An exhibition at the Library of the Royal Society of Medicine

Monday – Thursday: 9.00 – 21.00
Friday: 9.00 – 17.30
Saturday: 10.00 – 16.30
Admission free. Open to all.
The Library, Royal Society of Medicine,
1 Wimpole Street, London, W1G 0AE
Tubes: Oxford Circus or Bond Street
Richard Alan John Asher was born at Brighton on 3 April 1912, the son of a clergyman. He was educated at Lancing College and qualified in medicine at the London Hospital in 1935.

The following year he graduated with an MB, BS, and was appointed assistant medical officer to the West Middlesex Hospital. In 1942 he qualified as an MRCP and in the following year moved to the Central Middlesex Hospital, becoming senior physician in 1948. He was elected FRCP in 1952.

Throughout his career Richard Asher disapproved of over-specialisation, and remained true to his ideal of being a good, all-round physician. He did, though, develop special interests in haematology, endocrinology, and the effects of organic disorders on the mental state of the patient.

Richard Asher married oboist Margaret Eliot in 1943. They had three children of whom he was immensely proud - Peter, Jane and Clare - and they all remember childhoods strongly influenced by his wit, his rationality and his joy in language, music and the arts. He was a keen amateur actor and musician, and would gather his children around the dining table (after an evening of enjoyably gruesome stories from his day at the hospital) and cajole them into singing Gilbert and Sullivan in four part harmony.

Asher constantly made the case for clarity and simplicity in medical writing and his own writings unfailingly demonstrate their advantages. He warned that obscurity may appear to be profound, but is ultimately counter-productive because it prevents understanding.

The careless and inexact use of language will only serve to “perpetuate illness.” Poorly chosen words and phrases promote “syndromes and signs whose existence is doubtful.”
They deny recognition to others whose existence is beyond question and, moreover, they distort text book descriptions to conform to the chosen word."

His dedication to clarity extended to his own handwriting; fortunate correspondents would receive letters elegantly written in pen and ink, (often with miniature hand-painted illustrations) and even his prescriptions were models of legibility and style.

He was once described as “the most memorable epigrammatic arresting medical writer of our time. His papers will remain medical classics for clarity, perception, and wit.” For Asher, good medical writing was a matter of good medical ethics. In the same way that no doctor should ever be unapproachable and aloof from their patients and colleagues, no medical writer should indulge in vanity or obscurity.

His occasional book reviews paid close attention to stylistic matters and how they aided or hindered understanding. “Muddy waters may look deeper than they are, and a muddy style lends a certain profundity to this book” is a typical sentence from a typical Asher review. The author of one text book “certainly knows what he is talking about; but I am not sure that his readers will.” Another author is like “many others who feel uncomfortable in the world of sense, he tries to sell us tickets to the land of nonsense.” Asher affords faint praise where “quite a high proportion of the few facts in the book are correct and the pictures are cleverly drawn” and to another book that “says, in effect, that many elderly, fat, hairy ladies have thick fronts to their skulls and nobody really knows why.”

Asher came to be an active member of several medical societies including the Royal Society of Medicine. He was elected President of the RSM’s Clinical Section in 1964. Much in demand as a lecturer, one of his most amusing pieces written for The Lancet’s “In England Now” column concerns the hazards that await the unwary speaker invited to lecture in the Barnes Hall of the RSM.

In 1964 it was decided that the patients in the mental observation ward at the Central Middlesex Hospital would come under the care of a psychiatrist. Asher immediately resigned his post at the hospital and virtually gave up medical practice. Richard Asher died aged 57, on 25 April 1969.
He was remembered in The Lancet as a “superb diagnostician” and a “brilliant performer, linguistically, musically, and on a wide artistic front. There was nothing he could not set himself to do.” Others commented on how “despite the demands on his time he had many hobbies: perhaps his greatest love was the playing of wind instruments and the piano. His passion for music was greatly enhanced by his marriage to a distinguished musician.” A former colleague wrote of how “Nature endowed him with generosity, natural charm, kindness, gentleness, sensitivity, warmth of feeling, a sense of humour, and a sense of fun. Combined with an acute intelligence he had a vivid imagination, courage, and drive.”

