart's girls. If you were paid more you might find the “wrong type of girl” (*sic*) in your apron-white ranks sully the image of your noble and underrated profession—girls from Heathfield and the South or Hatfield and the North. And we must discourage the wrong type of girl. Do St. Bartholomew's Hospital nurses epitomise the right sort of girl?

The young women here are veritable Florence Nightingales and have a reputation that is unassailable and quite beyond compare. They are courteous and polite most of the time to most people. Busy all the time, with their on-duty minds constantly on their job, they always have a smile for everyone, even medical students. Do we like this?

In your fleeting spare time hours you are glad to climb demurely, prettily and with some alacrity into a medic's car for an evening of relaxation and fun with the men you work with, the men you can trust. During these few hours no one would blame you for relaxing utterly with only half your off-duty mind on the future. No one would be surprised if you decided to marry a medic—so ideal and fitting a match. Young women, carry on this spirited and selfless work. We adore you always. We love you frequently. Do we not marry you often enough?

#### Grasmere and all that

It is a sad fact that people do not grow on trees. People, en masse, are not part of nature, but part of civilisation. William Wordsworth walked and talked about the Lake District for half a century. The county is still beautiful with its high hills, large lakes and peaceful pools in unsuspected hollows. It is no longer strange and simple, savage and silent.

Now it is Lakeland and one vast holiday Lido of grey-flannelled men, cotton-printed women and children. A land of a thousand gift shops, camping sites, bed and breakfasts, guest houses, hotels, cash registers and greedy locals. Too many people set on enjoying themselves darken the countryside and dull their appreciation of it: imagine W.W. and S.T.C. on a walk from Hawkshead to Grasmere set on enjoying themselves. Camping in a valley between soaring slopes and a sun-smoothed lake is pleasant. Housewives' Choice adds nothing. People pollute.

#### The Lakes

Senior Service, Aspro, Ind Coope, Corona, Player's Navy Cut, Barker and Dobson, Bachelors, Mackintosh's, Cadbury's, Red Bass, Cherry Blossom, Old Holborn, Swan Vestas, Gordon's, Huntley and Palmer's, Colgate, Nelson, Park Drive, Disprin, Player's Weights, Kleenex,

Bronco, Scotties, Max Factor and Tate and Lyle.

All of these disused can be seen on walks through the Lake District (Lakeland in local jargon for the tourists), the country William Wordsworth loved and wrote about.

#### St. Bartholomew's Hospital Golfing Society

The Society met for the twenty-ninth Summer Meeting at the Beaconsfield Golf Club, when fifteen members attended. Unfortunately the weather was most unfavourable and the matches had to be played in drizzling rain, and an occasional downpour.

The Gordon-Watson Cup was won by A. E. Dossetor (39 points); runner-up D. H. Rushton (38 points). The Gillies Trophy was won by D. H. Rushton (38 points), and the Corbett Cup was won by R. J. Mitchell (31 points). The winners of sealed holes were A. E. Dossetor and N. Oswald.

It was previously announced that the Autumn Meeting would be held in the early part of September at the Addington Golf Club. The Secretary has come to realise that this is a particularly bad time as a number of members will be on holiday, and will not be able to attend. The meeting will now take place on Thursday, 10th October, at the Tandridge Golf Club, Oxted, Surrey.

#### Maccabean Prize and Medal

Entries for the 1964 Maccabean Prize and Medal are now invited for an essay of 5,000 to 7,000 words on some aspect of the history of medicine or pharmacy. Intending candidates, who must be under thirty years of age on 15th March, 1964, may apply for further particular to the Hon. Secretary of the Faculty, Dr. F. N. L. Poynter, The Wellcome Historical Medical Library, The Wellcome Building, Euston Road, London, N.W.1.

#### An Apology

At present the Editor, the Assistant Editor, the Manager, the Assistant Manager, the Women's Representative and our Social Correspondent are away on holiday. For this reason our August issue is a little thin. We are sorry about this.

**The September Journal will be published in the week ending 14th September.**

## AN ANNOUNCEMENT

Quite recently the Journal had to raise its subscription rate. This applies to new subscribers only and there will still be special concessions for recently qualified Bart's men and retired Bart's nursing staff.

Every effort is made to publish the journal in the current month. This has not always been possible. It is sad to admit that this issue is only the third this year to be published in its own month, sadder still that we have lost nearly two-hundred old Bart's subscribers over the past eighteen months. Rightly, they are unamused to read a July Journal in September—and have to pay for it. Regaining such a number of subscribers will be an uphill task. We hope that in the near future many old Bart's men will show their appreciation of an up-to-date Journal by becoming subscribers.

Editors are often faced with protracted struggles in the extraction of material from unwilling and unpaid contributors. This can, and frequently does, cause delay in publication.

The Journal is free to all medical students of the Hospital and Medical College. This will continue to be so although the numbers distributed in the students' cloakrooms will no longer be so ridiculously unlimited.

The price of the Journal to nurses will be reduced to 9d. a copy. We hope that this particular section of our readers will show considerably more interest in writing for us. The publications committee is always glad to consider contributions. They should be addressed to the Editor, c/o Abernethian Room, and sent in for publication by the copy date announced in the previous issue.

## CORRESPONDENCE

### AN ANNOUNCEMENT

Dear Sir,

May I congratulate you on the current issue. To my mind it is the only one for some time

which has made the effort of tearing off the wrapper worthwhile.

With all due deference, the contents of the Journal have been such that it really did not seem to matter how much delay there was in publication. And, in my humble opinion, it still will not matter too much in future if you can maintain the standard of the July issue. Most of it will be worth reading, however out of date, and—more important, perhaps—worth the money.

With best wishes for the recovery of those 200 lost subscribers.

Yours sincerely,

22nd July

P. E. PYM.  
Moat Farm,  
Wickersley.

[Thank you.—Editor.]

## STANDING ROOM ONLY

Dear Sir,

The article "Standing Room Only" by John Guillebaud in your June issue was an eloquent presentation of the problems facing the world if its population continues to increase at the present rate.

However, although overpopulation is a practical problem it is also true that no individual person will space or limit his family for reasons of overpopulation. People accept birth control for personal individual reasons of health, economy and so on. This fact has to be borne in mind when linking the idea of family planning with overpopulation. Overpopulation is a political national matter; family planning is an individual family matter.

Yours sincerely,

SHIRLEY WREN-LEWIS.

Information Officer,  
International Planned  
Parenthood Federation.

23rd July.

[John Guillebaud writes: "This is very true, and it would appear that birth control propaganda has more chance of success if its advantages to the mother and family are stressed rather than those to mankind. Otherwise, such is human selfishness, the individual is prone to say that 'everybody else is out of step', and why should he bother? . . .—Editor.]

## STANDING ROOM ONLY

Dear Sir,

May I congratulate you and John Guillebaud on the article in the St. Bartholomew's Hospital Journal for June, 1963, commenting on the present explosion of the world population. It is so important that we should be aware of this and should view it as logically as John Guillebaud did in his article, and should be prepared to recognise the logical and intelligent treatment of this state of affairs. In this country, one has only to consider that the death rate of children under 6 years in the early part of the 18th century is recorded as 750 per 1,000 births and now it is of the order of 35 per 1,000 births, to realise the effect of applying throughout the world the same social and medical measures which have achieved this result in this country. Even with the early death rate in children being of the order of 500 per 1,000 births, for at least two-thirds of the world's population, nevertheless, the geometrical expansion has begun and is well under way. This is one of the social and medical aspects of world health which cannot be ignored without great peril.

Clearly the need is for quality and not quantity of life in the world and one has only to recall the degradations and poverty of the overcrowded land of India to realise the full significance of this.

Yours faithfully,  
ROBERT WIGGLESWORTH,  
Consultant Paediatrician,  
Kettering and District Hospital.

8th July.

"DE GENERATIONE ANIMALIUM", 1651,

Dear Sir,

Much has been written about William Harvey, but it appears to me that one thing is still lacking, that is, a translation of his "De generatione animalium", 1651, for which I shall use a photostat of the 1766 edition of his "Opera omnia", printed for the College of Physicians of London.

This promises to be an enormous work, but I have been publicly committed to it by Sir Arthur MacNalty (*Proc. roy. Soc. Med.*, 1962, 55, 859-860), and I give this notice of my intention to complete the task, which I estimate will take me perhaps two more years. When I have finished it, it will, I hope, find a suitable place beside my volume 262 in Everyman's Library.

I have not received the support of various bodies to which I have applied, and I therefore acknowledge most gratefully the very generous help freely given to me by my wife, Dr. Ethel A. Franklin, who surely deserves well of all Harveians.

On 5 May, 1958, according to my files, I received from Dr. Arthur W. Meyer a letter headed, 121, Waverley Street, Palo Alto, California, which read, "Although I had a completely new translation of Harvey's 'De generatione animalium' made in 1935 for use in writing my analysis of that book, I failed to make further use of it, and hence shall greatly applaud an explanation by anyone else and shall await your copy with great interest. Very sincerely yours, Arthur W. Meyer (E.P.M.)". In 1939 he followed this first book with "The Rise of Embryology", and in 1956 with "Human Generation Conclusions of Burdach, Döllinger and von Baer".

On 5 April, 1958, John Fulton wrote a letter to Professor Donald C. O'Malley in which he asked, "Is Professor Meyer, by the way, still living? If not, when did he die? If still alive, he is touching 85, since he was born in 1875. Do you know of anyone who may be contemplating making the translation? If there is no one, I shall inform Franklin to this effect. Yours ever, John Fulton".

Recently, I have written again to Professor O'Malley who replied on 30th June, 1963, by air-mail, and he said that he did not know if Professor Meyer was still alive, but, if so, he must be close to ninety and that the translation which he had made for him of "De generatione animalium", was not a good one. Meanwhile, I have invited Professor R. J. Harrison, of the Department of Anatomy, the London Hospital Medical College, Turner Street, London, E.1, to act with me in preparation of the work. As he wishes to dedicate the result, in so far as he is concerned, to Professor G. W. Corner, of the Rockefeller Institute for Medical Research, 66th Street, York Avenue, New York 21, N.Y., U.S.A., to whom he feels a particular personal indebtedness, I have similarly asked the Librarian of St. Bartholomew's Hospital Medical College, who is also Librarian to the Harveian Society of London, if he will accept a dedication, which I am glad indeed to say, he has done.

I shall be pleased to receive any relevant information, and to acknowledge such, in our book. On page 216 of the 1766 edition of Harvey's "Opera omnia", published by the London College of Physicians, I was attracted by the words "Venarum ostiola", which recalled the words of Hieronymus Fabricius of Aquapendente to my mind.

Yours faithfully,  
K. J. FRANKLIN,  
"Broomfield", The Street,  
East Preston, Sussex.

16th July

## SIR ANTHONY BOWLBY

Dear Sir,

May I appeal for help through your columns to any Bart's man who subscribed many years ago to the fund which was raised to defray the cost of the oil painting of the late Sir Anthony Bowlby? I believe it hangs in the Great Hall at Bart's. I was a dresser on Sir Anthony's firm at the time when the late doctors Stanley and Just were his house surgeons. I subscribed to the cost of the painting and in due course was presented with an engraving of it. Sad to relate, the engraving is no longer in my possession and I should like very much to possess a photograph of it. I imagine it is quite impossible to obtain a duplicate of it, or am I wrong?

My grandfather, Nathaniel Barlow, M.R.C.S. (1799-1846), was at Bart's and was a pupil of Sir John Abernethy. I have in my possession an inherited engraving of Sir John which was presented to my grandfather who in his turn had subscribed to the original painting which was done by Sir Thomas Lawrence and engraved by William Bromley, A.R.A. I feel that this fact that grandfather and grandson subscribed to oil paintings of Bart's surgeons under whom they were privileged to serve must be unique. My father was born in Essex and had three cousins at Bart's.

Yours faithfully,

LANCE W. BARLOW.

15th July

## VOLUNTARY HOSPITALS

Dear Sir,

Firstly I would like to congratulate you on the improved format and contents of the Journal.

I liked your article on the Evolution of the Voluntary Hospitals, but would like to add to the last paragraph on special hospitals, The Royal National Hospital for Rheumatic Diseases at Bath which was founded in 1742, before any of those that you mention.

Yours faithfully,

GEORGE D. KERSLEY.

10th July

## ARMS AND THE CAR

Dear Sir,

Most people associated with the Hospital are aware that technically we have little right to use the familiar black and white coat of arms. This was a device originally used by John Wakeryng, Master of the Hospital in 1423, which has subsequently passed into common use without any

proper authority.\* I, personally, do not subscribe to the view that this is necessarily a bad thing. I like to feel that John Wakeryng himself would not disapprove of the use of his personal badge by the institution which he served, and I suspect that the College of Heraldry would at least condone it on the grounds of tradition.

It should, however, be a matter of deep concern that the authorities have seen fit to print the device in red on the new car parking badge. This is an anachronism. It is understood that it is intended to print the badge in a new colour every year. The imagination boggles at what will happen when all five heraldic tinctures have been used; will we then have a multi-coloured escutcheon? The heavens forbid! Let us end this harlequinade before the wrath of the Garter King of Arms is turned upon us.

Yours sincerely,

TOM B. BOULTON.

\* Editorial, St. Bartholomew's Hospital Journal, 1947, 51, 19.

## MR. W. D. COLTART

Dear Sir,

Many of your readers will remember Sports Day a few weeks ago; a great athletic and social success, marred only by a cold wind which chose to blow that particular day. In spite of this Mr. W. D. Coltart was there as he has been on every Sports Day, helping to judge each event and cheering on the competitors. As a student he was a hurdler and quarter-miler following in the footsteps of his two brothers; recently he has helped Bart's Athletic Club and United Hospitals Athletic Club in many ways. It was he who first suggested having Sports Day on a Wednesday; he was one of the people who made it possible for U.H.A.C. to take a team on tour in Sweden—the first team of its kind ever to do so; he was present every year at United Hospitals matches, Championships and Dinners; this year he welcomed Stockholm University to London on their return visit. His death is a great loss to our sport and Bart's in particular will miss his enthusiastic encouragement and interest. His trophies presented to U.H.A.C. and Bart's A.C. which were won by himself and his brothers will long serve to remind us of his loyal support.

Yours faithfully,

PETER LITTLEWOOD.

[Letters to the Editor should be addressed to the Abernethian Room and posted not later than a week after the current publication for inclusion in the following issue.]

**Births**

ARTHUR.—On 22nd June, to Joan (née Underhill) and Dr. Timothy Arthur, a daughter (Mina Frances), a sister for Barbara.

BOLTON.—On 1st July, to Janette (née Costin) and Dr. Tom Bolton, a daughter (Rosemary), a sister for Mark and Nicholas.

