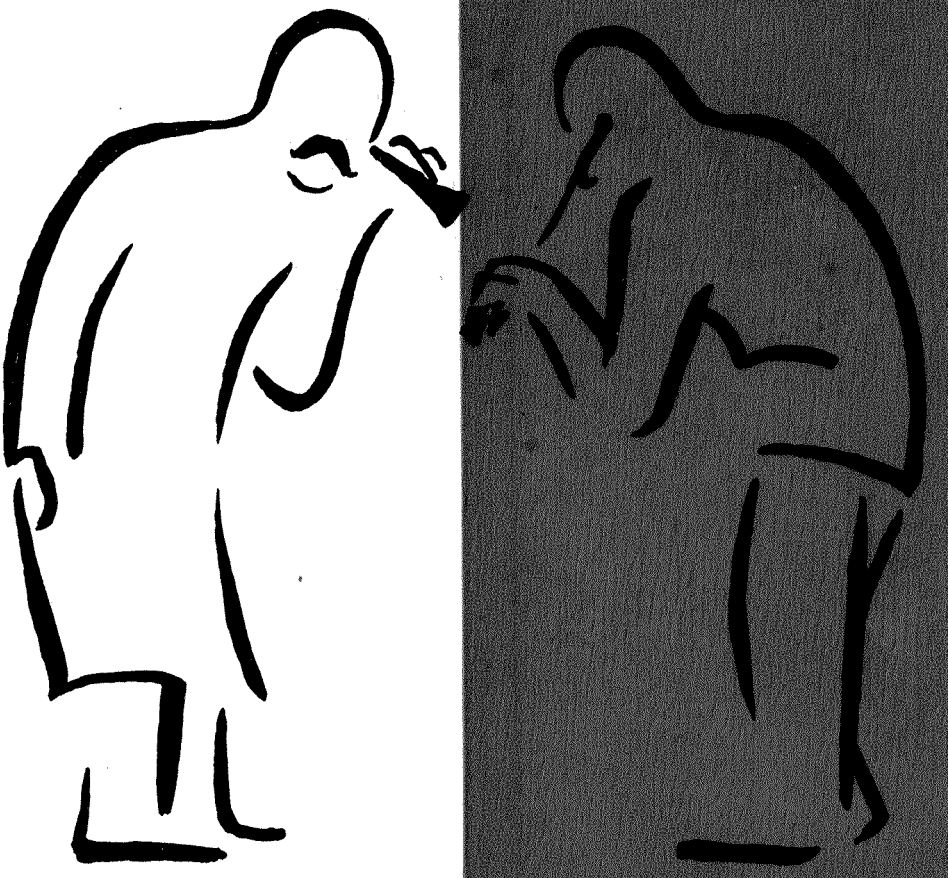
SYDNEY UNIVERSITY MEDICAL JOURNAL

1883 - - 1958



75th ANNIVERSARY EDITION

Vol. 48

SYDNEY UNIVERSITY MEDICAL JOURNAL

To mark the 75th Annversary of the founding of the Sydney University Medical School (March, 1883)

It is also 100 years since the University was first empowered to grant degrees in Medicine.

1958

Edited by: ANN JERVIE, B.Sc. (Med.)

Assisted by CHARLES LEES.

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THE DEAN'S MESSAGE

Research is a word in common use these days.

I wonder, however, if all who use it and those who hear it, have a clear concept of its meaning. To many, I am sure, its significance begins and ends with the cause of leukaemia and the prevention of poliomyelitis.

Actually its significance is as wide as the constellation of planets and as old as humanity. The dictionary defines research as "diligent inquiry in seeking facts and laborious search after truth". As such it applies to every branch of human knowledge. Medical Research indeed is one of its latest extensions.

Another misconception is that research is something requiring very special talents. There is no question that some are better at it than others as in the practice of Medicine, but I would like to dispel the idea that you have to be endowed with some sort of genius to carry out research. It is not so much a matter of special talent as an interest, a genuine interest, in the question "why".

Unfortunately, the lure of the greater reward of practice provokes the question "How much?" The answer has in the past been overwhelmingly in favour of practice, but I am certain that if the reward of top-ranking research men and women was in any way comparable with the reward of specialist practice offering similar security and standard of living for one's family, the picture would be vastly different.

In the past, research has been carried on mainly by those worthy (and often unworldly) people who have been prepared to sacrifice material reward for the satisfaction of making a contribution to knowledge. But that cannot continue. There is one country whose ideology we do not cherish, that has shown the scientific advance that can be made by exalting the status of the research worker.

Things are improving here, too. Facilities for research and improved salaries, although still far from adequate, enable young people to learn the A.B.C. of research here, and so later derive more benefit from expensive overseas travel.

But don't let us delude ourselves about the subject of research. Admittedly it can vary in its intricacy from the simplest of anatomical measurements to the maze of higher mathematics.

There is one fundamental definition that runs like a golden core through all research, and that is the Recording of Accurate Observation.

In 1954 I was talking to the late Sir Alexander Fleming in his laboratory in St. Mary's Hospital, London. He was a modest, homely gentleman who denied any claims to the honours for brilliance in research which the world in its gratitude had showered on him for his discovery of penicillin.

The London Times in an obituary described him in these words: "It was a long chance that the spore of a particular mould would float into St. Mary's laboratory and settle on a culture plate.

"When laden with honours towards the end of his life he used to emphasize this element of chance at the expense of his own contribution.

"But as Pasteur truly noted, in the field of observation, chance favours only the mind that is prepared."

To prepare the mind and develop accurate observation is the most important principle. And so Research, like Clinical Practice, in the Undergraduate's training for a doctor. starts in your student days.

One important reason for developing research in the University, as for example in the Queen Elizabeth II Research Institute for Mothers and Infants, is to enable students to feel the impact of the investigatory mind which we hope will produce in greater numbers "the mind that is prepared".

It is not practicable for Undergraduates to carry out much in the technical side of research, but there is an essential preliminary, and that is a mental research exercise.

I suggest that every student have in his mind a research idea. Think about it, talk about it, read about it, and I am sure that with minds so prepared this Country can look forward with an exciting anticipation to the future when we will no longer depend on Overseas people, but make Australian contributions to knowledge.

Rhodes Scholar, 1958

JAMES SAVILLE WILEY

Once again the award of the Rhodes Scholarship has been made to a Medical student, James Saville Wiley.

Jim left Sydney Grammar School in 1954, where he had achieved distinction as a scholar, a prefect and sportsman, who had won the G.P.S. mile, and had represented his school in cricket, football, tennis and swimming.

After achieving a maximum pass in the Leaving, he commenced the study of Medicine. Jim has demonstrated all the qualities of the Rhodes Scholar. Academically, at University, he has done outstandingly well, and after success in his third year examinations he elected to study for the degree of B.Sc. (Med.) in the Department of Biochemistry, where he has been investigating the B lactoglobulin of cow's milk. (This earned him the title of "Milko").

He continued his interest in athletics as an active club member, winning his Blue in 1956.

At Oxford, he will study for his B.A. (Hons.) in either Animal Physiology or Biochemistry; he may remain and read for his D.Sc. degree.

Throughout his course, Jim has displayed qualities which befit him for this honour, and we wish him success.

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The President . . .

ROSS DAVIS

1950 marked the entry of Ross Davis into the Faculty of Medicine from Sydney Grammar School. His early years were completed with an enviable record of Distinctions and Credits, as well as a fine sporting record — playing football and tennis with the University Clubs.

It was after his third year that he first showed interest in Neuroanatomy, studying with Professor P. O. Bishop, and his year's work was rewarded with a First Class Honours degree.

Soon after his return to the fold he demonstrated his qualities of leadership with his election as R.P.A.H. Year Representative — a position he held with distinction for three years. In 1955 he edited the Journal and in 1956 the Senior Year Book.

While on the Medical Council he was an enthusiastic Committee member distributing the War Memorial Fund; he re-introduced the Clinical Evenings, and could be relied upon to speak briefly, but pertinently, on important issues at meetings.

His fellows demonstrated their respect for his qualities of leadership and fellowship when he was awarded the "Robin May" Prize of 1956.

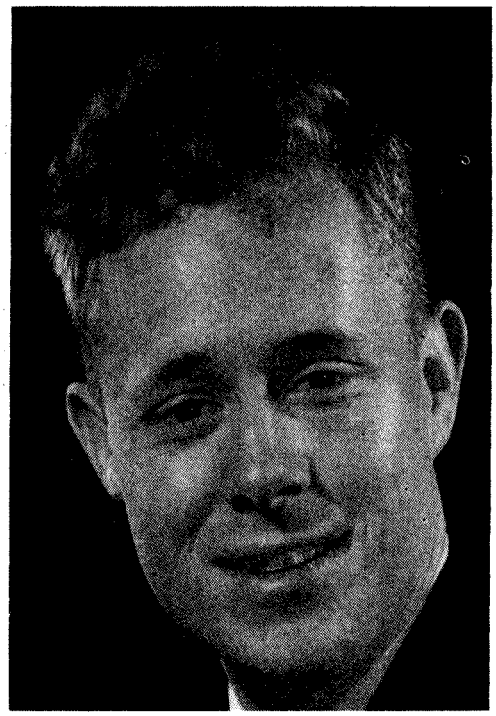
Last year, he served as a Junior Resident in the Professorial Unit after achieving Honours at Graduation. This year, he has returned as a Research fellow to the Physiology Department, where he is further investigating the visual system. He was recently married.

His election in 1957 to the Presidency of the Medical Society marked the culmination of an outstanding career in the Society. As a President, Ross has never lost any of his qualities of diplomacy, charm and courtesy. His quiet purpose and interest in all phases of activities resulted in an effective council, consolidating early gains, but also exploring and introducing new ideas.

His future success is assured, and we wish him well.

"Robin May" Prizewinner, 1957

MICHAEL CONNOLLY



Every year since 1948 there has been an annual prize awarded in memory of the young graduates who lost their lives at sea from the launch "Robin May". Election is by all members of the Final Year, and the prize is awarded for good fellowship and qualities of leadership.

This coveted award is a measure of the respect of the Final Year for one of its outstanding members, so it was with no surprise we learned that the 1957 "Robin May" Prize was won by Michael Connolly.

Mike started in the Faculty of Medicine in 1951. His student days were noteworthy — apart from consistently good examination results and a B.Sc. (Med.) with First Class Honours in Pathology, the number of his activities is legendary.

He represented his year with vigour, enthusiasm and success on the Medical Council; edited Journals (1956 and 1957) and the 1957 Senior Year Book; ran a Convention which will be long remembered for its inaccessibility. His voice was heard on the Union Board and the S.R.C.; and he was a foundation member and source of inspiration on the Leonardo Society.

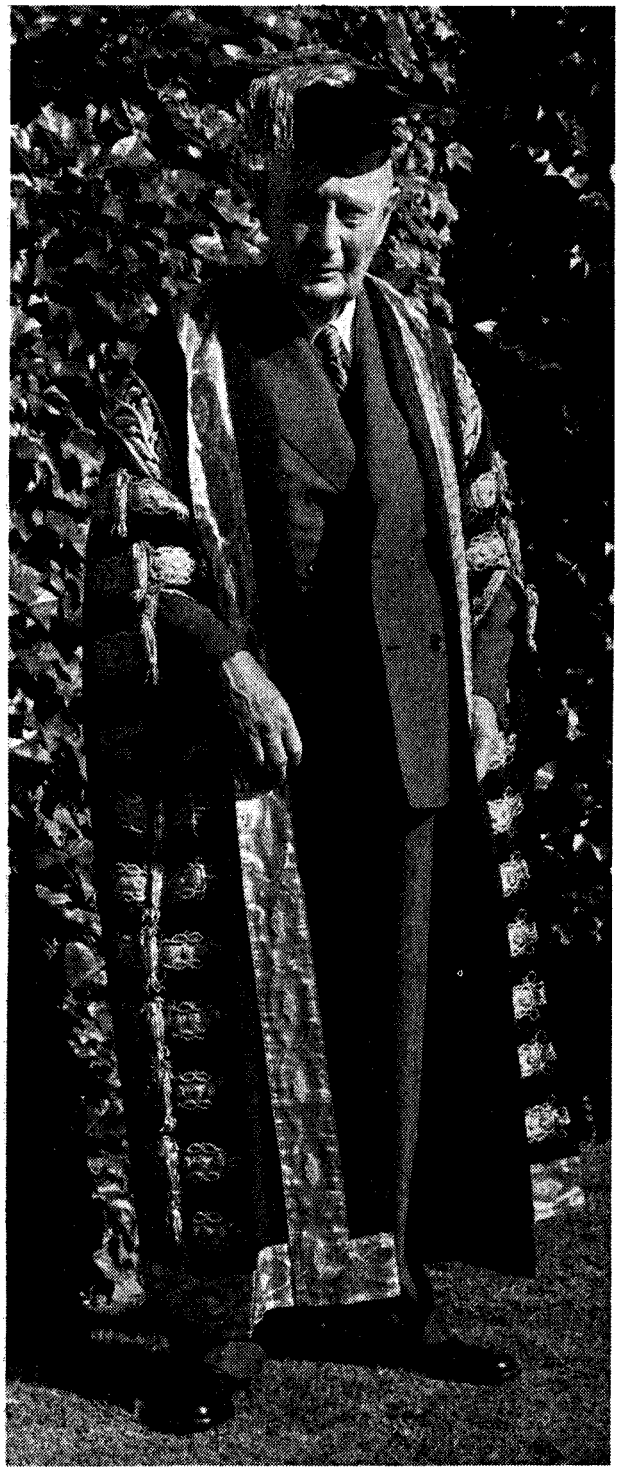
Throughout his student days he was active in encouraging his fellows to take part in activities designed to broaden their outlook and their education. He set a fine example with his wide knowledge, countless interests, and his success in all positions which he held.

No formal listing of his abilities and the range of his interests can hope to convey his frendliness, his vitality, his sense of humour, and his enthusiasm. He delighted in controversy, but even in disagreement has the capacity for making friends of all who know him.

His future career will be undoubtedly spectacular, as varied and colourful as the man himself, and we wish him success.

Special Honorary Life Member

SIR CHARLES BICKERTON BLACKBURN



The Council of the Sydney University Medical Society is empowered to confer Special Honorary Life Membership upon any person for eminent service to the Medical Profession or to the Society. This, the Society's highest honour, has been awarded only eighteen times in its history.

In recognition of his long and outstanding services, both to the Profession and the Society, Sir Charles Bickerton Blackburn, Chancellor of the University, Doyen of Australian Physicians, has recently been elected to special Honorary Life Membership of the Medical Society.

His University career commenced in Adelaide, where he gained his B.A., and was later continued at Sydney where, in 1899, he graduated M.B., Ch.M. After serving as a Resident and then as Superintendent at the Royal Prince Alfred Hospital, he was awarded his M.D. in 1903. From 1904 until 1911 he held the position of Honorary Assistant Physician; Lecturer in Clinical Medicine from 1911 until 1934; since which date he has been an Honorary Consulting Physician. He was appointed Dean of the Faculty of Medicine from 1923-5. As this is customarily held by one of Professorial status, his appointment was an expression of the high esteem in which he was held by the Faculty.

He has served on the University Senate since 1919, and in 1941 was first elected Chancellor, a post he still holds to-day. Honorary degrees from the University of Melbourne, New England and Technology have been conferred upon him. The B.M.A. and the Royal Australian College of Physicians elected him to the Presidency in 1920-1, and in 1938, respectively. During the First World War he saw active service, and was twice mentioned in despatches. During the Second World War, he served as a Lieutenant Colonel. His Knighthood was conferred in 1936.

His association with the Medical Society began during his student days and in 1902 he was elected to the Presidency. During his years as a Physician at Royal Prince Alfred and in the Department of Medicine he took an active interest in the students he taught. As Dean, he continued to further their interests and to guide them wisely.

SPECIAL HONORARY LIFE MEMBER — Continued.

It is as Chancellor that we know him best. He welcomed us to the University and his kindliness, wisdom, interest and understanding are known to all of us. His activities and energies never cease to amaze; he can be relied upon to support all our functions, to talk thoughtfully but with an evident sense of humour, with any students he meets.

Here, then, is an outstanding Physician, well-known and loved Chancellor. We, as students, award him our highest honour — Special Honorary Life Membership in the Society in which he has taken such an active interest for so many years.

OBITUARY

DR. PHYLLIS ANDERSON

The sudden death of Dr. Phyllis Anderson last year is felt deeply by her students, both past and present.

From the Methodist Ladies' College, Burwood, she came to the University in 1920 and entered the Faculty of Medicine. She was Director of the Women's Union in 1923 and served on the Debates Committee from 1922 to 1924. She graduated in 1925.

Dr. Anderson worked as an R.M.O. at the Royal Alexandria Hospital for Children, where she was later Senior Resident Pathologist. She became a Member of the Royal Australasian College of Physicians in 1938 and a Fellow in 1947.

In 1928 Dr. Anderson helped to found the Medical Women's Society of N.S.W., in which she held office for many years, being President from 1947 to 1949. She was a moving force in setting up the Bursary Fund for senior women medical students. She was a member of the Standing Committee of Convocation of Sydney University from 1950 until her death and served on the N.S.W. State Council of the British Medical Association from 1951 to 1954.

Her great interest outside Medicine was in music and ballet.

Dr. Anderson became known to medical students as a Teaching Fellow and later as part-time lecturer in Bacteriology. Many have known and appreciated her interest in teaching. Her enthusiasm for her work was infectious and the informal atmosphere of the practical classroom gave full scope for the exercise of her remarkable personal qualities and professional capabilities. Perhaps most notable was the speed with which she came to know and speak personally to each member of a large class. In teaching she emphasised always the practical application of the basic sciences, guiding students with a firm but kind hand through the often difficult transition between pre-clinical and clinical years.

Those who were fortunate enough to know her more closely knew her as a widely-read and thoughtful person whose conversation was pithy, original and informed. Accuracy of thought and economy of speech were lightened by a great fund of kindness, sympathy and wisdom. Many had been glad to draw on this, even years after graduation.

Her untimely death has deprived us and those who had yet to meet her, of a friend as well as a respected teacher. Her ideals remain.

DR. DUNCAN McLACHLAN

It with with both shock and deep sense of loss that the many friends of Dr. Duncan McLachlan learnt of his untimely death after but one day of practice as a resident at Parramatta Hospital.

Born in Scotland, he came to Australia in 1939, living in Grafton for 8 years before coming to Sydney. He was educated at Canterbury High School, and entered Sydney University after achieving a good Leaving Cerificate pass.

Throughout his University years, he became associated with lay preaching and University Christian affairs, combining an unflexibility of his basic beliefs with an understanding of his fellows, whom he was always ready to help. His ready sense of fun, his ability at chess, and his sporting achievements, which included weightlifting, cycling, cricket and football, ensured his popularity.

His ambition was to become a medical missionary, and he aimed to obtain as full a training as possible to fit himself for the task ahead.

The community and the medical profession have had a great loss in Duncan's death, and our deepest sympathy goes to his parents and his brothers in their bereavement.

JAMES SHUTE

The many friends of Jim Shute were shocked to learn of his death this year.

Jim left Sydney Grammar School to study Medicine, and was a fourth year student at the Royal North Shore Hospital at the time of his death. His activities as a student were carried on with enthusiasm; in particular he worked on behalf of the Grammar Old Boys' Union Social Committee and the Film Society.

Those who knew him well miss his friendly disposition and ready humour. In spite of many setbacks in life, including polio in his early years, he remained singularly purposeful in his determination to become a doctor and he displayed great determination as a student.

JAMES SHUTE — (Continued)

Right throughout his last illness and up until the time of his death, he remained cheerful and displayed the same friendly spirit which made him so popular.

We will all miss him: his passing leaves an unfilled gap. We extend our sympathy to his family in their bereavement.

JOHN KEIRLE

John Norman Keirle was born in April, 1937, the second son of a distinguished and respected family. He was educated at

Shore School, from which he came to this University in 1953.

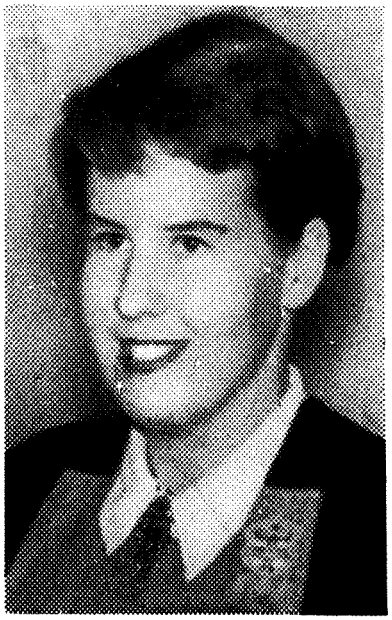
His passage through to Fifth Year Medicine, which stage he reached this year, was marked by repeatedly good and consistent results and was unmarred by failures.

John's death in August came as a shock to his friends. But more than the personal loss of such an amiable and gentlemanly companion, we cannot help but feel the tragedy of the loss to the community which John's death means.

He would have made the perfect practitioner, courteous and considerate to all people, responsible always in his work and in his dealings with others. He was dedicated not only to the study of medicine in the narrower sense, but more than that, to the study of humanity. John was an unselfish and self-effacing person who, whilst having the talent of being a ready and sympathetic listener, rarely talked of himself. Thus only a few of his friends know of his extensive and systematic reading of history, philosophy, psychology and classical literature. Perhaps, then, we will tend rather to remember the agile tennis player, the hard-hitting golfer, the good-humoured companion of many adventures.

Though of great sincerity and depth of character, John was superficially a simple and unpretentious person. So we can best commemorate his death in simple words, which yet will carry a wealth of meaning to those who knew him: we mourn the passing of a gentleman, a scholar and a Christian.

Editorial ...



Criticism and complaint on the narrow specialisation of our Medical Course has been often heard. Although so often discussed within the confines of a small group, action has at last been taken by students, and more recently by the Faculty.

A conviction of the truth of Osler's words — "While Medicine is to be your vocation, or calling, see to it that you have also an avocation — some intellectual pastime which may serve to keep you in touch with the world of art, science or of letters" — led to the establishment of first the Leonardo Society and more recently the Medico-Historical Club to provide the means to pursue both extracurricular interests and some related to the study of Medicine.

This, we felt, while a valuable indication of student interests in other branches of knowledge, was not enough. Accordingly, the replacement of the first year Botany course with a subject of the student's own choice is welcomed, as it represents the first real recognition by the Faculty of its responsibility to provide that broad, universal education without which a doctor can be no more than a technician, however competent.

But we must not be deluded that the memorising of facts sufficient to pass an examination at the first year level, whether in the Humanities or in the Sciences, need constitute a liberalising of medical education. Rather does a broad education imply an attitude of mind, a spirit of inquiry, an interest in all branches of human endeavour. Any of the Sciences or Humanities, when reduced to a series of facts to be learned for an examination, can fail to instil these ideals and attitudes into the mind of an unwilling or uninterested student.

Until a revision is forthcoming in the structure and the aims of our curriculum, the new First Year requirements represent a major advance and demonstrate the Faculty's awareness of the limitations of the present course. Perhaps this true University education is best provided by our teachers continuing, by example, to encourage the study of other fields of knowledge.

With all this in mind, I hope that adequate guidance will be provided to ensure that the incoming students are not misled by the possible "usefulness" of any of the courses offered, but are encouraged to follow a special interest. It cannot be too much stressed that in our study of man, no field of human activity, no learning, can be classed as irrelevant.

— Ann Jervie.

As our celebration of the 75th Anniversary of the founding of the Medical School in Sydney (March, 1873), we have invited Sir Charles Bickerton Blackburn, Mr. Douglas Miller and Mr. David MacMillan to contribute the following articles.

Seventy-Five Years of the Faculty of Medicine

To compress the events in the seventy-five year life history of a great medical school into an article of three thousand words is obviously going to be a difficult task, even though the writer is charged chiefly with its medical aspects. Some omissions are inevitable, but an effort has been made to ensure that what is recorded is accurate.

Probably the most important event in the history of the Medical School in the University of Sydney was the arrival in 1883 of its founder, Thomas Anderson Stuart, for from that date till his death in 1920 he devoted his life unreservedly to his objective of creating a medical school that should be of a parity with the best of those in the old world. Coming from what was then the most notable and best equipped medical school in the British Empire, he found himself sharing an as yet not quite completed four-roomed cottage with the Professor of Natural Philosophy. However, as he often said in later years, he contrived to make the aroma of his share of the building so disagreeable that the other two rooms were soon vacated, and he later succeeded in having two more rooms added.

This cottage housed the School till in 1889 it moved into its new quarters now known as the Old Medical School, but at that time as Stuart's Folly. When it was erected by the Government of the day it was regarded by his critics as so large that it would never be filled.

In the meantime, Stuart, assisted by his demonstrator, Alexander MacCormick, continued to teach anatomy and physiology in the "little-cottage" lecures in medicine, surgery, midwifery, materia medica and therapeutics, pathology and medical jurisprudence were being given in odd corners of the main buildings of the University and the standard of teaching was so good that the names of many of the very earliest graduates are permanently inscribed in our medical history, as, for example, Peter Bancroft, Cecil Purser, Harry Hinder, Arthur Mills and Herbert Maitland.

Stuart was extremely proud of his New Medical School and expected his students to honour the precincts with due academic gravity. Any scuffling or horseplay in the corridors was apt to be expensive, as "I fine you one pound" would be announced when least expected, and the pound was generally promptly paid. One daring student, feeling pretty sure he had not been recognized, took a risk and failed to toe the mark with the result that a notice was posted that the fine of the student who had not paid would be doubled each week till it was. It never was paid, and I remember the doctor, many years after graduating, wondering just how much he then owed to the University.