His obituary in the BMJ of 10 May 1969 describes how he had “illuminated many dark corners and set a standard for clear expression and straight thinking which will be long remembered.” Many of his students, among them Jonathan Miller, Oliver Sacks, Sir Roger Bannister and a host of what are now excellent and prestigious physicians, would remember with fondness and gratitude the inspiration and importance of his teaching.

A collection of his papers was published in 1972 under the title “Richard Asher Talking Sense”, and a further collection, “A Sense of Asher” was published in 1983.

In 2013 the family of Dr Asher kindly donated to the Library of the Royal Society of Medicine a collection of Dr Asher’s papers. This collection forms the basis of the current exhibition.
A prolific author, Dr Asher collected copies and offprints of almost every article he had written for the medical and lay press. He then placed them in home-made card covers on which he wrote their titles and their date and place of publication. Eager to maintain the integrity and completeness of the collection, he marked many of them “Last copy—please return to author” or “Please preserve carefully – last remaining copy.”

Included also are the annotated proof copies and manuscripts of the three Lettsomian Lectures given by Dr Asher in 1959 on Clinical Sense, Making Sense, and Talking Sense.

Among several unpublished works are the typed outlines of two proposed books on psychological stress and the origins, diagnosis, and treatment of common neurotic illnesses.
Some Asherisms

It seems to me that clinical knowledge depends upon three processes – observing, recording and thinking.

1. Use your eyes
2. Use your tongue
3. Use your loaf

When christening a baby we wait for the child to be born and then we find a name for it. When christening a disease we sometimes wait for the name to be born and then we try to find a disease to suit it.

To the laity, words give a feeling of power against a mysterious foe, even words like ‘congestion’ and ‘nervous exhaustion’ and ‘catarrh’, which carry so little factual content.

The scrutiny of one’s own clinical reasoning is an extremely beneficial process, but often it is very painful. Surely if a man comes to you with an itching anus and says he wants relief, he may have sincerely desired to be rid of it.

Do not put sticking plaster on hairy limbs; you can easily shave them first.

Now it is a strange fact that if a new drug (say for asthma) is prescribed by a doctor the patient thinks little of it, but if he finds it mentioned in the paper, or, more likely still, if his aunt, knowing he has asthma, cuts it out and posts it to him – then his confidence in the drug is unbounded.

Morals are a separate matter, of which I have very little knowledge.

Almost anything can be borne if someone thinks one is wonderful. The well-known jibe that specialisation implies knowing more and more about less and less is not without foundation.
Richard Asher:

Photograph supplied by Miss Jane Asher
Teach us to live that we may dread Unnecessary time in bed.

Get people up and we may save


Here he wrote against the assumption that “the first thing in any illness is to put the patient to bed.” According to Asher, “beneath the comfort of the blanket there lurks a host of formidable dangers” from which hardly any part of the body is immune.

After describing the adverse effects of bed rest on the blood vessels, the skin, the bones, the muscles and joints, the respiratory and nervous systems, the renal and alimentary tracts, and the undesired mental changes occurring in patients subjected to its regime, Asher admits that “I have painted a gloomy and unfair picture; it is not as bad as all that.

There is much comfort and healing in the bed, and rest is essential in the management of many illnesses. My object has been to disclose the evils of overdose.”
IT'S TIME TO
GET UP!

By THE MEDICAL CORRESPONDENT

"WHAT I need is a month in bed," is a common remark of the tired housewife. Length of time spent in bed is the yardstick measuring the seriousness of one's favourite malady; even doctors are assessed by their bedside manner.

Would the tired housewife, or anyone else for that matter, pause by a prolonged stay in bed? Recent research on the sleep question shows that we can get along on a minimum of four hours sleep and a maximum of eight hours in every 24. Any further sleep is of no value, and a few hours of deep sleep are worth any number of "cat-caps."