BONNER-MORGAN.—On 4th May, to Barbara (née Barnard) and Robin Bonner-Morgan, a daughter, sister to Sarah.

CHURCH.—On 27th June, to Rhoda, wife of Dr. John C. T. Church, a son (Simon Christofer), a brother for Jonathan and Martin.

**Marriage**

JOHNSON—LONGRIGG.—On 6th July, Paul Austell Johnson to Jean Sonia Longrigg.

**Deaths**

REES.—On 2nd June, Dr. T. P. Rees, O.B.E., M.D., F.R.C.P., D.P.M., aged 64. Qualified 1923.

RYLAND.—On 10th June, Mr. Archer Ryland, F.R.C.S. (Ed.), M.R.C.S., L.R.C.P., aged 81. Qualified 1909.

**Appointments, etc.****Birthday Honours**

The following Bart's men were included in the Birthday Honours list published on 8th June:—Arthur Capel Herbert Bell, M.B., B.S., F.R.C.S. Knighthood.

Edward Revill Cullinan, M.D., F.R.C.P. C.B.E.

Sir James Paterson Ross received a gold medal at the 50th anniversary celebrations of the Peter Bent Brigham Hospital, Boston, Massachusetts.

**Changes of Address**

Dr. H. W. Cornford from 111, Torquay Road, Paignton, to 364, Cherry Hinton Rd., Cambridge.

Mr. Frank Ileckford to 28, Dover Street, Ryde, Isle of Wight.

**HOUSE APPOINTMENTS**

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Dr. W. E. Gibb	D. Crowther		
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Dr. H. W. Balme	E. A. Shinebourne		

Dr. and Mrs. John Hunt from 38, Harley House, N.W.1, to 18, Wilton Place, S.W.1.

Dr. Stanley Shere from 1, Hermitage Lane, Maidstone, to 21, Tudor Avenue, Maidstone, Kent.

**Calendar**

Sat. & Sun. 17th & 18th Aug.: Dr. Graham Hayward  
Mr. A. W. Badenoch  
Mr. J. N. Aston  
Dr. R. Ballantine

19th Aug.: Copy date for September Journal.

Sat. & Sun. 24th & 25th Aug.: Dr. A. W. Spence  
Mr. E. G. Tuckwell  
Dr. Ian Jackson

Sat., Sun. 31st Aug., 1st Sept.: Prof. Scowen  
Prof. G. W. Taylor  
Mr. H. Jackson Burrows  
Dr. T. B. Boulton

3rd Sept.: Wine Committee Barbecue Ball.

Sat. & Sun. 7th & 8th Sept.: Dr. R. Bodley Scott  
Mr. Alan Hunt  
Mr. J. N. Aston  
Mr. G. H. Ellis

Sat. & Sun. 14th & 15th Sept.: Dr. E. R. Cullinan  
Mr. C. Naunton  
Morgan  
Dr. Bowen

16th Sept.: Copy date for October Journal.

The Physician Accoucheur on duty for the month of August is Mr. G. Bourne.

The Physician Accoucheur on duty for the month of September is Mr. J. Beattie.

**THE WINE COMMITTEE**

The 1963 Smoking Concert will be on Tuesday, 22nd October. Gentlemen with ideas of scripts or sketches please see Mr. Graham Chapman before Friday, 4th October.

Tickets are now available for the Barbecue Ball on 3rd September. A double ticket at 30s. brings you three bands, extensive buffet, a side-splitting cabaret, three bars and subtle illuminations.

PROFESSOR SCOWEN  
Dr. A. G. Spencer  
MR. C. NAUNTON MORGAN  
Mr. D. F. Ellison Nash  
MR. A. H. HUNT  
Mr. J. O. Robinson  
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M. C. Jennings  
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Mr. J. Howkins (G) Sandhurst  
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(G) Harley

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## LAST MONTH from EDINBURGH

Quite the worst possible way of travelling to Edinburgh from London is over night in a second class railway carriage. The fastest train leaves King's Cross at 11.15 and if you arrive by 10.15 you should manage to slip into the last unreserved seat. Seats, of course, cannot be booked by telephone, but only by a personal visit to a main line station, before 5 o'clock. Such is the efficiency of British Railways.

The train is scheduled to take just seven hours, but this appears mythical. It deposits you in Edinburgh at about eight o'clock in the morning, in order that you do not have to wait for the station restaurant to open, and serve you a 6s. 6d. B.R. breakfast. And then there's this question of sleep. At the beginning of the journey the train is continually altering speed and one takes some time to become conditioned to this. At about 3.30 a.m. under the influence of a medium acting barbiturate, one dozes, to be woken again as the train stops at Newcastle at 4 a.m. One buys a much-needed snack from a sour-looking woman on the platform (if this is her permanent job she has every reason to look sour) and then falls into fairly deep slumber. As soon as everyone on the train is asleep a guard throws open the compartment door and demands to see your tickets!

Whereas some great cities are built on rivers, Edinburgh is built on a railway; at least that is how it appears to a casual observer. The story is, I am told, that it was built on a loch, which was subsequently drained when the "new town" was built on its north side; the railway was built into the floor of the loch, and is well concealed, but a loch would look (and sound) better. Edinburgh is a handsome and clean city, and beer is 1s. 3d. a pint in most pubs. These pubs close on a Sunday and beer can only be obtained at the hotels, price up to 2s. 4d. a pint. To a visitor the city seems classless, almost everyone speaking with the same accent and using the same peculiar expressions. For example, in a cafe the bill is invariably called the cheque, and on asking for the bill I was served with another cup of coffee! One gives away one's nationality immediately when one calls the minister the vicar.

I flew back to London, which was only a little more expensive than the train, and took just over an hour. The disadvantage of this method is that you have no time to reacclimatise yourself to the English way of life; which explains why I looked so surprised when the guard on the first tube I entered removed the tyre of a bicycle wheel, with two old forks, in between stops.

## UP TO THE MINUTE, IN A MOMENT

This stop-press column, page or what-have-you is still very much in embryo. Its success, and more important, its topicality will depend on the Club secretaries' compliance with the instructions at the foot of this page—if and when they wish. Since it is pressed late, proof reading is cursory, even non-existent, and we must apologise for two small errors in the July Journal. [Mr. Roger Nicholson rows at No. 7, not 3 (our sporting correspondent counted heads from the wrong direction and included the cox), and Mr. Hugh Phillips had a long and not unexpected series of ducks—not "duties".]

In the world at large we go to press as Dr. ("so called," *sic*—Mr. Griffiths Jones) Stephen Ward suffers from an overdose of drugs, while eleven good men and true (and one woman) decide if his private life amounts to playing or poncing. Doubtless they will have to think on Miss Keeler's value as a witness. Of course, they will ignore Mr. Gordon's successful appeal because of Mr. Justice Marshall's strictures on this point. Let us hope that their decision is not influenced by the man's morals—or their own, and that it is made before 8th August (our publication date) when this could become sub-judice. Such are the values of our press or its readers that all this has submerged the good news of a partial test ban, notwithstanding Paris pride and Peking pipe.

On 8th July work began on the site of the new A.R., which will include a card room, a reading room and a snooker room for the men, and a locker room and a bed for the women.

On 19th July the Wine Committee extended its considerable patronage to a happy bus-load of beer-swilling revellers on a gay mystery tour to Southend—at no time was anyone in any doubt about the destination of the bus.

On 26th July the '61 Club had a sober dinner at the Cock Tavern, High Holborn.

[Note for old Bart's Vicarage men: the '61 Club was begun in 1961 for good Bart's London men—allegedly in a fit of heat because at that time the Vicarage was a closed-shop Cambridge Club. Contrary to common belief it does not have 61 members—by choice, not because even if every Bart's London man was invited to join they would be unobtainable.]

**Quotes of the Month.** "The Professor (Scowen) is quite a chap." Broadsheet, No. 12. "... death was caused by acute neurosis of the liver," said Dr. Charles Morgan Hall. "The Guardian."

This month our sporting correspondent missed the press.

*(In future, Club Secretaries wishing late news to be included in this page should contact the Assistant Editor not later than twenty days after the copy date.)*

## FIVE MINUTES FROM BARTS: 2

by our Drinking Correspondent. (Photographs by B. C. P. Lee)

This month I will discuss three pubs which are a bit further afield. They are all rather more interesting than the usual run-of-the-mill boozier.

Walk from the Hospital through the arch of the marker and head towards Farringdon Tube Station. On your left is the Blue Posts, conveniently opposite Francioni's—for use after closing time. Inside you are welcomed by Pat, the Irish landlord, and his pretty wife. Pat, who comes from Dublin, has been in the pub business for twenty-five years and there is not much that he does not know about the trade.

The Blue Posts is one of the smarter pubs in the Smithfield area and is recommended if you want a drink and a sandwich in relaxed surroundings.

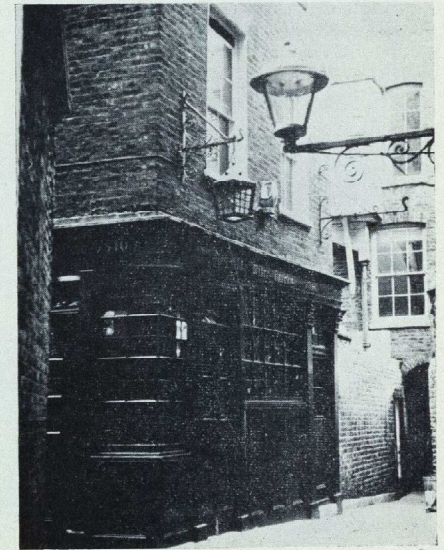


Pat, the Irish landlord.

A particular feature of the Posts is the food. Monster sandwiches and pieces of pie cost 2s. and



Blue Posts conveniently opposite Francioni's.



Mitre, serves Friary Meux.

are worth twice as much. Pat reserves the Saloon Bar for the gentry, but for the occasional thrash he turns a blind eye on the goings on in the Public Bar. The pub serves Worthington "E".

The Mitre, Ely Court, off Hatton Garden, is mainly of historic interest. It is just the place to take your bird for a touch of Ye Olde Atmosphere in the certain knowledge that there will be no Bart's boys around. It dates from 1546, closes at 10 p.m. and serves Friary Meux. That is about the lot.

Walk up High Holborn and opposite Chancery Lane Tube Station you will come to Henekeys.

The first written reference to Henekeys was in 1430—even in those days it was an inn, standing as it does at the top of the hill leading from the City of London. From those early times until the present day Henekeys has occupied the same site and has traded in wines and spirits.

In 1923, the building became structurally unsafe and was rebuilt. Happily, the Architect made full use of the old material and the cellars remain as they were in the old days.

When looking round the famous Long Bar



The famous Long Bar, not really for beer drinkers.

you will see the enormous vats from which Henekeys bottle their wines and spirits; many of them hold 1,000 gallons (6,000 bottles). The last was emptied just before the war, as the thought of this amount cascading down Holborn, burning fiercely after an air-raid, was too great a risk.

Many people believe that Henekeys is the oldest pub in London; whether this is true or not, it is a delightful place to spend an evening. It is not really for beer-drinkers, although there is a small bar where you can get a glass of Worthington. For the full impact you must go in the Long Bar. Here you can have a bottle of wine for as little as 7s. and sit in one of the many cubicles that run along both walls. At lunchtime you may eat enormous chunks of French bread stuffed with ham and if it is winter you can warm yourself in front of the iron stove which was built to commemorate Waterloo.

Henekey's is also an excellent place if you want to buy wine to take away, since they have a very extensive list ranging from the humblest to the most exotic vintages, all competitively priced.

Without doubt this is one of the great pubs of London.

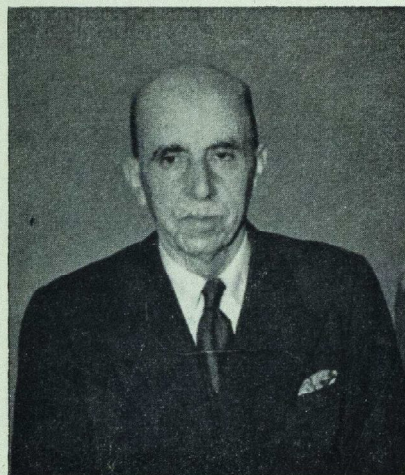


One of the great pubs of London.

## IN PECTORE ROBUR

### The Life and Works of SIR HAROLD GILLIES (1882-1960)

by Richard Petty



#### 1882-1914

**HAROLD DELF GILLIES** was born on 17th June, 1882, to Robert and Emily Gillies of Dunedin, New Zealand.

Robert Gillies was by profession a land and estate agent and represented his local community in the House of Representatives. His wife, Emily, née Street, was of English descent, a member of the Street family of Birtley, near Guildford.

Harold Gillies's childhood was marked by the early development of the characteristics of temperament which were to play such an important part in his future career. His first love was woodcarving; a pastime upon which he lavished many hours of patient work. Patience is a rare attribute in the very youthful, but not only was his work a product of meticulous carving, it also showed no uncertain degree of artistic merit.

At the age of thirteen, however, he left his home and his local school to become a boarder at Wanganui College, one of New Zealand's most distinguished public schools. There he quickly developed his athletic tendencies, and, with encouragement and coaching, exhibited great promise and proficiency in cricket, golf and rowing.

His golf and cricket were helped by a natural sense of timing and a "good eye for the ball" and his proudest achievement whilst at Wanganui was evidently his captaincy of the school cricket XI.\*

It was understandable that his academic career bore no resemblance in brilliance to his sporting achievements: a maximum of time, effort and energy was expended upon the perfection of the technique and fitness that he required of himself to play those sports to his own satisfaction. Despite this (or, more likely, due to this) he was awarded a place at Gonville† and Caius College, Cambridge, to study Natural Sciences. Somewhat unjustly people refer to this as a "sports scholarship", but Harold Gillies did have a very real wish to become qualified in medicine.

Having taken up his place in October of 1903 at Caius, the "medical college" of Cambridge, he quickly asserted his presence. In his own words, "I went up with the idea of playing cricket", but his first success came when he was asked to play golf for the University. His golfing prowess had been discovered entirely by chance during a rest period whilst training with the Cambridge Boat Race crew. He remained a playing member of the Cambridge Golf team for the entire three years of his residence.

A typical perfectionist in all things, he abandoned his interest in cricket to concentrate on the more taxing sport of rowing, and, in 1904, was rewarded by being invited to row No. 7 for the winning Cambridge crew in the Boat Race.

Harold Gillies soon gained a reputation as a wit with a distinctly *bizarre* sense of humour (one cannot help but think how much this, and his artistic flair, was due to his maternal great great uncle, Edward Lear‡). It is a tribute to

\* This is mentioned in Sir Harold Gillies's memoir in "Who's Who" cheek by jowl with his many decorations and major sporting successes.