It is unlikely that any one man will ever again have the ability or the opportunity to supervise and fashion over so many years a medical school of his own creation as did Anderson Stuart. As Dean he dominated the Faculty and sitting as its representative he was able to keep its needs constantly before the Senate and when in 1901 he became Chairman of the Board of the Royal Prince Alfred Hospital he virtually achieved the control of the policy and administration of the official clinical training ground of his students. Now personally controlling not only the preclinical but also the clinical training, he was in an ideal position to achieve the high standard for which he had been working, and when he died in 1920 he knew that graduates of his school were accepted as on a par with those of any medical school in the Empire. He could point to men like Grafton Elliott Smith as world figures and he knew that in the war that had just come to its close, the Australian army doctor had become famous for his courage, efficiency and resourcefulness.

Stuart might well have been faced with a difficult problem in the early days when the time came to provide clinical teachers for students passing beyond the preliminary science stage of their medical education. The great majority of the doctors then practising in Sydney, including many of those staffing the public hospitals, though quite sound practitioners had had no recent contact with clinical teaching.

"STUART'S FOLLY" — A Lionel Lindsay comment on St. Thomas Anderson Stewart's dream to build the Old Medical School.

Most of them had emigrated soon after graduating from one or other of the British Medical Schools and would have found it difficult to keep up with advances in medical knowledge at a time when the medical literature available was very scanty. Fortunately, a few really outstanding physicians were available and as the groups to be taught were small, only a few were needed. It is not possible in the space available to mention them all, but three stand out so conspicuously that they may well be regarded as the founders of the Clinical Teaching and Clinical Practice that have been such features of this School ever since. One of these, Robert Scot Skirving, had been a fellow undergraduate with Stuart at Edinburgh University, the other two, Philip Sydney Jones and George Rennie were Australians who had graduated with distinction in Great Britain prior to the opening of the local school.

Differing greatly in their personalities they had little in common apart from their devotion to medicine and their skill in teaching it. While constantly stressing the importance of cultivation of patience and good humour, they insisted upon meticulous care in the taking of a history and at a time when there were no accessory aids other than the microscope, stethoscope and thermometer, they demonstrated by precept and example how many obscure diagnostic problems could be solved by adequately trained special senses. As time passed, the students they had taugh began to replace them; the first notable example being Arthur Mills, who was appointed Lecturer in Medicine in 1910, and became the first Professor of Medicine (then part-time) in 1920. This is not the occasion for a critical appraisal of the now quite long line of his colleagues and successors who have graduated from the Sydney Medical School, but few will dispute that the clinical teaching has been and continues to be of a very high order.

Some reference must be made to the curriculum and development of the professorial staff. In the beginning an effort was made to combine some general education with medical studies and it was provided that all students except graduates in Arts should spend a year in the Faculty of Arts before entering upon the four year medical course, but in 1890 this plan was abandoned, and the medical curriculum proper was increased to five years and this continued till 1922, when the period was extended to six years.

From his arrival till 1890, Stuart, as Professor of Anatomy and Physiology, was the only medical professor in the Faculty, but in that year the Chair was divided, Stuart retaining Physiology and J. T. Wilson, who had succeeded MacCormick as demonstrator of Anatomy, became its Professor. A further addition to the professorial staff was made in 1902 when another Edinburgh graduate, Dr. D. A. Welsh, became Professor of Pathology.

By this time, the number of students in the school had grown from the original four to two hundred and four, and as the numbers continued to mount it became obvious that the accommodation and the supply of clinical material at the Royal Prince Alfred Hospital were becoming inadequate to meet their needs. The difficulty was overcome in 1909, when the Sydney Hospital was officially recognized as a second Clinical School and from that time a certain proportion of the students entering their clinical years have been allotted to the Sydney Hospital. Actually, from quite an early stage, through the courtesy of the Hospital Board and the goodwill of the staff, some clinical teaching had been given there, final year students having had a standing invitation to attend ward rounds once a week, and at that time those of Dr. E. J. Jenkins were especially popular.

Reference may here be made to the arrangements for the teaching of Paediatrics that were formally entered into in 1906. Since 1879 there had been a hospital for sick children at Glebe Point and by the courtesy of the staff medical students were welcomed and allowed to accompany them on their ward rounds, but when in 1906 the Royal Alexandra Hospital for Children was

established in Bridge Road, Camperdown, one of the objects set out in the Act of Incorporation was that provision should be made for "Systematic Instruction and Practical Training of Medical Students of the University of Sydney in Diseases of Children". Ever since that time there has been the happiest co-operation between the hospital and the Medical School in the provision of instruction in all aspects of Paediatrics.

The outbreak of World War I in 1914 naturally had a disorganizing effect on all University departments, but perhaps nowhere more than on the Medical School. Probably in no group in the community was there exhibited a greater eagerness to enlist in the services. First and second year students just disappeared, but when the war fever began to attack the staff, Anderson Stuart, now Sir Thomas, for he had been knighted in 1914, had to step in and announce that he would not grant leave to any member of the staff unless there were a suitable substitute available. Intensely loyal himself and in full sympathy with the general attitude, he pointed out that it was the first duty of the staff to continue to provide a steady stream of young doctors to meet the needs of the services.

As the war dragged on, there was a considerable fall in enrolments, no doubt mainly due to matriculants enlisting rather than coming to the University, and at the same time there began to develop a feeling of unrest among the students that were in the School, an anxiety lest the war might be over before those eager to take part in it could graduate. This combined with the knowledge that there was a real threat of a shortage of officers in the R.A.A.M.C., led to the Senate, in May, 1915, approving a recommendation of the Faculty of Medicine that the curriculum for Fourth and Fifth Year medical students be accelerated to enable students to graduate as quickly as possible and to join the forces. In August, 1915, the Senate approved the adjustment of the Third Year course to suit the accelerated Fourth and Fifth Year work. The acceleration was brought about not by curtailing the amount of instruction but by students attending during vacations.

It was a device that entailed very strenuous work for both teachers and taught, but it did enable some graduates to serve who would not otherwise have done so. When the war ended in November, 1918, it was realized that the influx of students entering the Medical School in the next few years would entail dealing with numbers far larger than had been envisaged as likely in the ordinary course of development. Stuart, who felt strongly that a place should be found in his University for any matriculant who had served his country, had no thought of restricting numbers and was already making plans to meet the emergency when he died early in 1920. As was expected, the numbers soared rapidly; thus in 1914 the number of undergraduates registered in the Faculty of Medicine was 521, while in 1920 it was 986, but thanks to the willingness of the whole staff to carry an enormous increase in their teaching responsibilities the crisis was met and many who have since served medicine with great distinction graduated in the then record years of 1925 and 1926.

It was fortunate that just when the strain on the clinical material seemed likely to be almost overwhelming, the situation was eased by the recognition in 1923 of the St. Vincent's Hospital as a Clinical School, it being provided that the school should be under the direction of a Board of Medical Studies and that clinical teaching should conform to the time-table and regulations of the University. It may be opportune to note here that ever since that date the St. Vincent's Medical School has coninued to play a very prominent part in the clinical teaching of the University.

As medical knowledge advances, constant changes have to be made in the curriculum, something redundant being dropped, something new added, and this had always been quietly going on, but in 1922 it was felt to be inevitable to extend the length of the course from five to six years, the change entailing some reorganization in the earlier years but mainly extending the length of the clinical period.

Not only the Medical School but the whole University suffered a devastating loss when one of its most outstanding graduates, John Hunter, who had been appointed Professor of Anatomy in 1922, died in Engand in 1924, from an illness contracted while on a lecturing tour of the United States of America. In the following year the Chair of Anatomy was accepted by Professor Burkitt.

In 1924 the Senate adopted the report of a Committee set up at the instigation of one of its members, Dame Constance Darcy, recommending the establishment of a Chair in Obstetrics, and in 1925 Professor J. C. Windeyer accepted a part-time professor-ship in Obstetrics, being promoted to full-time professor in the subject in 1933.

A notable event in 1927 was the receipt of a gift from a great philanthropist, George H. Bosch, to found a Chair in Histology, to which Professor Stump was appointed. This generous gift was followed two years later by a very much larger one, given for the purpose of establishing three full-time Chairs — in Medicine, Surgery and Bacteriology, and in 1930 Professor Lambie was appointed to the Chair in Medicine, Professor Dew to that in Surgery and Professor Ward to the Chair of Bacteriology.

Acknowledgements...

I should like to record my gratitude to all those who contributed articles; for their enthusiasm and good humour, even when given short notice.

My thanks are also due to Mrs. Nicholas and to Burwood Press, for invaluable help.

— Ann Jervie.

Under the guidance of the greatly increased professorial staff the course ran smoothly and nothing notable occurred till the Second World War broke out in 1939. As was the case in World War 1, the immediate effect was a reduction in the numbers entering the school, but when it became evident that victory was in sight there was a great wave of anxiety as to how the school would be able to deal with the large numbers that would be likely to seek admission on discharge from the forces. There were many, chiefly outside the University, who said that it would be impossible to deal adequately with such large numbers and that the standards would deteriorate unless some restriction were exercised. Most of those in the school felt that though the strain on the teaching staff would be very heavy, there would be no need for the standard to decline, and to many it was a happy chance that under The University Act entry could not denied to any

How great was the task that was faced can best be apreciated by noting that the actual numbers in the Faculty mounted from 867 in 1939 to 1,159 in 1945, and 1,921 in 1948. The strain was most severely felt by the teaching staff in the preclinical years, as the position in the clinical years was greatly eased when, in 1949, the Repatriation General Hospital at Concord, and the Rachel Forster Hospital consented to become temporary Clinical Schools.

The whole staff of the School rose to the occasion as it had done in the 1914-18 war and time has shown that the undergraduates who attended those crowded lecture rooms and laboratories are no less competent doctors to-day than their predecessors who were taught in much smaller groups.

It was during this war period that Professor John Windeyer, after devoting sixteen years to building up a first-rate Department of Obstetrics, reached the retiring age and in 1941 he was succeeded by Professor Bruce Mayes, who has in the succeeding years fully maintained the high standard of training set by his predecessor.

Additional facilities for clinical teaching became available when after some preliminary discussion in 1947 between representatives of the University and the Board of Directors of the Royal North Shore Hospital, it was decided to recognise the hospital as a Clinical School for medical undergraduates and the School was formally inaugurated in 1948. Clinical lectures are delivered in accordance with the University curriculum, and thanks to the enthusiasm of the teaching staff the School has achieved great success, the percentage of passes among the students presenting themselves at the final year examinations having been uniformly very high.

After the first two or three post-war years the numbers of undergraduates registering in the Faculty began to decline, but in keeping with the rapid growth in the general population, it is now showing a tendency to rise again rather steeply.

Speaking generally, since the conclusion of the last war the work in the Medical Faculty has proceeded smoothly, the most notable events that should be recorded being a number of changes in the professorial staff during the past six years. When Professor Ward reached the retiring age, Professor de Burgh succeeded to the Chair of Bacteriology in 1952, and the following year Professor Magarey succeeded Professor Inglis in the Chair of Pathology. When the Chair of Anatomy became vacant owing to the retirement of Professor Birkitt through ill-health, Professor MacIntosh accepted it in 1955, and in 1956, after rather prolonged negotiations between the University and the State Government, Professor Trethowan became the first Professor in Psychiatry, while on the retirement in 1956 of Professor Dew from the Chair in Surgery and Professor Lambie from that in Medicine, Professor Loewenthal became Professor in Surgery and Professor Blackburn in Medicine.

Reference has been made to such notable changes in the curriculum as the extension of the course from four years to five years and later from five years to six years, but throughout the seventy five years of the history of the School less spectacular changes have been constantly taking place as new knowledge has been incorporated in the various fields of instruction. While it is inevitable that medical education will be always one step behind medical knowledge, the Faculty has endeavoured to secure that its course of study should be as little behind as possible. In this effort it has always looked for assistance from its professorial staff. Particularly has assistance come from new occupants of the Chairs who are naturally zealous to incorporate most recent knowledge in their courses of instruction. So long as this zeal continues, the standard of medical education in the University will be maintained at a high level.

Before concluding, some reference should be made to the Post-Graduate teaching that has become an increasing concern of the Faculty in recent years. Since early in the present century there has been a growing appreciation of the need for practising doctors to have access to the new knowledge that is constantly becoming available in all fields of medical learning, but for many years it was only by going abroad that a young Australian could obtain systematic post-graduate instruction. As this avenue was obviously open to only a very limited number of practitioners, the Council of the New South Wales Branch of the British Medical Association determined that it was fully time to provide facilities for the instruction of those who had to stay at home, and in 1932 established a Post-Graduate Committee in Medicine. Three years later, in 1935, the Senate of the University amended its By-Laws to enable it to take over the Post-Graduate Committee, which has since that date functioned as an important University Committee. This is not the place to refer personally to the many members of the profession who have assisted in the development of what has now become an extremely efficient organization, especially planned to meet the needs of a large, rather sparsely settled State like that of New South Wales, but one name can hardly be omitted — that of Dr. Victor Coppleston, for there is no doubt that the present high status of the Post-Graduate Committee in Medicine is in the main due to his unity of purpose, enthusiasm and drive.

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FORERUNNERS IN SURGERY

— DOUGLAS MILLER, F.R.A.C.S.

There are few public responsibilities as heavy as that of being appointed to the task of teaching and training students in Surgery.

Frederick Milford had the honour to be the first lecturer in Surgery at the Sydney Medical School. This appointment came to him in 1884 when he was fifty years old. It was an appropriate appointment, for he had been the first at other things too. He had been the first to walk the wards of Sydney Hospital as a student attached to that colourful and fascinating character, Charles Nathan. Then he had gone abroad and studied in the famous wards of "Barts", but had elected to take his degree of M.D. at the ancient University of Heidelberg, a fact of which he was always very proud. In those days, of course, aspirant doctors from this land had to go overseas for training and qualification, and it was common enough for them to choose the great schools of Europe for their Alma Mater. Heidelberg, Brussels, Paris, were chosen almost as commonly as Edinburgh and London.

Milford had the advantages of belonging to a well respected family, his father being a Justice of the Supreme Court, and of being endowed in unusual degree with personal characteristics of courage and enterprise. These were indeed days when a surgeon required great courage, exact knowledge and manual alacrity to compensate for the primitive state of anaesthesia and to enable him to support a life heavily burdened by suffering and disease he could not alleviate and an operative mortality of tragic incidence he could not understand. Then, as to-day, the young graduate sought eagerly for a hospital in which to gain experience. He was fortunate in 1859 in being appointed surgeon to the young St. Vincent's Hospital, where he worked hard and constantly until his appointment as the first lecturer in Surgery, which obliged him to undertake the care of beds at Royal Prince Alfred Hospital.

These were the days of the dawn of antiseptic Listerian surgery and young Alexander MacCormick was demonstrating the strange culture to sceptical and amused colleagues. Milford, a man of iron determination and a good deal of stubbornness, was not to be influenced by these new-fangled ideas. Indeed, until his death he was never converted and was known among students good naturedly as "Old Pus", for he continued to hold strange ideas about the origin of infection, attributing evil influence to the west wind in particular, and scorning the new idea. If he made few contributions to Surgery, he made many to his profession, being one of the founders of the Australian Medical Association, and later of the Branch of the British Medical Association. He started and ran the medical paper known as the Medical Gazette largely at his own expense, both as financier and contributor, until he could support it no longer, and then he was later the honorary editor of our Medical Journal af Australia when it started. The Medical Benevolent Association he also pioneered. All these activities made him a benefactor to the men of his day and to all who have come after.

Keen of eye, short of stature, emphatic in expression and strong in his convictions to the end, this colourful figure who had been such an influence in public life for so long, was taken to his reward in 1902.

As Lecturer in Surgery he had been succeeded by Alexander MacCormick in 1889. This young Scottish graduate had arrived in Sydney in 1883, brought by Anderson Stuart as demonstrator in Anatomy. He was possessed of a fine knowledge of Anatomy and was fired by enthusiasm for the new Listerian principles. On being appointed to the Royal Prince Alfred Hospital as Surgeon, he was given two beds.

Soon the amusement of senior colleaues at this envoy of Listerism turned to wonder and perhaps to envy and opposition, as they realised that through these two beds more patients passed to recovery than went through their own 60 beds. MacCormick had operative dexterity, courage and enterprise and soon was pioneering abdominal and advanced soon was pioneering abdominal and advanced cancer surgery in this State. His ascendancy was not to be disputed and he reigned unchallenged leader of Sydney surgery for over fifty years. Strong physically and intellectually direct, he was gifted with a strong grip of first principles, an almost intuitive judgment and a mind ever to remain critical but receptive to new ideas. The unfortunate thing about this new lecturer was that he could not teach. He was very inarticulate and at his best his teaching was epigrammatic. It could have been said of him, as of the great Syme, that he never wasted a word, a drop of blood, or a drop of ink. These may be good characteristics, but not in a lecturer.

MacCorwick religiously delivered his lectures unusually early in the morning—so as not to intefrere with practice—and I have heard that he usually read them out of one of those synoptic text books of Surgery. There is no doubt that they were very dull. MacCormack gained and stored an experience given to a few men, but as he was sparing with the pen, as with the word, most of this treasure has been lost. He had a prodigious memory to which he trusted rather than to those records which he hardly ever kept. In the latter years of his life he could trace the occurrence of disease in families he had cared for and remember them all in vivid detail. He was at his best in the operating theatre, where his demeanour was always serious and dignified. Hs technique was so gentle and clean and his operations not prolonged by purposeless pottering or hindered by indecision. He made up his mind quickly and did what he had to do deftly and finished each step with meticulous care. Himself never having an eye on the clock, onlookers were impressed by his performance time. He scorned the surgeon who fussed or flourished and was amused by professional flambuoyance. He knew surgeons the world over, for he was a great traveller and liked to visit foreign clinics. He was a very kindly doctor whose very presence gave heart to his patients, and he never spared himself in their care or became casual about their welfare. Charitable to the poor, he had a good idea of the value of his services to those who could afford to pay for them.

In those Sydney days surgery was rather provincial, but he who might so easily have done so never relaxed effort or became self-satisfied, but maintained an internationa1 standard and status. It is a never-ending pity that his influence did not extend far beyond his immediate associates.

He lived on a dignified scale as befitted one who had amassed a great fortune. Fifty years of high income, minimal taxation and fortunate investments had made him a millionaire. It was not in his character to be ostentatious or extravagant, but he did love a beautiful yacht, and in this alone he was self indulgent. He owned a succession of beautiful craft, in one of which "Ada" he sailed from the Firth of Forth to Sydney when he was in his seventies and with a very small crew. He was never so happy as when on the open sea, whatever the weather.

The pity about MacCormick was that he gave so little back to Surgery that had given him so much. He took no interest in the public affairs of the profession, was a name only in the foundation of the Royal Australasian College of Surgeons, and made no benefactions, as did Gordon Craig for the training of surgeons and the betterment of surgery.

He was well over seventy when with no evidence of failing competence he relinquished practice, and left the land of his adoption to live in the Isle of Jersey.

There, when he was over ninety, he was laid to his rest, and is remembered now with affection and respect by a few remaining disciples and too soon will be erased from human memory.

MacCormick was succeeded by Francis Percival Sandes, who was appointed Lecturer in Surgery in 1915, and first McCaughey professor in 1921.

Sands had a good academic Sydney record, but had not studied elsewhere and lacked what we today could consider proper surgical training. The appointment of professor was part time and probably was a small advance on the practice of having lectures. His was an attractive personality, for he was friendly, approachable and had a good sense of humour. As a public speaker he could rise at times to certain heights, but as a lecturer he was dreary and most soporific. His approach to the sacred trust of practical surgery often seemed to be carefree to the point of frivolity, an attitude which did not make a good impression on most students, and may have detracted from his success in consulting practice.

He had to cope with the instruction of those very large years that followed the first world war, and it may be he had but poor support, it may be that he was a bad organiser, but whatever the reason, the teaching of surgery at this time under his leadership was indifferent and casual. So many teaching rounds were hurried affairs in which the most valuable remarks of a successful surgeon might amount to "Gall bladder, we did him yesterday", and at the next bed, "Hernia, we will do him to-morrow". There was at this time no plan in the teaching of surgery and but a poor tradition. Indeed in the training of young surgeons suppression often seemed to be more important than apprenticeship. The value of study and qualification overseas was disparaged and in short, Sydney was very much the preserve of the parochial.

In the late twenties, largely owing to the influence of Professor C. W. Stump, a substantial benefaction from Mr. G. H. Bosch led to the foundation of a full-time Chair of Surgery.

Sandes had retired in 1927 in order to be-

come director of cancer treatment under the aegis of a very ill-omened University Cancer Appeal organisation. In this position he probably achieved more than as professor of Surgery. He awakened interest in the various forms of cancer treatment and stimulated the formation of consultative panels in the teaching hospitals.

I think he enjoyed most of this free lance experimental period of his career. In 1945 he died, having in his day filled many offices and done much hard work in the faculty.

When in 1927 Sandes retired from the chair, Mr. B. T. Edye was appointed lecturer in Surgery, and the following year Acting Professor, which he continued to be until 1931 when the first Bosch professor was appointed.

Harold Dew came from Melbourne. A fellow of the Royal College of Surgeons and a recent winner of the Jacksonian Prize, regarded in Melbourne as a man of considerable drive and vigour, his arrival looked a happy day for Sydney surgery. He soon collected around him some younger men and breathed his own enthusiasm into their spirits. He was always an eager helper in any problem, and to his early stimulus we owe the overdue establishment of the specialty of Neuro-surgery. Dew had to face many difficulties and was frustrated at many vital junctures, but he led Sydney surgery out of a morass hedged by indifferent standards. For many years then he became Dean of the Faculty and had to devote his valuable time to coping with the unparalleled difficulties of the enormous post war years. Soon he was to become known as the Dean rather than the Professor of Surgery.

In the last years of his work he was deservedly honoured by being President of the Royal Australasian College, Simms Commonwealth travelling Professor, and by knighthood.

He left Sydney the richer only by thousands of grateful friends among his students and colleagues, and in that he had established for all time the justification of a full-time Chair of Surgery. He broke through difficult and heavy ground, and has left open to his own student successor wide and promising fields for further cultivation.

Men of Medicine, the University's Origin and Her Development

— by DAVID S. MACMILLAN, University Archivist

There is good reason to believe that the first man in the Colony of New South Wales to press constantly the idea of founding a University, was a Medical Practitioner.

The name of Henry Grattan Douglass is omitted from many Australian dictionaries and biographies and lists of noble men, for he played no prominent part in the turbulent politics of the 1840's in Australia. Born in 1790, he was very young when he served in the Peninsula and later in the West Indies during the Napoleonic Wars.

A miniature of Douglass which has recently come to light, shows him in the uniform of an assistant surgeon with the 18th Regiment of Foot. It must have been painted shortly before he was invalided home to Britain where he resumed his medical studies. Douglass graduated M.R.C.S. in 1815, and in 1819 he graduated M.D. at Dublin. Having qualified, he left his native Ireland and proceeded to London, where he was associated with Elizabeth Fry in the cause of Prison Reform. In May 1821 he arrived in Sydney in the vessel "Speke" and became a surgeon at Parramatta. Douglass was a friend of W. C. Wentworth and of Charles Nicholson, and as early as the 1830's he was putting forward the idea of establishing a University on similar lines to those on which the then new new University of London had been founded.

As was fitting, Douglass soon became a member of the University Senate. He was not one of those appointed by proclamation on the 24th December, 1850, to the first Senate, but in 1853 became a member and continued in this capacity until his death in 1865. The first Senate of 1850 contained two medical men; Charles Nicholson and Bartholomew O'Brien. During his service on the Senate, Douglass pressed for the establishment of a medical school, but in view of the smallness of the early grant made by the Government to the University, funds were not available for this purpose. In consequence, Sydney University lost students to Melbourne, which had a medical school from its foundation in 1857.

Another outstanding figure in the earliest days of the University was Professor John Smith, first Professor of Chemistry and Experimental Philosophy. Smith graduated M.D. at Aberdeen shortly before applying for the post of Professor of Chemistry at Sydney, and he, too, was anxious to see a medical school set up at the University. Smith's specialty as a chemist was water analysis. He served as Chairman of the New South Wales Water Board for many years and he advanced interesting theories on the effect of water supply on health — then a very new field of investigation. Smith was an energetic and capable individual and like many men of science at that time, he took up the new art of photography. Then in its early stages, photography in the 1850's and 1860's required a deft manipulation of many chemicals after exposure of the Collodion covered glass plates that were used instead of film. Smith's photographs show considerable artistic ability and a high level of technical excellence. In 1955 several hundred of his negatives came to light in the University — the largest collection of photographic material of this period to be discovered so far in Australia. Several of Smith's photographs illustrate this article. He had a wide range of subjects — family groups, views of Sydney, landscapes photographed during his many journeyings in New South Wales and beyond in connection with his scientific activities. Most interesting of all, however, is the record of the construction of the University of Sydney, for many of his photographs show the main building and Great Hall under construction in the latter 1850's. No other university founded and built at that time possesses such a photographic record.

The University of Sydney under construction, 1857. This photograph, taken by Professor John Smith, shows the front of the main building, with the Great Tower half completed. The Great Hall is shown on the right, completely roofed. By this time, classes had begun in the part of the University between the Tower and the Great Hall.

The Act of Incorporation of the University provided for the recognition of medical institutes and schools "whether in the Colony or in foreign parts" from which it might be expedient to admit candidates for medical degrees. Until the establishment of a complete medical school at the University in 1882, there was a standing Board of Examiners to test the qualifications of candidates. The requirements in this pre-medical school era were high. The Standing Board of Examiners required evidence of sufficient general education and of having completed four years' attendance at a recognised medical school. The first Board of Examiners consisted of Dr. A. M. a'Beckett, Dr. George Bennett, Dr. Richard Greenup, Dr. J. MacFarland, Dr. D. M. McEwen, Dr. Charles Nathan, Dr. James Robertson and Dr. George West.