A year ago a medical specialist, A. A. J. Asher, aroused the medical profession to the dangers of going to bed by an article in the "British Medical Journal."

**Muscles waste**

Maintenance of one position, without change, causes the collection of secretions in the lungs. Likewise, the blood does not flow through the body with its usual briskness, and stagnating blood in the lung may cause clots and even embolism. Muscles waste become drained of their nutrients, appetite disappears. Bones and the patient sink into a vegetable condition. In an instance the desire to.

Dr. Asher deliberately overs

stated his case to lend force to his argument. No one would say that bed has no value in medical treatment. Fever, influenza and the like naturally require treatment in bed.

Nevertheless, the medical profession are coming round to the view that the less patients are kept in bed the better. This particularly applies to post-operation cases, who are sometimes exposed to the danger of blood clots and pneumonia in the first week or so after the operation.

50 years ago

The idea is not new; it was mooted in 1890 by an American surgeon, Emil Ries. His advice was not taken, and up to 1899 patients still spent from 10 to 14 days in bed after an operation.

With the war-time demand on beds: it was sometimes necessary to get people in earlier and these cases were found to make good progress.

One fear the surgeons had was that stitches would drag and wounds heal more slowly if the patient moved about. This did not seem to be the case, and experiments showed that those allowed loose healed up more quickly than those kept immobile.

It was found that fractures healed better when holding the weight of the body than when suspended in the air. Finally show that complications after operation is reduced by half if the patient is made to set up on two days after injury and applies to maternity cases.
Asher’s work in the mental observation ward of the Central Middlesex Hospital resulted in his paper on *Myxoedematous Madness* published in the BMJ on 10 September 1949. This paper gives detailed accounts of 14 cases of myxoedema with psychoses and opens with Asher’s description of myxoedema as “one of the most important, one of the least known, and one of the most frequently missed causes of organic psychoses – important because it may respond so gratifyingly to treatment, little known because little has been written about it, often missed because the textbook description of myxoedema is not the rule but the exception.”

This paper has all of the stylistic clarity typical of Asher’s writing. It displays a healthy contempt for received opinion and never fails to hold the reader’s attention. It is also full of good practical and original advice: “I consider there is only one infallible confirmatory test for myxoedema. Take a good photograph; then give thyroid for a month or more and take another photograph. The change between the two photographs is clear confirmation of the diagnosis. In many cases where I have not been certain of the diagnosis the change recorded by photographs has been the only unequivocal proof of the answer.”
Medical articles should, like after dinner speeches, finish before the audience’s interest has started to wane. A squeaking trolley should be considered a slur on a ward.

Style is what matters most; grammar, syntax, spelling, and punctuation are only useful conventions.

It is inevitable that editors have to accept a certain amount of junk both to fill their papers and to avoid giving offence to eminent medical men.

Even if you own a computer it is advisable to spend a certain amount of time in thought.

Bedpans are a source of much clanging and rattling.

Just as we swallow food because we like it not because of its nutritional content, so do we swallow ideas because we like them and not because of their rational content.

Stocks and shares are no more variable than medical theory, and one can make money out of their fluctuations.

Hearts should be judged by what they can do and not only by the noises they make.

The analogy with motor-car engines is false, and the only point where it applies is that when the trouble is very serious the patient is very likely to be returned back to his Maker.

Too often a sister puts all her patients back to bed as a housewife puts all her plates back in the plate-rack – to make a generally tidy appearance.

Fate is such an insubstantial target for blame compared with a damp wall, a large tonsil, or a bad smell.
Richard Asher’s
Six Honest Serving Men
for Medical Writers:

What are you going to write about?
“…fairly obvious clinical things such as a physician comes across…”

Why are you writing this?
“The best motive is the natural wish to tell others when you have noticed something unusual or interesting…”

When to write an article?
“When you have something to say and you have had time to think about what you are going to say.”