† **Gonville Hall** founded on 4th June, 1349, by the Reverend Edmund Gonville. **Gonville and Caius College** incorporated on 4th September, 1557, by Dr. John Caius, President of the College of Physicians, 1555-1563, practising in the parish of St. Bartholomew the Less. Physician to King Edward IV.

‡ **Edward Lear** (1812-1888). Ornithological Draughtsman, Zoological Society, 1831. Published "Book of Nonsense", 1846. Landscape painter, 1836 to death. First exhibited in Royal Academy, 1850.

the stability of his character that these personal successes, and the subsequent worship of a sports-loving generation of students, did nothing to change his extrovert personality from self-assurance to unbearable conceit. Due to this strength of character combined with a genuine streak of humility, Gillies always retained the respect, admiration and friendship of those who were close to him. In fact, on a first meeting, he would give the impression of a quiet and courteous man, not at all the broad, rough-tongued *Kiwi* that might have been expected.

He came down from Cambridge in 1905, having gained a second-class honours degree in the Natural Sciences Tripos, and entered the Medical College of St. Bartholomew's Hospital, following a strong precedent set by many other Caians and distinguished members of the medical profession in the past.\*

At Bart's the necessity to do a modicum of work curtailed his sporting activities, but he still managed to retain an active interest in golf and rowing. He played golf well up to his usual standard and, in fact, played for England against Scotland whilst still a student in 1908.

During his student days at Bart's he shared a flat with four of his Cambridge contemporaries at 26, St. James's Square (Holland Park!) where he paid thirty shillings a week for his board and residence. At one stage the threat of eviction hung over their heads when the owners of the house gave the landlord notice to quit, prior to the sale of the property. Always quick to size up a situation, Harold Gillies organised a syndicate and the members of the flat bought the house retaining the landlord as general *factotum*.

If Gillies missed a day's training with the Boat Club he would disappear soon after breakfast with the words, "Just off for a few swings", and would be found perched on a stool in his bedroom practising rowing exercises. He always managed to keep fit despite the fact that he enjoyed supremely "the good things in life".

Considering his ardent pursuit of social and sporting interests, his academic career was good if not impeccable. He always impressed his teachers with a mental agility and ingenuity which probably covered many gaps in his knowledge of medicine at that time.

After his qualification, M.R.C.S., L.R.C.P., in 1908, he became, in common with all other for-

\* Including William Harvey (1578-1657) who studied at Caius from 1593 to 1597, graduating B.A. He graduated M.D. at Padua, 1602. Elected physician S.B.H., 14th October, 1609. Physician Extraordinary King James I, 1618. Published "Exercitatus Anatomica de Motu Cordis" at Frankfurt in 1628.

mer medical students, a responsible member of the medical profession overnight. He was appointed to the House and became Sir D'Arcy Power's\* junior house surgeon on the Light Blue firm.

It was during this period, under the shrewd and friendly eye of his eminent chief, that his interest in surgery flowered. He also discovered his attraction to otorhinolaryngology and made no secret of the fact that it was in this that he wanted to specialise. In 1909 he was awarded the Luther Holden† Scholarship for research in surgery.

As 1909 occurred during the period in which no medical house job was required of a prospective surgeon to fulfil his preregistration commitments, he continued to serve Sir D'Arcy Power as senior house surgeon. But, towards the end of this appointment, an irresistible chance came his way of seeing some of the world before he was overtaken by the inevitable ties of practising surgery. He was offered the post of medical officer to an expedition travelling to Egypt in search of the lost "Tomb of the Kings". It is a moot point whether he was attracted by the archaeological aim of the expedition or by the speculated size of the treasure to be found within the tomb! Whichever it may have been, Sir D'Arcy Power, no doubt with the dictum in mind, "one is only young once", gave Harold Gillies permission to relinquish the remaining two months of his appointment and join the expedition.

In 1910 the expedition returned empty-handed, but the adventure had helped to broaden the outlook of Harold Gillies and to give him a taste for travel which he never lost.

It was in 1910, at the age of 28, that he was elected F.R.C.S. and was appointed surgical assistant to Sir Milsom Rees,‡ a post he retained until 1915. He was subsequently appointed Surgeon to the E.N.T. Department of the Prince of Wales General Hospital, Tottenham, and Pathologist to the Throat Hospital, Golden Square.

In 1911 he married Kathleen Margaret Jackson.

\* Sir D'Arcy Power, F.R.C.S., K.B.E. (1855-1941). Qualified S.B.H., 1882. Appointed Surgeon S.B.H., 1904. Appointed consulting surgeon and archivist, S.B.H., 1920. Appointed Governor of S.B.H., 1920. Prolific writer on history of surgery and S.B.H.

† Luther Holden, surgeon to S.B.H., 1865-1879.

‡ Sir Milsom Rees, F.R.C.S., C.V.O. Qualified S.B.H., 1889. Laryngologist to H.M. Queen Alexandra, to H.M. Household, to Royal Opera House, Covent Garden and to Guildhall School of Music.

Despite his heavy professional commitments he still pursued the game of golf, and, in 1913, won his highest award in that field by taking the Royal St. George's Grand Challenge Vase, the most valuable golfing trophy in the world, in the face of the competition of the best amateur golfers in the United Kingdom.

## 1914-1916

"War is the only true stimulant to progress."

I. G. WELLS.

The outbreak of hostilities against the German Empire in 1914 found Harold Gillies pursuing the accepted and comfortable course towards his final goal, the achievement of a consultancy in otolaryngological surgery. His work for Sir Milsom Rees brought him in contact with a rich and cultured world which he had not previously experienced, and he numbered among his patients Alfred De Rothschild and Dame Nellie Melba.

By 1915 many of his colleagues had volunteered as medical officers to the British Expeditionary Force in France. Harold Gillies realised, in common with many others at this period, that the Government's promises of a quick victory were unlikely to be fulfilled for some considerable time. The war came to a sanguinary standstill in the trenches; the British expeditionary Force expanded into Kitchener's 2nd Army and medical officers were in great demand to deal with the thousands of casualties\* pouring daily into the casualty clearing stations and base hospitals.

Early in 1915 Gillies volunteered and was commissioned into the R.A.M.C. with the rank of captain. He was immediately posted to France, to the base hospital at Wimereux, well behind the line of battle, where he took up general surgical duties.

Wimereux was within earshot of heavy gunfire from the forward areas, and the dull, soul-destroying routine of wound surgery in those days combined to make his life a constant frustration.

It was in this atmosphere that the first seeds of inspiration were sown, seeds which germinated and flowered into a massive undertaking which was not only to affect Gillies's life but also the lives of many thousands of suffering men, the pathetic, broken products of the holocaust of war.

Gillies had first met Sir Charles Valadier, the dental surgeon, on landing in France at Boulogne. Sir Charles was campaigning among his more influential patients for the institution of dental and jaw units to treat the many facial wounds

\* Of the 56,000,000 men called to arms during the First World War, 26,000,000 became casualties.

occurring through the devastating effects of flying-shrapnel. It was whilst Gillies was serving at the base hospital that Sir Charles was given his first unit in Wimereux and he was invited to assist at the first operation performed in it.

A close friend of Gillies, an American, Dr. C. W. Roberts, returned to Wimereux having spent six months with the American Ambulance in Paris, and having watched and participated in the jaw surgery being performed there. He also brought back with him a book recently published by the German surgeon Lindemann, who was reported as having miraculously patched up many hideously mutilated soldiers sufficiently well for their return to the war machine.

These two events opened Gillies's eyes to the pressing need for the utilisation of plastic surgery not only to the advantage of the British war effort, but also to that of the thousands of wounded, men so disfigured that their living would be more of a pain to them than their dying.

In June, 1915, he spent his leave in Paris. Armed with an introduction, he visited the Martinique surgeon Hippolyte Morestin, who was working in the Val-de-Grâce Hospital. Gillies had heard rumours that Morestin was doing for the French soldiers what Lindemann was doing for the German. He was not disappointed. Morestin was only too pleased to demonstrate to the young surgeon the techniques he had developed in *chirurgie plastique* and showed him in particular an operation for removal of a cancer of the face with subsequent plastic repair of the tissue defect. Gillies was delighted: in his own words, "It so thrilled me that I fell in love there and then".

It was apparent that similar techniques to those he had seen performed and had read about could be readily put to use, but he was shocked that there was so little attention paid to the cosmetic result of the operations. Gillies determined that, should the chance occur for him to practice this surgery, as much regard would be given to the appearance as the physical function of the repaired soldier.

He returned to Wimereux with one object in mind; to persuade his superiors that there was a vital need for the institution of specialist hospitals in England to deal with the problem of facial surgery.

Gillies was lucky to have as chiefs two sympathetic, broad-minded men, Sir Anthony Bowlby\* and Sir Anthony Alfred Bowlby, Bt., F.R.C.S., K.C.M.G., K.C.V.O., K.C.B. (1855-1924). Qualified S.B.H. 1876. Appointed consulting surgeon, S.B.H., 1919. Appointed consulting surgeon B.E.F., 1914; 2nd Army, 1915. Subsequently General Adviser to the Director General, Army Medical Service.

and Sir John Rose Bradford,\* both of whom had distinguished themselves in civilian practice before the war. Both men were impressed by Gillies's arguments and enthusiasm, and, as a result, contacted Lieut. General Sir Alfred Keogh,† Director General, Home Medical Service, to enquire about the possibility of instituting a pilot plastic surgery unit in England.

By the end of 1915 Gillies had been recalled to England, and, in conjunction with Col. Sir William Arbuthnot Lane,‡ Director of the Cambridge Hospital, Aldershot, plans were made for the experimental unit.

By an amazing feat of organisation the first operation was performed by Gillies in the completed unit at the Cambridge Hospital, Aldershot during the February of 1916.

### 1916-1918

*"War is the only proper school for a surgeon."*

#### HIPPOCRATES.

Gillies threw himself into the challenging work of plastic surgery with enormous drive and enthusiasm. His knowledge, in fact, was minimal at this time and he was compelled to rely upon his own experience of general and otolaryngological surgery and the sparse published work that was available.

Plastic surgery is an ancient art whose roots run deep into history. It flourished during times of war, and it was the greatest war that man had ever witnessed that caused its rebirth and its growth to maturity.

Few men in recent times had treated plastic surgery as anything except a cosmetic aid to appearance, below the dignity of a self-respecting surgeon to practise. Gillies had to turn to the literature of the earliest writers; to Celsus, to the Sushruta Samhita and to Gaspare Tagliacozzi§ to find accounts of successful procedures. From those and from the published work of such more or less contemporary surgeons as C. Nélaton of

\* Sir John Rose Bradford, Bt., F.R.C.P., K.C.M.G., C.B., C.B.E. (1863-1935). Qualified U.C.H., 1881. Appointed physician U.C.H., 1900. Appointed consulting physician B.E.F., 1914; 2nd Army, 1915. Neurophysiologist of distinction.

† Lieut. General Sir Alfred Keogh, F.R.C.P., F.R.C.S. (Hon.), G.C.B., G.C.V.O.C.H. (1857-1936). Director General, Home Medical Services, 1914-1916.

‡ Sir William Arbuthnot Lane, Bt., F.R.C.S., C.B. (1856-1943). Qualified Guy's, 1872. Appointed surgeon Guy's, 1888. Consulting surgeon to the Aldershot Command, 1914-1918. Organised and opened Queen Mary's Hospital, Sidcup.

§ Vide: "History of Plastic Surgery" below.

France (1807-1873), Karl Thiersch\* of Germany and Keegan and Smith of India, all contemporaries, and Carl Ferdinand Von Graefe (1787-1840), he garnered sufficient data upon which to base his first principles.

The first months at Aldershot were spent in trying every known method and technique mentioned in the literature. He was surprised to find that many of the methods described in modern times tended to be unsuccessful unless based firmly upon ancient principles devised by the classical surgeons. Gillies is quoted as saying: "There is hardly an operation—hardly a single flap—in use today that had not been suggested a hundred years ago" (1923).

Gradually a pattern evolved, and, with great ingenuity and imagination, he applied the successful techniques to each surgical problem as it presented, adapting and extemporising as operations progressed.

After many disappointments and false alarms, and after much hard-won experience had been gained, Gillies was able to formulate a series of "principles", which, if correctly applied, would yield reliable results. These principles were not, in fact, inflexible rules by which the plastic surgeon was to be governed, but merely techniques, the use of which in solving a specific reconstructive problem, if not a guarantee of success, would enable the surgeon to produce the best possible results within the limitations of his capabilities.

Before the war the implantation of foreign substances had been practised and advised for the reconstruction of the facial skeleton, but Gillies rightly deduced from the lowness of the short-term survival rate that the long-term survival rate of these heterogenous grafts would be even worse. He is quoted as saying: "There is no royal road to the fashioning of the facial scaffold by artificial means, the surgeon must tread the hard and narrow way of pure surgery" (1920). All his techniques utilised living tissues from the body of the patient himself.

By the end of 1916 Gillies felt that he and the team of nursing staff and assistants which he had trained were sufficiently proficient to run a plastic surgery unit independent of the limiting confines of the Cambridge Hospital.

Sir William Arbuthnot Lane, recognising the potentialities of this branch of surgery as applied

\* Karl Thiersch. Professor of Surgery at Erlangen and Leipzig. Revolutionised practice of modern plastic surgery by invention of skin graft, described at a meeting of German Surgical Society in 1874. For Von Graefe and Nélaton vide "History of Plastic Surgery" below.

to war wounds, pressed the Red Cross to find Gillies a site for a new specialist hospital. A committee was formed to help negotiations in this matter and included Lady Nelson and Lady Keynes. Gillies said: "(The Committee) had such social and political prestige that the War Office gave us permission to move to a new and larger premises".

The team which was to undertake the move consisted of Nurse Catherine Black heading the all-important nursing staff; the Chief Dental Surgeon, Captain C. A. B. King, aided by A. L. Fraser and joined subsequently by Captain Kelsey Fry, M.C.;\* the chief radiologist, Captain H. Mulrea Johnston; a lay photographer, Sidney Walbridge, and an assistant surgeon, Lieut. J. Edwards, who was responsible for the preparation of the plaster casts necessary for the planning of each operation.† Other lay members of the unit were E. F. Greenway and R. Seymour, both of whom had been among Gillies's first patients and had stayed on to help with the organisation of the complicated filing system which had developed. The former had been a member of the business staff of the "Daily Express" before the war and returned to his job at the end of hostilities, but the latter, "Big Bob" Scymour, remained Gillies's devoted friend and secretary for forty years. Last, but by no means the least important, was Professor Henry Tonks, principal of the Slade School of Arts before the war, who had volunteered for service, and, although too old to fight, had been given clerical duties with the rank of full lieutenant. It was behind a desk that Gillies discovered Professor Tonks, a most distinguished artist in his own right, and persuaded him to help the unit by making a permanent record in diagrammatic and sketch form of all operations performed. In this way it was possible for Gillies to correlate known techniques with extemporisation and hence, through a series of cases, to be able to develop and find inspiration for new methods.