In 1859, when the new University buildings were finally occupied, a scheme of teaching in Medicine was adopted and it was intended to commence these studies in 1860. Edmund Blacket, the University's Architect, was instructed by the Senate to prepare plans for an anatomical school, but the classical influence among the Professors was strong and John Woolley, Professor of Classics and Principal of the University, opposed the idea on the grounds that the institution of such studies and the establishment of a medical school would retard the completion of the curriculum in the Faculty of Arts. In addition, the University had financial difficulties and the scheme was dropped. In 1866, there were further consultations and a scheme was drawn up providing for the appointment of a Professor of Anatomy and the building of an anatomical museum. Again, due to financiad difficulties, the scheme lapsed. In the 1870's, Professor Smith and a group of progressively minded people pressed for the establishment of a Medical School. William Macleay, the acknowledged leader of the scientific circle in New South Wales, bequeathed his museum of natural history specimens to the University in 1874 and did his best, in conjunction with his father-in-law, Sir Edward Deas Thomson, to bring about the establishment of a Medical School. Macleay himself had been a medical student in Edinburgh as a young man, but the financial difficulties of his old but impoverished family had made it necessary for him to give up his course and seek a fortune on the Plains of the Murrumbidgee. He had prospered exceedingly, but he always regretted the loss of a medical and scientific career. Eventually his benefactions were to assist in bringing about the establishment of a medical school at Sydney University.

As a member of the first Senate from 1875 to his death in 1891, Macleay was able to do a great deal towards establishing and developing the facilities for training in Medicine as well as in Natural History and Geology.

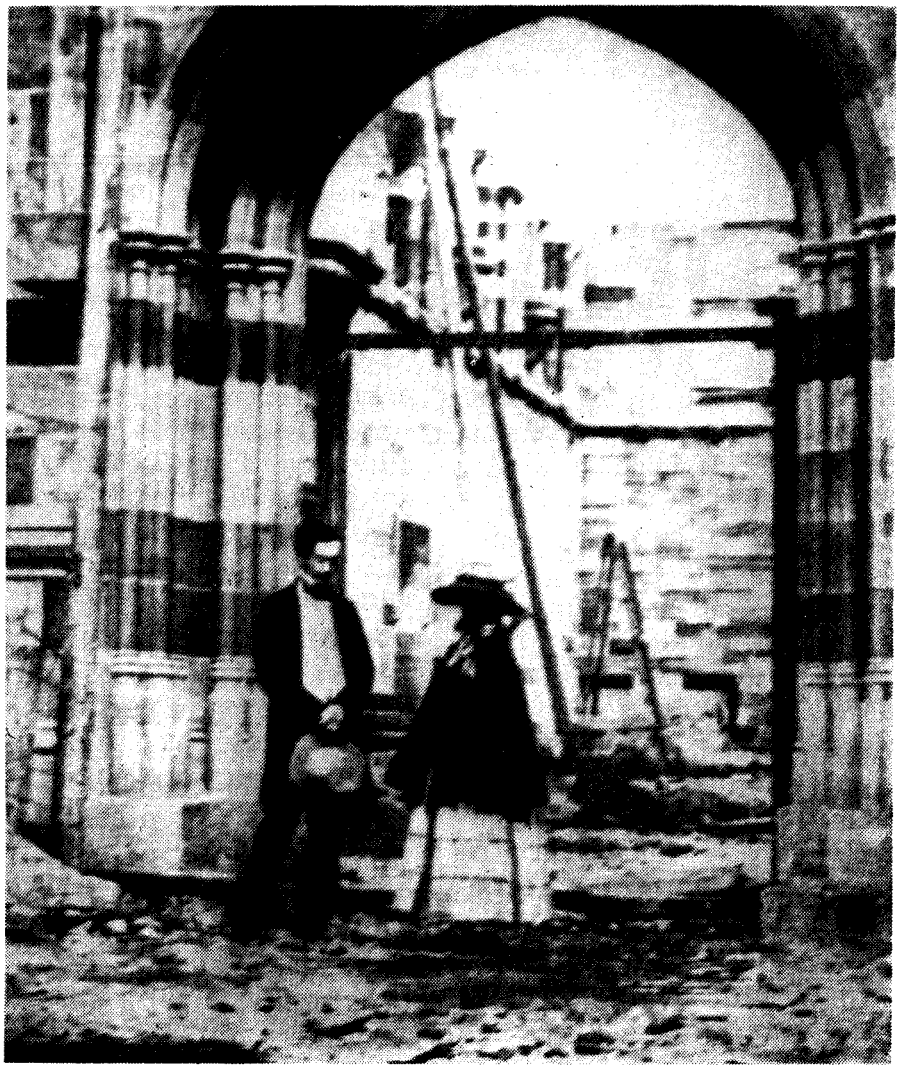
The Early Records of the University.

When investigation and survey of the early records of the University began in 1954, it was found that although the records themselves in both the Central Administration and the various Departments were scattered in various locations, there nevertheless existed a fairly complete body of material. Examination of the early letter books and Senate Minutes have shown that some of the views held in the past on the foundation of the University and on the parts played by individuals, must be revised.

It is generally accepted that W. C. Wentworth was the one great outstanding personality who brought about the foundation in 1850, but examination of the earliest records and of the political and social background of Sydney in the 1840's make it clear that although Wentworth took the lead in securing the University Act in the Colonial Legislature, the most consistent supporters and the true founders of the University were men like Dr. H. Grattan Douglass and Dr. Charles Nicholson both medical men with a taste for culture in its broader sense. Nicholson was an amazing personality, one of those who exercised terrific influence without appearing to take the lead. It was his ability in this direction that made him such a success as Speaker of the New South Wales Legislative Council between 1845 and 1855. As Vice Provost and then Chancellor of the University, Nicholson quietly but firmly guided its progress. During the 1850's when the great Sectarian Controversy raged over the part which the denominational colleges were to play in the new University, Nicholson restrained both the leaders of the Church, embattled Bishops and fire and brimstone Presbyterian Divines on the one hand and politically-minded and radically-inclined University men like John Woolley on the other — a difficult task.

The part played by Nicholson in these difficult years, right up to his final departure for Britain in 1865, has never been fully recognised. With a different hand at the helm the young University might have become a battleground and undoubtedly would have suffered the fate of universities elsewhere which too often in that age of controversy became involved in religious and political polemic.

The earliest records show that in the 1860's and the early 1870's the University of Sydney fell into rather a decline as a result of the foundation of Melbourne University with its medical school and owing to the falling-off from the first enthusiasm that greeted its foundation. Professor John Smith's photographs give many glimpses of that



Edmund Blacket, Architect of the Main Building and the Great Hall, standing with his daughter at the entrance of the half-built Great Hall about the year 1857.
(Photograph by Professor John Smith).

age, both of the period of enthusiastic foundation and the aftermath of disillusion and decline. By the early 1880's, with the great improvement in the fortune of the University, photography had become a less difficult process and there were many authors to leave a lasting photographic record of the building of the first small Medical School and its imposing successor. By 1885, the establishment of a Medical School and the great endowments of Thomas Fisher, Sir William Macleay and J. H. Challis had completely changed the picture. A new period in the history of the University had begun the growth and expansion of facilities in many directions. The trying times of the 1850's and 1860's were past and the effect of the Education Acts in the 1860's was to ensure a continual stream of students.

From the central administrative records and the Departmental records of the University, a picture can be built up of this gradual process of growth and extension. The aim is eventually to document as fully as possible every aspect of the University's history and development. Private individuals have been generous in presenting photographs and documentary material, and with the establishment of the University's Archives Repository in 1957, it became possible for this wealth of material to be gathered together in one place. The task of sorting it and processing it in such a way as to make it readily available, was begun. Such discoveries as that of the great Smith Photographic Collection have supplemented the wealth of documentary material that has survived. It is to be hoped that in the next few years more material will come to light, casting further light on the origins and growth of Australia's first university.

It will be interesting to see how many of our existing ideas about early University life in Australia will be revised in view of such discoveries.

The prescription was returned by the pharmacist after it had been dispensed. Subsequently the patient used it for years as a railway pass, twice as an invitation to a dance, once to a wedding, used it frequently as a letter of credit, and in the evening his daughter played it on the piano.

* * *

Again from Oxford University:
A lecturer in haematology: "Technology is scorned at this University unless it is so out-of-date as to be called history."

* * *

Surgeon (during circumcision): "This may look a crude operation, but it always heals well. There's a divinity that shapes our ends, rough-hew them how we will."

LAMBIE-DEW ORATION

DELIVERED BY PROFESSOR M. WINTROBE

Professor Wintrobe first of all called his oration "Medical Research and the Art of Medicine," and then filled this in by saying that he thought he would discuss questions with Medical Students which perhaps deserve some discussion.

"The Medical Student rarely gets time to stop and think what is in store for him," said Professor Wintrobe. "What is the Medicine of the future going to be?"

Professor M. Wintrobe

Having set himself the problem, he decided to look back over events in Medicine since he graduated 30 years ago, especially in his own field, haematology.

He recalled 1920 when haematology was pure morphology — merely looking at blood through a microscope. This, he pointed out, was the result of the strong impetus produced by medical student Paul Ehrlich who became interested in aniline dyes and staining.

The assembly was given fresh hope when it heard that Ehrlich was almost thrown out of Medical School.

"He was a poor student, but a special student," continued Professor Wintrobe. "In his spare time he used to 'probe around' in the Professor's laboratory, and now we know just how much he accomplished. He has been called the "Father of the Therapeutic Age."

In the twenties, Professor Wintrobe went on, the understanding of the physiology of formation of the cellular elements was primitive, and here, to bear out his point, he cited the roughness of classification of anaemias.

In 1926, liver therapy was introduced for the treatment of pernicious anaemia— still without any knowledge of the physiological factors in the disease.

But at this time, fertile seeds were being sown. The dynamic stage was in progress.

The Professor related Whipple's trials on anaemic animals to determine the dietary factors necessary for the normal production of Red Blood Cells, and showed how these experiments led to the use by Minot and Murphy of liver for the treatment of pernicious anaemia.

Workers now began to learn more about the basic physiological processes. The observations of Minot stimulated Castle, then a young man in a laboratory, to further investigate anaemia. As a result he performed his now classical experiment with beef muscle, and attention began to veer away from what Professor Wintrobe termed the "sterile" concept of primary and secondary anaemias.

More followed about other advances in the various sections of haematology — coagulation and so on.

Professor Wintrobe took his listeners back over 400 years of medicine to what he termed the "anatomical" period, which began with Vesalius, through the "physiological" period of William Harvey, and the "aetiologic" period, which featured people such as Pasteur and Koch.

"If we look on events in medical history in that way, we can say that we are now in the "therapeutic" age and on the verge of preventive medicine," said the Professor. "It is clear that medicine has advanced vastly in six decades. The basic principles have had the sciences grafted on to them."

He cited as the best example of the integration of the sciences of physics, chemistry, genetics, and the principles of

clinical medicine, Pauling's discovery that as a result of an abnormality in one amino acid in one protein in red blood cells, a complex series of clinical events and pathological changes takes place. Until Pauling's discovery this series made no sense. The professor was referring to "Sickle Cell" anaemia. Since then a whole series of similar diseases has been discovered having not only clinical implications explaining disease, but having also added to khowledge of man's genetic progress.

From this joyous and triumphant note, Professor Wintrobe became a little sombre and, to the dismay of the Medical students, announced that the graduate of today must be familiar with preclinical science. He must be a student all his days, and must understand research reports and methods.

He would have to distinguish research reports not founded on sound study from the scholarly report based on sound experimental principles.

Professor Wintrobe pointed out the tendency in some quarters to consider the research man a vastly different individual from the practising physician, and then strongly denied that such a strong distinction existed. "Both must be able to think clearly, and to work out evidence, being sceptical of their own observations the while," postulated the Professor. "What is good differential diagnosis but research applied to the problem of the individual patient?" He poined out that both could be good or bad at their particular job.

The future of medicine was the final thing to attract the professor's attention, and he predicted an increase in the understanding of disease, more exact methods of diagnosis and more specific methods of treatment. Thus the great medical problems of the past (e.g. infections) will become less prominent, and will be replaced by others, mainly the degenerative disorders, malignant disease and the genetically controlled abnormalities.

"What will this require of the doctor of the future?" asked Professor Wintrobe. "He will have to know more and more. He must be a student all his days or he had better not start. The teachers must ask themselves how they can best prepare the students for this. No student is capable of knowing everything that is to be known about medicine in the present day. The alternative is to teach the student how to learn for himself—to stimulate and guide him and to show how one proceeds to find out more."

The professor suggested that the student be given opportunity to intensively study comparatively few patients rather than to study many superficially.

To learning and scholarship must be added certain qualities of the good physician — this is the art of medicine.

First, said Professor Wintrobe, he must be conscientious and thorough: "any physician with experience will repeatedly say, and cite experience to prove, that good history and thorough physical examination are essential. There are no short cuts to these. In short, the good physician must be a superb detective."

The next qualifications are that he must be imaginative and factual, of good judgment, discretion and wisdom. He must be able to see the forest as well as the trees, and the trees are getting very numerous. He will pick up many minutiae, and will have to determine what is meaningful and what is superfluous.

The students were told that they must:

- know when to act and when to restrain themselves from action,
- be critical of themselves and others,
- be cultured with economical, political and social awareness;
- and above all: **Be Human beings.**

"The true physician cares for people," said Professor Wintrobe. "He must have a Shakespearean breadth of understanding of the various types of people he will encounter in his practice.

"No one can be all these things," concluded the professor, "but the nearer a person approaches them, to that extent the nearer he is to being a good physician."

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WOMEN IN MEDICINE

— KAY BARNES, Med. III

The feelings of men towards professional women throughout the ages is effectively expressed in the following quotation from an address by the President of the American Medical Association in 1871: "In every department of active life, man excels woman, excels her even in things for which she is deemed most fit . . . We believe that all experience teaches that woman is characterised by a combination of distinctive qualities, of which the most striking are uncerainty of rational judgement, capriciousness of sentiment, fickleness of purpose and indecision of action which totally unfit her for professional pursuits."

In early days, the tending of the sick was an important part of the life of the convents. All abbesses and nuns were expected to undertake the work, some indeed had a great and honorable reputation for their skill in the art; others, royal and titled ladies, also practised Medicine. Among the Greeks there were celebrated women physicians; there is, in Tunis, an inscription to a woman doctor dating from the third century.

In a French manuscript of the fourteenth century there is a delightful picture of two women surgeons examining a patient's liver, and the existence of women in medical practice is accepted as commonplace. In Italy, where scientific studies were at an early date more advanced than elsewhere in Europe, the Universities were open to women, who not only learned, but also taught in them. In the eleventh century Salerno School there were female professors in the faculty and gradually the department for the diseases for women was handed over entirely to women. Among distinguished professors was Trotula, whose books on Gynaecology were studied for 500 years.

Occasionally, there were outbursts of hostility from the men. A pleasant tale of Athens tells of the passing of a law to prohibit the practice of Medicine by women. A noblewoman, horrified at the low standard of male practitioners, disguised herself as a man, studied medicine and practised most successfully among women. Her disguise being penetrated, she was condemned to death; whereupon her patients invaded the court, threatening to abandon their homes and husbands unless the sentence was reversed and the law repealed.

Quackery became rife, one, Joanna Stephens, claimed to be able to remove stones from the bladder, and many eminent patients testified to the efficacy of her potion. She sold the medicine to the British Government in 1739 for £5,000, when it was found to consist of nothing but saponified snails.

Women distinguished themselves from the outset in America. At the time of the first colony there was a female physician, reputedly a witch, named Margaret Jones, who was imprisoned in 1648 and later executed for witchcraft — the first execution in the Colony.

The first recorded English-speaking woman doctor with qualifications was Dr. Barry, who served in the British Army for more than 50 years, rising by a series of steady promotions to the highest rank in the Medical Service—Inspector-General of Hospitals. Her success was undoubtedly due to the fact that it was not until her death in 1865, when her Army colleagues performed an autopsy that the secret of her real sex was discovered. This revolution threw the mid-Victorian British War Office into a state of panic. Dr. James Barry had joined the army as a man, had worn a trousered uniform, and had been cited for bravery at the Battle of Waterloo! She scored one of the most remarkable records for sex impersonation of all time.

America can claim he first woman medical graduate, Elizabeth Blackwell (1821-1910), who had emigrated from England. Her father, believing in the equality of the sexes, gave all his children a similar education and thus Elizabeth was used to working with the opposite sex. The suggestion that she should become a doctor came from a friend dying of cancer who said: "If I could have been treated by a lady doctor, I should have been spared half of my suffering." Elizabeth recoiled from the suggestion, but her upbringing made it impossible to reject an opportunity of service merely because it was distasteful. While thus vacillating, she fell in love but decided to sever the connection because, as she remarked at the time, she had a distinct presentment that "his views were too narrow and rigid to allow of a close companionship." She elected to study in Medicine partly because she felt it her duty and partly to free her from this entanglement.

She wrote to doctors of her acquaintance asking about opportunities for training and the replies were unanimous: "The idea was a good one, but impossible to accomplish." Henceforth she had no doubt of her vocation to study medicine as the answers roused in her all the pugnacity inherited from her dissenting, reforming forbears. After an unsuccessful attempt to enter Philadelphia Medical College, she applied to the University of Geneva (N.Y.), where she was admitted on a vote of the students.

Her course was completed in 1848, but at the last minute the Senate of the University hesitated — to give a woman an M.D. seemed almost too daring. After an impassioned address by the Dean, the Senate yielded. Elizabeth had achieved best results in the class. She became news, everyone was eager to see her and "Punch" saluted her in verse. Although enjoying the publicity, Elizabeth was eager for more experience and went to France where, despite rumours of equal opportunities for women in Medicine she found that she could be accepted only by "La Maternité", the national training centre for midwives. Here she spent one difficult year so that she might become the best obstetrician, male or female, in America. From there she spent a year in practice at St. Bartholomew's in London before returning to New York and establishing a successful "New York Infirmary for Women and Children".

The arrival of Dr. Blackwell in London to practise caused such a wave of horror through the profession that a Medical Act was passed to make sure she had no imitators; for the idea of women prying into the secrets of anatomy, and in the company of men, struck most Victorians as the last word in immodesty and immorality. So with this Act and a "gentleman's" agreement between all the recognised Medical Schools in England the men felt themselves safe from petticoat invasions. But they had reckoned without Elizabeth Garrett whose enthusiasm had been kindled toward medicine by Elizabeth Blackwell.

Elizabeth Garrett (1836-1917) came of a large British middle-class family and her father gave all his children an excellent education. At the time when she was faced with spending week after tedious week helping her mother in the house, she heard Dr. Blackwell speak, and she determined to study medicine. Dr. Hawes, of the Middlesex Hospital, suggested that she should spend some time testing her powers of endurance by working as a hospital nurse — an occupation in the pre-Listerian days designed to daunt her spirit — but she loved the work and was treated more as a student than as a nurse.

Despite the many unsuccessful attempts to enter the hospital as a student, she persisted, and in 1861 was successful in enrolling for some lectures. She paid her fees and wrote triumphantly: "I have had to sign my name in the College books in token that I will not smoke, but will in every way comport myself as a gentleman."

In the examinations she gained a certificate of Honour in every subject. The deflated male students then demanded that she be expelled and they manoeuvred her removal from the hospital. It was a bitter blow, but she had become sure of her cause.

She then discovered that there was nothing in the charter of the Society of Apothecaries (overlooked in the Medical Act) to prevent her receiving their licence after apprenticeship for 5 years and instruction from recognised tutors (which was only possible, for her, privately). By 1865 she was ready, and applied to the Society for examination. Both furious and embarrassed, the Apothecaries at first refused, but capitulated with the threat of legal action, and Elizabeth passed with credit. The Society prevented a recurrence of the disaster by immediately passing a resolution that future candidates for their diploma must have worked in a recognised School.

For Elizabeth Garrett, too, the battle had been won. Active leadership in the campaign then passed to Sophia Jex-Blake (1840-1913), who enrolled in Boston Medical School whilst in America studying education reforms. On her father's death and her recall to England, she was advised to try Edinburgh University. She found four supporters, and after much controversy, they obtained permission to sit for the matriculation examination. They passed (well above average) and thus became the first women undergraduates in a British University. Their opponents sat back and waited for the enthusiastic women to fail, but at the end of the year their complacency was rudely shattered. No woman had failed, four out of five had gained Honours, and, worst of all, one had the temerity to top Chemistry!

The faculty immediately expelled the women who lost a Court case aiming to achieve their reinstatement. (The judge was notably anti-women). It was a dismal end to a gallant fight; but they now had much support and had proved that the female brain, though smaller, was by no means inferior.

Meanwhile, Elizabeth Garrett had established "St. Mary's Dispensary for Women" (later the New Hospital for Women) and a solid reputation for herself. In 1871, she married J. G. Anderson, proving herself to be a competent physician, wife and mother. After meeting her on her brief visit to Sydney, Dr. Scot-Skirving remarked that he "was very much impressed by her wisdom and ability."

With all doors closed to them in Great Britain, Sophia Jex-Blake and her supporters decided to establish a Medical School for Women in London, and generous public finance was made available. The school was opened in 1874, staffed by professors and doctors already recognised by the London schools: the numbers in the first session increased from 14 to 23.

In 1875, a Bill "to give Universities the power to admit women and to grant degrees to women" was introduced into Parliament. The debate lasted three days, and the Bill was finally passed after the Medical Council resolved that "The Medical Council is of the opinion that the study and practice of Medicine and Surgery . . . present special difficulties to women . . . but the Council is not prepared to say that women ought to be excluded from the profession."

This represented the turning-point, but victory was not yet assured; teaching had still to be made available to the 17 students of the London School of Medicine for Women. Application to the London Hospital was refused, but the Royal Free Hospital in Gray's Inn Road, although dubious, accepted the women.

As the School of Medicine for Women became firmly established, it became necessary to elect a secretary. Although coveting the position, and despite the fact that the establishment of the school was her work, Sophia Jex-Blake was considered too headstrong and capricious for the post, which was awarded to Isabel Thorne. Bitterly disappointed but generously realising the reasons for her non-appointment, Sophia elected to

practice in Edinburgh. The debt owed by medical women to her cannot be estimated. She established the entry of women into the profession, but by her founding the London School of Medicine for Women she did much more than this: she ensured that women entering the profession were welcomed rather than tolerated, (as proved to be the development in France.) There, the women doctors had to remain content to be dressers and assistants, only, watching with envy their English colleagues running hospitals and taking responsibility during World War I.

In 1883, with the appointment of Elizabeth Garrett Anderson as Dean, the London School was extended, and later modernised. The successful, established, stable school which she left after her retirement in 1903 was largely due to her vision and guidance. In 1896 the East Anglia Branch of the B.M.A. paid tribute to her character and leadership when she was invited to become its President.

In Australia, Constance Stone battled unsuccessfully to enter the University of Melbourne between the years 1881-1884, and later obtained a degree in the United States. After this, a group of female medical students were successful, despite opposition, in entering the Melbourne Univerity. In Sydney, Dagmar Berne entered the faculty of medicine in 1884, the first woman to do this. However, she graduated from Edinburgh, not Sydney; the first women to graduate from Sydney were Ida F. Coghlan and Grace T. Robinson in 1893.

Further acceptance of women into medicine was achieved when, at a time with the rights of women as a burning question, the excellence of women doctors serving on battlefields in the first World War convinced the British War Office of the necessity of appointing women to the Forces. At the beginning of the war, limited fields had been indicated in which it was thought that women might give "adequate" service. By the end of the war, the women had proved themselves; they had put into the field and had maintained many units entirely organised and staffed by women; these had proved to be efficient and economically run. The courage and competence of the women was recognised by all, English and Allies, evidence that the claims made by the women's movement over half a century were justified.

The final acceptance of the women and the recognition of the excellence of their service came after the war with the establishment of the principle of equal pay (as the result of a protracted battle). But even now, a woman applying for a post must be just a little better than the best man if she is to be appointed. Nonetheless, the principle has been established that appointments are open to all, equally paid and awarded irrespective of sex. Today, women doctors in Great Britain number more than 7,000 (about 10 per cent. of the total registered practitioners) and in Australia, over 1,000 (again 10 per cent.).

In the future, men and women working together in the profession face a task of immense complexity. In the modern conception of medicine, it is not merely the science of healing but the whole art of healthy living for which a nation looks to its doctors for guidance. It is well, in view of the problems to be faced, that energy is no longer to be dissipated in a fruitless struggle between the sexes.

Whisper Who Dares

"or, A FRESHER ORIENTATES

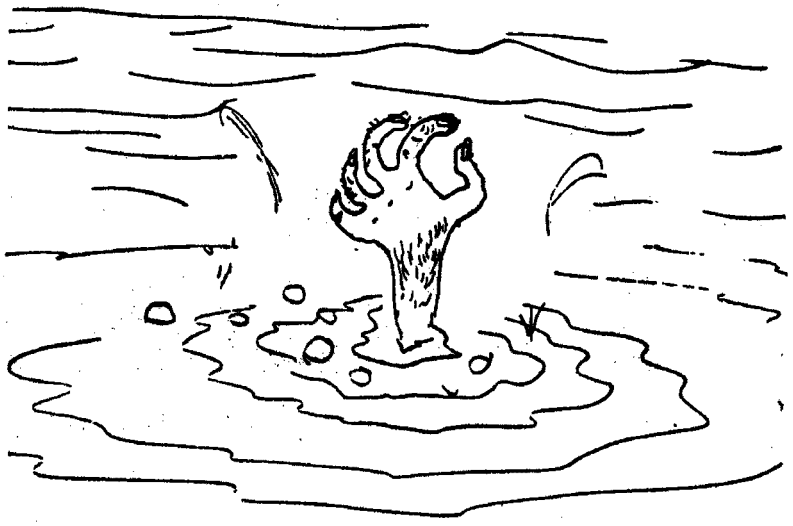
Of course, the first thing to do was to make a grand survey of the country she was going to travel through. It's something like learning Geography, thought Alice. — *ALICE THROUGH THE LOOKING GLASS.*

As a tyro first year student, a "Fresher" I believe I am called, I would not have the temerity to draw attention to myself in company if I had not been expressly asked to do so. Your Editor complained that no "Fresher" contributed to this journal, and I honestly felt that on behalf of all the stunned and awestruck mob who are milling about the grounds this week, someone should say thank you . . . THANK YOU, CHAPS !