How, that is in what manner or style are you going to word it?
“Start by sitting at a desk with a pen and some paper.”
Where to write it?

“In any place where you feel comfortable doing so… The early stages can be managed comfortably in an armchair with a board about ten by twelve inches to write on. Later stages go better in a more disciplined position at a desk.”

Who wrote the article?

“You did, of course, so do not list as co-authors a host of people who never wrote a word of it; if they helped in other ways thank them at the end of the article… Six people can no more write an article than they could all drive a car simultaneously.”

The Lancet of 10 February 1951 carried Asher’s paper on “a common syndrome which most doctors have seen, but about which little has been written. Like the famous Baron von Munchausen, the persons affected have always travelled widely; and their stories, like those attributed to him, are both dramatic and untruthful. Accordingly, the syndrome is respectfully dedicated to the baron, and named after him.”

In Munchausen’s Syndrome a patient presents at hospital showing initially convincing signs and symptoms of organic illness requiring investigation and admission to a hospital ward. Upon further examination, the patient’s symptoms are found to be spurious and their story consists of falsehoods.

The patient is often well-known to hospital staff, and enquiries show that the patient has also presented at other hospitals with a similar story. They often bear the scars of previous surgical investigations. They almost always discharge themselves, often against advice, are truculent and argumentative in manner, and frequently end up quarrelling with doctors and nurses.
Asher writes: “Unlike the malingeringer, who may gain a definite end, these patients often seem to gain nothing except the discomfiture of unnecessary investigations or operations. Their initial tolerance to the more brutish hospital measures is remarkable, yet they commonly discharge themselves after a few days with operation wound scarcely healed, or intravenous drips still running. They lie for the sake of lying. They give false addresses, false names, and false occupations merely from a love of falsehood. Their effrontery is sometimes formidable, and they may appear many times at the same hospital, hoping to meet a new doctor upon whom to practise their deception.”
Richard Asher’s
Seven Sins of Medicine:
Obscurity, cruelty, bad manners, over-specialisation, love of the rare (spanophilia), common stupidity, and sloth.

Cruelty: “…probably the most important and prevalent sin in the list I have chosen. Usually it is due to thoughtlessness, and not deliberate.”

“By saying too much we often burden a patient with a load of anxiety which adds to the illness we are trying to relieve.”

“By saying too little one can cause fear of the unknown; the gap may be filled in by the patient with alarming inventions and superstitions.”

“It must be remembered that patients have ears, and that sotto-voice murmurings about polysyllabic diseases strike needless terror into their hearts.”

Bad manners: Towards patients – “Impatience in taking a history from a slow-witted patient; making jokes at the expense of the patient; and reading the patient’s newspaper which lies on his bed and displays headlines far more exciting than the story the patient is telling.”

Towards nurses: “Students will find that a courteous good morning to the sisters makes their access to patients and to ward equipment much easier. Too many students or house-men call for a nurse in the manner of an impatient diner calling for a waiter.”

Towards medical staff: “In general, students should aim at a reasonable respect for their seniors but avoid an oily deference. I further caution against bad manners when they become more senior, and suggest such courtesies as asking their colleagues’ permission before seeing a case on their wards, and writing and congratulating them on their publications and appointments.”
Obscurity: “…clear style and short words are best. Obscurity is bad, not only because it is difficult to understand but also because it is confused with profundity, just as a shallow muddy pool may look deep.”

Over-specialisation: “A good doctor should be a jack-of-all-trades and master of one. For example, a surgeon should be able to advise a patient with simple obesity about her diet and not refer her to an endocrine clinic; a gynaecologist should be capable of treating a mild iron-deficiency anaemia without referring her to an anaemia clinic; and a physician ought to squash a small ganglion on the back of the hand with his thumbs (or bible).”

Love of the rare (spanophilia): “Headache and vomiting are more often due to migraine than to cerebral tumour; nose-bleeding is more often due to picking the nose than to multiple hereditary haemorrhagic telangiectasis; and wasting of the small muscles of the hand occurs in old age and rheumatoid arthritis more often than in motor-neurone disease or cervical rib.”