The Red Cross, with War Office sanction, responded rapidly to Sir William Arbuthnot Lane's entreaties by requisitioning Frognaal, the home of the Earl of Sidney outside Sidcup, and erecting a complex but well-planned system of hatted wards within its grounds.

Under the command of Lieut. Col. J. R. Colvin and in its new and salubrious surroundings the unit expanded rapidly. Many novel proce-

\* Sir William Kelsey Fry, F.R.C.S., C.B.E., M.C. Qualified Guy's, 1912. Dental Surgeon, Guy's Hospital. Senior Dental Surgeon, Queen's Hospital, Sidcup and East Grinstead.

† Vide "Works".

dures were devised and evolved during the unit's residence in the ordered atmosphere of Frognaal, but the most important development was the rationalisation of plastic surgery as a positive entity within the framework of surgery itself. Also, through dire necessity, the concept of rehabilitation and convalescence for plastic surgery cases was born. Beds were beginning to become increasingly scarce and some method of "parking" ambulant patients between operations had to be devised. Gillies was told of Parkwood, an unused mental hospital on Swanley Hill, which was empty but staffed. It was arranged that patients, as soon as they were fit, should be moved from Frognaal to Parkwood and there await the next stage in their reconstruction. This proved successful not only in relieving the acute congestion at Frognaal, but also in occupying the many dull days of waiting that the soldiers had to endure.

Eventually, however, the unit outgrew the 320 beds at Frognaal and was moved, on 18th August, 1917, to Queen Mary's Hospital, Sidcup.

No sooner had the unit arrived in its new home than the substantial flow of patients was suddenly and shockingly increased. The opening days of the Battle of the Somme produced unbelievable numbers of casualties, and, within the space of ten days, 2,000 patients were accepted and admitted, arriving in convoys of up to 500, exhausted after the arduous three-day journey across France and England: many were still caked with the mud of Flanders. The staff worked day and night to give preliminary treatment to the injured, to encourage primary healing and to cover extensive tissue loss with grafts. This nightmare of effort came close to overcoming the resources of the unit at a most critical stage in its development, but, through the tenacity of its members, the crisis passed and it now only remained to start the long process of reconstructing the features and minds of the shattered *mutiles*.

To accommodate the patients a ramp extension was built onto Queen Mary's Hospital which housed 200 additional beds. The problem of finding the staff to deal with the influx had now to be tackled. Sir John Goodwin, who had replaced Sir Alfred Keogh as Director General, Home Medical Service, had had the foresight to allow Gillies to keep the nucleus of staff he had trained at Frognaal despite the acute shortage of qualified surgeons in more general fields of work. He now recruited surgeons from the member colonies of the British Empire, and Gillies was joined by Major Waldron and Captain Risdon from Canada, Colonel Newland from Australia and Major Pickerill from his home country, New

Zealand. An American unit, "observers and advisers", also followed and included Ivy and Ferris Smith, who were to found plastic surgery in the United States after the war. The great American surgeon, Vilray Papin Blair\*, had spent some months with the unit at Frognal and had given much constructive advice.

Gillies passed on to these men the accumulated knowledge that had been won during the months at Aldershot and Frognal. He was a good but hard teacher; his criticism was invariably cruelly destructive and outspoken, but he invariably followed it with useful and kindly advice. A total of eight British surgeons and dental surgeons eventually passed through Sidcup and it was through this that Gillies was responsible for the teaching of the first generation of plastic surgeons *per se* in Great Britain.

There existed an atmosphere at Sidcup of friendly competition and co-operation, which was described by Captain T. Pomfret Kilner on joining the unit in 1919 as "intellectual fervour and surgical enthusiasm".

Gillies's greatest personal achievement during the two years that had passed since the small beginnings in 1916 at Aldershot was the conception and development of the tubed pedicle flap which overcame the limitations imposed by the simple free graft. This technique in the transference of tissues from one part of the body to another had been directly inspired by the work of the 16th-century surgeon Gaspare Tagliacozzi. Other personal contributions, to be described later, included an original and ingenious method of blepharoplasty to correct ectropion of the eyelid due to scar contracture and many variations of existing techniques, especially those of Esser, converting cumbersome methods into neat, practicable operations.

Great advances were also made in the fields of radiology, dental surgery and, particularly, anaesthetics under the gifted Ivan Magill.†

On 3rd December, 1917, Gillies read a paper to the Medical Society of London outlining his work and describing the ethics of plastic surgery within the realm of war. He stated that his first duty was to the Services—"to send back to duty as many soldiers as possible in the shortest time"; his second duty was to the patient, to do

\* Vilray P. Blair had written in 1912 a revolutionary work on "The Surgery and Diseases of the Mouth and Jaws".

† Sir Ivan Whiteside Magill, F.R.C.S., K.C.V.O., Senior Anaesthetist, Westminster Hospital/Brompton Hospital, Consultant, "King George's Hospital, Ilford/St. Andrew's Hospital, Dollis Hill/Admiralty/Ministry of Health/Royal National Hospital for Diseases of the Chest.

all that was in his power, to give back that which had been lost and to restore morale and self-respect; his third duty was to "the science and knowledge of surgery". He observed that the fulfilment of all these duties concurrently was the most difficult problem that the plastic surgeon had to face. During the paper he remarked, "I often wish that a better surgeon than myself had had the chances that have come my way"; a supreme example of Gillies's great and essential humility.

By the time Armistice had been signed in 1918, 11,000 patients had passed through his hands. The last patient did not leave his care until late in 1921 and only ten individuals of the eleven thousand were considered by the Ministry of Pensions as incurably disfigured.

Gillies had twice been mentioned in Dispatches and was decorated with the Order of the British Empire for valuable services to his country in 1919. He was promoted C.B.E. (Military) in 1920.

### 1919-1930

"Sapiens qui Prospicit"

*Motto of Malvern College*

1919 was a sad year for Gillies as the team of surgeons at Sidcup quickly disintegrated, members returning either to their pre-war specialities, or, in the case of those from the Dominions, to their native countries. It was to replace this loss that the War Office appointed a newly-qualified surgeon, Captain Thomas Pomfret Kilner,\* to the unit at Queen Mary's. This was the commencement of a close association that lasted until 1930.

Gillies now had two alternatives open to him. Sir Milsom Rees had promised that he could return to take up the assistantship he had left in 1915, which would have guaranteed Gillies both security and financial and professional success: in his own words, "There was an enticing position waiting for me in my previous E.N.T. speciality, but in plastic surgery there was only a nebulous future. Would there be good work and enough of it, or would I become a mere cosmetician?" The second alternative was to apply to his old hospital, St. Bartholomew's, for an assistantship, with the hope that, despite the junior position, he would have the chance of practising at least some plastic surgery.

\* Professor T. Pomfret Kilner, F.R.C.S., C.B.E. Qualified S.R.H., 1913. Emeritus Nuffield Professor of Plastic Surgery at the University of Oxford. Consulting plastic surgeon, Queen Mary's Hospital, Roehampton/St. Dunstan's Hospital/County Dublin Infirmary. Ex-President of B.A.P.S.

With little regret but much soul-searching, Gillies decided to abandon the world that Sir Milsom Rees offered him—the world of celebrities and royalty, and he contacted St. Bartholomew's. He was immediately offered a choice of two posts; that of an assistant in general surgery with a chance of practising plastic surgery on the side or that of chief assistant to the Ear, Nose and Throat Department with the opportunity of being able to concentrate almost wholeheartedly on plastic surgery. He accepted the latter with alacrity.

In the meantime he had been invited to visit America by the many friends from that country who had spent greater or lesser periods of time at Sidcup. Gillies was glad to escape the atmosphere of reaction and anti-climax in post-war England, and, armed with seven hundred slides, he undertook the long sea journey.

During the first week of his visit he received what he admitted to be a "bitter blow". He learnt that Filatoff, the ophthalmologist working in Odessa, had forestalled him in the publication of the tube pedicle method of transferring tissues. Although Gillies realised that any surgeon aware of the problems of grafting would sooner or later conceive the idea of the tube pedicle, the discovery still made him a disappointed man.

The full weeks of visiting and lecturing helped him to forget. He first presented his collection of slides illustrating the work at Sidcup at a surgical dental meeting in Chicago. He then visited the Mayo brothers at their Clinic in Rochester and Vilray Blair in St. Louis. There followed in quick succession a lecture to the American Dental Association in New Orleans and an address to a surgical meeting in New York with Risdon and Waldron, his Canadian colleagues, as companions. The last weeks were spent visiting the remaining previous associates, Kazanjian\* in Boston, Ivy and Dorrance in Philadelphia, Sheehan in New York and Logan in Chicago.

Everywhere Gillies had travelled he had been acclaimed and praised. His lectures had been an unqualified success and his own personal charm had endeared him to many he had not known previously. In his own words, "The trip brought home to me, and I may say to my American colleagues, that, at Queen's Hospital, Sidcup, we had witnessed the organisation of a new surgery. The justification for such a bold assertion lies in the fact that plastic surgery had passed from the empirical to a stage based on

\* Kazanjian had been responsible for the preliminary treatment of many casualties in the French Jaw Unit before their transfer to Sidcup.

sound principles".

Gillies returned to England encouraged by the enthusiastic response of the American medical world to plastic surgery, and confident that it would eventually meet with an equally good reception in England.

The first show of confidence came in his appointment as surgeon in charge of the newly-formed plastic surgery department at the Prince of Wales Hospital, Tottenham, the first civilian plastic surgery unit in England.

In 1920 his book, "Plastic Surgery of the Face", was published by the Oxford University Press and Hodder and Stoughton. This was a collected and edited account of the work performed between the years 1915 and 1919. Gillies had had little time to produce papers during the war and so many procedures described in the book were entirely novel to its readers. It was not only acclaimed by the medical profession itself but also by the lay public, and many enthusiastic reports were published in the daily press. It did indeed mark a monumental development in the field of surgery and confirmed the reputation that Gillies had gained during the war.

At Bart's Gillies's chief, Mr. Douglas Harmer,\* was most enthusiastic in finding work for his assistant. Gillies said he was "the scrap basket for the whole hospital", and with some justification, as many patients were referred to him as a last resort. For instance, in December, 1922, he was asked to see a young man, nineteen years of age, who had had an incapacitating ulcer on the left knee for seven years and had been re-admitted for amputation. A series of attempts to graft the ulcer by the Thiersch method had been attempted over the years and all had failed. Gillies, over a period of eleven months, succeeded in giving the boy full movement to his knee by using the tubed pedicle technique.

Cases such as these led to the full acceptance of plastic surgery in Bart's, but many years passed before it was deemed necessary to elect a consultant in this speciality.

Gillies had had a number of private patients in the wards at Sidcup during the war, and by 1922 his private practice was growing healthily. He shared rooms at this time with Kilner at 7-9, Great Portland Place and they travelled many miles together from these, their headquarters. The work was hard as they operated long hours at a time at Sidcup, Roehampton, Bart's and

\* William Douglas Harmer, M.C., F.R.C.S. Qualified S.B.H., 1899. Surgeon Throat Department and Lecturer in Diseases of the Throat, S.B.H.

Tottenham, and one of Gillies's vivid memories of this period was the immense weight of the bags of special instruments they had to transport from one hospital to another.

The practice was helped by the occasional cases of deformed noses for rhinoplasty and old secondary harelips for buccal inlays. These two techniques were Gillies's specialities and surgeons and practitioners were only too pleased to refer such cases to his care. It was during this period that he developed his technique for face-lifting, but he did little to encourage patients to undergo this treatment as he was most anxious to avoid the stigma "beauty surgeon" at this, a most critical stage in the growth of the practice.

In 1923 he accepted his first student, Albert Davies. Davies was to begin a long line of plastic surgeons who were to join Gillies for periods of a year or more to "drink from the fount of knowledge". Each student paid £100 token training fee, and, in return for this, was entitled to follow Gillies into all hospitals and private clinics he visited in the course of his work.

When Gillies had returned to Paris before he finally left France in 1916, he had visited Morestin a second time at the Val-de-Grâce Hospital. For some inexplicable reason Morestin had refused point-blank to see him. This had been a great disappointment to him and he claimed that this was the reason he always went out of his way to help students himself. He remarked "Teaching has always been a joy" (1957) and there are many plastic surgeons practising today who benefited from his pleasure.

In the March of 1924 the world was shocked by a tragic incident at sea. The Royal Danish Naval Ship "Geysir" whilst carrying out smoke screen experiments off Copenhagen was gutted by fire as a result of the explosion of a phosphorus bomb. The blast itself killed many sailors but there was a total of sixty severe burn cases from flash, phosphorus and fire. Gillies had been visited the previous year by a Danish surgeon who had watched him operate at Sidcup, and it was as a result of this contact that he was asked to visit Denmark to treat the injured.

Gillies travelled to Copenhagen and worked for two weeks giving primary treatment, covering widespread tissue loss with grafts and protecting healthy eyes by sewing together the scared lids. On 3rd April, after the preliminary work had been completed, he was received by King Christian. He was accompanied by a Danish naval attaché to the Royal Palace and spent half an hour in audience. During this time Gillies ex-

plained the nature of the operations and presented the King with a copy of *Plastic Surgery of the Face*. He was then decorated with the red and white ribbon of the Order of Dannebrog for his valuable services to the Danish people.

For two years the Danish seamen visited Gillies in England to undergo the completion of their repairs.

Golf was still his main pastime and in 1924 he was ranked tenth in the amateur golfing world. Some years previously he had introduced the use of wooden tees, which measured between five and fifteen inches in height: this was when the vast majority of golfers were still using piles of sand off which to drive. He achieved great accuracy and power with his flat swing and was a much sought-after player at his two clubs, Rye and Woking. In fact, he caused a sensation in the sporting world when he used a beer bottle tee at Woking during an important match as the ground was too hard to take his wooden one!

Gillies had also taken up fishing and was fast becoming a very accomplished fly-fisher. He belonged to the Houghton Club at Stockbridge on the River Test, which is famed for trout in its higher and salmon in its lower reaches. He delighted in the game of stalking the large, old trout and found the sport an ideal form of relaxation.

In 1924 he was honoured with the position of consulting plastic surgeon to the Royal Air Force, a post that he held until 1938 when he was succeeded by Sir Archibald McIndoe.