Believe me, we are grateful. And don't think we are not aware of the time and effort you have given for us. We only hope that after a few years of following your footsteps we will be as generous and thoughtful of others as you have shown yourselves during this, our introduction to you. Particularly are we impressed by the fact that the academic staff should find time to speak to us in an informal manner on subjects not strictly academic. We wish we know how to thank them, not only for their time, but also for the kindly words of advice and observations of wisdom they have all so carefully given us. Our eminent Dean referred to us as "colleagues" which was rather breath-taking, but while appreciating his sense of humour, we hope that one distant day we can approach nearer to the state of having earned this generous title.

This gentle form of initiation is far different from what one usually associates with the joining of select groups, clubs or fraternities. This, our first impression, is one of fellowship and welcome which henceforth will be associated in our uncouth minds with such ideas as "culture", "duty" and "dedication". We hope to strive so that some day we will no longer be uncouth, but will be, as the barmaid said, "As couth as you are".

It is, of course, pointless mentioning our feelings or making observations, for you have all been through it; you already know it all. However, we do have one unique quality that distinguishes us above all others, albeit briefly, but here we stand, more honourable than any order in existance, being the order of Innocence. But let's face it, we are now "Freshers". Which sounds like an attack of the 'flu, and is about as useful. So let's get on with the business. Sam, pick up my musket — Let battle commence !



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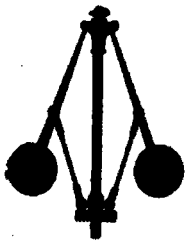

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SYMPOSIUM : 1958

A SECOND MEDICAL SCHOOL FOR N.S.W.

In this, the 75th year since medical students were first formally trained in a School in this State, it is appropriate to reflect a while on the proposal to establish a second Medical School in N.S.W. The question is highly contentious; opinions conflict on almost every point. What will be the outcome we cannot tell; but we can speculate, advise and criticise.

PROLOGUE

In 1957, the Murray Committee of Inquiry into Tertiary Education in Australia, on behalf of the Commonwealth Government, recommended the establishment of a second Medical School in N.S.W. and remarked that there was "much to be said" for siting the new school at the University of Technology.

Early in 1958, the N.S.W. Government announced, through the Minister for Health, its intention of establishing the school at Kensington at the institution to be renamed "The University of N.S.W.". A committee, chaired by Dr. K. Starr, was appointed to advise on its establishment.

Immediately the Government's apparently hasty decision was criticised by political observers, members of the Profession, other interested and even disinterested parties. The storm of bitter controversy still rages from time to time in editorials, in correspondence columns and on news pages in the downtown press.

The critics, often enraged, only sometimes informed and rarely pleased, firstly disputed the decision to rename Technology the "University of N.S.W.", although most welcomed proposals to increase the status of that body by including a long-overdue Faculty of Arts. The place of the Universities of Sydney and of N.S.W. in the community must be considered in the light of such developments.

Many have felt that the decision to establish a Medical School at Kensington was hasily arrived at, ill-conceived, and ignored the claims of other institutions. They pressed for at least a formal Commission or Committee of Inquiry into possible sites, into general principles and lines of development of medical education in N.S.W. before final decisions are reached. Others were more partisan, urging the claims of a particular institution.

Others were quick to note that only a year ago the Minister for Health himself suggested the Royal North Shore Hospital as a possible site and wondered at the suddenness of his change of opinion.

The composition and function of the Government Committee was criticised because of its apparent "weighting" in favour of two teaching hospitals at the expense of the others and of the University of Sydney. (Resignations have further increased this tendency). The publication of that Committee's recommendation of a five-year course for M.B., with an optional Honours year plus a further two years study for the B.S. if desired, re-awakened controversy.

Further problems which the critics were delighted to point out relate to the provision of teaching hospital facilities at Kensington.

Soon after the announcement of the Government's proposals, the B.M.A. set up a committee inquiring into Medical Education and their report is awaited with interest.

For different viewpoints on this complex problem, we have selected some of the conclusions reached in the lengthy Medical Society report on the problem (as presented to the B.M.A.) and have invited Dr. Douglas Piper (from the Royal North Shore Hospital) and Martin Davey (Education Officer of the N.U.A.U.S.) to contribute

FROM THE MEDICAL SOCIETY REPORT ON MEDICAL TRAINING IN N.S.W.

- **The establishment of a second Medical School in N.S.W. is urgent.**

BUT there would be no value in this unless the school undertakes to train a significant number of doctors each year — not only increasing the number of graduates to the State's requirements in each year, but also to relieve some of the pressure of grossly excessive stud- urgent reforms necessary at the University of Sydney.

- **We emphasize deficiencies in the course at the University of Sydney for two principal reasons:**

1. Money must still be made available for the urgent reforms necessary at the University of Sydney, even in the face of the enormous costs of establishing a new Medical School.
2. There are grave dangers in regarding the organisation and course at the University of Sydney as the normal for this State or even perhaps as desirable.

- **Although a host of defects is discussed, most relate to the excessive numbers of students and the comparatively small numbers of staff members. Included are:—**

1. Absence of tutorial teaching and reliance upon didactic methods of teaching only.

2. Large practical classes.
3. Lack of staff-student contact.
4. Inadequate common-room, study facilities and other amenities.
5. Absence of Distinction courses (with the exception of two departments).
6. Lack of correlation between subjects (Professor Blackburn's clinics representing here a major advance).
7. Absence of "cultural" subjects—perhaps partly overcome in the new provisions for first year, enabling students to select a subject instead of Botany.
8. Inequitable distribution of students at Teaching Hospitals:

Bed/Student Ratio	*Hospital*
2.3 : 1	R.P.A.H.
5.6 : 1	RN.S.H.
4.4 : 1	St. Vincent's
3.4 : 1	Sydney

Overseas standards are 5:1 as a minimum, 10:1 or more as ideal.

All these have resulted in high failure rates and high student wastage:

1957	*Enrolled*	*Passed*	*%*
Medicine I	497	320	65%
II	350	227	65%
III	232	213	92%
IV	216	202	94%
V	194	195	100%
VI	169	173	Not
(not including repeats)			determined

- **The relationship of any second school to the University of Sydney must be carefully considered.**

1 **Entry:** Clearly the same standards of entry must apply to both schools or there is a grave danger of one becoming a second-class institution training rejects from the first. **We feel strongly that the only entry requirement should be on matriculation.** Surveys (in Adelaide) have shown that the Leaving Certificate examination is a poor guide to University success; that the single interview is unreliable (overseas reports); and that even the most carefully designed aptitude tests are unreliable (Melbourne). There is also the problem of restricting entry into only one faculty at the University.

However if restricted entry is accepted, it must apply to all Medical Schools in the State.

2. **Course.** It is our opinion that:
   (e) The two Schools should be autonomous.
   (b) But that the standards achieved by both should be comparable,
   (c) In general principles, the course should follow the recommendations of the General Medical Council of Great Britain — i.e., a 6-year course with a basic training in Medicine, Surgery and Midwifery, so that the graduate is free, and adequately trained, to enter general practice or any specialty.

- **The siting of Medical Schools is considered, and it is felt that in general:**

1. A preclinical and a clinical school should be one unit.
2. The ideal site for both is at a University.
3. A Medical School cannot be separated from any or all of its teaching hospitals if it is to function efficiently.

No. 2

The Second Medical School

— D. W. PIPER.

The Need for a Second Medical School

There can be no doubt that Sydney University is overcrowded, and in the Faculty of Medicine this overcrowding, worse in the pre-clincal years, spreads to the clinical schools. The largest intake in any medical school per year in U.S.A. and the United Kingdom is 150 with an average intake of 80-90 students, which is considered optimal. The Faculty of Medicine has an intake of 500-600 per year, so that on overseas standards four medical schools are desirable. Also, it is estimated that enrolments in the clinical years will increase by 40 per cent. over the next few years.

The Changing Face of Medical Curriculum.

In many aspects the medical curriculum in Sydney has not undergone any really radical revision since the days of pre-scientific medicine. At the beginning of the present century, the sharp division of the medical course into preclinical subjects of anatomy and physiology and the three main clinical subjects of medicine, surgery and obstretrics, was generally accepted. At that time, too, it was accepted that there was little direct connection between the preclinical subjects, except that anatomy was the basis of a surgeon's training and surgery was the only really active aspect of therapeutics available. All this has changed; physiological knowledge has become the basis of medical and surgical diagnosis and treatment. Out of physiology has grown biochemistry and the teacher of to-day is unable to delineate the boundary between biochemistry and physiology on one hand and clinical medicine on the other.

With the growth of medical knowledge, other facts must be accepted. First the capacity of the human mind is limited so that men must specialise or at least have a special interest within the profession. Secondly, general practice is as much a specialty as any other branch of the profession. As the Committee of The Royal College of Physicians of London stated in 1956, it is no longer possible to give before graduation a full training in every branch of medicine nor it is essential in view of the changes in the economic structure of medicine. For that group destined to enter general practice, several years are spent in hospitals after graduation and then a further year is usually spent as an assistant to a more skilled practitioner. Health schemes have made consultant services available to all.

The Modern Concept of a Teaching Hospital.

All authorities agree that a medical school should be a part of the University and the teaching hospital should ideally be in the closest proximity to the University. More important, for reasons stated, the pre-clinical subjects should not be separated either by distance or by the curriculum from the clinical subjects. One of the greatest and most successful administrators of a teaching hospital, Dr. Nathaniel Faxon, of Massachusetts General Hospital, has clearly stated the function of a teaching hospital:—

"The functions of a teaching hospital are first, to advance knowledge; second, to set an example of practice; and third, to train future doctors; they are not primarily to cater for local needs."

In the medical care of the community, no single factor is of greater importance than the standards of medical practitioners that graduate, for without this being satisfactory, all schemes, whether based on grandiose buildings or the principles of the welfare state must fail. The aim of the medical course must not only be to train the doctors in the scientific basis and practice of medicine but to train and inspire him to continue that quest for knowledge for the remainder of his life. And as Sir Richard Livingstone pointed out, "people learn what is first rate by contact with it."

The Report on the Establishment of a Second Medical School in New South Wales.

A Committee was set up in 1957 and first met in February, 1958; the final report being issued in May, 1958. As far as one can determine from the conflicting statements, the site of the medical school was decided by Cabinet as Kensington and was not discussed by the

Committee. It recommended, inter alia, that the medical course be shortened and be properly integrated, that a University hospital of 200 beds for four clinical professors be established presumably at the University of Technology, associated with 1500 beds in neighbouring hospitals and that a post-graduate hospital be provided. The principle of a single University hospital for the Faculty of Medicine of the University of Technology was not acceptable. It also recommended that the University have the power to restrict the entry of students and the Degree of B.S. be awarded three years after graduation on the recommendation of the Honorary Medical Staff of the Hospital to which the resident belonged.

The Fallacies of the Kensington Report.

What was wrong with this report that caused such an upcry from the medical and lay press and such resentment among all sections of the medical profession?

1. The site of the proposed medical school should have been within the terms of reference.
2. The Committee was not a truly representative body. The members were predominantly from one teaching hospital and many were close professional associates of the Chairman. No effort was made to include many distinguished doctors who had devoted years to medical education, nor to avoid the obvious appearance of bias in the composition of the Committee.
3. The report was composed too speedily, as if preconceived. The whole inquiry lasted 5 months. It was obviously impossible for members of the Committee, all being busy doctors, to consider the voluminous literature on education referable to medical teaching throughout the world, plus the detailed minutes, etc., in the short period available.
4. The isolation of the clinical professors in a special University hospital from their colleagues would be a serious disadvantage to them and their clinical colleagues. Apart from the disadvantage of academic isolation, for this small number of patients all the specialised departments of a major hospital would be needed, otherwise the clinical professors would be at a serious disadvantage with regard to patient care, student teaching and research, compared with their colleagues in the affiliated clinical schools.
5. Though stressing the need for integration of all aspects of medicine, the final report recommends a scheme with more schisms than any course at present in existence. No mention is made of the relationship of the preclinical departments to the clinical either as regards administration or geographical arrangements. The students are scattered over several hospitals, each separated from the preclinical departments and from the professorial units.
6. It is not possible to give doctors an adequate training in surgery in three years after graduation. To attempt to do so would interfere with present schemes of training surgical aspirants for a higher degree, and perhaps give false signifiance to the B.S. degree.
7. Where are the affiliated hospitals mentioned to be built and from where are going to come the 1700 patients necessary? Hospitals in this area that could be used for teaching are St. Vincent's, The Prince of Wales Annexe of Sydney Wales Annexe of Randwick, and Prince Henry Hospital. Prince Henry Hospital has been laid aside as a post-graduate hospital. If the intended 1700 beds are to be distributed over new hospitals, it is extremely doubtful if they could be kept filled, as Prince Henry Hospital in this area has always empty beds and the Kensington area is an area of falling population density. If Sydney Hospital is to be moved to Randwick (as has been stated) and St. Vincent's Hospital affiliated with University of Technology little or nothing would be done to relieve the present congestion in the teaching hospitals and three to four million pounds would be spent on this re-arrangement without adding another patient to the clinical material available, and leaving the integration of the clinical and preclinical phases of medical education as far away as ever.

In the controversy that followed this report certain facts become clear. Kensington is not the ideal site for the new medical school. There is not within that area the clinical material available for the 300 to 400 students that are envisaged in the three clinical years and this problem would be accentuated because the population density in that area is decreasing. This is taking place at the rate of 8000 yearly according to County of Cumberland data. Secondly, it is not easily accessible to students; a survey done by a group of students recently showed that only 4 per cent. of present students have direct access to Kensington by public transport, the remainder would have to go to the city and thence to Kensington. Hence the creation of a medical school there would not solve the present problem of the time spent by students in travelling to the University and from there to the clini-

cal school. Thirdly, it is clear that before any new ambitious and expensive plan is entered upon, the present clinical schools must be brought up to an acceptable standard. Lastly, the new medical school at least initially should be a College of the University of Sydney which would include as well faculties of Arts and Science.

What Should Be Done ?

The relief of overcrowding of the University and the Clinical Schools is urgent and must be done in stages.

1. Each of the four clinical schools must be given facilities to teach a fixed number of students. These include:

(a) Each clinical school admitting approximately 100 students should contain 250 medical and 250 surgical beds, with a total of 1000 beds.

(b) Adequate demonstration rooms off wards, libraries, lecture rooms, pathological museums, etc., needed for the instruction of students.

(c) The establishment of sub-professorial units in Medicine, Surgery and Obstetrics under the general control of the Professor of that Department of the University of Sydney.

(d) Adequate means made available to enable hospitals to fulfil the purposes of teaching and research to set an example in the care of patients.

2. As the needs of the rapidly growing population increases, other major hospitals should be developed that later could be used as clinical schools. In the overall plan, whichever hospitals are developed to this end, the population density and transport facilities available should be borne in mind.

3. University Colleges be established containing at least faculties of Arts and Science, these Colleges being near a clinical school where the medical student would have daily contact with other faculties and where the clinical and preclinical subjects could be fused to form the Faculty of Medicine. It appears certain, however, in view of the present overcrowding, which will become critical in the next five years, there will have to be a temporary compromise of this ideal. The basic science year can be done at a University or one of the present University Colleges and Departments of Physiology, Biochemistry, Pathology, etc., created at the present teaching hospitals. This would achieve integration of the preclinical and clinical and relieve the congestion on above departments at the University of Sydney. For an initial period at least there should be only one examining body conferring the degree of M.B. B.S. (Syd.)

Dr. Piper is Supervisor of Clinical Studies and assistant to the Professor of Medicine at the Royal North Shore Hospital. He wishes to stress that the views expresed in this article do not necesarily represent those of the Royal North Shore Hospital or the Department of Medicine.

3. — THE STUDENT VIEWPOINT

— MARTIN DAVEY, Med. V

It sems unnecessary to urge the case for the establishment of a second Medical School in Sydney. This need is recognised by a'l persons connected with the profession and the teaching of Medicine; for the present School at the University of Sydney does not provide adequate facilities for the training of the students it enrols, and its quota of graduates bare'y fills the minimum requirements of the community.

The Murray Committee, in stating this need, merely emphasised the obvious; but it sparked controversy when it remarked that there was "much to be said" for the association of such a school with the University of Technology. In fact, opinions as to the desirable site and conformation of a second school will vary with the holder's conception of the ideal medical school, and, in practice, with the attitude towards the University of Technology and teaching hospitals allegiance.

The short-sighted and unimaginative will fail to see any major faults in the present Australian system of Medical Education, as represented by the established schools in Sydney and Melbourne, showing all the signs of haphazard development, lack of uniform standards, and imitation of a foreign model (the British schools.)

The pattern of each school is a group of academic departments housed within a University and a satellite group of teaching hospitals— Sydney and Melbourne each have four general and several specialised teaching hospitals. Individual curricula are adopted by each University, and there is no central supervisory body; the standards most closely followed are those laid down by the General Medical Council of Great Britain.

All the established schools share the problem of over-crowding, which is most critical in Sydney where there are minimum restrictions on entry to the course. Student failure rates and

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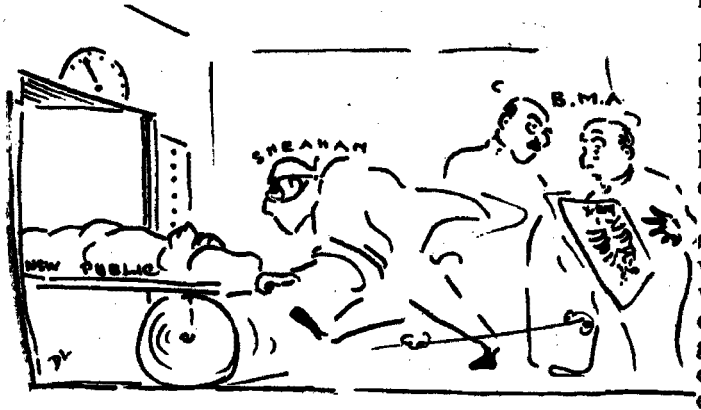


"Sorry boys, can't wait for your diagnosis."

withdrawals are high — the wastage rate (students not completing the course) in all schools is about 30 per cent. of first year enrolments. Some failures may be accounted for by the need to restrict student numbers in the senior years of the course.

Features of the Sydney School include the extreme overcrowding, particularly of first and scond year facilities. The overall position of the teaching hospitals appears reasonable — the teaching beds/students ration is 3.3 : 1 overall (1956 figures), as compared with approximate figures for some English schools of 3.5 : 1 (Westminster) and 5: 1 (Kings College). Allowance must however be made for the fact that almost half Sydney's students are at the Royal Prince Alfred Hospital, where the ratio is as low as 2.3 : 1. It is generally recognised that there should be between 5 and 10 teaching beds per clinical student. The only Sydney hospital achieving this standard is the Royal North Shore (5.6); the Oxford clinical school outstrips it with 13.

It appears to be the general opinion of teachers in Sydney that optimum numbers for the present school would be about 60 to 80 students in each year.

But possibly more serious than the overcrowding is the lack of correlation throughout the course, which makes the study of medicine in Sydney appear as the serial acquisition of isolated bodies of knowledge, which are serially forgotten. The pre-clinical student is lucky if he ever sees the inside of the hospital—the ideas that the principles of, say, fluid and electrolyte balance might be clarified by clinical demonstration, or that anatomy might come to life in the operating theatre, seem never to have been seriously entertained by his teachers.

Worse still until a year ago clinical students lost all contact with their preclinical studies as soon as they left third year, and with Pathology and Bacteriology as soon as fourth year ended. Professor Blackburn has now attempted to correlate Physiology and Biochemistry with Medicine; but we have yet to see Applied Anatomy taught with Surgery, and Clinical Pathology effectively taught in fifth and sixth years. Students see little or nothing of hospital laboratory procedures.

Further, they are taught and examined in such a way that they cannot readily perceive the overlapping of Medicine, Surgery, Paediatrics, Psychiatry and othr academically distinct fields in clinical practice.

Steps towards reform of the clinical curriculum will necessarily be slow while the present decentralised teaching system persists. Professors in all subjects (possibly excepting Paediatrics) have only the loosest control over the hospital honoraries who are the real teachers of Medicine.

The present Sydney school has however substantial assets which should be among the provisions for any new foundation. The association with a University is the first, and carries with it opportunities for students to acquire a wide general education, particularly during their preclinical years. It also implies the association of all Medical departments with "pure" scientific disciplines.

It is possible to conceive of an ideal teaching unit arising at the University of Sydney, within the University — Prince Alfred — King George V — Royal Alexandra axis. Erection of a preclinical school on a site between the Women's College and St. Andrew's)a step already mooted by University planners) and reduction of student numbers would be necessary concomitant steps.

Why ideal? Because such a centralised teaching unit offers the best—almost the only—possibility of elimination of the present deficiencies and difficulties, listed above; and would allow medicine to be taught as a reasonably integrated whole. Unnecessary barriers between preclinical and clinical teaching, and between the various aspects of clinical training, could be removed, as could the distinctions between academic and clinical teachers. Students would be able to continue their association with the University throughout their courses.

Having defined an ideal and its realisation at the existing school, one can turn to define the opportunities for a new school achieving this ideal.

There are two existing University centres in N.S.W. with which a second school might be associated: the University of Technology, and its College at Newcastle. There are probably four hospitals which are, or will be, sufficiently developed to be the core of a Medical school; Royal North Shore, Royal Newcastle, Sydney and St. Vincent's.

A number of possibilities have been mentioned for the University of Technology. It seems certain that the Preclinical school proposed by the Government will be sited within the University. It is also likely that the major section of Sydney Hospital will be shifted to Randwick in the forseeable future, and this would provide adequate clinical facilities for at least fifty students per year. The association of St. Vincent's (as close to Kensington as to Camperdown) and Prince Henry (if developed into a general hospital) with a school at Kensington must also be considered.

The choice of any or all of these as teaching hospitals for this school must imply either dissociation of the academic clinical school (at Kensington) from the hospitals, or its dissociation from the University. Of these possibilities the second — a single clinical school closely associated with one teaching hospital — seems the most desirable. In any case, it is inevitable that

the preclinical school will be quite isolated from the clinical departments: in fact, the split could be even wider than that in the Sydney school.

A plan for the development of such hospitals as St. George and Royal South Sydney to teaching status has also been mentioned. This would be nothing but a perpetuation and an extension of a system whose inefficiency blights the teaching of medicine at present.

The most satisfactory basis on which to continue the system of teaching hospitals is the foundation at each hospital of a complete clinical school. Students might then sit for examinations conducted by the University of Sydney or, as in London, by any one of several examining bodies; but all their clinical training would take place in one centre. The objections to such a system are strong, and include the disssociation of preclinical and clinical training implied, the duplication of teaching facilities, and consequent inefficiency and expense. Complete dissociation from a University could only be met by a revision of the whole structure of Medical education condensing preclinical training and making some pre-medical general tertiary education a necessary part of the course.

A better solution might be found at North Shore. It has been mentioned that a Medical School associated with this hospital might become the core of a University College, which would eventually achieve autonomy. Such a proposal should be looked on with favour by all who recognise that the University of Sydney is dealing with too many students in most faculties — not only in Medicine — and that the development of the University of Technology has not appreciably affected enrolments at the older institution. The maximum number of students for this has been set by the Murray Committee at 12,000. The optimum is closer to 6,000 and the present enrolment nearly 9,000.

A Medical School in Newcastle would naturally be associated with the Newcastle University College and the Royal Newcastle Hospital: and this grouping seems in many respects similar to the proposed Technology/Sydney Hospital association. Such a school would serve upwards of half a million people, and could be expected to train not more than fifty graduates annually.

Clinical teaching in Newcastle can be expected to depart to some extent from established patterns because of the policy of employment of full-time medical staff which is adopted by that hospital. Much closer correlation of teaching in various departments should be possible under this system. It is to be hoped that dislike of a system of hospital staffing will not become the basis for opposition to the provision of medical education in Newcastle.

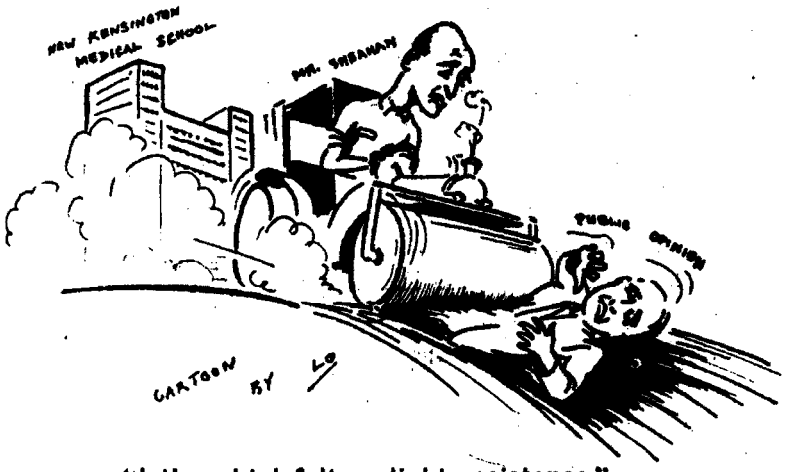
It is clear from the above that the ideal of a single-unit medical school within a University will not be fully realised except by the foundation of new teaching hospitals or new Universities. If we discount the remote possibility that new hospitals might be founded at Kensingon or at Tighe's Hill the only hope is the foundation of a University College at North Shore — this may eventually be possible, but it must await the stabilisation of existing Universities.

In the meantime, one must accept the fact that there is to be a Medical School associated with the University of Technology (or of N.S.W.) —the Government has said so, and the University has agreed. Then, the best plan for clinical teaching appears to be one associating a clinical school and a teaching hospital near the University; this is preferable to the placing of the academic clinical departments within the University.

An equally satisfactory school can be set up in Newcastle. Further, it seems desirable to reorganise the present school to provide for a better integrated curriculum under central control; or to reconstitute the present teaching hospitals as autonomous clinical schools, with a central examining body. This last step would enable the development of the University/Prince Alfred group as outlined previously.