Common stupidity: “…the commonest type is what might be called therapeutic automatism. No illness has a rigid code of treatment which must be advised in all circumstances; one must cut one’s therapeutic coat according to the mental and economic cloth of one’s patient. It is mere foolishness to order an elaborate diet for a busy working-class woman with instructions to add on the fourth day one and three-quarter ounces of steamed red mullet to the graduated scheme prescribed.”

Sloth: Physical sloth “often causes the omission of blood-pressure estimations, ophthalmoscopy, or rectal examination, and leads to aseptic ritual…” Mental sloth is “commoner and more important. If the day is hot, the patient deaf, the doctor in a hurry, and the history garnished with reminiscences and irrelevances, it requires enormous patience and concentration to distil the essence from it.”

A lecture given to the University College Hospital Medical Society on 17 March 1948, and published in The Lancet of 27 August 1949.
I define malingering as the imitation, production or encouragement of illness for a deliberate end. The patient is quite conscious of what he is doing and quite cognisant of why he is doing it. With that definition, pure malingering – the planned fraudulent faking of illness – is, in my experience, a very rare condition. Either that, or else I am a very gullible physician.

I know I have been mistaken before now without being suspected. I shall show you the portrait of a case where I was grossly deceived. It was over a matter of malingering associated with hysterical ataxia, scissor gait, and aggressive outbursts.

One Sunday, when my daughter was two years old, I promised my wife that, if it was not taken as a precedent, I would myself get her up from her afternoon rest, dress her and take her for a walk. I performed these duties without difficulty or loss of dignity, until the walk started. Then there was trouble. The child kept falling to the left; she walked with a ridiculous scissor gait and she frequently fell to the ground. She cried and said she had a pain. She behaved abominably, and I spent a wretched afternoon in Park Square West attempting to coax her into good behaviour. I knew this was sheer devilment, a malignant aggressive demonstration against the father figure; I would not submit.

At last my wife returned and undressed her for her evening bath. There was a sudden cry: ‘Do you realise you’ve put both her legs through the same hole in her knickers?’ I can still remember, after those tortured limbs had been freed from their crippling garments, how that gay, naked figure raced unrestrictedly to the bathroom without a trace of malingering. That incident taught me to be cautious about diagnosing malingering or hysteria.
“The portrait of a case where I was grossly deceived”

This photograph was kindly supplied by Miss Jane Asher, shown here aged 2, and is used with her permission.
Student days

Richard Asher qualified in Medicine at the London Hospital in 1935.

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I would like the public to realise that, in general, a little of what you fancy does you good.

If for a moment we consider the dynamic formulation of both objective and subjective thought fantasy, then cognitive functions can easily become projected into an integrated but psychically barren wish-fulfilment.

That last high-sounding sentence, as I hope you noticed, has no meaning whatever and is pure nonsense…

Words not only provide a vehicle for conveying thought, but even provide wings for its flight which make it travel either straight or crooked.

Whenever we read of autonomic imbalance or endocrine imbalance we are in for a piece of nebulous thinking.

If you can’t get a letter or an article published, at least you can publish the behaviour of your intestines.

We doctors rarely know what our patients think of us and rarely learn what effect our talk, tact, and treatment have had.

This is an age of compensation; not only out of loyalty to our colleagues should we decline invitations from patients to criticise each other, but for the good of the patients themselves.

However good your memory is, you should look up everything you quote.
Some more Asherisms

When a patient is seeking confirmation for an erroneous belief which does no one any harm and gives him the comfort of something to blame, it is questionable if much good is done in correcting him.

Many people simply want a pleasant chat, but instead of going along to the local public-house for a drink of beer and a chat with the landlord they go along to the local hospital for a drink of medicine and a chat with the doctor.

Do not try to get Sir Bernard Bronchus on his special subject, he may suspect you of toady ing to him, for everyone knows he has been writing the same article about gall-stones for years.