By 1927 Gillies felt himself sufficiently secure and well-established in his work to practise fully the techniques in beauty surgery that he had developed. This controversial aspect of plastic surgery was claimed by many of the medical profession to be both unethical and unnecessary, but Gillies defended it with the words, "It is easy to agree to do a beauty operation, but not always quite so easy to be certain it is justified. A frightful looking old girl comes in for a face lift; a deep swallow is taken before surgery is begun for it is obvious even after the most wonderful face lift she will still look like the North Pole. That is only to us, not to her. She is tickled with any improvement. Often while lifting a face I have had the feeling of guilt that I am merely making money. Yet . . . is it not justified if it brings even a little extra happiness to a soul who well needs it? The less they have the more they appreciate the little we can do for them—this is a plastic surgeon's ode to an ugly woman, but a woman" (1957). He later added, "Certainly a beautiful woman is worth preserving and should

be kept youthful while she is still young enough to enjoy it".

It was during this year that Gillies and his family moved into a house in Queen Anne Street, a reflection of his increasing prosperity.

In 1930 the tall building that had replaced several late Georgian houses at the junction of Harley Street with Marylebone Road was completed. This revolutionary ideal of a private hospital, with consulting rooms and operating theatres and beds contained within one precinct, was initially financed by thirty-six members of the medical profession, including Gillies, who each contributed £2,000. In return for their support they were entitled to the use of all the amenities offered by the organisation, which was known henceforward as *The London Clinic*. Gillies's consulting address was now 149, Harley Street.

It was with great regret that the eight-year-old partnership of Kilner and Gillies was, through this move, dissolved. They both had decided that, with so much work now available, it would have been to their mutual disadvantage to remain together: they therefore took separate rooms.

These innovations made Gillies's life somewhat easier in that he could now operate upon his private patients in one efficiently-run premises, as opposed to the previous inconveniences of travelling from one nursing home to another, operating under poor conditions and transporting great quantities of instruments from place to place.

Gillies first became associated with Rainsford

Mowlem\* during 1930. Mowlem, a fellow New Zealander, was at this time a general surgeon at the Hammersmith Hospital, and, in the course of his work there, had come into contact with a number of Gillies's patients and hence became a convert to the cause of plastic surgery.

1930 was indeed a significant year for Gillies, for it was in this year that he received his highest accolade: he was knighted by King George V for his services to his country during the Great War of 1914-1918.

Extract from the London Gazette, July, 1930:  
Central Chancery of the Orders of Knighthood,  
St. James's Palace, S.W.1.  
Tuesday, 3rd June, 1930

The King has been graciously pleased, on the occasion of His Majesty's Birthday, to signify his intention of conferring the honour of Knighthood on:

Harold Delf Gillies, Esq., C.B.E., F.R.C.S., L.R.C.P., Major R.A.M.C. (retd.), Chief Plastic Surgeon to the Ministry of Pensions. For valuable services in the treatment of facial disfigurement.

Page 3474.  
Investiture Page 3874.

\* Rainsford Mowlem. Qualified Otago, M.B., Ch.B., N.Z., 1924. Surgeon i/c Plastic Dept., Middlesex Hospital/Centre for Plastic Surgery, Mount Vernon, Northwood. Consulting Plastic Surgeon, Birmingham Accident Hospital/Luton and Dunstable Hospital/King Edward VII Hospital, Windsor/St. Luke's Hospital. Assoc. Surgeon in Plastic Surgery, Prince of Wales General Hospital. Ex-President, B.A.P.S.

(To be continued)

## FIFTY YEARS AGO

### COMING EVENTS

#### (Cast their shadow before)

In Lancashire many old superstitions survive, but a very modern one seems to have arisen, as the following anecdote will demonstrate.

A young fellow called at a certain hospital to interview the H.S.

"A've coom for ma mother," he explained.

"Why?" queried the H.S. in astonishment.

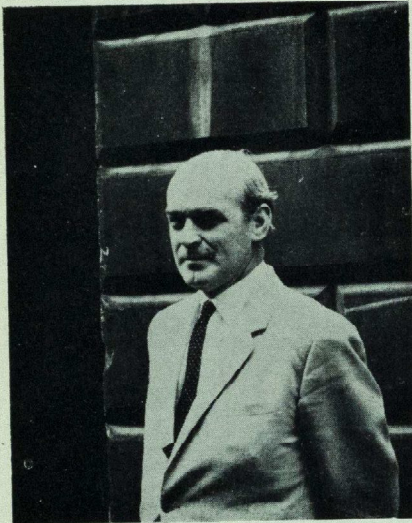
"They give 'er the black bottle yesterday, an' we won't 'ave 'er killed."

Pressed further as to his meaning, he stoutly maintained that at a certain stage of sickness patients were "given the black bottle" to kill them off quickly and save further trouble.

Dawn broke at last! His mother, in a state of collapse, had been given oxygen. Since patients needing this remedy are often in a state which, to say the least of it, is precarious, it is not difficult to see where the superstition arises that "None as has the black bottle ever gets well".

## BEHIND THE SCENES : 2 STEWARD'S DEPARTMENT

by Antony Brett



Mr. A. B. Brett, the Steward.

The Steward's first responsibility is the general administrative care of all in-patients: his second responsibility is to maintain, and if possible improve the delicate relationship between the Hospital and the public. The present Steward regards this dual responsibility as being of great importance to the general efficiency and well-being of the Hospital as a whole.

### General Administrative Care of All In-Patients

On entering a Hospital, the patient hopes to benefit by the skill of the doctor and the care of the nurse. In his own mind, this is all he asks for and if these two conditions are lavished upon him with the calm, gentle efficiency for which this Hospital is justly proud, then where does the administrative care come in?

Prior to his admission, the average patient is seen in an Out-patient clinic, told that he should ultimately be admitted, given a card, and sent to the Steward's office. Here he is interviewed about personal and family "snags" which will crop up on his admission (holidays, work

limitations, children or aged parents to be looked after, etc.), and told he will be put on the Waiting List. The Waiting List at present is over 2,000, and a non-urgent surgical case—hernias, varicose veins, etc.—may wait for well over a year.

The Steward must ensure, when a patient is eventually asked to come in to Hospital, or indeed when he is admitted as an emergency, that there is a vacant bed available for him under his own physician or surgeon. If there is not, then the Steward must find one. In practice, this responsibility is accepted fully by the House Officers. It is only when there is no bed available in the appropriate ward that the Steward himself is called in.

When the patient arrives at the Hospital, he is pleased to be directed to the correct office and ultimately to the correct ward, by a polite staff in clean uniform, and with a pleasing manner. On many mornings anything from 30 to 35 patients are admitted through the Steward's office in a matter of two hours. Each patient arrives with at least one relative and luggage. I have rarely, if ever, seen the receptionists get flustered by a roomful of patients, or address any of them in a quick manner. The present staff, each and every one of them, are quite excellent, and I am glad to be able to pay them my personal tribute in public.

After a few days in the ward, when the strangeness has worn off and acute anxieties are easing, the patient has more than enough time to think about his own personal circumstances. He suddenly decides it might be wise to make a Will!; he gets anxious about his Sickness Benefit from the M.P.N.I.; he remembers that he is a member of the Hospital Savings Association and wonders how to obtain his benefit from that; he knows that he has a large amount of cash in his locker and would like someone to lock it up for him. It is the duty of the Steward and his staff to look after all these and many other such anxieties. In this connection it should be remembered that there are normally between 750 and 775 patients in the Hospital at any one time.

Whenever a patient is treated in Hospital as a result of injuries sustained in a road traffic accident, the Hospital may claim from the driver

of the vehicle (or his Insurance Company) an emergency treatment fee of 12s. 6d. Furthermore, if the injured party makes a successful claim, for personal injuries or loss of wages, etc., the Hospital may claim further treatment fees of up to £50 for In-patients and £5 for additional Out-patient treatment. It is the duty of one of the Steward's Clerk Receptionists to keep a constant eye on these cases, send out the claim forms—and reminders—and collect and account for the takings. The same young lady also sends for blood donors at the request of the House Officers, arranges for their reception, and completes all the forms required for this particular activity. In addition, she lists the daily Bed Returns and types out the details of all patients discharged from Hospital the previous day.

The routine duties of the Clerk Receptionists, in addition to writing out the Front Sheets for all the patients on their admission, are the recording in permanent registers of all In-patients' particulars, keeping "live" the loose-leaf books of all current In-patients, checking dates of discharge and completing appropriate M.P.N.I. Forms.

It is the Steward's personal duty to interview the relatives of all those who die in Hospital. In addition to handing the Doctor's certificate to them and instructing them as to what they should do, the Steward must obtain, if he can, the relatives' consent for the Hospital to perform a post mortem examination on the deceased. This can be a delicate task.

It may not be realised that in 1962, 745 patients died in the Hospital (or were brought in dead). If week ends and Bank Holidays are excluded, this makes an average of nearly three interviews of this nature per day. It is quite common for the Steward to be occupied with such interviews from 9.30 a.m. to 11 a.m. each day.

The Beadle, who is another member of the Steward's staff, not only acts as mortuary attendant but also handles the deceased's personal property, ensures that the appropriate House Officer signs up the necessary certificates, and completes the various documents required.

### Maintenance of Relations with the Public

The Steward's Office is still the main Recep-

tion Office of the Hospital. To it come almost all visitors who arrive without a specific appointment with an hospital officer.

The Police, the Press, patients' relatives and friends who may not know where to find the patient, visitors from overseas who are merely rubbernecking, commercial travellers, lorry drivers and car-men delivering supplies addressed simply to St. Bartholomew's Hospital, florists, messengers, visiting priests of all denominations, and of course complainants. All these people have to have their explanations and questions listened to and solved. The Steward's staff deal with 90 per cent. of such callers; the Steward himself deals with the difficult 10 per cent.!

In addition to these visitors from outside the Hospital, the Steward welcomes any member of the staff with personal or business problems. In this department we try never to be "too busy" to turn away anyone.

### Off-Duty Calls

The Steward is at present the only senior administrative officer who is resident in the Hospital. This throws upon him certain responsibilities which would not normally be his. In this connection, however, I should like to stress that Matron and her team of highly experienced and responsible deputies and sisters are a constant support to me. I am well aware that Matron or her department has often dealt with incidents when I have been out of Hospital. All thanks are due to her.

Nevertheless, on an average, the Steward deals with 15 to 20 calls per week during his so-called off-duty hours. However, the night nursing staff are excellent and the Steward is very rarely called between 11.30 p.m. and 7.30 a.m. The bulk of such calls are made in the early evenings and over week-ends.

In mentioning this matter, I do not wish to convey a resentment of these calls during off-duty hours. I am provided with a delightful flat for the express purpose of being available at such times. Ward Sisters, nurses, and indeed others, must never refrain from ringing when the Steward's help or advice could be of use.

## COULD YOU HAVE BEEN A SCHOOLMASTER?

Now that is one thing you could have been, and with little or no trouble too—not necessarily a good schoolmaster, mind, but a schoolmaster. I will explain why and how in a minute; and whether you would have liked being a schoolmaster is another matter we might go into.

To start with, schoolmasters can be roughly divided into three groups, those working for the state, those working for public schools and those working for preparatory schools. Group one is inevitably enormous and makes demands as to the qualifications of its members, who seem to me to be a highly dedicated and devoted lot of chaps, and who have in some cases a hell of a tough job to do in very unpromising surroundings. Others of course are pampered by working in the exotic surroundings of a newly-built school with the most fabulous equipment, but I fancy they are in the minority.

The second group contains the Public School masters. This group, too, is not easy to get into, because beside enthusiasm for the job you must have some sound qualifications. Diplomas of education, certificates from teachers' colleges and so forth are of less value than a good degree at Oxbridge, and if the degree is not a first, then some shining athletic qualifications are needed. "Good heavens", I hear someone say, "then schoolmastering could *not* have been for me", as he recalls how he squeezed through his first M.B., and never could spell with absolute certainty, how he farked at mixed hockey, never got around to the rules of cricket, and was knocked flat on the floor in the first half minute when he thought that perhaps boxing was different, and better, than dreary team games.

But don't worry! We come now to group three, Preparatory School Masters. They are always short on the ground, and Messrs. Gabbitas and Thring and Messrs. Truman and Knightley are constantly stalking through the London em-

ployment jungle trying to capture a few. Qualifications in this market are less important than enthusiasm. Prep. schools are (so far) stable concerns educating the Public Schools' raw material, and, in spite of ever-rising prices, they find a very steady demand for their educational services. You would think then, that there would not be much difference between the standards demanded at staff level in the Public and Preparatory schools; but there is. And the reason I have given already: Prep. school masters are in short supply. Why? It does not seem to be a question of money: it is somewhat more a matter of kudos. Many young men do not want to be Prep. school masters for the same somewhat vague reason that both sexes avoid domestic service. There is a stigma of some kind, stemming from the past. It's silly, mind you, because if ever a chap was going to be in clover nowadays it would be as a butler—just think of the perks, the comforts, the "use of car" and the telly; and it is equally silly in the case of a Prep. school master, because the pay nowadays is by no means despicable, the standards of comfort very adequate, and the general amenities excellent.

But one thing is of vital consequence—that you should like children—and I mean children, not adolescents—and have a feeling for the strange indefinable charm of the human boy between 7½ and 13½; friendly, generous, eager, brave, but sometimes sulky, selfish, idle and cruel; and almost invariably madly untidy.

A Prep. school master should be a reasonable scholar, a natural psychologist, an all-round enthusiast for games, a clubbable man who can tolerate and indeed enjoy community life, and above all a good nanny. Fulfil those or some of those conditions and you would have the most utterly satisfying and rewarding of occupations.

J.H.

### SPECIAL DEPARTMENTS: II

## DEPARTMENT OF FORENSIC MEDICINE

by R. D. Teare, M.D., F.R.C.P., D.M.J., Lecturer in Forensic Medicine at St. George's and St. Bartholomew's Hospital

### Historical

The teaching of Forensic Medicine at St. Bartholomew's Hospital started in 1830 at the request of the Society of Apothecaries for a course of lectures for their students. It was about this time that other specialised subjects were taught for the first time in teaching hospitals in this country. It is of interest that this was not the only occasion that the Society of Apothecaries was to give an impetus to Forensic Medicine as only last year they instituted a Postgraduate Diploma in Medical Jurisprudence, the only one available.

The first lecturers appointed to the Hospital were Drs. Roupell and Burrows followed successively by Drs. Farre, Baly, Black, Martin, Edwards, Odling, Southey, Hensley and Herringham, not as far as I know practitioners with any specialised forensic knowledge. In 1912 Dr. R. A. Lyster, a medical officer of health, was appointed and continued as lecturer up to 1939, by far the longest tenure of the post. During part of this time Sir Bernard Spilsbury was lecturer in Morbid Anatomy at St. Bartholomew's; from 1919 until 1927, when he relinquished his appointment to undertake work at the Home Office. It may appear paradoxical that the outstanding forensic pathologist of his day was not lecturing in his own subject at the hospital, but, of course, the post was already occupied. At the time he occupied a small room on the first floor overlooking Smithfield Market, using it as a private laboratory, as he had severed his association with his own teaching hospital, St. Mary's, before coming to St. Bartholomew's. Dr. Lyster was succeeded in 1940 as lecturer by Dr. John Taylor, whose lectures were in direct contrast to Spilsbury's prosaic and monotonous style. This was the first time that a forensic pathologist had been appointed to the post. Dr. Taylor died in 1949.