The greatest threat to the standards of medical education in this State at present is probably the acceptance by those planning its development of present practices as normal and desirable. There is an opportunity at present for new and better standards to be set: I hope that it will not be lost.

COMMENT BY LO —



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Samuel Pepys and The Medical Profession

— M. C. F. PAIN, Med. VI.

Pepys lived his threescore years and ten between 1633 and 1703. He came from yeoman stock of some antiquity and the family had farmed in the area north of Cambridge for at least 250 years. Pepys rose from a position as clerk in the Shipping Office to be Secretary of the Navy and the virtual founder of the Royal Navy.

The famous Diary was written in the reign of Charles II and covers the period 1660-1669. It contains 1,300,000 words and covers 3000 quarto pages.

The Diary — Pepys called it his Journal — is a great record of day to day activities with some episodes of historical recording and commentories of matters of the day. Pepys surely meant his diary to be commonly available to the public for he willed it, together with his library, to Magdalene College, Cambridge. It was written in a shorthand of Pepys's own composition. In 1818, Lord Grenville, when shown one of the dusty volumes at the College, worked out the key in one night and the first edition was published in 1825. (ref.1)

When the Diary commences, William Harvey had been dead 3 years. The great Thomas Sydenham was coming to the height of his fame with his commonsense approach in the consideration of disease. Francis Glisson in 1650 had published the first monograph in England with his treatise "De Richitide" (ref. 5). These giants, however, did not immediately influence the practice of the time. The vast majority of practitioners were floundering in the medicine of Galen, bound down with theory and hopelessly irrational therapeutics. Charms, then as now, were held in popular use.

The following remarks deal mainly with medical references in the Diary with some comments on Pepys' personal health.

Since his twentieth year, Pepys had suffered repeated attacks of what was diagnosed as stone in the bladder. This worsened during the winter of 1657-8 (Pepys was then aged 25 years) and by March an operation was plainly indirated. The surgeon was Thomas Holier Snr., lithofomist to St. Thomas' Hospital, London, who had been a neighbour of Pepys's father, Dr. Joyliffe, a brillint young physician and discoverer of the lymphatics, also attended young Samuel. The operation was performed at his cousin Jane Turner's house in Salisbury Court. Hollier called into consulation Dr. James Molins (his former tutor) of St. Thomas', who had cured Oliver Cromwell of gravel in the bladder. He prescribed as a preoperative measure a draught of white of eggs, rose water, marshmallow, cinnamon, milk and liquorice. At operation a calculus the size of a tennis ball was removed. "The cutting probably followed the lines suggested by Ambrose Pare, since a translation of his works had appeared shortly before. The urethra was exposed and opened by an incision to the left of the midline, since the median raphe was supposed to heal badly. A grooved staff was passed into the bladder and along it, a series of duck-billed forceps were slid, each one larger than the last. If necessary, the stone was crushed before removal. Sterility was quite common and occurred in Peppys's case. The left vas was cut and the right so bruised by the forcible dilatation of the wound as to produce stenosis (ref. 10).

The operation was a great threat to Pepys's life as mortality from infection was high, although in that year Hollier had successfully operated in thirty consecutive cases with no fatality. Pepys had the stone mounted in a case and was wont to produce it when a friend needed encouragement for the operation.

Although commenced in 1660, the first personal references to medical matters in the diary occur in 1663-4. In the autumn of 1663 Pepys had suffered from some spasmodic abdominal pain. Thinking it was a recurrence of the stone, he consulted Mr. Hollier, who assured him that there was no rause for anxiety. One especially bad attack seized him while at the office. It started with an excruiating pain in the lumbar and hypogastric regions. He went to bed, took a clyster and after two hours of crying in anguish found that the pain began to diminish. It recurred during the next two weeks. At the height of the attack he could neither empty his bladder nor open his bowels.

Helier this time ronsidered he had another calculus. He consulted a physician, Dr. Burnett. who diagnosed not a stone but an ulcer of the kidner or bladder. Hollier told Pepys on his next visit that there was no stone: it was only the cold in his legs breeding wind that caused the pain, the thickness of his water being due to overheat in his back as a result of walking about in nothing but his dressing gown. By way of treatment, Pepys consumed three bottles of Epsom water with completely satisfying results. That Pepys had further stones was proved at that final court of appeal — the post mortem room. In a letter to the other diarist of this period, Evelyn, Pepys's heir, John Jackson says. "I must not omit acquainting you, Sir, that upon opening his body there was found in his left kidney a nest of no less than seven stones of the most irregular figures your imagination can frame and weighing 4½ oz. together but all fast linked together and adhering to his back". (ref. 8.).

Although Pepys remained in London during the plague epidemic of 1665, his diary is not very informative concerning the disaster. This is probably because he was very busy — he was the only executive still in the Navy Office — looking after the Naval administration concerning the war against Holland. Pepys had a profitable and pleasurable year, particularly as his wife and household were removed to Woolwich.

The first reference to the epidemic is on the 7th June, when he noticed in Drury Lane three houses marked with red crosses upon the door. To allay his apprehension, he bought some roll

tobacco to smell and chew. He warned his wife Elizabeth to avoid Drury Lane at all costs. On the 10th June the household of his neighbour, Dr. Burnett, was infected. Pepys's coachman, a week later, was suddenly taken sick and unable to see. He records, on the 21st, the streets full of coaches and waggons packed with movables and heading for the country. In the preceding week, 267 had died of the plague. For the next six months, Samuel, aged 32, while prepared to die, lived pleasantly. While the Bills of Mortality announced the terrific increase in deaths, Pepys records the sight of human bodies unburned at Combe Farm at Greenwich guarded by armed watchmen, "this disease makes us more cruel to one another than if we were dogs".

The August Bills for plague were over 6,000. Corpses were carried openly through the streets in daytime. By October the Bills were showing a decline and sick were walking the streets with open sores. By December the masses were returning. Most of Pepys's relatives had escaped. The King paid him honour. "Mr. Pepys," he said, "I do give thanks for your good service all this year, and I assure you I am very sensible of it." Summing up his life in the last six months, Pepys says: "I have never lived so merrily (besides that I never got so much) as I have done this Plague time". Dec. 31st, 1665.

It is unfortunate for us that Pepys had no contact with the Medical Profession during this period, or if he did he records nothing of its work. It must not be supposed that London was bereft of Medical attendants during this awful time, when in the two years, 1664-66, at least 68,596 (from Bills) and possibly up to 100,000 deaths occurred.

Coming back to Pepys's health again, the next complant concerns the diarist's eyes. The first record of any trouble occurs in January, 1664, the same month as he suffered his renal colic. He says "my eyes began to fail me and be in pain; which I never felt till nowadays, which I impute to writing and reading by candlelight.

This could well be a case of eyestrain in the presence of some refractive error, for he was in the nightly habit, after working at the accounts at the Navy Office, of working in his room over household accounts and his journal and diary—all in a minute handwriting and by a flickering candle until 2 in the morning. He refers to his eyes on the 13th December, 1666. On the 24th of that month he bought a pair "of green spectacles to see if they will help my eyes or no". Apparently they made little difference for, on the 31st, he worked on his accounts, listing his fortune "till my eyes became very sore and ill, and then did give over, and so to bed!"

During the year 1667 there are at least seven similar references and things were worse during 1668. "So to bed, my eyes being very bad." (D. March 18th) and "To bed, my eyes bad but not worse only weary with work " At the close of that year his accounts are very much behind, "having not the use of my eyes to help me". But he is comforted on hearing that his mother-in-law is praying for him. During 1669, the last year of the diary, his eyesight became worse. On May 12th, the candlelight prevented him seeing a new play called "The Roman Virgin" "due to the trouble of my eyes".

The last entry in his diary, May 31st, 1669, after recording the day's activities, concludes pathetically with "and thus ends all that I doubt I shall ever be able to do with my own eyes in the keeping of my journal . . . for all the discomforts that will accompany my being blind, the good God prepare me".

Thus there is no doubt that at the age of 36 Samuel Pepys believed he was rapidly going blind. That he did not is another story. It is true that he no longer kept his journal in his fine shorthand and that his day journal was probably dictated to a clerk, and therefore not so confidential. Pepys had tried a pair of spectacles when, not before time, he decided to enlist the aid of an eye specialist. He asked, on the 22nd of June, 1668, one of his friends at the Royal Society, the Hon. Robert Boyle, for his advice and he was referred to a Dr. Tuberville, of Salisbury. (ref. 2). Daubigny Tuberville, M.D. (Oxon.) was an oculist of some repute and Pepys consulted him on the 23rd. Dr. Tuberville was a prudent man not given to hasty decisions, for of the consultation Pepys says, "He did discourse, I thought, learnedly about them, and takes time before he did prescribe anything, to think of it", and what was probably most important, "he gives me hopes that I may do well".

After some experimenting on his own account with some form of spectacles recently demonstrated at the Royal Society (they were made of leather and tubular in shape with lenses purchased at Dumblebey's) which gave him some relief for close work, Pepys became resigned to his fate and takes no further medical advice.

Apart from several colds and some recurring abdominal colic (ably protected against by his hare's foot), Pepys's eye trouble was the only physical ailment suffered during the period covered by the diary. This is the more remarkable when his amorous relationships with women are considered (not all of them would have been above suspicion of infection). As he says he risked nothing on most occasions, but not always.

How different the fate of poor Boswell, who in a not much more profligate society 100 years later in London, had the misfortune to receive in full the "wages of love" on two occasions in the space of 18 months (ref. 9).

The late Sir D'Arcy Power, surgeon and noted Pepsyian scholar, has defended Pepys by suggesting that his aberrations were due to the injury sustained to his genito-urinary system at the removal of so large a stone. The evidence seems to be against this. From his earliest entries, it is obvious that Pepys had an eye for a pretty face. Except when he goes too far for his Puritan upbringing, Pepys is not smitten with remorse; he is not at all put out by his activities, and in fact he enjoys his life to the full. The writing of some of his more frank passages in a mixture of Latin, French and Spanish is perhaps some concession to his conscience, for he could not have thought they would escape translation. In a revealing statement he says, "However musique and woman and I cannot but give way to, whatever my business is". (D. March 9th. 1666).

Pepys had a large circle of friends, amongst

whom were some of the scientific leaders of the day: Boyle, Sir George Ent, Dr. Wilkins. Being partial to speculative discourse, it is not surprising that Pepys should have have been interested in the Royal Society and his friend, a Mr. Povy, proposed Pepys for membership and he was duly elected on February 15th, 1665. "Was this day admitted by signing a book and being taken by the hand of the President, my Lord Brunkard, and some words of admittance said to me. But it is a most acceptable thing to hear their discourse and see their experiments".

At the meeting on May 3rd, Pepys witnessed some experiments in physiology. The Duke of Florence had developed a new "poyson". A cat was ffectively killed by the same substance. Pepys adds, however, "and saw it proved that the oyle of tobacco drawn by one of the members do the same effect and is judged to be the same thing with the poison both in colour and smell and of effect."

The next entries of interest deal with the early development of blood transfusion techniques. Pepys in his entry for Nov. 14th, 1666, states that he attended the meeting at Gresham College and there saw a pretty experiment involving the transfusion of the blood of one dog into the second while the second was bled through a vein. The first dog died but the second did pretty well. This led to much discussion and it was decided that an amusing experiment would be to run the blood of a Quaker into an Archbishop. Pepys makes a prophetic statement in saying "if it takes it may be of mighty use to a man's health, for the mending of bad blood by borrowing from a better body."

The first animal transfusion was carried out by Richard Lower (1631-91), an able physiologist and successful practitioner, in Feb. 1665, and was reported as "A Method for Transfusing Blood" in the Philosophical Transactions for 1666. It may be that the experiment Pepys recorded was based on that article. The first transfusion on a human body was carried out on June 15th, 1667, in Paris by Denys. The first performance in England was by Lower on 23rd Nov., 1667 (ref. 4).

On the 21st — two days beforehand — Pepys attended a boring meeting at the Royal Society, but afterwards, at a nearby tavern, conversation with Dr. Whistler turned upon the subject of the forthcoming experiment to be performed. A frantic man, described as poor and a kind of minister and debauched, had been hired for 20 shillings to have some sheep's blood let into him. About 12 ozs. in a minute are to be run in and the effects will be closely observed. The opinions differed, some saying that the cool blood will improve him, being frantic; others that there will be no effect at all. Discussion along these lines prompted Dr. Whistler to tell a story of Dr. Caius who, in his old age, was nursed on expressed breast milk. So that, receiving milk from an angry fretful woman, was so himself: later on, changing to a good-natured patient woman, he did so become, beyond the common temper of his age. (Reported in "Health Improvement" by Thomas Muffet, 1655, p. 123 (ref. 1).

Pepys records several more meetings of the Royal Society, none of which were concerned with medical things.

Although obtensibly a man of science, Samuel Pepys was not above the usual superstitions of his day. Mention in his diary is made of various charms. In the last entry for the year 1664, Pepys reflects on his good health that winter and says, "I am at a loss to know whether it be my hare's foote, or the taking every morning a pill of turpentine or my having left off the wearing of a gern."

In October the Queen Mother was ill and pigeons were laid at her feet as a last resort.

"The husband of Kath Joyne fell into a pond and later developed a death rattle. Pigeons were laid at his feet and all in dispair over him." (D. 21st Jan., 1668).

Scrofula was called the King's Evil, since it was popularly held that the touch of the monarch could heal this troublesome condition. Pepys records (D. 23rd June, 1660) going to see Charles II touch for the Evil, "but he did not come at all, it rayned so." The custom of touching went on until the early 18th century.

Finally, let me conclude these rambling abstractions from the diary with a mention of a most interesting visit paid by Pepys and Commissioner Pett, of the Navy Office, to Chirurgeons' Hall on Feb. 27th, 1663. In 1540, Henry VIII had united into one company the Barbers and Surgeons, but it was expected that "no person using any shaving or barbery in London shall occupy any surgery, letting of blood or other matter excepting the drawing of teeth". Barbers and Surgeons were divided by an act of 1745, when the College of Surgeons was granted a charter (title Royal granted in 1843). (ref. 3).

At the meeting in 1663, Pepys and Pett were shown into the lecture theatre and then entered the Master and Company with the morning lecturer. The lecture was the second of a series "on the Kidneys, Ureters, etc., which was very fine." Pepys notes that at lunch they drank the King's Health out of a silver cup with bells attached, presented to the Company by Henry VIII. The bells were rung after each man had drunk. After lunch they viewed in a private room some specimens of kidneys, and Dr. Scarborough answered all Pepys's questions concerning the stone in which he was naturally interested. The

afternon lecture was delivered on the heart and lungs (Harvey's theory of circulation) and thus ended Pepys's day among the "many learned doctrs of physick, and we were used with extraordinary respect."

What, then, can we deduce from the medical references in his diary about the man himself?

Firstly, his insatiable curiosity becomes apparent in medical things surely above the normal for a Naval government servant in his early thirties.

Not only is curiosity plainly evident, but Pepys gives the impression that he has a firm grasp on all this medical stuff. And yet is this only an impression? Somehow I think it is. His carefully recorded meetings at Gresham College when read carefully — and I have not quoted at length — lead me to suspect that he is out to impress. To get the point across that he — Sam Pepys — moved in the highest scientific circles and was treated with respect by these great men, to boot. Knowledgeable and intelligent, he undoubtedly was. His handling of the Naval organisation after the Dutch War is proof enough of this.

But the poet William Cowper wrote:

"Knowledge is proud that he has learned so much,
Wisdom is humble that he knows no more . . ."

References.

1. Everybody's Pepys, edited by O. F. Morshead, 1935.
2. Samuel Pepys — The Man in the Making. Sir Arthur Bryant.
3. Haydn's Dictionary of Events. Vincent, 1878.
4. History of Medicine. H. Fielding Garrison.
5. Osler's Modern Medicine. McCrae, 1925.
6. Medicine in Pepys's Diary. Aust. M.J., 1951 ii, 177.
7. London Journal. J. Boswell, 1763, Reprint Society.
8. Samuel Pepys and Medicine. S. J. L. Taylor, St. Thomas' Hospital Gazette, April, 1932.

Technical Terms Illustrated —

'Rotating a posterior".

Synchronous Occurrence of Primary Neoplasms in Stomach And Transverse Colon

— S. GREEN, Med. VI.

The patient, a fifty-seven year old woman residing in Sydney, was admitted to the Royal Prince Alfred Hospital on 11th June, 1957, from the Out-Patients' Department. In August, 1956, ten months prior to her admission, she was treated at the Out-Patients' Department for diarrhoea with "pain in the bowels".

Diarrhoea thus was intermittent and at first lessened with treatment, but in January, 1957, became continuous. There was an onset of melaena in December, 1956; this was intermittent at all stages and was never fresh blood.

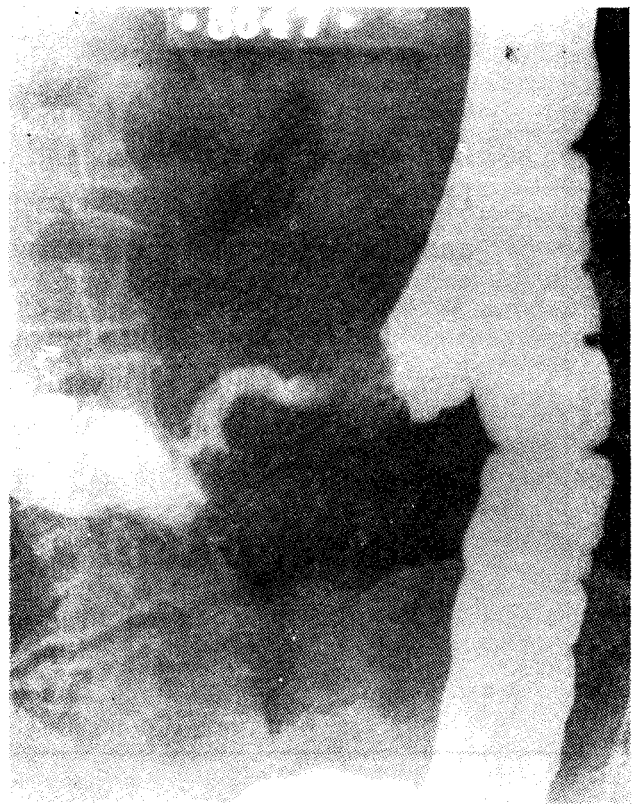
Her appetite had been poor over the ten months from August, 1956, especially in the final three months. She had gradually developed drawn-in eyes, and had noticed herself tiring and becoming breathless more rapidly. In April, there was retching and vomiting which was first intermittent and related to meals, preceded by nausea. The vomitus consisted of recently-ingested food. In May, one month before admission, the vomiting began to increase in frequency, and also occurred in the absence of the intake of food or liquids. The vomitus was by then a thick, light yellow fluid.

From the beginning of May the patient noticed that food seemed to "stick" in the epigastrium, occurring generally several hours after a meal; and relieved by vomiting.

Pallor had been present since April, 1957, but had become worse over the fortnight before admission on June 11. Weight loss was marked, two and a half stone being lost in six weeks from April 1957 (13st 6 lbs) to the beginning of June (11st.).

Over the two weeks before June 11, she suffered from continuous pain and tenderness in the left hypochondrium, which was relieved by sitting up. In the second week of this final fortnight the patient "collapsed" twice, remaining conscious on each occasion. While in hospital, prior to operation, she complained of weakness in both forearms.

BARIUM MEAL, showing deformity of pyloric antrum.



BARIUM ENEMA, showing filling defect of transverse colon.

FAMILY HISTORY: Her mother had died of "cancer of the bowels".

ON ADMISSION: An obese woman of apparently the stated age was seen lying comfortably in bed. The buccal mucosa was pale. There was extreme tenderness in the epigastrium (with no rebound tenderness) and the suggestion of an epigastric mass. There was evidence of recent weight loss in the anterior abdominal wall. Liver and spleen were not clinically enlarged, and apart from a subcutaneous mass in the right inguinal region (possibly a lipoma), there were no other abdominal masses felt. On rectal examination second degree haemorrhoids were noted at eleven o'clock.

INVESTIGATIONS: On 24th May, 1957, a Barium Enema showed a constant, stenotic portion of transverse colon proximal to the splenic flexure. It was about 4 inches long, not fixed. The appearance was that of malignancy.

On 11th June, the haemoglobin concentration was found to be 7.2 Gm per cent. After transfusion this rose to 10.9 Gm per cent. on 13th June.

On 18th June Chest X-ray (P—A) "no metastases seen in lungs".

Sigmoidoscopy on 20th June revealed no pathological condition.

On 21st June, Barium Meal demonstrated "a deformity of the pyloric antrum. There was peristalisis in the stomach, but it did not pass freely through the antral area. There was a central gastritis and possibly a very broad shallow ulcer on the lesser curve. Neoplasm could not be excluded."

Gatroscopy was performed on 24th June. "The stomach was noted to contain some dark material which was very suggestive of altered blood. The pyloric antrum could not clearly be seen. It was obviously deformed and the instrument could not be made to pass through this segment during the examination, suggesting that there was possibly infiltration of the stomach wall in this zone. Although a lesion could not be seen, the absence of peristalsis and the presence of altered blood were strongly suspicious of an active lesion in the pyloric antrum, probably neoplastic."

OPERATION was performed on 26th June, when it became clear that two primary carcinoma were present, one in the stomach in its distal third attached to the free margin of the liver and infiltrating this part of the liver; and the other at about the centre of the transverse colon, with considerable dilatation and hypertrophy of the colon proximal to the lesion. Both lesions appeared to be of comparable size. The lesion in the colon encircled the bowel completely. No evidence of lymphatic or peritonaeal metastasis was found.

PATHOLOGY: The specimen consisted of the distal two thirds of the stomach, much of the greater omentum; and a deep wedge of the liver 5 x 4 x 3 cms. adherent to a carcinomatous ulcer 7 x 4 cms. on the anterior wall in the prepyloric region. Also included in the specimen (removed en bloc) were transverse colon (the middle one-third) and transverse mesocolon, the middle colic artery and lymphatics.

Immediately beneath the pylorus was a mass of lymph nodes, the largest measuring 3 cms in diameter, containing necrotic carcinoma. In the transverse colon opposite the tumour of the stomach, but separated from it by normal omentum, there was an ulcerating carcinoma involving all layers and producing constriction of the lumen; and adherent to fat. Proximal to the tumour there was a small pedunculated polyp measuring 1 cm. in diameter. The greater omentum appeared normal.

Operation specimen.

On microscopic examination, the carcinoma of the stomach was seen to be a poorly differentialed adeno-carcinoma with a tendency to diffuse infiltration, and glands adjacent to it were invaded. The carcinoma in the colon was better differentiated with well-marked gland formation. A lymph node adjacent to it was not invaded.

The pathologist regarded these as **separate carcinomas in the stomach, having different histological appearance from that in the colon.**

One year after operation the patient is well and free from evidence of recurrence or metastrasis.

DISCUSSION :

Multiple malignant tumours have featured frequently in the literature over the eighty-nine years since the pioneering article by Viennese Surgery Professor, Theodore Billroth in 1869.

The criteria for the diagnosis of multiple malignancy, amended by various authors from Billroth (1869) are:

1. Each tumour must present a definite picture of malignancy.
2. Each tumour must be distinct. Macroscopic and microscopic appearance of the tumours must be that of original carcinomas of the organs involved.
3. The probability of one's being a metastasis of the other must be excluded.

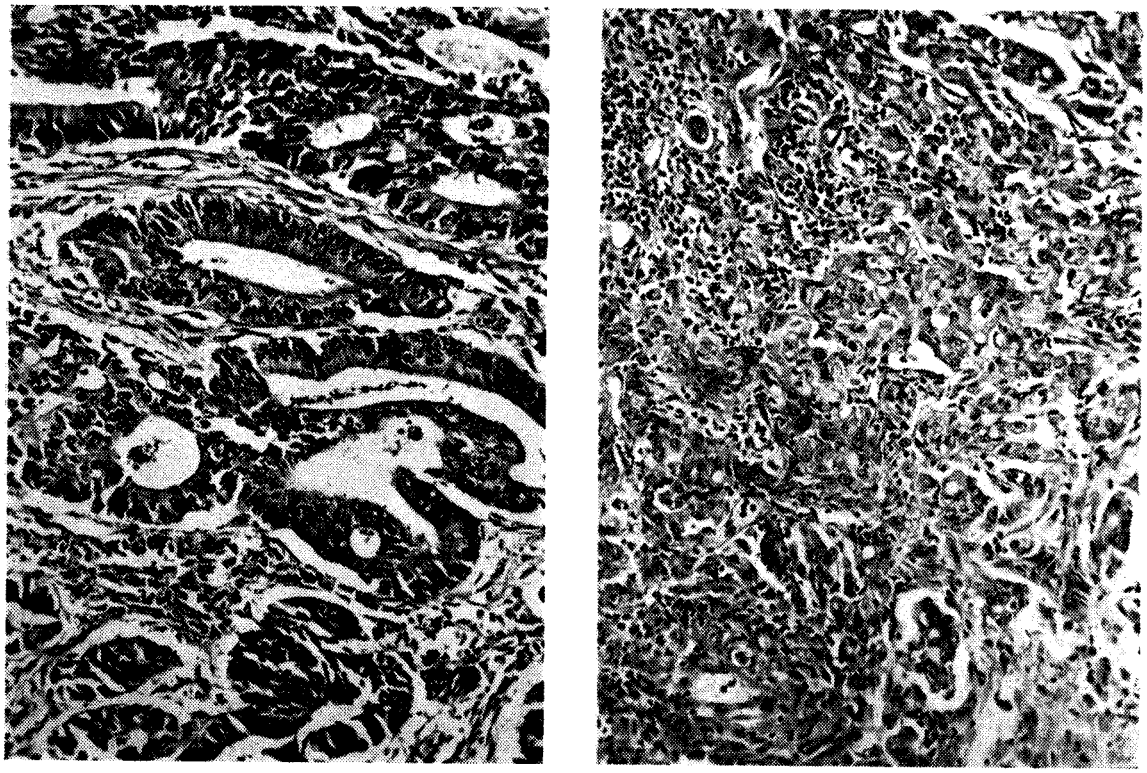


PHOTO MICROGRAPHS: Showing the different histological appearances of the carcinomata in the stomach (ulcer—cancer with fibrosis) and in the colon.