Though many lives are saved by antibiotics, there is much evidence that by giving them too readily for trivial infections we kill the more susceptible organisms and so leave ourselves with the army of resistant organisms which now defy a large proportion of the antibiotics we use.

The Ministry of Health could save millions of pounds by producing a preparation of aspirin called simply Asp and another preparation of calcium aspirin entitled Casp, especially if they were brilliantly coloured capsules in decorative bottles rival ling the proprietary remedies in allure.

Drug addiction tempers the wind of reality to the psychically shorn lamb, and it is only with neurotic patients that doctors must be careful in giving opiates.

In truth, the reasons a man may feel better after a pill are numerous – he might have felt better anyway, he might have felt better because he had such faith in the pill, he might have felt better because you had such faith in the pill, or he might really be improved by the pharmacological action of the pill.
"Much Love from Papa"
(or: Letters From a Peculiar Parent)

“I never regard the to and fro of epistolatory exchange as if it were a game of tennis and because I launch something or several things my end you need never feel I expect each service to be returned.”

Addressed variously to My Super Daughter, My Dearest Clarywary, My Dearest Clareoh, Darling Super-Clare, My Dearest Clareissima, and Dearest Daughter-waughter, Dr Asher wrote regularly, sometimes several times in a single week, to his daughter Clare while she was a student at Oxford and later working as an au-pair in France.

The letters are often augmented with newspaper cuttings, musical scores, and small hand-coloured illustrations. A typical letter, in the words of its author, is likely to be “based on nothing in particular, bears no requests, carries no news, answers no questions, conveys no information, poses no problems and demands no answer; for it is just general blah & blether.”

Nevertheless, they do give news of home and family matters, and offer fatherly advice such as this disquisition on putting one’s thoughts into writing: “The manipulation of a thought into a clear enough form for it to be captured in words, and the art of selecting those that will best succeed in capturing it requires an effort of mind which greatly strengthens the mental musculature. Not only do you get better at putting down what you think, but you get clearer about your thoughts; and your thoughts not only become clearer, but travel further. Paucity of vocabulary and lack of fluency with verbal manipulations does allow people to talk incredible nonsense, particularly on abstract subjects, without the absurdity or emptiness of their ideas becoming apparent to themselves as might happen if they were enclosed in a more transparent verbal enclosure.”

In response to her complaint about not having been given a middle name, Dr Asher made efforts to make good this omission by awarding Clare with a different middle name on every envelope he addressed to her.

We are grateful to Mrs Clare Gillies who has kindly loaned to us a collection of her father’s letters for inclusion in this exhibition.
A final few Asherisms

For letting off steam and entertaining others, write fiery letters in the correspondence columns of the medical journals on perennially controversial subjects.

We must not be so busy preventing disease that we have no time to enjoy freedom from it.

The danger of crooked statistics is that its fallacies are less likely to be noticed because of the mixture of awe, suspicion, and reverence with which statistical thinking is regarded by most of us.

It is too easy to assume that the frequency or regularity of normal bowel action has been decreed by some natural law.

Not only the way a doctor speaks, but his gestures, his manner and his smile all play their part. There are also accessory aids – a book written by the doctor himself lying carelessly on the desk, the use of a large shiny motor-car and chauffeur, or (less expensive but quite effective) the skilful manipulation of a really thick pair of horn-rimmed glasses.

Surely, to refer a man back to a physician to have the number of his fingers counted argues a degree of specialisation which has altogether obliterated common sense.

The psychological harm done to patients by long-continued litigation is even more extensive than the expense and trouble caused to the medical profession.

It is very probable that statistics would show erythroblastosis foetalis to be twenty times less common among the offspring of opium smokers. This is no argument for encouraging opium smoking in the maternity wards.

So I turn with relief to the more solid ground of common sense or horse sense.

Exhibition Curator: Robert Greenwood
Booklet Compiled by: Ashley Phillips
Special Thanks to the family of Richard Asher for making this exhibition possible. 23/10/2014