### Teaching

Forensic Medicine, medical jurisprudence or legal medicine are all similar terms for the practice of medicine in relation to the law, at least in this country, although in the United States of America each term is more separately defined. Essentially the subject covers not only a Practitioner's relationship to the law, his duties to the public and professional colleagues but also the investigation of sudden death of all forms, both natural and violent, as well as post mortem examination of traffic accidents, injuries and drug intoxications. In addition, the subject has provided material for research and led to advances in preventive medicine by showing the dangers of coal gas, electricity and other hazards in both home and factory. A course of lectures is given at most teaching hospitals, but it is only at three London Hospitals (Guy's, The London and St. George's) that the subject is pursued any further,

in that there is a separate department of Forensic Medicine where pathological material and cases are available for further study and research. In the Department at St. George's Hospital there is a laboratory where histological examination and simple toxicology (alcohol and barbiturate estimation) are carried out. A library of text books and of case histories is also maintained. There is no department at St. Bartholomew's, but the Hospital has one advantage over those without a formal department in that visits to Coroner's Courts and public mortuaries are available to students so interested. In London, as in several other University centres, the subject has been dropped from the final examination although the lectures are still obligatory and in most instances well attended. Whilst there are certain good reasons for excluding "forensic" as a subject, in that a curriculum already overcrowded needs constant pruning, the results of such a policy are not always beneficial. The absence of any real interest or instruction in student days can lead to an astonishing number of blunders on the part of a newly-qualified practitioner, when faced with a Coroner's Inquest, or even involved as a witness in some minor criminal procedure. Although from an undergraduate and academic viewpoint it must be admitted that the subject has lost much ground it has advanced on a broader post-graduate front. It is of some importance and advantage that the subject should be kept specialised. Not only should post mortem examinations be made by a trained pathologist with some experience in these matters as laid out in the Coroner's Rules, 1953 (still not always carried out), but lecturers in the subject should be those who have a practical knowledge and understanding of it. In some medical schools this is still not the practice. The significance of pathological findings in relation to injury and disease cannot easily be appreciated by those not practising in the subject. In lecturing, too, the use of slides illustrating certain aspects of sudden and violent death are of vital importance. Colour transparencies of a case of hanging or cut-throat can hardly fail to cause some interest or response in the most bored student whereas a description may be dull and monotonous. Indeed, the time is almost here when cine-film projection, preferably in colour, of post mortem changes and appearances will be used as an aid in teaching. At the same time one must remember that the average doctor will not come into contact with a single case of murder in his entire career so there is

little point in his appreciating the finer points of a gunshot wound of the head.

#### Routine Work

Forensic medicine is not only concerned with violent death as it covers all forms of both sudden and natural death revealing, on occasions, hitherto unrecognised causes of death. It brings doctors into contact with many different facets of life and a variety of pathology not seen in routine hospital laboratories.

The pathologist travelling from mortuary to mortuary, attending inquests, compiling lectures and demonstrations, engaged occasionally in investigations of violent death, assessing toxicological analysis, especially in relation to natural disease or injury, certainly has a full and varied life which makes it a most fascinating branch of medicine.

The forensic pathologist has an earlier start to the day than most morbid anatomists owing to the necessity of carrying out a number of autopsies before attendance at a local Coroner's Court on inquests of previous cases, which may take up most of the morning. Contrary to public belief it is not often that a night call disturbs his sleep, and then it is generally due to some inexperienced police officer or surgeon mistaking changes of decomposition, in the long since dead, for the outward signs of violent death. Often genuine murders are left for discovery by the milkman on his round (or a neighbour following failure of collection of the milk). Lunch is often a brief snack between mortuaries and the forensic pathologist must not prefer the seclusion of the laboratory bench to the bustle of work in mortuaries and courts. Indeed, it is only towards the end of the afternoon that there is time for the cutting up bench and the interpretation of post mortem findings under the microscope.

#### Training and Career

At present there are very few opportunities for a student interested in forensic medicine as a career. In this country the subject should be more correctly termed forensic *pathology*, as it depends almost entirely on post mortem examinations carried out in public mortuaries. Abroad, however, especially in Europe, autopsy examinations form only a part of the whole field of forensic medicine which includes blood serology in paternity cases, examination of drivers and body fluids for alcohol intoxication whilst driving, and of course the whole range of toxicology. There are signs that at some time in the future medico legal centres may be formed in this country, especially in the larger centres of population where many more pathologists may be able to work. An important paper at the recent Third International Congress in Forensic Medicine proposed a National Medico-Legal service which could do away with many, if not all, of the present deficiencies.

For the student, whatever the future holds, there remains one essential preparation, that is a knowledge of morbid anatomy and clinical patho-

logy as a basis from which to assess tissue changes in injury and disease. This is not to say that a knowledge of general medicine and surgery is unnecessary, for the practitioner must be keenly aware of any advance especially those concerning new drugs and the latest surgical techniques. At least two years' preparation and study in a Pathological Laboratory is essential before embarking on a career in forensic medicine. This is also the time to start to attend lectures or meetings on the subject, to obtain additional qualifications, and join one or two societies. The Forensic Science Society and the Medico-Legal Society for instance, welcome all those interested in forensic medicine. There is also no reason why visits to other centres in forensic medicine should not be made during this time.

So much for training. What are the actual prospects of a career? In essence this depends upon an apprenticeship to a master in the subject and obtaining a post in a forensic medicine department so that post mortem examinations may be made under the aegis of the local Coroner. Gradually, expertise and judgement may be acquired, and happy is the man whose early examinations and inquests are held under the authority of an understanding and approachable Pathologist and Coroner. For there is no certainty of success. A brilliant academic pathologist may present a pathetic picture in the witness box, even under simple cross examination.

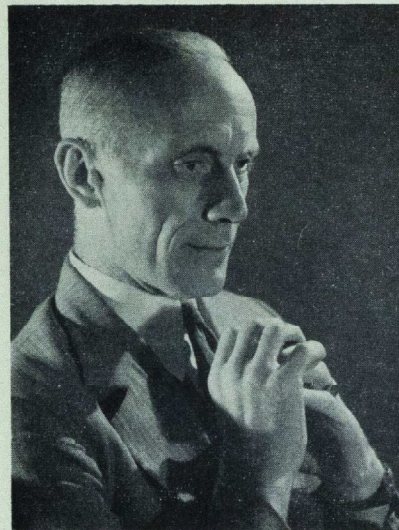
In London, in theory, there is room and room again for more full time forensic pathologists. Other centres in the Provinces tend to have insufficient post mortem material and outside the Universities there is insufficient population to support a whole-time man. In the smaller towns and cities a Coroner will accept the services of a local hospital pathologist who may or may not have a serious interest in the subject. Indeed, there are a number of such pathologists who may see a wide range of forensic material, so that an early interest is not always without profit. For a pathologist to regard "Coroner's work" as a necessary evil to useful pocket money, or to attempt to confine his activities to doing "natural cases" (as has been done, and still is done) can do the subject nothing but harm, and lower its prestige in the eyes of his professional colleagues.

Finally, the possible need for forensic pathological services must lead eventually to a greater regional organisation with the establishment of centres of post mortem examinations in single large mortuaries instead of using several small and often inadequate ones.

It is a pleasure to acknowledge the help I have received from Dr. Nelly Kerling, The Archivist, St. Bartholomew's Hospital.

## THE MEDICAL MISSIONARY

by Dr. H. G. ANDERSON



*Dr. H. G. Anderson, who was Morley Fletcher's medical assistant in 1925 and is now secretary of the Medical Consultative Panel of the Commission of the Churches on International Affairs.*

#### Missionaries In Commerce

"Let it be remembered," said an official of an American missionary society to one of their recruits for West Africa in 1833, "that the sacrifices made by you and your friends, the privations and hardships to which you will be subjected, and the dangers which you will have to encounter, and which appear so formidable to many, are extraordinary only in the history of missions! In the history of commerce and science they are common and familiar scenes. . . . Commerce has no difficulty in procuring her missionaries for any portion of the earth, and even now they are going forth into all the world. . . . It is lamentable that the Church should make so much of personal sacrifice endured for the glory of Christ and the salvation of men, when the World counts them so little endured for the sake of wealth or fame."

#### Security and Self

"Lamentable" indeed, now, when the sacri-

fices have become relatively minor and no longer comparable to the mortal perils from tropical hardships and disease which all adventurers faced in Africa and the East in those days. Even if such adventuring has become only mildly distinctive, it at least promises better for success and satisfaction in a missionary career than self-interested caution. Especially for the married, security can become an obsession, as Jesus Christ pointed out.

Self-sufficiency too, as cold and unattractive a quality as caution, can be a real obstacle, especially where it is allied to self-centredness. But that is not to be confused with a maturity which is prepared to sacrifice many of the amenities of social culture for, what experience has shown to be, greater good, and which is always ready for new adventures in living.

For example, Christian embassy necessarily implies restrictions on behaviour regarded locally as offensive, however innocently esteemed in the West. To many fellow expatriates such taboos may seem hypocritical; so the gap between missionaries and their own countrymen, already present because of different tasks and different income levels, may be further widened. And so misunderstanding has to be lived with, and lived down as time plays its healing role; men of sincerity will always find a bond in mutual sincerity; but would that gossip could do less damage and find less ready hearers!

#### Tough Enough Job

The medical missionary faces a tough enough job in all conscience, but for those prepared to face the rough with the smooth there is a rosy side, especially for those also prepared to make theirs a life job. For a start, no medical missionary receives a salary, all are on allowances calculated at a reasonable subsistence level under local conditions, whether of work or furlough—there is therefore no "keeping up with the Joneses", for there are no Joneses! Professional competition becomes entirely irrelevant, except for the reputation of the hospital as a whole, and more especially for the Christian integrity of its work. Every penny donated, every fee gained from the wealthier patients, is devoted to the maintenance of the hospital; it does not even go to other branches of the work. Governments sometimes supplement these receipts.

Every missionary doctor meets with, not only

diseases of the tropics and diseases of deprivation, but meets them at advanced stages, only possible in situations of "the survival of the fittest" in areas of high mortality. He finds, as common-places of his daily practice, conditions which were considered as merely very occasional rarities in Western clinics or even in medical text-books.

#### Extreme Economy

He meets and often overcomes all kinds of challenges to his adaptability. Basically many of his lacks are due to the chronic financial shortage resulting from inadequate home support. In one leading missionary society, home support including the allowances of the medical missionaries, amounts to only one fifth of its total medical expenditure abroad. The missionary surgeon, with the aid of local craftsmen, has often produced effective equipment and tools at a fiftieth of their western export prices. The missionary physician similarly produces simple but elegant pharmacopeal preparations, or discovers alternative local vegetable or other drugs.

In fact, the extreme economy that has to be practised often shocks the newly arrived modern recruit who has become accustomed to a "money-relatively-no-object" National Health Service; and yet, in these under-privileged countries where missions work, on what other basis can any health service function at all?

#### To Preach?

Under conditions of severe professional isolation, personal responsibility is of course heavy, and not infrequently productive of breakdown. To his medical duties the medical missionary has to add those of administration and teaching under

particularly difficult circumstances. To simple peasant peoples he is a worker of miracles, and to this semi-messianic creature they will bring all their problems, and he will be the recipient of confidences and self-revelations which rarely come to others.

Are medical missionaries expected to preach? Yes, indeed, they are, and by their patients first and foremost. Lucky people! Half those sermons can be preached without the utterance of a word; but their patients will *demand* the other half too. It is hard for sophisticated westerners to realise how basically religious and aware of another world is the average African or Asian.

In so short an article much detail must be omitted. Omissions are those most fully covered by the recruiting and other publications of the great missionary societies available through the Conference of British Missionary Societies at 2, Eaton Gate, London, S.W.1. Missionary vocation should not be a matter of a snap decision. To wade in is far wiser than to jump in. The plunge should come at the end of the wade and not replace it.

One final word of warning to the inexperienced. When one is young one tends to think that to enter a noble vocation will make one noble. Far from it. You will still be the same *you*, and to hope or pretend otherwise is to risk hypocrisy and final self-disgust at the best, and cynicism at the worst. In an official capacity I have had to deal with hundreds of would-be missionaries, and my conclusion is that action must wait on certainty, and to those called assurance will come.

## Case Report: URINARY DIVERSION IN THE TREATMENT OF A CHRONIC URINARY TRACT INFECTION

by J. F. Ratcliffe

Mr. C., aged 59, a stockjobber in the city, was admitted to another hospital in November, 1961, complaining of general malaise of two weeks' standing.

His previous medical history dated from 1952, when, while carrying a barrel of beer "something snapped in his back". Three weeks later, he developed an acute retention of urine and was admitted to a Nursing Home, where he was catheterised. At this time he was found to have loss of cutaneous sensation below the waist and weakness of the legs. A protrusion of an intra-vertebral disc was diagnosed and laminectomy performed to relieve compression of the spinal cord.

After this operation, the sensation in his trunk and legs improved, but his feet, the backs of his legs and an area over his buttocks and around the anus remained anaesthetic. His peroneal, anterior tibial, foot and toe flexors were paralysed, as were his anal and urethral sphincters. After two months he regained control of his anal sphincter, but remained incontinent of urine. He dribbled continuously, but using a bag urinal by day and a bottle by night, he led a relatively normal life, although his walking was very much impaired. Subsequently, a chronic urinary infection developed, which exacerbated and remitted over the next four years.

In 1956, the patient was first seen by Mr.

Badenoch, and a transurethral resection of the bladder neck was performed to improve urinary drainage and to discourage infection. This worked well until the time of his admission in November, 1961, when on examination he appeared ill and pyrexial. The blood urea was 60 mg. per cent. and a culture specimen of urine revealed a growth of *Proteus* which was treated with Furadantin. The blood urea continued to rise, however, reaching 350 mg per cent. with a serum potassium of 7 m.eq. per litre. He became severely oliguric and was transferred to Bart's on 30th November, 1961.

On arrival, he was drowsy, obviously ill and mentally lethargic. He complained of anorexia, headache and insomnia, but there were no urinary symptoms.

On physical examination he was pale and dehydrated; the tongue was furred and the skin dry. The chest and heart were normal and the blood pressure was 100/85 with a pulse rate of 96. The abdomen was normal with no renal angle tenderness. Rectal examination showed an insensitive anus, lowered sphincter tone and faecal impaction. Neurological examination was normal except for his perianal region, which was anaesthetic, and his legs, in which the power and sensation were decreased.