These cases are divided into those in whom the tumours are of different chronological ages (Metachronous) and those in whom the tumours are of the same age (Synchronous).

Some authors considered it necessary for multiple primary tumours to be synchronous. However, Warren and Gates (1932) insist that this is of slight significance", and Hanlon points out that the microscopic appearance must be different.

Warren and Gates' comment that "multiple cancers occur at approximately the same age as single cancers", is disputed by Hanlon whose statistics showed that "these dual tumours occurred among patients older than those who had a single tumour". The average age of the group with one cancer was 55.2 years and those with multiple cancer was 62.6 years.

Warren and Gates consider that multiple malignancy more frequently occurred than can be explained on a basis of chance, but T. A. Watson (1953) reported that "the incidence of true multiple cancers does not differ from the ordinary incidence rate of cancer in a normal population". Meade Burke notes that "with an absolute increase in the recorded cancer mortality, an absolute increase in multiple primary cancers is to be expected".

The aetiology of multiple malignancy has been discussed by Warren and Gates, Hanlon, Willis, Meade Burke, Pellor, Watson. No conclusions have been reached, but Willis notes the multiple carcinomata found in polyposis coli (which may be associated with polyps of the stomach). Pedler observes that "A cured tumour leaves protection of the body against the development of other primary neoplasms"; but T. A. Watson notes no "immunity" following a first cancer.

Double primary carcinomata involving colon and stomach have occasionally been reported, but cases in which the colonic site was the transverse colon appear to be singularly rare. More commonly affected are sigmoid colon and splenic flexure (excluding the rectum).

In 1932, M. P. Bull, of Oslo (Norway) reported two cases of cancer of the colon and of the stomach observed in two brothers. As the original article in French has not yet been translated into English, the following summary may be of interest:

The colonic site in one of the brothers was splenic flexure and in the other was transverse colon. The onset of symptoms occurred at the age of fifty and forty-nine and their occupations were sea captain and farmer respectively. They had not lived together for years. Some history of cancer on both maternal and paternal sides was recorded; and a sister and brother had died of intestinal cancer.

One presented with a history of one year's abdominal distension, "accompanied by gurgling and hissing" and a palpable tumour lying transversely below the left costal margin, about the size of an egg, of cartilaginous consistency, tender and moving slightly with respiration. Barium enema demonstrated a filling defect in the transverse colon.

At laparotomy five days after caecostomy the colonic tumour was found to be about the size of a fist, infiltrating locally. On the greater curvature of the stomach a second tumour was discovered — a hard ulcerating mass, flat, circular and about six centimetres in diameter.

There were no lymphatic or distant metastases. The gastric tumour was excised locally by a large wedge-shaped resection and thirty centimetres of colon were extirpated. Both tumours were adenocarcinomata, but microscopically different.

Four years after the excision of the tumours, the patient was in perfect health.

The second brother was found to have multiple neoplastic changes in the stomach, with a cancer on the lesser curvature, a carcinomatous polyp and two cancers on the posterior wall, associated with a carcinoma of the splenic flexure.

L. K. Stacker (1937), in association with J. de J. Pemberton, reports that "the incidence of multiple primary malignant tumours in all cases of cancer is approximately four per cent. The simultaneous occurrence of carcinoma of the stomach and colon is a rarity." This was reiterated by Pemberton and Shands (1952).

Warren and Shields (1945), in their studies of 3974 necropsies on cases of malignant disease, found a multiple cancer rate of six per cent. "This is tenfold or elevenfold the expected incidence."

Pemberton and Waugh reviewed the literature up to 1944, found thirty-eight cases of multiple malignancy with colon and stomach, occurring simultaneously in all but three instances. They reported two cases, which, as far as could be determined, were the only recorded instances of the removal of primary simultaneous carcinomas of the stomach and colon at the same operation.

Stalker and Ciak (1957) noted, "The majority of these cases (double malignancy of stomach and colon) have been found at necropsy, but a few were reports of surgical treatment. The majority of the patients were treated surgically in two separate procedures."

SUMMARY:

A case of a 57 year old woman with primary carcinomata of the transverse colon and stomach is presented.

The incidence of such cases is discussed.

ACKNOWLEDGEMENTS:

Thanks are due to Professors J. Loewenthal and F. Magarey and to Dr. V. J. McGovern for invaluable advice and assistance; and to Mr. S. Woodward-Smith for his excellent photography.

REFERENCES:

Bull, M.P.: Soc. Nat. D. Chir. 58: 1338-43, 1932.
Meade Burke: Am. J. Cancer 27: 316-325, 1936.
Hanlon, W.: Am. J. Cancer 15: 2001-2, 1931.
Peller, S.: Am. J. Hygiene 34A: 1-11, 1941.
Pemberton, J. de J. and Shields, W. C.: J. Clin., North America, 32, 1197-1202, 1952.
Warren, S. and Ehrenreich, T.: Cancer Research 4, 554-570, 1944.
Warren, S. and Shields, W.C.: Nat. Cancer Inst. 5: 375, 1941.
Warren, S., Shields, W.C. and Gates, Olive Am. J. Cancer 16, 1358-1414, 1932.
Watson, T. A.: Cancer 6, 365-371, 1953.

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From Trades Guild To Royal College

— SIR JAMES PATTERSON ROSS, President, Royal College of Surgeons

If you look carefully at the inscription on the front of he Royal College of Surgeons of England — AEDES COLLEGII CHIRURGORUM ANGLICI DIPLOMATE REGIO CORPORATI, A.D. MDCC — you will notice that the word "ANGLICI" differs slightly from the others. Formerly the word had been "LONDINIENSIS", and the present appearance of the inscription provides visible evidence of the change in the title of the College which occurred in 1843. "The Royal College of Surgeons of London" was established by a Royal Charter granted by George III in 1800, and it may be assumed that this is as far back as one needs to go to understand the origin of the College. This, however, is a near-sighted view, and we must delve deeply into the history of the City of London if we are to obtain a true picture of the ancestry of the College, and of the events and developments extending over several centuries which led to the establishment of the College on its present site.

Accurate details of the history of London in the Middle Ages are not easily obtained, but it is clear that in the 13th and 14th centuries there was a steady growth in the size and influence of a "middle class" of craftsmen who formed craft or trade guilds which were the predecessors of the City Companies. The guilds were formed to regularise the practice of the particular calling; to lay down rules for the appointment of apprentices; to safeguard the rights and privileges of members; and to perform certain religious duties. They obtained the right of using a particular livery.

Such a guild or confraternity of surgeons was formed by the military surgeons who served in the 100 years war (1337-1444), but the earliest known charter concerning surgeons is that granted to the Barbers' Company by King Edward IV in the year 1462. No doubt the Guild of Surgeons had little or no authority in the City because of its small membership — the records show that in 1491 there were eight and in 1513 only twelve members — yet it is strange that the Barbers' Charter should deal almost exclusively with surgery, as though this craft were entirely in the hands of the Barbers. The Charter states that the free men of the Mystery of Barbers (mystery is the same word as the French métier) had for long exercised "the Mystery or Art of Surgery, as well respecting wounds, bruises, hurts, and other infirmities of our liegemen, and healing and curing the same, as in letting blood, and drawing the teeth of our liegemen". It further stated that through the ignorance, negligence and stupidity of the unskilled "very many and almost infinite evils" had befallen our liegemen; and so the Charter was granted for the purpose of remedying these evils, and charged the Company with the superintendence, scrutiny, correction and government of freedom of the City being Surgeons and exercising the Mystery of Barbers, and of all other foreign Surgeons practising in the City of London and its suburbs.

It may be asked how it ever came about that the practice of surgery was in the hands of the barbers. In the middle ages the clergy were the physicians, but as time went by the priests began to feel the competition of Jewish physicians and lay surgeons. The Jews were thwarted by excommunicating their patients; but all the church could do to the surgeons was to brand surgery as an inferior and derogatory calling, and to forbid priests to undertake any operation which involved the shedding of blood. Rather than allow the control of surgery to slip from them, the priests selected their servants the barbers, who were known to be dexterous with sharp instruments, not only to shave their tonsures but also to be taught the surgical art under their direction. These pupils of the priests became Barber-Surgeons.

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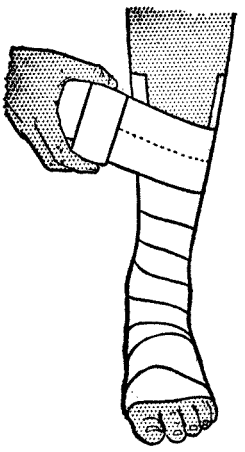

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It has already been pointed out that the Surgeons, though men of a better class and with attainments of a much higher order than the barber-surgeons, were too few to gain any authority in the City, so they attempted to establish themselves by union with the Physicians. A conjoint College of Physicians and Surgeons was formed in the City under the authority of the Mayor, but this arrangement proved unsatisfactory because the physicians, most of whom held university degrees, looked down upon the surgeons who were less well educated, yet were constantly striving to raise the standard of their craft and to inculcate high ideals in regard to responsibility towards their patients. As an example of this, one may quote the regulations made about the middle of the 15th century whereby members of the Guild were to elect apprentices, to punish malpractice, and to be available for consultation in cases of serious illness — in fact, it was an offence for a surgeon to fail to call in the Master under such circumstances.

The Conjoint College did not last long, but the Surgeons were unable to exist alone and therefore agreed to combine with the Barbers. A charter was granted by Henry VIII in 1540 to the Surgeons and Barber-Surgeons, but it must be understood that the combined company consisted of Barbers, Barbers practising surgery, and Surgeons. The Charter gave the Surgeons control over the Barbers practising Surgery, and by the rules of the Company surgeons were not allowed to practise shaving, and Barber-Surgeons were not allowed to do more than draw teeth. If any of the Barbers became Surgeons it was only after some years of apprenticeship, attendance at lectures and demonstrations, and obtaining the Bishop's licence.

We see in the establishment of these Guilds and Companies a sense of high responsibility and a desire to set up good standards of service to the public, or as in this case, to patients. This is borne out not only from the study of the rules and records of the Companies, but also from the writings of their prominent members. To read these records of the thoughts and ideals of men of a by-gone age helps to keep us humble; so often we may be inclined to think that because they knew less than we do, and their methods were more crude, that they must have been not only ignorant but brutish. In fact, we have not outgrown their faults, and we cannot improve upon their noble ideals; it was their fine character that has made their names survive.

The first Master of the Company of Barber-Surgeons was Thomas Vicary, Sergeant Surgeon to King Henry VIII and a Governor of St. Bartholomew's Hospital. It is sometimes stated that he was surgeon to the Hospital, but although he played an outstanding part in the life of the Hospital for many years, and exercised supervision over the duties of the surgeons, as over much of the rest of the work of the Hospital, he was not appointed to one of the four surgeons to the Hospital at the time of its second foundation. Vicary wrote "A Profitable Treatise of the Anatomie of Man's Body", a book which had little merit as far as anatomy was concerned, since it was merely a translation of an ancient text, but is most valuable as an indication of what Vicary regarded as the attributes required in a man who would be a surgeon. "Four things most specially that every surgeon ought to have —

"The first, he ought to be learned and that he know his principles, not only in Chirurgerie but also in Phisicke, that he may the better defende his Surgery; Also, he ought to be seene in natural Philosophie, and in Grammar, that he speake congruitie in Logike, that teacheth him to prove his proportions with good reason. In Rethorike, that teacheth him to speak seemely and eloquently: also in Theorike, that teacheth him to know things naturall, and not naturall, and things agaynst Nature. Also he must know the Anatomie, for al Authors write against those Surgeons that worke in man's body not knowing the Anatomie, for they be likened to a blind man that cutteth in a vine tree, for he taketh more or less than he ought to do . . . . . it is as possible for a Surgion (not knowing the Anatomie) to work in man's body without error, as it is for a blind man to carve an image and make it perfyt.

"The second, he must be expert . . . he oughte to knowe and to see other men work and after to have use and exercise.

"The thirde, that he be ingenious or witty: for al things belonging to chirurgerie may not be written nor with letters set foorth.

"The fourth, that he must be wel mannered, and that he have al these good conditions here following — that a Chirurgion must take heed to deceive no man, with his vayne promises, nor to make of a smal matter a great, because he woulde be accounted the more famous . . . Likewise they shal give no counsayle except they be asked, and then say their advise by good deliberation, and that they be wel advised afore they speake, chiefly in the presence of wise men. Likewise they must be as privie and as secrete as any Confessor of al thingis that they shal eyther heare or see in the house of their pacient . . . And see they never prayse them selves for that redoundeth more to their shame and discredite than to their fame and worship: For a Cunning and skilfull Chirurgion neede never vaunt of his doings, for his works wyll ever get credite ynough. Likewise that they despise no other Chirurgion without a great cause; for it is mete that one Chirurgion should love another, as Christe loveth us al".

We begin now to understand what we mean when we say that the Royal College of Surgeons has inherited a great tradition, and why it is that we trace our origin back to the old Guilds.

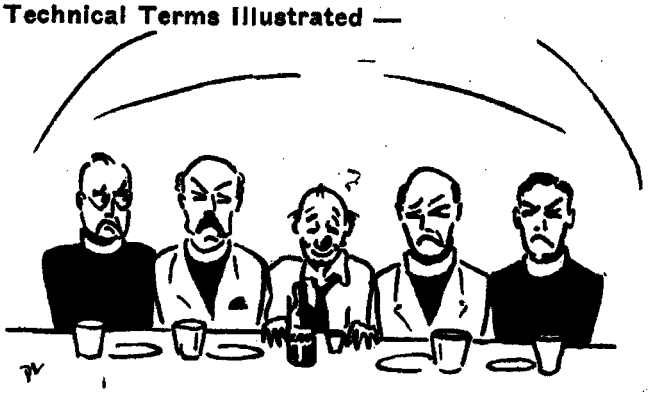
Though the association with the Barbers gave the Surgeons more power in the City, it was otherwise to their disadvantage especially in their relations with the Physicians who regarded it as a sign of their inferiority and forbade surgeons to prescribe for their patients. Not till Abernethy's time did surgeons obtain this right. In spite of the special privileges which the Barbers allowed to their surgical brethren — for example, at meetings of the Court of the Company, after the general business was over, the Barbers would withdraw and leave Surgeons to discuss their own professional affairs in private — the union was on the whole an unhappy one and was dissolved in 1745 when the Surgeons were incorporated as a separate Company with their own Surgeons' Hall in Old Bailey. Here lectures were

given in Anatomy and Surgery by Percivall Pott and later by his pupil, John Hunter, but as the century neared its close the affairs of the Company went from bad to worse. It was difficult to find lecturers and to obtain audiences for them; interest was lacking in the general well-being of the Company; and there were even complaints about the conduct of the examination of the Surgeon's mates for the Navy.

It is important to note the association of the Company with the Navy, for the Court not only examined candidates for the medical service, but also acted as a tribunal to assess the claims made by Naval Officers for compensation or pensions for wounds and "hurts". Among the treasures at the College of Surgeons there is the record of a claim made by Admiral Sir Horatio Nelson for his surgical treatment when he lost his arm. The anchor on the College Coat of Arms bears witness to this link with the Royal Navy.

It seems strange that interest in Surgery should have flagged at a time when John Hunter was so busily introducing the method of experiment into the study of surgery, and placing the subject of a more scientific foundation. It seems clear that although a few men like Astley Cooper appreciated his leadership, the majority heedlessly continued to follow the old-fashioned empirical practices, and the teaching of surgery at Surgeons' Hall languished and finally died when the Company was dissolved in 1795. Within 5 years, however, the Royal College of Surgeons came into being, charged by Royal Charter with "the promotion and encouragement of the Study and Practice of the Art and Science of Surgery". The building of the College in Lincoln's Inn Fields was designed to contain John Hunter's museum and a library; the greatly expanded museum and library are still among the principal concerns of the College to-day.

Technical Terms Illustrated —



"A Threatened Ectopic".

The original College buildings which were completed in 1813 soon proved inadequate to house the steadily increasing number of specimens which successive Curators, following the Hunterian tradition, were adding to the collection. The College therefore was enlarged in 1835, and again in 1855 and 1891, but the only departments represented were Anatomy and Pathology. In 1931 Sir George Buckston-Browne presented to the College a "Farm" adjoining Darwin's house at Downe in Kent, which consisted of a residence for research workers, farm buildings to house large as well as small animals, and a laboratory suite with an operating theatre. Excellent surgical experimental research was conducted at the Farm under the direction of Sir Arthur Keith, the first Master.

In 1937 a further extension was made to the College itself when, thanks to the generosity of the Bernhard Baron Trustees, another floor was added to the main building to accommodate a research department of Physiology. When war broke out in 1939, the activities of the College, which had been steadily increasing, were brought to a halt, and its treasures, including the pictures, much of the library, and the most valuable of the Hunterian specimens were sent away for safe keeping in many parts of England and Wales. On the night of May 10 1941, the College suffered very serious damage in an air raid, and although the front of the building in Lincoln's Inn Fields was less severely affected, all the museums on the Portugal Street side were completely gutted.

When building operations became possible after the War, the Council of the College decided that in order to provide for the expanding activities in the fields of post-graduate education and scientific research, it would be useless to rebuild on the previous plan. Though the Hunterian Museum and the Library were still the chief concerns of the Council, accommodation had to be found not only for new museums, but also for lecture rooms, demonstration rooms, and research laboratories in the departments of Anatomy, Physiology, Pathology and the newly-formed department of Pharmacology. Furthermore, the Faculty of Dental Surgery and the Faculty of Anaesthetists, both recently established, also required laboratory and office accommodation. These new departments, and the Nuffield College of Surgical Sciences, which is a residence for 80 students, acounts for the enormous building operations now proceeding on the South side of Lincoln's Inn Fields.

Although the scientific departments are not yet properly housed, members of their staff are already engaged on many problems which have a direct bearing upon clinical surgery. In the Anatomy department, the minute structure of nerve cells is being studied using an electron miscroscope supplied by the British Empire Cancer Campaign. In the Physiology department, most interesting work is being done upon the physical and chemical factors which influence the healing of wounds, electromyographic studies are being carried out on the muscles of mastication in relation to orthodontics. The vasomotor control of the nasal mucosa is being investigated with a view to elucidating allergic reactions in the nose. The Biochemistry sub-department is engaged in research upon lipid metbolism. The workers in the department of Pathology are carrying out research into carcinoma of the lung, and also into disorders of collagen formation, and in the department of Pharmacology important research is being done to study regeneration in the autonomic nervous system, and the effects of ganglion-blocking agents. At the Buckstone-Browne Farm work of fundamental importance has been done on skin

grafting and on organ transplantation, and recently a team of research workers has been making excellent progress with the extracorporeal circulation.

One of the conditions on which the Hunterian Collection was delivered to the Company of Surgeons provided that "one course of Lectures, not less than 24 in number, on Comparative Anatomy and other subjects, illustrated by the preparations, shall be given every year by some Member of the Company". In spite of a promising start, as years went by history repeated itself, and the difficulty of finding a suitable lecturer each year led to the suspension of the lectures. Therefore, application was made for permission to alter the conditions, and in 1894 the Lords of the Treasury agreed that each year one Series of Lectures not less than twelve in number, should be given by Fellows or Members of the College, and since that time applications for Hunterian Professorships have become steadily more numerous, so that now there is intense competition for the 12 appointments and an astonishing amount of excellent material is offered by applicants, even by the unsuccessful ones.

There are many other named surgical Lectureships in addition to the Hunterian Professorships, and the College now has an organization for arranging courses of lectures in surgery for post-graduate students at regular intervals throughout the year.

The College Departments of Anatomy, Physiology, Pathology and Pharmacology also play their part in University education, as teaching departments in the Institute of Basic Medical Sciences of the British Post-graduate Medical Federation in the University of London. This intimate association with the University enhances the academic status of the departments, and provides some very welcome financial assistance. It will be understood, therefore, that the cost of the educational programme does not fall entirely upon the College and its Fellows.

A function which the College has inherited from the Guild of the Barber Surgeons' Company and from Surgeons' Hall is to "test the fitness of persons" to practise Surgery. The Court of Examiners which is elected by the Council is entrusted with the maintenance of the high standard traditionally associated with diplomas granted by the College.

Let me repeat that the College was founded by Royal Charter and is justly proud of being a Royal College. It has been privileged and honoured by a close association with the Royal Family, and the visit paid by Her Majesty Queen Mary to see the effects of the bombing in 1941 is gratefully remembered. Many members of the Royal Family, including Her Majesty The Queen and Prince Phillip Duke of Edinburgh, have graciously accepted the Honorary Fellowship, and the College was particularly favoured when The Queen laid the Memorial Stone of the new buildings just before her Coronation.

Finally, it must be realized that since the Royal College of Surgeons attracts postgraduates in large numbers from overseas, it constitutes and will always continue to maintain a vital link between England and the Commonwealth.

Medical Social Work

— PETER F. SINNETT, Med. V.

Every illness has a social component either consequent upon the disease or as the basis of its aetiology—for obviously, a disabled limb means a disabled person and, in consequence, a disturbed family unit.

Similarly, the financial burden imposed by illness (especially if prolonged) can, by reducing the family's standard of living, predispose to further ill-health among its members. Lengthy illness in a member of a family is a costly business, especially if the father is the person affected.

To-day, much has been done to relieve the financial stress, by Government aid in the form of invalid pensions, sickness benefits, by allowances and numerous financial subsidies for treatment. Even so, it must be remembered that prolonged illness in the family is still a common cause of mothers going out to work, and children being denied the advantages of higher education — certainly, in every case the family's living standards must be reduced.

Every illness imposes an emotional strain on the family; the most common basis of the problem lies in the normal roles assumed by the various members of the family with an increased responsibility falling on the wife and even on the children.

Frequently, too, the problem arises as the result of an illness, the patient is no longer capable of carrying on his former occupation and must be adapted to suitable work within his capacity, if he is to remain a self-supporting and useful member of the community.

A similar problem that presents itself is the education and adaption of handicapped children so that their potentiality is maximally exploited.

It is curious that although an appreciation of the social implications of illness must have existed from the earliest of times, yet it is only recently that they have come into prominence in medical planning. In fact, Medical Social work dates from the appointment in 1891 of a Select Committee of the House of Lords to investigate overcrowding of the Outpatient Departments and certain abuses of the London Hospitals by patients — the feeling existed that patients who could afford private treatment were exploiting the free facilities of the Hospitals.

It was at this juncture that Sir Charles Loch, a leading Social Worker, proposed to the House of Lords Committee that trained Social Workers be appointed to Hospitals to determine the needs of patients applying for relief.

It is obvious he was not only concerned with the abuse of hospital facilities but also saw clearly the futility of attempting to treat a patient while disregarding his social needs, for, in 1892, he wrote, "At the present time, what more glaring picture of charitable impotence is there than that destitute patients should constantly apply to a free dispensary for drugs, which cannot benefit them if they lack the necessary food."

This result was that in 1895 the "Charity Organising Society" of which Loch was Secretary provided a Social Worker to the Royal Free Hospital and thus Miss Mary Stewart became the first Hospital Almoner."

Miss Stewart's duties as laid down by the Hospital Board were threefold:

1. To prevent the abuse of the hospital by persons able to pay fees.
2. To refer patients, already in receipt of parish relief and such as are destitute to the Poor Law Authorities.
3. To recommend suitable persons to join the Provident Dispensaries.

By contrast to this negative and limited approach to medical-social work, which was initially adopted, it is significant that

to-day the management of the social problems of ill-health is regarded as primarily the responsibility of the Almoner. With the increase of specialization in medicine, and the decline of the family doctor, she is fulfilling a role of ever-increasing importance. Certainly, the medical team would be incomplete without her.

Today the Institute of Almoners explains her work as follows: "An Almoner is a social case worker in a medical setting. Her work is concerned with the problems connected with illness that trouble the individual patient and may hamper his recovery. Her function is first and foremost to help in the treatment of the patient."

More simply, the Almoner is a specialist member of the medical team usually attached to a public hospital or similar institution, who, by virtue of her professional training and her personality, is in a position to offer practical assistance to the patient in the personal problems associated with his illness. This assistance covers everything from the solution of financial to emotional problems, from arranging for help in the home and facilitating transport centres to watching the patient's interest in compensation claims.

An understanding of her work is not just an interesting adjunct to the study of medicine, but is vitally important to a full understanding of the problems of the patient who, in a few years, will be our responsibility.

Technical Terms Illustrated:

"A low count".

Something of the History of Epilepsy

— Ann Jervie, Med. V.

Ever since man inhabited the earth, epilepsy has been known to him. The long history of the disease is a story of man himself; tracing his religions and philosophical beliefs, his standards of civilisations, behaviour, and his moral ideas as reflected in his attitudes and treatments. Much of its history throws little credit on man; a disease surrounded by mysticism and rejection, even after wise physicians had recognised its nature, if not its cause. Its history lies in that borderland of medicine and of religion; it was as often regarded as belonging to the province of the priest as of the physician.

Even its many titles reflect this — Morbus sacer (the sacred disease of Hippocrates' day), morbus divus, divinus, scelestus, Herculeus, daemonicus relate to its divine or demoniac origin; morbus chronicus its protracted course; morbus puerilis, its incidence in childhood; morbus deprehensio, morbus major or minor, clonus epilepsia, hieranósis, prehensia, catalentia,, analepsia, cataptosis, viradellus, sonticus, seleniacus, vitriolatus, mensalis, caducis (or falling sickness) and m. comitialis all partly descriptive, m. lunaticus, m. lunaticus astralis or australis, interlunius, relate the disease to the moon and to silver — an early and close association resulting in the empirical use of silver nitrate and silver internally as a therapeutic measure or externally prophylactically as charms and amulets until the 19th century. Later, with the advent of Christianity, the disease became associated with St. Valentine, St. Vitus, St. John, and many other local saints — St. Eninemond of Lyon, St. Nymphase of Cahors, St. Matthieu of Sens.

A sidelight to the study of the disease was the discovery of the number of prominent people sufferers from the disease — from the earliest days epileptics were set apart. Reliable evidence points to Mahomet, Luther, Loyola, Dante, Petrarch, Pascal, Schumann, Richelieu, Byron, Paracelsus, Beethoven, Flaubert, Moliere, Alexander, Julius Caesar and Dostievsky, whose writings contain some of the finest descriptions of the malady.

In the neolithic times, the trephining of skulls was an established surgical procedure, as it is among modern primitive peoples. Epilepsy is one of the indications for the operations among several of these of the present day, notably in the Pacific area, to release malign demons. It is reasonable to postulate that neolithic devils or evil spirits causing the convulsive disorder were similarly set free by craniotomy, usually performed on children. This operation also survived in Europe (France) as late as the 17th century in the form of scraping away areas of the cranium in epileptics.

Highly prized were the skulls of those surviving the operation, and after death, relics cut from the trephined opening or "rondelles" were regarded as potent amulets to ward off the disease. From this developed the use of bone powder as an early remedy, which can be traced from the days of prehistoric man through the works of Pliny, Galen and Paracelsus to the end of the 19th century.

The earliest writings from Babylon, Assyria, and later, Israel, reveal cognisance of the disease, but it is not mentioned in the medical papyri from Egypt possibly because its nature was regarded as divine and in the province of the priest. In other, earlier communities, the priests were drawn from among the epileptics; or the disease was treated by means of mystical remedies, often designed to be applied to the umbilicus.

The Talmud from Israel and Babylon records laws relating to epilepsy. The evidence of epileptics in Hebrew law was disregarded, or accepted only with reservations. Marriage to epileptic women was forbidden as the disease was regarded as hereditary, due to improper conduct during sexual intercourse or to standing naked before an open flame. In Babylon, it was regarded as contagious, a belief which again became popular in the middle ages. Yet, the supernatural nature of the disease is apparent — "When the spirit siezes him, the patient screams suddenly, falls down . . . ."

The sanitary laws of Midrashim, an even older Oriental code, describe a charm to be worn prophylactically and prohibit the marriage of epileptic women. Similarly, in Delphic law the disease was regarded as a 'secret fault" and marriage was annulled on its first becoming manifest.

The greatest single advance in the history of epilepsy was the writing, in about 400 B.C., of Hippocrates' "on the Sacred Disease" which represented the first recognition of the brain as the seat of the disease (and incidentally of emotions). During the course of his treatise he denies strongly its supernatural origin — "It is no more divine than any other disease", describing in detail the beliefs of his day, only illustrate their futility and inadequacy.

He mentions the aura and premonitory signs: "but such such persons as are habituated to the disease know beforehand when they are about to be seized and flee from men . . . This they do from shame of the affliction and not from fear of the divinity as many suppose". His descriptions of the disease itself illustrate the accuracy of his observation: "The patient loses his speech, and chokes and foam issues by the mouth, the teeth are fixed, the hands contract, the eyes distorted, he becomes insensible and sometimes the bowels are evacuated. And these symptoms occur sometimes on the left side, sometimes on the right side and sometimes on both". (This description of unilateral fits or "Jacksonian" attacks pre-dated Houghlings Jackson by 2,300 years).

His discussions of aetiology and nature of the disorder are illustrated by pathological investigations and dissections of afflicted goats. While his theories of aetiology relate to the humoral pathology, he notes the hereditary nature of the

disease. Excess of Phlegm and a disordered "Pituitra" was his theory — the latter part revived in more sophisticated terms this century by Cushing and his studies of hypopituitrism and epilepsy. As in all Hippocratic writings, he is preoccupied with the effects of the seasons and the weather; but with epilepsy he takes no chances, describing it as a disease of spring, summer, autumn and wet weather.

This wisdom and clinical judgement was respected by some of the physicians of the Greek and Alexandrian schools. That it was ignored by others is illustrated by the treatments listed in 280 B.C. by Serapion of Alexandria, a pupil of Herophilus and Erasistratus — "castoreum, brain of camel, heart of hare, rennet of seal and blood of tortoise". Its rejection in Israel can be demonstrated by the Biblical account in Mark, Chapter 9, with its obvious belief in a supernatural aetiology — "And one of the multitudes answered and said, Master, I have brought unto thee my son, who hath a dumb spirit; and wheresoever he taketh him he teareth him: and he foameth and gnasheth his teeth, and pineth away . . . ."

Technical Terms Illustrated —

DELAYED UNION

Another beautifully written case history occurs in Lucretius poem "De Rerum Nature", some 50 years previously:

"Oft too, some wretch before our startled eyes,
Struck as with lightning with some keen disease
Drops sudden; by the dread attack o'erpowered.
He foams, he groans, he trembles and he faints;
Now rigid, now convulsed, his labouring lungs
Heave quick and quivers each exhausted limb.

He raves, since soul and spirit are alike
Disturbed throughout and severed each from each
As urged above, distracted by his bane;
But when at length the morbid cause declines
And the fermenting humours to the heart
Flow back — with staggering foot first treads
Led gradually back to intellect and strength".

(III, lines 486/504)

About this time in India, delusions and epilepsy were equated technically in accordance with earlier teachings from about 600 B.C.

Celsus, in A.D. 26 showed a confusion between true epilepsy and other conditions, and, while describing its aetiology in humoral terms indicated the association of the sex glands noted in Israel. He advocated fasting (indeed, Hippocrates' comment is appropriate — "most healers advocated hygiene and hoped for luck"), and the warm blood of a freshly slaughtered gladiator, as well as surgical procedures such as burning and cupping. Cautery remained popular throughout the middle ages.

Pliny (23-79) described crushed pig's testicles in milk as a sovereign remedy.

Archigenes (54-117) specifically described the premonitory signs as had Hippocrates before him, but the description and naming of the aura or "breath of cold air" has, by convention, been credited to Pelops of Smyrna who was responsible for the popular theory of epilesy originating peripherally and then spreading to the brain.

Claudius Galen (130-200), a pupil of Pelops, added nothing but confusion to Hippocrates' lucid account. He again based the disease in the brain, but even his clinical descriptions are marred by his preoccupation with the humoral pathology. His treatments are in part general hygienic measures, including the ubiquitous purging, and in part a strange series of food prohibitions, seeming to date from pre-Hippocratic superstition. They are well documented in his "Advice to an Epileptic Boy".

Arataeus (2nd-3rd century) describes the aura — visual, auditory, olfactory or epigastric discomfort ("meteorism in the hypochondria"). Although he obviously again includes a variety of convulsive disorders, his rescriptions of the typical attacks is worth quoting — "In the attack, the person lies insensible, the hands are clasped together by the spasm, the legs are not only plaited together but also dashed about hither and thither by the tendons. The calamity bears a resemblance to slaughtered bulls; the neck bent, the head variously distorted . . . . . they gape wide, the mouth is dry, the tongue protrudes so as to incur the risk of a great wound or of a piece of it being cut off should the teeth come forcibly together with the spasm; the eyes rolled inwards, the eyelids for the most part are separated and affected with palpitation; but should they wish to shut the lids they cannot bring them together, insomuch that the whites of the eyes can be seen from below."

Later, he describes the unconsciousness, the lividity, and by inference, the cyanosis, the epileptic cry, the pulses "strong, quick and small in the beginning; great, slow and feeble in the end and irregular throughout", the personality and mental changes between attacks; and the aversion of Jacksonian attacks was recognised.

His description of the end of the attack illustrates the attitude of his day to the disease — "At the termination they are torpid in their members at first, experience heaviness of the head and loss of strength, they are languid, pale, spiritless and dejected from the suffering and shame of the dreadful malady".

Will it be a boy or a girl? Soon the anxious waiting will be ended. Soon everyone will know. To-day and every day people put their trust in medicine . . . and doctors and nurses put *their* trust in C.I.G. equipment and gases—a trust that is well founded.

138 BOURKE ROAD, ALEXANDRIA, N.S.W. • OXYGEN • NITROUS OXIDE • CARBOGEN • CYCLOPROPANE • CARBON DIOXIDE

Caelius Aurelianus (400 A.D.) added sweating to Aureteaus, mention of incontinence, frothing at the mouth; and describes clearly amnesia for the fit, automatism and status epilepticus with its great danger to life as fit relentlessly succeeds fit. He differentiated the true from the hysterical fit (in which he noted no foaming and no loss of consciousness). Among the valueless remedies of his day he lists brain of vulture, heart of the raw cormorant, and domestic weasel. He advocated the avoiding of sea journeys and sexual intercourse, and removed from the diet all foods containing starch, fat, spicing and vitamins!

Alexander Traillanus (525-603), the only original thinker of the Byzantine school, discusses the aetiology in the vaguest of terms: "In the head, constriction and opening of the ventricles and certain other parts," Lombard Warimpontous of Salerno (d.1050) quoting the Byzantine teachings of the 8th and 9th centuries, describes vaguely three types of epilepsy, corresponding to no known classification. The first was analepsia, ascribed to over-indulgence in food, coitus or luxuries; an enduring theory only recently disproved.

Of the Arabian schools, Haly ben Abbas (d.994) wrote an authoritative treatise on epilepsy which stated that while there could be no cure, fasting, peony mirrh, and cascara were of assistance, with the African ginger which remained popular for centuries. Rhazes (850-984) had previously quoted the ubiquitous roset-oil treatment. Avicenna's (980-1037) treatise superseded that of ben Abbas and in it the word epilepsy was first used. The great advances of the Arabians related to the increased care of the underprivileged, including the insane and the epileptics.

In England and Europe at this time, the Church taught that the disease was of divine origin, and among the many remedies were "cramp rings", the use of which dated back to Edward the Confessor who is said to have given his own ring to a beggar who turned out to be St. John the Evangelist himself. Since the disease at the time was known as Morbus Sancti Ionni, the ring was recovered by exhuming Edward's body, and copies became popular in therapy. Other remedies of the time and for many years afterwards included the hoof of the "right foot behind" of the deer, which was held in the left hand and rubbed on the heart and the ear; mountain goat's brain drawn through a golden ring for the disease in children, the matrix of a sow, the claws or hoofs of an elk, the bone powder dating back to the days of trephining, the silver remedies and connections with astrology, and elder and mistletoe dating from the time of the Druids.

In 1200 the Ancren Ruele — "For it is very necessary for an anchoress of holy and pius life to have the falling sickness . . ."

The disease was one of the eight considered contagious in the Middle Ages. In the lines of Bernard de Gordon (1307):

"Febris acuta, ptisis, pedicon, scabies, sacer ignis,
Anthrax, lippa, lepra nobis contagiopraestant."

Epilepsy is said to be the disease Pedicon. This belief is a linear descendent of the similar Babylonian belief, and that it was still held in 1486 is shown by the establishment, in that year, of St. Valentine's home at Rufach for the isolation of epileptics.

John of Gaddesden (1280-1360) wrote what must be the most useless treatise on epilepsy in its long history. "Epilepsy is of three kinds, true, truer, truest . . they are minor, major and medium . ."

Jean Fernal (1497-1558) differentiated categories of the disease and based his therapies on rational clinical deductions, but Jean de Renon (15th century) remains close to the superstitions of the time: "The emerald can not only preserve from the falling sickness all those who wear it set in gold on a finger, but can also fortify the memory and resist the forces of carnal lust."

Paracelsus (1493-1541), in a major disagreement with, and break from, Galen's theories, defined the disease in picturesque form: "the earthquake of the microcosm, the microcosm in revolution and the result of the revolution is the efferevescence of vital spirit or epilepsy". In 1607 Erastus recognised the aura as part of the disorder, not its cause.

A "Pathway to Health" of 1664 indicates the little effect of these advances. To ward off epilepsy it advocates the taking of blood from the little finger and writing:

"Jasper pert mirrham; Thus Melchior, Balthazer aurum
Hae quicunque secum portat tria nomina regum
Salvitur a morbo, Domino pietate, caduce".

to wear as an amulet. And about 1650, the black cat (or 3 drops of blood from its tail) or the fat of a wild cat were considered to cure the disease; an example of the association of the disease with witchcraft. In 1685 the mummy of a jaybird was recommended as alternative to the more expensive but apparently efficacious Egyptian mummy.

Thomas Willis (1621-1675) made valuable pathological investigation on the disease.

Boorhaeve (1668-1738) recognised the predisposition to convulsions or the "epileptic diathesis" — "a pre-existing peculiar condition of the brain", and recognised as separate the eclampsias, the fits following intoxication and haemorrhage. He recognised petit mal and aberrant attacks, and his views on aetiology are surprisingly modern: "Epilepsy a disease of the sensorium communi and the affection is such that the working part where the sensation grows conscious is entirely abolished and the place where the muscular movement (of voluntary muscles) arises, is irritated abnormally by some stimulation of unusual strength". While accepting the hereditary nature of the fits and the influence of prenatal factors (e.g. conception during menstruation or violent emotion), he sought for the initial and initiating causes.

He realised that the patient was unconscious at the time of the cry, and noted that in hysterical fits the eyes were closed, which they never were during a true fit.

Then some of the confusion which exists today and a multiplicity of theories entered. The demoniac theory was repopularised by Jean-Joseph Gassner in the 18th century, himself an

epileptic, and observations accumulated on unilateral fits, and fits with a unilateral aura (e.g. Bonet, 1700). Heberden noted that the aura diminishes with time, and he differentiated epilepsy and childhood culvulsive disorders and discredited many of the therapies of the day — purging and bleeding in particular. His advice to avoid terror, liquor and the intemperate use of women indicates "sound hygiene by confused aetiology".

In the early 19th century, little advance was made, but the confusion increased. Wenzel (1810) revived the pituitary theory of Hipocrates, later reintroduced on a sounder basis by Cushing (1912). Marshall Hall (1851) regarded the fits as originating in the medulla oblongata as suggested by van Sweiten in 1733; this was "confirmed" by van de Kolk in 1859. Brown regarded the fits as of reflex origin, reminiscent of the days of Pelops and his peripheral theories. Similarly, Radcliffe (1864) regarded fits as entirely peripheral, only mechanical in origin.

The humoral theory was redressed by Todd in his suggested toxic aetiology "morbidly disturbed polarity". He also noted a paralysis which bears his name following the fit and ofaen associated with organic disease of the brain. Trousseau (1866) regarded embolus and thrombus of small vessels as vital, and congestion as secondary, whereas one of the most popular theories with it roots in antiquity was that the congestion was the primary cause. But then it was shown by Kaussmaul and Tenner that the opposite condition or anaemia may cause fits. The "mantle of protective generality" clothed the theory of Russel Reynolds — "a change in the nutrition and intersitial processes of nerve centres".

Yet for all this abstract theory and scientific endeavour, in 1852 fried mole was solemnly recommended as a therapeutic measure.

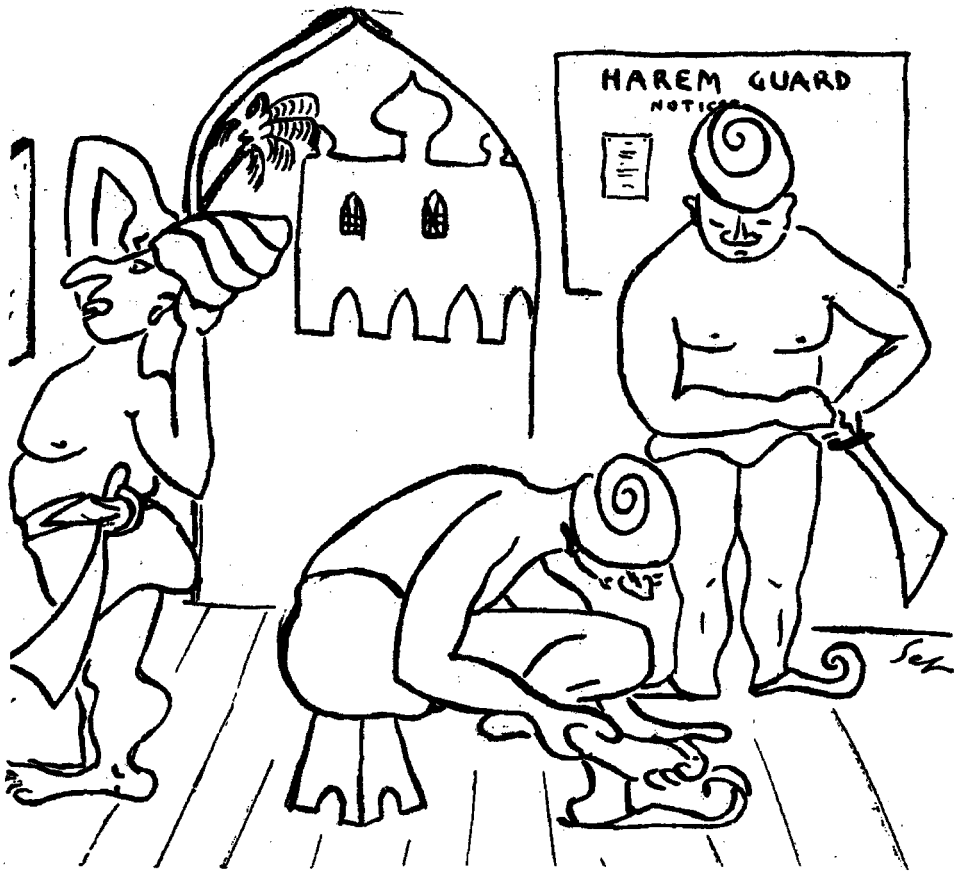
The greatest advances in the 19th century were in the fields of therapy with the introduction of bromides in 1859 and the waning of the mystical remedies, and in the recognition of the focal fit. These, described in the earliest of writings were well documented by Richard Bright, before 1850, and illuminated by his pathological investigations. Charcot, Romberg and Breavis all made investigations of the problem, and some focal fits of traumatic origin had been cured surgically by Larrey (1829). Astley Cooper (c.1820) and W. C. Wells (1812). It was Hughlings Jackson in the latter part of the century who organised the material and defined the disease in words now used: "Occasional, sudden, excessive, rapid, local discharges of the grey matter." With the discovery of the excitable motor cortex by Fritsch and Hitzig, this definition was accepted.

Then came Gowers, whose masterly accounts of epilepsy in the 1800's dispelled much of the confused thinking and poor observation. He clearly differentiated epilepsy from "borderland" conditions and his descriptions and clinical classifications have never been surpassed.

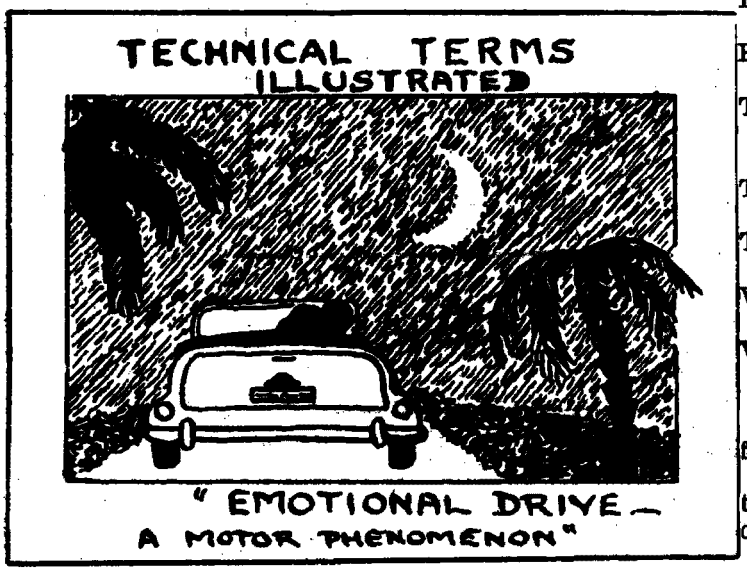
This century, progress has been made but theories of aetiology are myriad once again, often only rephrased from earlier writings. Among major advances was the introduction by Berger in 1927 of the electroencephalogram, and the successful surgical ablations of discharging foci by Penfield and his associated workers.

Technical Terms Illustrated :

STERILE DRESSINGS.



So this history reaches the present day — the sacred disease of many centuries being described in rational terms and objectively. Because of its nature, it has inspired dread and dismay in the minds of men, and despite accurate and informed clinical observation and description, ignorance and superstition have played the greatest roles in its story. It was nearly 2,400 years ago that the idea of the Sacred dsease was first abolished; yet superstition and fear remain, even in civilised communities. Only slowly has rejection and distrust of the disease given way to care, understanding and rational therapy.



Selected References :

W. R. Gowers:
"Borderland of Epilepsy".
"Neurology", vol. II.
Hippocrates: Tr. Adams (1939 ed.)
J. H. Jackson: "Selected Writings".
Garrett: Myths in Medicine (1884).
McKenzie, D. (1927): The Infancy of Medicine.
Mettler: History of Medicine (chapter 8), p. 487. (1947).
Penfield and Erickson: Epilepsy and its Cerebral Localisation (1941).
Penfield and Jasper: Epilepsy and the Functional Anatomy of the Human Brain (1954).
Pirkner: Epilepsy in the Light of History. Ann. Med. H. (N.S.1.), 1929, 453-480.
Temkin, O.: Epilepsy in an Anonymous Work on Acute and Chronic Diseases. Bull Inst. H. Med. IV, 1936, 137-144.
Temkin, O.: Galen's Advice to an Epileptic Boy. Ann. Med. H. (N.S.2), 1934, p. 179.
Temkin, O.: Views on Epilepsy in the Hippocratic Period. Bull. Inst H Med. I, 1933, p. 41.
Von Storch, T.C.: An Essay on the History of Epilepsy. Ann. Med. H. (N.S.2), 1930, 614-650.
Various "Histories of Medicine" e.g. Garrison, Guthrie

"You should see my new girl. She's as beautiful as a mirage."

"That's the wrong simile. A mirage is something you can see but you can't get your hands on."

"That's my sirl!"

DIAGNOSTIC QUIZ

CASE I. —

Mr. A., aged 45, was admitted to hospital one week ago. On admission, he complained of an increasing weakness and fatigue on effort so severe that he was forced to give up his job as a carpenter immediately prior to admission.

Over the same period, he had noticed that he had become breathless on mild exertion, and had experienced occasional palpitations. Over the last 3 weeks he had become aware that he was bleeding more easily.

He gave no history of any drug therapy.

On examination: He was noted to be exceedingly pale, and his spleen was just palpable. His temperature was 99.6 deg.F. Some petechial haemorrhages were noted in his skin.

Investigations revealed a haemoglobin level of 5.2 Gm. %; the anaemia was found to be the normocystic and normoblastoc type. His white cell count was 3,200 per cubic ml, of a normal distribution (70% neutrophils, 20% lymphocytes, 8% monocytes and 2% eosinophils). The platelet count was 70,000 per cubic ml.

What would you do to confirm the diagnosis?

* * *

CASE II. —

Peter, aged 12, was brought into casualty in an extremely drowsy state, with a severe headache. There was a mild degree of neck stiffness present.

His parents stated that prior to the onset of drowsiness, he had complained of "feeling sick" for 24 hours, and had not eaten anything during that period.

During the next 24 hours his condition worsened: he became delirious and then comatose.

Examination revealed a temperature of 101 deg.F., but no abnormal findings in any system.

Lumbar Puncture revealed a pressure of 190 mm. of water, protein of 50 mgm per cent., normal chloride content, and a cell count of 110. Lymphocytes predominated.

Then, the next day, the Honorary on his round looked quickly at the child and the diagnosis was made.

* * *

CASE III. —

Mrs. C., aged 57, presented with a history of vague abdominal discomfort after meals which had been present for some weeks. Her appetite was declining, and she had lost weight (about half a stone) over the same period.

There were no other symptoms.

In the past, she reported that she had borne 4 children and had had a hysterectomy performed 10 years ago for a chronic metritis. She had suffered from "inflamed veins" in the legs on and off for 6 months.

On examination, there was evidence of recent weight loss, her liver was palpable 2 fingers below the costal margin and there were no other findings.

A barium meal examination revealed nothing abnormal.

What is your diagnosis?

* * *

CASE IV. —

Mr. D. was seen in hospital with a red, inflamed eye. Prior to this episode, his face had swollen, painlessly, on the right side, later on the left.

On specific interrogation, he recalled that he had not been feeling entirely well for an indefinite period of some weeks. He had been feeling tired, listless, and had felt nauseated. He had not been eating well also, because his mouth was very dry.

On examination, there was seen to be an iritis and mild conjunctivitis, swellings in both paratoid glands (painless) and a few enlarged lymph glands were found in the neck.

(See answers on page 79)

STUDENTS!

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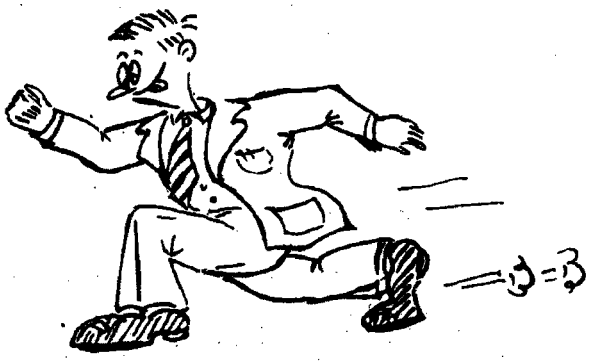
Society Activities



ANNUAL MED. DINNER 1958

The 1958 Dinner was held in Lent Term in the Union; students outnumbering tutors and lecturers by only a small margin. All who were present carried away happy memories, in varying degrees of clarity, of an outstandingly successful dinner.

The toasts of the evening were proposed and answered by Sir Charles Bickerton Blackburn, Professors Blackburn and Loewenthal, the newly-elcted President, Dr. Ian Cooke, with Stuart Renwick and Ray Ahearne as impressively fluent representatives from amongst the students. Sir Charles presented the "Robin May" Prize to Dr. M. Connolly, and the Gilbert Phillips Memorial Prize to Mr. G. Danta to complete the formal proceedings.