The preliminary diagnosis was pre-renal uraemia, pyelonephritis and a spinal cord lesion involving the segments below L.1.

#### Treatment

This was considered under two headings:—

1. Correction of his fluid and electrolyte imbalance.
2. Treatment of his urinary infection.

Rehydration was achieved with an oral and intravenous three litre fluid intake and Resonium A was given to reduce the high serum potassium. His general condition improved and the serum potassium fell to normal, but the blood urea was elevated in spite of a good diuresis having been established. Four days after admission, he became pyrexial; his temperature rising to 102° F. This was considered to be due to his severe coliform urinary infection, which was resistant to all the usual antibiotics. A 5-day course of Colomycin was given and he again improved, this time with a fall in blood urea. This progress was not maintained, however, and the temperature again rose precipitously. Blood culture was performed and revealed a staphylococcal septicaemia. The antibiotic was changed to Methicillin, which gradually controlled this infection, and his general condition improved. The blood urea fell to 85 mg. per cent. and he was mobilised.

In the New Year, his condition again began to deteriorate. He became pyrexial and his blood urea rose to 215 mg. per cent. It became apparent that it was impossible to control his urinary

infection without some more adequate form of drainage of his lower urinary tract to by-pass his neurological bladder with its 400 ml. of residual urine.

An ileal loop urinary diversion was considered most suitable. On 17th January, 1962, Mr. Badenoch explored the abdomen through a mid-line lower abdominal incision. The bladder was displayed and the ureters identified and transected. A portion of terminal ileum about eight inches long was selected and isolated, the ends of the remaining ileum being anastomosed end to end. One end of the isolated segment was oversewn and both ureters were implanted end to side into the ileal loop. The free end of this ileal segment was brought to the surface through a terminal ileostomy in the right iliac fossa. The abdomen was closed in layers.

The day after his operation, the ileostomy was draining well and his blood urea started to fall.

He was discharged on 11th February, very much improved physically. A year later he was in very good health with a normal blood urea.

#### Discussion

The interest of this case lies firstly in his recovery from the severe pyelonephritis and staphylococcal septicaemia, which would have been impossible but for the advice from Dr. Spencer and the careful bacteriological studies obtained from Professor Shooter and his department.

Secondly, the case demonstrates the difficulty in controlling a severe urinary tract infection in the presence of incomplete drainage, and how, when adequate urinary diversion is established and maintained, marked improvement in renal function is achieved.

It is interesting to speculate whether the patient would have developed such a severe infection and renal depression had this operation been performed at the time of his initial spinal injury in 1952.

Ileal loop diversion, first described by Bricker in 1950, has only been in common use in this country since 1953, when Professor Charles Wells published a short series of cases in which the procedure had been used with success. Since that time, many such operations have been performed, and it is now the established treatment for the management of the bladder in cases of congenital (Nash, 1956) and acquired spinal palsy.

#### Acknowledgement

I am grateful to Mr. A. W. Badenoch for his kind permission to report this case.

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## PLASTIC AND RECONSTRUCTIVE SURGERY

by Percy H. Jayes and Antony F. Wallace

### Wrong Image

The lay press, the advertisements of charlatans, the half truths whispered by some patients, and the professional reticence of most plastic surgeons together help perpetuate the myth that plastic surgery consists mainly of cosmetic surgery. Nothing could be further from the truth. Only a small proportion of the cases operated upon by any reputable plastic surgeon are for purely cosmetic reasons. Most operations are for congenital deformities of the face, oral cavity, hands, feet and genitalia; for burns, both in the early acute stage and later when the skin is healed with scars and contractures; for cancer surgery and subsequent reconstruction in the head and neck region and elsewhere; for the provision of primary skin cover in cases of injury of the hands, face, and skin everywhere; and for certain disorders of the hands, including Dupuytren's contracture.

Plastic and Reconstructive Surgery (the true title of the specialty) comprises many types of grafting in addition to skin grafting. Autografts of fat, cartilage, bone and fascia are frequently used. Homografts and heterografts have little current application to plastic surgery except where immediate "off the shelf" availability is essential, such as in extensive burns with few available donor sites and a desperate need for skin cover. Despite inevitable rejection at some time skin homografts are invaluable in getting the patient past the first few critical weeks after burning.

### When To Operate

The National Health Service lays down no rules as to which types of case may be treated in a public bed. The dividing line between what is, and what is not, acceptable is left to the judgement of individual surgeons. Abuse of the special techniques practiced by the plastic surgeon is avoided by his experience and integrity in selecting cases for operation. The urgent pressure of a long waiting list would automatically act as a brake on frivolous surgery if this was necessary.

The plastic surgeon must never offer to operate unless he feels reasonably confident that he will be able to achieve anatomical improvement. He must never operate, and this applies to the purely cosmetic as well as to other surgical problems, only because the patient "wants" an operation. Symptoms which are really due to an inferiority complex will not be helped by surgery. Conversely an inferiority complex and some other

types of mental disturbance are, *per se*, no contraindication to plastic surgery providing that the patient does have some feature which can be improved, either functionally or in appearance.

Particular care must be exercised in the selection of cases. Emotionally immature and psychoneurotic female patients with an *idée fixe* concerning some particular anatomical feature are to be avoided. Effeminate males are judged by similar criteria. Middle-aged women in the throes of divorce and those trying to retain a roving husband occasionally centre their hopes on a cosmetic operation. Sometimes a specialised psychological assessment is of considerable value, but unrewarding types of case usually follow a few markedly similar clinical patterns making out-patient recognition and assessment by the surgeon reasonably accurate and fair.

### Scars and Misconceptions

It is a common misconception that plastic surgery can remove all scars. This is not the case. A scar can sometimes be improved or realigned such that, after an interval of time, it may be almost invisible, particularly when cosmetics are used skilfully. Hypertrophic and keloidal scars present many unanswered problems and their unexpected occurrence is a potent cause of disappointment and anxiety. The quality of a scar depends on many factors—site, direction, underlying tissue, age and race of patient, type of skin, etc. It depends only to a limited extent upon the quality of the surgery. Dirt ingrained scars, adherent scars, distorting scars, broad and irregular scars may often be improved. No scar reaches its best until at least three months after initial wound healing. It follows, therefore, that no unsightly scar should be excised until more than three months after injury and that the subsequent surgical scar should not be judged finally until three months or more after operation.

It is also a common misconception that skin grafts become invisible or as good as the original tissue. The colour and texture of each area of the human skin is different and any graft brought from a distance is a visible patch however carefully a donor site is selected, and however skilfully the graft is applied. For this reason a local skin flap, despite the extra scars, is often more suitable, particularly on the face. All skin grafts tend to contract, flaps do not.

Skin grafting of coloured skins, black, brown or yellow, is particularly worrying since, unpre-

dictably, the graft may become permanently hyper- or hypo-pigmented, or a mixture of both. Dermo-abrasion, a technique used to improve the quality of pock-marked skin, is equally fraught with risk in these patients. Coloured skins can make gigantic keloids.

### General Surgery First

A plastic surgeon combines highly specialised training and experience with certain specialised techniques. In England, and in most other countries, plastic surgeons must have completed a training in general surgery before starting to train in plastic surgery. A significant proportion of their cases are referred from other specialists—dermatologists, orthopaedic surgeons, oto-rhinolaryngologists, ophthalmologists, genito-urinary surgeons, gynaecologists and dental surgeons. There is no strict demarcation for any specialist whatever his speciality, his practice is a combination of custom and personal choice. This is true of the plastic surgeon who may be called upon to use his techniques and experience in many different situations.

Some plastic training is highly desirable for surgeons in other specialities. The need for gentle handling of tissues is universal, but rarely actually taught. Skin grafting has many applications in all specialities. The plastic surgeon's particular mental orientation towards conservation and reconstruction has to be appreciated together with an understanding of what it is reasonable to attempt for a particular patient. Prostheses have a well-defined role to play, especially in the elderly and when, after a massive facial resection for malignant disease, the prognosis is bad.

No plastic surgeon can function *in vacuo*. He leads a team consisting of an anaesthetist, specially trained nursing staff, physiotherapists, occupational therapists and a clinical photographer—the latter is essential to record clinical progress, the written word must always be inadequate in this respect.

### Research, The Future and The Past

Plastic surgery is by no means all technique! Fundamental research underlines much recent progress and must support *all* future advances. The decades of inspired clinical experiments are yielding, of necessity, to laboratory experimentation and guidance. Permanently sur-

living homografted skin would be of inestimable value. Much time, thought and money is being spent in the effort to secure a "break through" in this field. Storage techniques for autogenous tissues are imperfect. The ideal burns dressing has yet to be made. There is much to be done. Many recent improvements and innovations have been made possible by improved anaesthesia and the antibiotics. It is interesting to recall that endo-tracheal anaesthesia was developed (by Sir Ivan Magill) because of the need of the plastic surgeon for free and unhurried access to the nose, mouth and pharynx.

Beginning in 1915, Major Harold Gillies, with his colleagues from Commonwealth Countries and the United States of America, proceeded to establish many of the now standard techniques for tissue transfer and repair. By 1920 results of treatment were frequently and predictably successful, but nevertheless the specialty was not properly recognised by the profession as a whole for one or even two decades. Prior to 1939 there were only four full-time plastic surgeons at work in the United Kingdom. The first appointment of a plastic surgeon to a teaching hospital was in 1930 when Sir Harold Gillies was appointed to St. Bartholomew's Hospital. Mr. McIndoe, later Sir Archibald, was appointed in 1946. These two men contributed greatly to the leadership of the specialty throughout the First and Second World Wars and in the intervening years. The men that they helped to teach carried the specialty to many other countries.

### The Third Generation

During the years of the Second World War many more plastic surgeons were trained and had broad experience in the treatment of burns and injuries. With the formation of the British Association of Plastic Surgeons in 1946 and the advent of the National Health Service the specialty has become firmly established and well organised on a regional basis. There are now approximately sixty full-time Consultants in Plastic and Reconstructive Surgery; they represent the second generation of British plastic surgeons, the men now in training a third generation. There are some eighteen special centres in the United Kingdom with units devoted entirely to this growing specialty.

## CONSULTANTS' PAGE

### Comment

#### Manners makyth Man

... "What does the wise old family doctor give that the machine cannot? It is not professional skill or scientific knowledge; it is human sympathy and understanding that form the very core of medicine."

... "I fear that what we are selecting for our future doctors may be nothing more nor less than swots. If some of them happen to be boys of spirit and character—well, that's a fortunate accident. Pedantry and the pursuit of mediocrity are in the ascendant, and they will be until some group of university teachers has the insight and the courage to say, 'This has gone too far—if we systematically neglect character we shall ruin our society, and particularly medicine'."

The theme of Sir George Pickering's recent presidential address to the B.M.A. has wide applications and poses problems that are of the world as much as of our own N.H.S.

Civilization can properly be equated with civility. Its original background was wealth and the class structure. The code of manners was set from the top; in course of time it embraced all classes and became the accepted style of social intercourse.

An enormous change has come over the world since those days. Courtesy, the fine flower of civilization, has withered and only the stalk remains to remind us that it once decorated our daily lives. It is the symbol of a lost heritage.

Decline set in after the First World War. Of that there can be no question. In the higher social strata it could be traced to the impact of vulgar wealth, acquired mainly through war profiteering, on the old code of social manners and personal behaviour, which frowned on display.

Lower down the social scale the decline was most marked among the children, bereft by the war of the guidance and control of fathers and the domestic influence of mothers engaged in various kinds of war work, often away from her home.

In short, war, which is a relapse into barbarism, ran a harrow over social codes, and courtesy became one of its first casualties. The process can be directly traced to the break-up of the domestic centre, among rich and poor alike, and the inability after the war to return to the pre-1914 standards of social intercourse.

Twenty years later Germany proved to be the burial ground of that code of personal honour,

dignity and self-respect which had sustained civilization in Europe since the Middle Ages. Under the inspiration and example of the guttersnipe Hitler, whose personal standard of conduct had been formed in the doss-houses of Vienna, the German masses broke loose from the fragile moorings which had held them in uneasy partnership to nations to whom courtesy came naturally, through tradition, and was not imposed as a means to an end.

There is nothing wrong with class codes so long as they are not linked to political hatred. Consider the high standard of manners in The House of Lords. To emulate one's so-called social superiors may not be a bad thing, since in the course of time polish can become ingrained, as it certainly is with many of our simple men and women who have never set foot in a mansion. But the reverse process is certainly bad, as is very evident at the present time.

Good manners tend to close the class gap and, therefore, to promote equality. Courtesy to all is the mark of the gentleman and the gentlewoman—and there is no more striking mark of the decline than the derision in which those honourable titles are now held. They are not exclusively connected with wealth or social status; one can earn them by conduct without a penny in one's pocket.

It may well be that the Second World War completed the barbarous process of the First, and that the real business of nations today ought not to be the pursuit of peace, which is impossible without civilized standards of conduct, nor the dangerous and deceptive circumlocutions of diplomatic chicanery, but the recovery of standards of personal courtesy and national honour.

... "Twenty years ago I remember several examiners remarking to me, 'That man was unkind to his patient. I don't think he's fit to be a doctor. I shall fail him'. Recently, I have not heard this."

... "The welfare state is one of the most substantial attempts to translate an ideal into practice. Naturally, not all of its implications were foreseen. Medicine perhaps presents the outstanding example of how greatly the realization of this modern attempt at Utopia depends on character, on an attitude of mind. I do not think this has yet been realized. And I fear that, unless it is, our attempt at Utopia will destroy itself. Manners makyth Man."

#### BARCLAYS FAMILIAR QUOTATIONS

'A fierce,  
vindictive  
scribble of red'

Yellow, we are now told, is more startling and more easily visible. But the news comes too late. Red will for ever be the colour of dangers and alarms.

It is understandable therefore that its sudden appearance among the sober blacks of a bank statement should produce a sinking feeling.

Occasionally there may be some reason for this. But usually there is not. Money is our business and the granting of overdraft facilities is simply a part of that business. We cannot, alas, scatter these facilities with a fine, careless rapture.

But if your case is good and your intentions honourable you will, in due course find red upon your statement. It will not, however, be fierce. It will never be vindictive. And (so long as our accounting machines continue to function) it will not be a scribble. Apart from that, the quotation seems remarkably apt.



**BARCLAYS BANK**

*'Money is our business'*

In case you forgot, the quotation is from Browning's 'Easter Day'

## ART EXHIBITION, 1963



(Photographic Department)

*"All Art constantly aspires towards the condition of music." W. Pater.*

I THINK everyone who went to the Art Exhibition will agree with me that it is a great pity Bart's has only had seven exhibitions since the first in 1938. This year there were 200 pictures submitted by over 60 contributors. This large and unexpected response was the cause of my first adverse criticism which is that the pictures were too crowded; a second is that the exhibition lasted only a week. These comments apart, I think the organisers did extremely well in the space and time available. As for the pictures, the standard was generally high although a few were decidedly poor. It is, of course, unfair to judge amateurs by a professional yardstick even though amateurs have the advantage of not competing professionally in their art, thus importing an air of uninhibited informality, as well as a pleasant inexperienced naïveté. There was a wide range of subjects painted using a wide range of media, the majorities being landscapes and oils respectively. There were, also, many portraits and still-lives, but disappointingly few abstracts.