The excellent and enjoyable official speeches were followed by others, more informal in type, from Professors, lecturers and tutors. Some of the jokes are still being retold with enthusiasm to those who were unlucky enough to miss the dinner.

We then adjourned to work up a thirst singing the traditional "alcoholic ditties" accompanied on the piano by Dr. Maddison. An appreciated, if noisy, end to a memorable dinner.

*

2nd Year Dinner, 1957

Carrying on a new tradition, the Second Year Dinner was a resounding success. Chaired by Bob Middleton, the dinner was attended by about 120 enthusiastic students.

There were memorable speeches — Professors Macintosh, Bishop and Cleland, with David Lindsay, Bob Middleton and Charles Wood, contributed to the official part of the proceedings, and numbers of lecturers to the unofficial part.

One feature was the attendance of the Anatomy demonstrators — celebrating their success (announced only that morning) in the Primary Fellowship exam. Dr. Philomena McGrath replied charmingly on their behalf.

Another characteristic and memorable feature was the singing of traditional songs — with vigour, enthusiasm and at length, even if not exactly harmonious.

Altogether a most enjoyable dinner which will be remembered as a highlight by those present. All credit is due to Bob Middleton for his fine organisation and chairmanship.

* * *

Junior IVth Yr. Dinner, 1957

The usual lively standard of Junior IVth Year Dinners was upheld in 1957.

Professors Magarey, de Burgh, Thorpe and Bishop successfully evaded perfumed water pistol shots while entertaining us with a few well chosen jokes. Bread rolls were rather more unfashionable than in previous years as ammunition.

Graham Utley very ably chaired the Dinner. Amongst other students who spoke were Joan Payne, Elaine Rigg, Michael Quilter and Jim Friend.

The evening ended on a happy note with the singing of songs (dubious) to accompaniment (excellent) on the piano by Robert Dick.

* * *

Senior Fourth Year Dinner

A large number of students was present at the Senior Fourth Year Dinner in October last year, but the date unfortunately coincided with an important meeting at R.P.A.H., attracting many of the physicians. The early serious note and the early departure of a number of our guests to the rival function was disappointing, but the dinner was greatly enjoyed by all present.

The official speeches by Josephine Glen-Doepel, Professor Thorpe, Dr. Joseph, Brian Thomson (who displayed an unsuspected lyrical ability), Professor Magarey and Mal Stuart will be long remembered. These were followed by more formal proceedings; other Professors, lecturers, tutors and students addressed the multitudes.

Some of us retain odd and disconcerting memories—Dr. Joseph's reminding us beforehand that Sputnik I would be visible for the first time that night; the Rebelasian muttered comments of a staid and highly respected physician during dinner; tutors reminiscing of student days far wilder than ours; and the lesson in pharmacology

learnt as one student tried large doses of alcohol on top of his phenobarb mixture.

These dinners providing as they do an opportunity to relax in pleasant company with enjoyable liquid and other refreshments, to entertain tutors and meet staff members informally, are an essential part of student life and will be reembered longer than any hard-won facts.

* * *

Annual Medical Ball

The 1958 Medical Ball was held in June, for the first time at the Empress Ballroom — an innovation welcomed by all who attended.

It was a wonderful night, and the Ladies' Committee is to be congratulated on their fine organisation. The War Memorial Library Fund should benefit substantially from a well-attended function.

All present are unanimous in their praise of the evening, declaring it to be "the best ever" — the surroundings were pleasant, the music compelled dancing, the company delightful. The floorshow was most enjoyable, and many thanks are due to Professor and Mrs. Trethowan for their hard work.

Students attended in greater numbers this year, and their enjoyent ensures the future success of the traditional Ball.

★

Orientation Week, 1958

This year's Orientation proved to be ambitious, but thoroughly successful; a record number of freshers joining the Society during the week. By spreading functions over the whole week, and by introducing a varied programme, interest was sustained.

On the Tuesday, the Official Welcome was held in a packed Wallace Theatre. The Dean, Professor Mayes, the President, Dr. Davis, and Dr. Condon spoke, with Ann Jervie in the chair. The following day saw an outstanding and thought-provoking symposium entitled "Does the Medical Course provide a Liberal Education?" and we were privileged to hear Professor O'Neill, Dr. C. G. MacDonald and Jim Friend debate the issue under the chairmanship of Brian Thomson. The last question "What is a Medical Student?" was answered by Professor Thorp, Dr. Marsden and Tony Gallagher, and the meeting was chaired by Brian Casey. The various symposia are remembered by freshers and others present as stimulating, controversial and entertaining.

The popular exhibition of text-books required was held, with the innovation of including a sale of second-hand First Year books. This proved successful, being only limited by the numbers of books offered. Next year this could well be expanded.

A welcome return to tradition was the showing of some medical films — the number of casualties was not great.

Again, a feature of the week was the unselfish help given and time spent by Society members on the Table in Science Road. The opportunity to meet senior students and discuss with them problems of first year, remains undoubtedly the most valuable function of the week.

★

1958 Convention

Only 50 students were at Berowra for the 1958 Convention; the rest of the faculty have been regretting their missing it ever since. In idyllic surroundings, peaceful because of a degree of inaccessibility, the 50 relaxed; enjoying swimming. boating, ball games played at a leisurely pace, even (for the intrepid, energetic types) hiking, and camp-fires.

Aim of the Convention — to encourage free discussion amongst students and staff — was certainly achieved. Speakers were conveyed to the camp to lead in symposia on "Artificial Insemination", "Radio activity and the Human Body" and "Death". Doctors, a theologian, a solicitor, social worker, physicist and a philosopher were enthusiastic speakers, who had obviously spent much time on preparation of their material.

Lively debate ensued on each of the topics, well chosen to stimulate controversy. Some energetic students were especially active in disagreement and discussion.

John Hammett and Don Lawrence are to be congratulated. Surely a Convention to remember on many counts, it has set a high standard to be maintained in 1959. The appointment of a "permanent" annual Convention Committee early in Michaelmas term will ensure better continuity.

Haunted by nostalgic memories of cool water and hot debate, blue skies, campfire smoke and funny stories, I hope I'll see you there next year.

* * *

Lambie-Dew Oration

1956 marked the retirement of Professors Lambie and Dew from their long tenure of the Chairs of Medicine and Surgery, respectively. An Oration was instituted by the Medical Society to commemorate their work during their long associaion with the Medical Faculty; a measure designed to interest and benefit students.

Professor M. M. Wintrobe, of the University of Utah, a renowned haematologist, kindly consented to deliver the Oration, and over 400 students were present to hear him speak on "Medical Research and the Art of Medicine".

The atmosphere created in the Great Hall is something intangible, adding immeasurably to the occasion. We were very honoured, too, that Professor Lambie was able to be with us, as was the Chancellor of the University, the Acting Vice-Chancellor, and a large number of our Professors and lecturers.

It was most unfortunate that Dr. Ian Cooke was snowbound and unable to attend, as he had played a large part in initiating and in organising the Oration. Ray Ahearne, at very short notice, undertook to chair the meeting, and deserves the highest praise for his introductory and concluding remarks, which played no small part in the success of the evening.

Professor Wintrobe, hitherto known to us by his book, his method, and the Wintrobe tube, proved himself to be a forceful and original speaker, tracing developments in Medicine since his own graduation, with special reference to advances in haematology and discussing possible future development in Medicine (see elsewhere.) His defining of the qualities of the successful research worker and ideal physician emphasised the need for the thoroughness taught by Professor Lambie.

His inspiring thought-provoking and at times controversial address, specifically for the students, will be remembered and discussed at length by those present; just as we will remember his readiness to meet and talk to student afterwards at supper (which also provided a rare opportunity for students to meet staff members informally.)

The inaugural Lambie-Dew Oration has set a very high standard which must be maintained in future years.

Clinical Evenings

Only two Clinical Evenings have been held this year, a disappointing number.

At Sydney Hospital, chaired by Dr. Stokes, a successful evening was held at which Lionel Sinnathamby, David Garlick and Tibor Pietzch presented cases. Tibor, especially, confounded all with his impressively learned discussion on aphasia.

Another was held at Royal Prince Alfred. Dr. Reader took the chair and Jim McGrath (organiser), Peter Schiff and Alick Hobbes participated. A lively discussion and dissent followed the presentation of one case; and the mysterious physical signs were only successfuly interpreted later, post operatively The Clinico-pathological case was missed; but there were some near guesses.

These evenings, providing as they do an opportunity for students to present and discuss cases, are both informative and entertaining. It is to be hoped that future Final Years will not allow them to lapse into oblivion.

Medico-Historical Club

A new field of student interest has been developed with the establishment of the Medico-Historical Club in 1958.

The club's monthly meetings have been well attended by members and visitors. At each, one Graduate and two Undergraduate members have presented papers. These have been of a uniformly high standard and have covered a wide field both in medical history and in related topics. (Some of these have been printed elsewhere in this Journal).

Graduate speakers have included Professors Ford, Loewenthal and Bishop, Drs. MacArthur, Brown, Walker-Smith, Billington.

Another club venture has been the sponsoring of lunch-hour addresses for junior years, and the organising of an essay competition.

The formation of such a club is a notable step; Kerry Goulston and his committee are to be congratulated on the success of their venture in its first year and on the uniform excellence of papers presented.

Not only to sponsor the study of the fascinations of Medical History, the Club also successfully provides a much-needed opportunity for reading, research and presentation of material.

* * *

Sport, 1957

Medicine once again proved its superiority on the sporting fields by winning the Penfold Shield for 1957. Despite strong opposition and determined organisation by the Engineers, we managed to total 63 points to their 52.

It was in Athletics, Basketball, Cricket and in the Boat Race that our most notable successes were scored, as we won all four. We won minor places in Golf, Hockey, Tennis and Swimming, but in the Shooting and Football we can only say that we fielded a team.

Although a Faculty with a large sporting potential, the scattering of students at different schools within the University and a vasly different points of the compass for clinical teaching, makes successful organisation very difficult. The enthusiastic few in some of the sports ensure our success; but lack of interest in others (notably football) in which we should excel, ensure our defeat.

We must learn from the smaller faculties whose few students provide an example of enthusiasm in participation and in active, noisy support.

Let us strive for the ultimate success — a win in every sport !

CONGRATULATIONS

To athletes David Abramovitch and Jim Penfold, who represented Australian Universities in New Zealand this year. David also ran for Australia at the end of last year, in Israel.

To Sax White who toured Europe with the Wallabies Football team, 1957-58.

Sporting Females

For the first time for many years we are able to rejoice in the success of the Medical Faculty in winning the Interfaculty Women's Sport Shield. This was no easy victory.

After unsuccessful appearances, or even non-appearances in the Athletics, Basketball, Tennis and Swimming, we had not gained impressive numbers of points and were trailing rather badly. But a first place in the Table Tennis was followed by a meritorious second in the Hockey, after losing a replay of the final. Still behind Arts and Science at that late stage, a resounding victory in the Cricket ensured our success by one point.

The appointment of a Women's Sport Representative would ensure the more efficient organision so necessary if we are to retain our position. The presence of more supporters and enthusiastic barrackers would undoubtedly favourably influence the results of hard-fought matches.

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DEFINITIONS:

A Surgical teaching round: "Shifting dullness".

A Surgery Lecture: Smooth on the surface, and apparently firm, but ragged at the edges and unrelated to surrounding structures.

And the Lecturer: Diminished vocal resonance which accounts for the main sign of his lectures — stony dullness.

* * *

Heard at O.P.D. (from Oxford):

The patient insisted that he was anaemic, that he had been told so at a previous attendance. In desperation, after the doctor showed him the pathological reports, he triumphantly produced a form, saying, "I told you there was a defect in my blood: it says "Wasserman negative'. "

* * *

One of the few passages in Osler's "The Principles and Practice of Medicine" to survive from the first edition:

"Certainly it is better, as St. Paul says, to marry than to burn, but if the former is not possible, there are other altars than those of Venus upon which a young man may light fires . . Idleness is the mother of lechery, and a young man will find that absorption in any pursuit will do much to cool passions which, though natural and proper, cannot in the exigencies of our civilisation always obtain proper and natural gratification."

* * *

Quote from a lecture: "Steel for naval purposes is made by Siemen's process."

* * *

A medical man was walking along a street one day, met an old patient, and asked how he was.

"Not too well, doctor."

"Well, call at my surgery in the morning and I'll go over you for £2."

"Right! If you can find them well have one each."

* * *

A prominent Macquarie Street surgeon in a more gracious age was in a horse-drawn cab. At the end of a 'er' y and snail-like journey he remarked "That's the most anaemic horse I've ever seen."

Replied the cab driver:

"That's funny — only last Thursday Dr. M— said it was the b—iest horse he'd ever seen.'

God and the Doctor we alike adore,
But only when in danger, not before;
The danger o'er, both are alike requited,
God is forgotten and the Doctor slighted.

* * *

"Mother," queried little Ermyntrude, "where did I come from?"

"The stork brought you, my dear," was the reply.

"And you and father?"

"Yes, the stork brought us also."

"What about grandpa and grandma?"

"The stork brought them too. But why all these questions?"

"I've got to write an essay on 'My Family'.

"And what have you written?"

Ermyntrude read out: "I am not very conversant with the history of my family, but, from inquiries, I have gathered that it is somewhat unusual in that for the last three generations reproduction has been along asexual lines."

* * *

Hear about the laundryman who stuck his head in the nunnery window and called out: "Any dirty habits?"

* * *

Hear about the perverted swan? He swam about with his head under water looking for cygnet rings.

* * *

And then there was the hypochriandical medical student who, doubtful of the purity of his supply of beer, took samples of two leading Sydney types and sent them to the Board of Health with a request for analysis.

He received the report that "In our opinion, neither horse is fit for work."

* * *

"Now, Granny, you are not to worry; the doctor says it is not appendicitis."

"Deary me! Was that the doctor? I thought he was very familiar for a clergyman."

* * *

Honorary: "Is the patient's temperature going up or down at present?"

Student: "Yes."

Honorary: "Yes, what?"

Student: "Yes, SIR !"

Into a temperance hotel staggered a drunk, helped by his more sober friend. The manager looked at them in alarm.

"You can't bring a drunken man in here. This is a temperance hotel."

"That's all right," said the friend. "He's too far gone to notice."

* * *

Then there was the ingenious soldier who obtained leave by explaining that his wife was going to have a baby. On his return his Captain asked: "Are the mother and baby all right?"

"What baby?"

"The baby you said your wife was going to have."

"Oh, don't be silly, sir, it takes 9 months!"

* * *

Patient (to visiting clergyman): "And your reverence, could you say a prayer for my floating kidney?"

Clergyman: "Isn't that a little unusual?"

Patient: "But only last Sunday in church you prayed for all loose livers."

* * *

Little Willie only swallowed a tray bit, but the canny doctor made him cough up ten and six.

* * *

"Vere novo gelidus canis cum montibus humor liquitur" (or, with the return of spring the cold moisture melts on the white mountains) was translated by a schoolboy:

vera novo — strange but true.
gelidus canis — the cool dog.
liquitur — makes water.
cum montibus — on the mountains.
humor — as a joke.

A glorious glamorous gigolo
Ruptured his ligament of Bigelow,
Which altered his stride
From a glimmering glide
To a rather ridiculous wiggle-o.

* * *

Before I heard the doctors tell
The dangers of a kiss,
I had considered kissing you,
The nearest thing to bliss.
But now I know Biology
I sit and sigh and moan,
Six million mad bacteria,
And I thought we were alone.

* * *

Hush! Hush!
Whisper who dares!
Christopher Robin
Is falling downstairs.
He's fractured his coccyx
And ruptured his gut;
He needs a transfusion
And M. and B. — but
Hush! Hush!
Whisper who dares!
Let's leave the prig falling
Who cares!

* * *

DEFINITIONS:

Mistress: "Between a mister and a mattress." adultery."

Little Red Riding Hood: A Communist contraceptive.

Psychiatrist: "One who finds out if children have as much fun in childhood as adults have in

* * *

ON LUNG CANCER:

Hear about the bloke with the King size with the filter tip?

Lord Ponsonby and his daughter were driving through Poona in their new red Jaguar when they were stopped by a road block set up by bandits. The bandits raced up to the car, held them up at gun point, stole all their money, valuables and clothes, and drove away in the car.

"By gad! This is awful!" said Ponsonby. "Here we are, left stranded, stark naked without a penny in the world."

"There's one consolation, Daddy," said his daughter, showing him a large diamond ring. "I saved this."

"Good heavens! How did you save that?"

"Oh, we girls have a place to hide these things."

"Well, if I'd only thought of that I'd have brought your mother along and saved the car," said Ponsonby.

* * *

Did you hear about the woman who named her three children: Innocence, Accidence and Negligence?

* * *

There was a young man from Bombay
Who thought syphilis just went away,
He thought that a chancre was just a mere canker
Derived from lascivious play.

Now he has acne vulgaris
The sort that is rampant in Paris;
It covers his skin from his head to his shin,
And all his friends ask where his hair is.

* * *

His senses grow number and number,
His aorta's in need of a plumber;
His heart is cavorting, his wife is aborting,
With all he's developed a gumma.

There's more to this patient's sad plight,
His eyes won't react now to light;
Along with his rabes and saddle-nosed babies
He's developed a gun-barrel sight.

Though treated in most every way
His spirochaetes grow day by day;
He's developed paresis, converses with Croesis
And thinks he's the Queen of the May.

* * *

Heard on the 'phone:

"Is that Dr. Wasserman?"

"Yes."

"Are you positive?"

* * *

Film posters seen in the city:

"MOTHER DIDN'T TELL ME"
"AND BABY MAKES THREE"

"IRON MISTRESS"
"NIGHT WITHOUT SLEEP"

Student taking gynae history:

"When did you first menstruate?"

Embarrassed reply: "Oh! I didn't do that until I got married."

* * *

Then there was the P.A. student who kept her out until the oui hours of the morning.

* * *

Did you hear about —

The Statistician whose wife had twins; he had one baptised, and kept the other as a control.

The cautious surgeon who built his house on piles.

The student who led a dog's life — always relying on posts.

* * *

Quote from "The Oxford Review" :

"It is reported that Professor Krebs was lately knocked down on his way to Council by an undergraduate cyclist . . . one cycle too many!

* * *

Elvis the Pelvis wants to deny that he has a brother called Enis.

* * *

A day with Bacchus
A night with Venus
A year with mercury.

* * *

A man in O.P.D. claimed that his local doctor was treating him with "suppessaries".

Are you suppositive ?

* * *

There is apparently above a certain labour ward the words "Primat non nocere" (first do no harm). However, it has been pointed out that other possible translations include "No harm is just once".

* * *

Tutor: "A dermoid cyst is easily recognised by its well-circumcised edge."

* * *

A surgeon is one with no faith in nature's capacity to heal before the operation, and infinite faith in it afterwards.

* * *

There was a British Army major caught in the early hours of the morning dressed in pyjamas, pursuing a comely maiden claid in flimsy negligee, down the corridor of a hotel in Cairo. Things looked black at the court martial until his lawyer came to the rescue — British Army officers need not wear their uniforms provided they are suitably attired for the sport they are pursuing.

* * *

The difference between a thrill and a shock? Nine months.

* * *

From the front page of The Lancet of some years ago "our book of the month . . . Contraceptive Technique — a Handbook for Senior Students."

* * *

Hula dancer — a snake in grass.

Hormones of Schering A. G. Berlin

Female hormones

follicular and corpus lutem hormones

Oestradiol	PROGYNON
Oestradiol benzoate	PROGYNON B OLEOSUM
Oestradiol valerianate	PRIMOGYN—DEPOT
Ethinyl oestradiol	PRIMOGYN C
Ethinyl oestradiol	PRIMOGYN M
Progesterone	PROLUTON
Ethisterone	PROLUTON C
Nor-Ethisterone	PRIMOLUT
Oxy Progesterone Capronate	PROLUTON DEPOT

Male hormones

androgens

Testosterone propionate	TESTOVIRON
Methyltestosterone	TESTOVIRON BUCCAL TABLETS
Testosterone in alcoholic solution	TESTOVIRON T
Testosterone oenanthate	PRIMOTESTON-DEPOT

Mixed hormones

Progesterone + oestradiol benzoate	DOUGYNON
Testosterone propionate + progesterone	TESTOLUTON
Methyl testosterone + Ethinyl oestradiol	PRIMODIAN
Testostorone oenanthate and Oestradiol valerianate	PRIMODIAN-DEPOT
Oestradiol + Oxy-Progesterone Capronate	PRIMOSISTON

Adrenocortical hormones

Adrenocorticotropic hormone	ACTH "Schering"
Adrenocorticotrophin-Depot	ACTH—DEPOT
Cortisone acetate	SCHEROSON
Hydrocortisone	SCHEROSON F
Desoxycorticosterone acetate	PRIMOCORT
Desoxycorticosterone glucoside	PRIMOCORT i.v.
Prednisone	DELTA-SCHEROSON
Prednisolone	SCHERISOLON

Pregnenolone

PREGNENOLONE

Methylandrostenediol

METHYLANDROSTENEDIOL
"Schering A. G. Berlin"

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Chorionic gonadotrophin	PRIMOGONYL
Thyrotrophic hormone	PRIMOTHYRON

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ASSISTANT EDITOR — CHARLES LEES

BLISTERS AND FOMENTATIONS

From a woman's magazine:

"James Mason" does not approve of make-up in his parts."

The father of 22 children was fined £5 for stealing chemist's supplies.

* * *

Professor (in lecture): The Aedes is a civilised mosquito. It only breeds in man-made pools.

* * *

(Authentic). Fifth Year P.A. student presenting a patient with acute rheumatic fever to his fellows — a 23 year old woman. Having detailed the history, he went on to Specific Interrogation. "No history of oedema, fainting, breathlessness or palpitations — except once in hospital while she was being examined by Professor B. . . ."

* * *

The scene was a Scottish Army Commando School, and the exercise was being discussed.

"You're to go out all night, stand still, and pretend to be a tree. Under no circumstances do I want to see yon until to-morrow morning." With which the Commander went to bed.

Accordingly, he was irate when woken by the return of one of the company at 3 a.m.

"Weel, Private?"

"Och, sir, I took up my position as ordered, and stood still. It got awful cold, but that was all richt, even when my feet froze to the ground. I didna mind the wee dog leaving his mark; I didna even move when twa lovers courted at ma feet. But I thocht it was a bit much when those two squirrels ran up ma legs, and one said, "Shall we eat them now or save them till later?" "

* * *

Hear about the two Lesbians who bought an organ so they could play hymns ?

Did you hear about the woman who went into the grocer's and asked for a grip of Tarzan's tube?

* * *

"I call my girl Versuvius."
"Why, is she as fiery as that?"
"No, covered with eruptions."

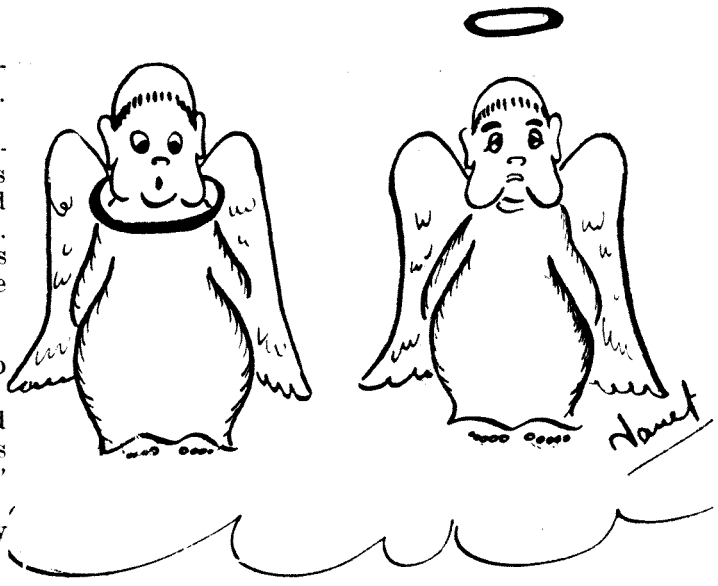
Answers to Diagnosic Quiz

CASE No. 1: Marrow biopsy, which in this case confirmed the diagnosis of a leukaemic leukaemia, as it revealed the presence of large numbers of immature white cells.

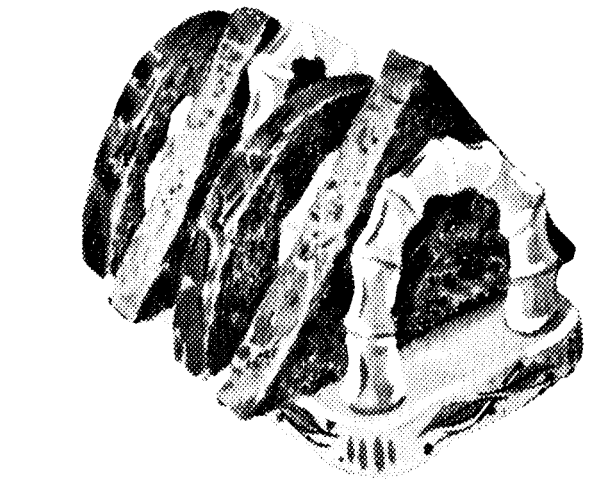
CASE No. 2: Mumps encephalitis. The typical parotoid swelling gave away the diagnosis after 2 days.

CASE No. 3: Mrs. C. was found to be suffering from carcinoma of the tail of the pancreas which proved inoperable on laparotomy.

CASE No. 4: The patient was suffering from the uveoparatoid syndrome of sarcoidosis, confirmed on biopsy of one supraclavicular gland.



My apologies and thanks to all the journals from which we have borrowed so freely — without acknowledgement. I should also like to record my dismay in the decreasing numbers of student journals still printing jokes. I hope this is not an indication that medical students are losing their traditional sense of humour.



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