This year there were two special exhibits, one was the memorial exhibit consisting of painting

by the late Robert Foster-Moore and the late Sir Harold Gillies. Both men exhibited in 1938 with Dr. Geoffrey Bourne, R. Morshead and A. P. Bentall, all of whom also exhibited this year. Robert Foster-Moore's paintings all showed great artistic and technical ability, using watercolours in landscapes to their fullest advantage. I liked Sir Harold Gillies's "Chestnut Trees at Bossington", but his other pictures disappointed me. The other special exhibit was of Medical Art, which contained a selection of drawings and paintings by Peter Cull, H. B. Stallard and William Serumaga. Medical Art is meant to guide the learner and any aesthetic components are secondary. These pictures all showed remarkable clarity of line and technical precision essential for accurate interpretation; some, in their simplicity, were almost beautiful in an esoteric way.

In the main part of the exhibition Gerald Duff stole the show with his Sickert-like, sombre-coloured views of London using thick purple oils. Bob McDowall made clever use of heavy impasto in his view of Queens'. John Challis's im-

## BOOK REVIEWS

**Cleft Lip and Palate—3rd Edition (1963)** by W. G. Holdsworth. William Heinemann, Medical Books, Ltd. Pp. 204. Price 50s.

Since the first edition appeared in 1951 this has become the best "short" textbook on the subject in the English language. It covers thoroughly the surgical management of these cases (which occur in about one in every thousand live births). The earlier chapters on anatomy, aetiology and embryology are comprehensive, and fascinating partly because of the challenge they present to research. They are of interest to all doctors, paediatricians especially, and to all medical students.

This book is prescribed reading for all plastic surgeons in training and is a valuable book of reference for any surgeon who finds himself responsible for the care of an isolated community. It contains more than is required of a candidate reading for the Final Fellowship, while the undergraduate actually *needs* little from it, other than some knowledge of the timing of the various operations and an idea as to what they can achieve.

The concise style makes reading a pleasure, and in this new edition previous omissions have been corrected. The chapter on secondary procedures has been enlarged. Recent advances are surveyed. There is a discussion on the current place of bone grafting for the infantile cleft alveolus.

Mr. Holdsworth continues to give pride of place to a modified Langenbeck operation for repair of the cleft palate, despite most British surgeons' preference for the Wardill method of closure. However, since this is a personal book written by a most experienced plastic surgeon, one hopes for, and finds, evidence of individual practice and prejudice.

The price has increased by only 8s.

A.F.W.

**Handbook of Operative Urological Surgery** by John Swinney, M.C., M.D., M.S., F.R.C.S., and D. P. Hammersley, B.A. Publishers: Ian S. Livingstone Ltd. Price 55s.

This book provides an excellent survey of the technical aspects of modern genito-urinary surgery.

As the authors suggest, it is primarily designed for the post-graduate student, and as a guide for the general surgeon who occasionally deals with urological problems.

For the under-graduate, a brief examination of the clear and instructive illustrations could provide for rapid revision and clarification of the major points of surgical urology, without need to refer to the specialised text.

J.E.A.W.

pressionistic landscapes were good, as were Robin Husband's, J. S. Malpas's and R. B. Keighley's, who cleverly expressed light and distance contrasts. John Chaltrey's "Figtree Court" showed good composition and technique, while R. N. Ballantine painted good foregrounds. W. G. Scott-Brown, C.V.O., had a notable view of the Thames. The watercolour landscapes of Reginald Morshead and David King showed considerable skill and Morshead's "Demolition" illustrated a similar ability in townscapes as did A. P. Bentall's "Norwich Market Place". Geoffrey Sparrow's pen-and-ink and watercolour pictures showed good animal drawing and movement.

A leaning to Cubism was shown by Simon Brett's "Still Life" and "Nude", while his full-length portrait of a girl was painted with great delicacy and feeling. Pauline Harris's thoughtful portrait of Wendy was sensitive, but Monica Lynch's ambitious numbers lacked life and warmth. Amongst the still-lives there were many fairly good flower paintings and sketches, but I thought Jane Kingdon's "Flower Painting" on black paper and W. E. Hector's studies of orchids especially good. Cynthia Castledon's "Still Life" of fruit and Louise Tyler's "New Life" and "Shells" were also good. Angela Richardson's abstract "Strawberries and Cream on a Black Dish" was very effective; however, the best pure abstract was Sue Ray's blue, white and coke "Hurricane". Mike Church's treatment of the Lascaux Cave Murals was original, but the lighting did not do justice to the rough plaster.

The sculpture submitted was either very good or frankly bad, which is surprising because this medium is more plastic than painting and avoids creating an impression of the third dimension. The portrait heads by A. Bignall of "Jenny" and by Beth Jukes were excellent, while Fianne Packer's "Nude" was delightfully simple and compact. The clay lamp-stand "Obstetrician's Nightmare" of a cyclops with cleft lip and macrostomia lent some ironic humour to the other rather crude bits of clay.

To end on this critical, perhaps hypercritical, note would be unfair because on the whole the exhibition was good and I enjoyed it. For the smooth running of the show we must thank the Committee and all their helpers in the hard work of putting up the stands and hanging pictures. We must also thank the Governors for the use of the Great Hall, which was an ideal setting, and although the Hogarth murals overshadowed our artistic efforts they, no doubt, put the exhibition into the right perspective.

J.F.R.

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## SPORTS NEWS

### SPORTS EDITORIAL

One is naturally disinclined to liken the Swimming Club to an Empire, but at least in its behaviour over the years it has waxed and waned with remarkable regularity. The recent history of the Club goes back for about seven years, during which time it has seen great successes and dismal failures. Bart's swimming reputation has never been higher than during the era of Shand, Ruoss, Groves, Mr. King of the Biochemistry Department, Shorey, Merry and Davies. These members were always in peak condition, and could tackle almost any club in London and run them a good race in every field of swimming.

At the present time the Club relies on the tail end of this group, for though Shorey, Shand—who is now Captain of the United Hospitals' Swimming Club—and Groves are still here, their availability diminishes rapidly as Finals approach. Of recent times there has been no-one new in the College who can in any way match the ability of any of these; for although both Britton and Lask are adequately competent, neither has that extra quality which makes the outstanding player. However, a new preclinical member, Quinn, promises much and in his

first season has been of great value to the Club. In addition to these names, there are many others who have rendered valuable service, often at short notice.

The competition programme for the Club varies with the available talent, but they aim to enter water polo teams for both the United Hospitals and University Leagues, and enter individuals and teams for their separate competitive galas. Members are free to swim for the University, if selected, and other Clubs. Friendly matches are arranged, from time to time, with various teams.

The College was fortunate in having amongst its student body at the same time the quartet of Ruoss, Shorey, Shand and Groves, all of whom knew each other beforehand in local and National swimming and all of whom had made some name for themselves in these fields. It is unlikely we shall be so lucky again for some time.

Until that time the Club must look forward to a period of rather less success with more average players, and be content to play second fiddle to other Clubs with better facilities and more able men.

G.H.

### MEN'S TENNIS CLUB

#### Saturday, 25th May. 1st VI v. St. Thomas's.

This fixture had been arranged prior to any knowledge that we should meet in the United Hospitals Cup, and consequently although the fixture was a friendly one, a certain tension was apparent throughout the afternoon's tennis.

The Bart's first pair settled down very quickly in their opening match to take the first set fairly easily. As so often happens however, they relaxed completely in the second set with the result that casual tennis lost them the set. With concentration and a general tightening up of all shots, the final set went to Bart's six games to one. The second pair played very steady tennis in both their matches, and the final outcome of the match was a win by four matches to nil. Team: Mitchener, Kohli, Edelstone, Fryer.

#### Wednesday, 5th June. 1st VI v. Metropolitan Police.

On a very hot afternoon a relatively weak Hospital team played the Metropolitan Police at Hampton Court. The Police team was, as usual, made up of some strong hitting players and also a pair of very steady fifty-year-olds. This latter pair, although occasionally in trouble when made to run, had little difficulty in beating all three Hospital pairs by sheer steadiness. The only two wins recorded by the Bart's team were against the more powerful but erratic Police third pair. If anything was to be learned from this match, it was that in the standard we play through the season, it is generally controlled tennis which obtains results.

Result: Lost 5-2.

Team: Kohli, Edelstone, Mitchener, Cantrell, Gordon, Nightingale.

#### Thursday, 6th June. U.H. Cup Match. 1st VI v. St. Thomas's.

St. Thomas's, last year's winners of the Cup, were automatically placed at the top of this year's draw and Bart's were drawn to play them. Thomas's were only left with two of their winning team while this Hospital was in the more fortunate position of having four of last year's cup team. However, because they possessed a very strong first pair, one of whom was the University of London Captain, it was decided that Bart's would have three moderately strong pairs rather than two strong and one relatively weaker. After the first round, Thomas's led two matches to one, this result largely being due to the failure of Mitchener and Kohli to beat a pair who two weeks' earlier they had easily outplayed. After the second round the score was level at three matches all, and the outcome of the match therefore depended upon the final round and, in par-

tical, whether Carden and Latham could defeat their second pair. This they succeeded in doing which gave Bart's a final win of five matches to four.

Team: Carden, Kohli, Edelstone, Mitchener, Latham, Fryer.

#### Saturday, 15th June. 1st VI v. St. George's.

As a result of a large number of regular first six players being unable to play, the Bart's team did not appear on paper to be very strong. However, this presented the opportunity of trying new players and also giving them first team experience. During the course of the afternoon only one match was lost by the Bart's team. The good result was mainly attributable to very steady and consistent play by every member of the team. Result 9-1.

Team: Mitchener, Fryer, Bowen, Cantrell, Roy, Smiley.

### CRICKET CLUB REPORTS

#### Sunday, 30th June. Bart's v. Old Roans. Match Drawn.

On a wet, slow wicket the Hospital found runs difficult to come by. H. Phillips and D. Abell batted well before lunch. J. Harvey and D. Delany then added runs rapidly, and a score of 188 was finally reached.

Old Roans had several escapes from the Bart's opening attack, then C. J. Richards, bowling first change, took 3 wickets in his first over, narrowly missing a hat-trick. He went on to take 6 wickets in a well-controlled spell of bowling, and Old Roans managed to play out the last 15 minutes for a draw.

St. Bart's 188 (D. Abell 49; H. Phillips 28; D. Delany 25 not out).

Old Roans 118 for 9 wks. (C. J. Richards 15-4-37-6).

#### Sunday, 7th July. Past v. Present. Lost by 5 wickets.

Dr. Oswald fielded a strong batting side against the Hospital in the Annual Past v. Present Match, on a warm sunny day at Chislehurst. The present, batting first, were soon in trouble, and after an hour's play were 41 for 4, when J. Harvey and D. Delany batted sensibly and a collapse was averted. Harvey remained the anchor, while N. Offen and D. Goldie each scored runs, and with the score at 162 for 7, a reasonable total was at last in view. The remaining wickets, however, fell for 18 runs, and the Past were left to get 180 in 145 minutes.

M. Brambridge and J. Stark added 66 runs for the first wicket, while the Hospital fielding reached a new low. Eventually the catches went to and stayed in hand, and 3 wickets had fallen for 97 with 60 minutes remaining. J. Tomlinson

batted very correctly and R. Jeffries then added 40 runs for the fourth wicket. Finally H. Ross hit the winning run off the third ball of the last over of the day.  
 Present 180 (J. Harvey 49; D. Goldie 26; D. Delany 21).  
 Past 184 for 5 (M. Brambridge 43; J. Stark 37; J. Tomlinson 35; R. Jeffries 29 not out).

**SWIMMING CLUB REPORT**

Since the last Swimming Club report we have had only two engagements. We won the London Hospitals' Invitation Relay Cup after Guy's had been disqualified for swimming one of their men twice.

Then a week later we entered a team for the United Hospitals' Water Polo Knock-out Competition. We had small hope of doing very well, particularly when it became apparent that we were going to have difficulty in raising a satisfactory team. The first round was against Charing Cross. Some sound tactics amidst the confusion of our opponents allowed us to win 3-0.

**COPY DATES:** For September, 19th August; for October, 16th September.

In the next round we met the London. B. Shorey promptly knocked out one of our opponents when trying to get the ball and this probably helped towards our slender 1-0 victory. We thus advanced to the final where we met our familiar rivals, St. Mary's. Once again their shooting and passing were too good for us and we lost 4-0.

It was a pleasant evening for the team (including two of our American colleagues) who were better satisfied than they either deserved or hoped! We look forward to another successful season in the United Hospitals' League, but unless more keen swimmers appear, we may have a lean time.

**Teams:**

Relay—B. Shorey; D. Shand; B. Lask; P. Quinn.  
 Water Polo—B. Shorey; D. Shand; J. Britton;  
 B. Lask; G. Haig; K. Steinhouse; M. Kurtz.

Colours have been awarded to:  
 B. J. Britton  
 B. D. Lask.

From the day you qualify . . .



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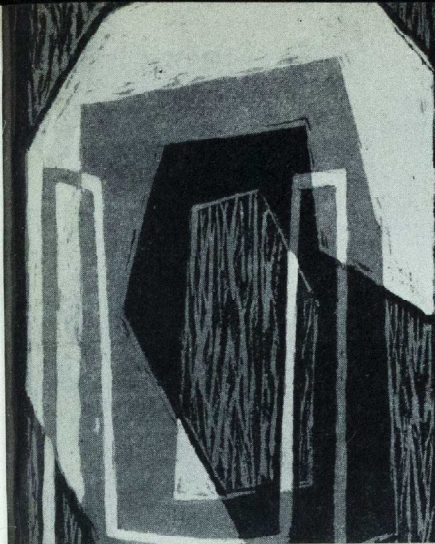
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Erratum: Page 259, Fig. 2. The Figure should be inverted.

**EDITORIAL**

**At a loss**

Every well equipped hospital journal office has twenty-seven subjects jotted down on a precious piece of paper. They are boring subjects about which a desperate editor can quite successfully write nothing at all for a page or more.

Medical Education: if ever little children have grown fat and happy at mummy's breast then the

batted very correctly and R. Jeffries then added 40 runs for the fourth wicket. Finally H. Ross hit the winning run off the third ball of the last over of the day.

Present 180 (J. Harvey 49; D. Goldie 26; D. Delany 21).

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