The Royal Society of Medicine

RFS

Retired Fellows Newsletter

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Cover: The Parthenon on the Athenian Acropolis, Greece

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Editorial:

Catherine Sarraf

Ecstatic! The lockdown is mostly over. The other day, we went to visit some friends in Bromley. A delightful table had been set up in the garden, food and wine were delicious, even the weather was just perfect for sitting out for lunch. Only four of us present, but what a joy to, again, be in the company of further RFS Fellows. We went via Chislehurst, but didn't stop at the caves this time.

Chistlehurst caves are not really caves at all, but are extensive man-made tunnels, here south east of London. History tells us that they were burrowed out between the mid-thirteenth and early nineteenth centuries, for the purposes of mining flint and lime-burning chalk. There is a ninth century Saxon charter that refers to this mining and they are again mentioned in 1232, in mid-Victorian times the 22 miles of intersecting tunnels were developed for producing lime. However, Edwardian publications claiming that the site was used in Druid religious ceremonies and Roman as well as Saxon ones, seem to have been fantastical.

During World War I the caves were filled with ammunition, as storage from the Royal Arsenal at Woolwich, but by the 1930 they were just the site of peaceable mushroom cultivation. In World War II, during the blitz, the caves became very efficient air raid shelters accommodating up to 15,000 people, arriving by train from London and paying to have the privilege of sheltering there. The tunnels had electric lighting, toilets and washing facilities, a chapel and also a hospital.

Subsequent to our 'adventure' travelling in south London, I'm prompted to comment about public transport in these trying times. My kitchen windows overlook a bus stop. Throughout even the deepest of lockdown, buses were going past every 10 mins, EMPTY, day in day out. Alternatively, in those days, the queue to get into Wimbledon Waitrose was in their car park, parallel to railroad tracks. Again, day in day out vacant trains, zoomed by. I have no idea how much it costs to run multiple, empty, trains and buses. This cannot be right? Why was public transport not stopped or at least seriously curtailed for use of essential workers only? We needed to protect the health of the drivers. TfL and all the railway companies are losing money. Guess who will be paying? The tax payer, us, no doubt - who largely have been staying at home.

Fellows! I sincerely invite you to submit a 'piece' to this, our journal. Everyone has a story in them, begging to come out, be it recollections of professional life (humorous or serious), tales of other times or today, vignettes of general interest to our Fellowship. Pier review doesn't exist here! Please take a glance at our 'Instructions for authors' on the back cover, and get writing!

Autumn activities at the RSM are still not totally clear. There will be full RFS programmes, consisting of Webinars, (possibly) lectures, London walks and Camera Club events. The organisers of all these components of the RFS have written information for you in the following pages.

The Retired Fellows Society 2020 AGM and the new committee

The Retired Fellows Society AGM should have been held in June 2020, but has been postponed until it would be possible for us all to meet in person.

In the meantime the following committee members have been provisionally appointed. They will be formally proposed at the AGM, when it will take place.

Chairman: Dr Richard Lansdown
Hon. Treasurer: Mr Ian Stephen
Hon. Secretary: Dr Memo Spathis
Intramural Events Organiser: To be announced
Extramural Events Organiser: Dr Rosalind Stanwell-Smith
Hon. Editor: Dr Catherine Sarraf
Camera Club Representative: Dr Memo Spathis

Ordinary members
Dr James Carne
Mr Michael Kelly
Professor Linda Luxon
Dr David Murfin
Dr Michael O'Brien
Dr Jane Reeback
Dr Jeffrey Rosenberg
Dr David Shanson
Mr Harvey White
Professor Robin Williamson
Dr Julian Axe

Richard Lansdown, July 2020

Announcement

On the 18th of December it was happily declared that Harvey White FRCS had won the Twenty-Second Queen's English Society Prize for Excellent English, notified to the Editor of this *Newsletter* by Bernard Lamb. The prize was awarded to Harvey for his article, in *RFS Newsletter* August 2018, issue 62, 32-33, *Through a glass darkly: reflections on dementia*.

Congratulations Harvey! Long may you continue to support the *Newsletter*, and successfully win prizes for your efforts.

FORTHCOMING MEETINGS

Intramural meetings

15 October 2020 – 17 June 2021

The presentations agenda for the Retired Fellows Society remains *in limbo* due to the pandemic. In theory we have a wonderful programme of distinguished speakers for you, scheduled from October through to next June.

We are currently contacting our lecturers for titles, abstracts and most importantly, to discover whether they are willing to deliver their content *via* webinar format. Most of our speakers are active academics so should be adept and comfortable with webinars. We are also most encouraged by the recent very successful webinar on Hindu Temples, as demonstrated both by the number of attendees and much positive feedback for our speaker Dr Michael O'Brien and chair Dr Memo Spathis.

Finally, Fellows should have received a short questionnaire designed to gauge your interest in both future webinars and on-site events, when the RSM reopens.

With best wishes for a continuing safe, healthy and happy summer

Jeffrey Rosenberg
Intramural events organiser

Extramural excursions

Cruise organised by Sue Weir

Paris & Normandy, Seine River Cruise

New date: May 20-27, 2021 cruising for a week on the luxury 5 star Ama Lyra, having travelled to France by Eurostar. The tour includes visiting Monet's Garden at Giverny; the pretty harbour of Honfleur; Normandy Landing beaches; medieval Rouen, and much more. This is the perfect relaxing and interesting holiday for RFS members, train times being out 10:00am Eurostar to Paris and return 2:45pm Paris to London.

Walks by Sue Weir 2021

Missing our usual walks in 2020 I am planning to do them next year - dates yet to be confirmed - BUT I would love to see as many of you as are able to join me.

FITZROVIA - an area you may think you know but be prepared to be surprised!

REGENT'S PARK - flowers, roses, vegetables, a secret garden and a wild life area in the middle of London.

EAST OF WAPPING - exploring the quaint eastern reaches of the Thames to modern Canary Wharf

AROUND CHELSEA - writers, painters, pensioners, potteries and picturesque streets.

Camera club programme 2020

In January there was a full house for the Members' Meeting, indeed extra seating had to be brought in. During these meetings, members are encouraged to show their photographs or prints for general appraisal, or lead the discussion on ways to improve their work. Technical queries are often aired and answered by someone with greater experience, though we do have a specific meeting devoted to Technique. Additionally, the Camera Club offers one-to-one or group tuition if a request is sent to Richard Lansdown, our Chairman: these can be arranged in various parts of London, and open to any member of the RFS.

In February we again had a full house. Memo Spathis talked about Infrared photography and Richard Lansdown discussed the mental state of one of the world's most famous photographers, Ansel Adams.

Lockdown forestalled a further Member's Meeting, presentations by one of our most accomplished members on *At altitude in the Alps* and two outside speakers, one on *Macro photography and much, much more* and one on *Antarctica – wildlife at the end of the world*. We hope to be able to incorporate these into next year's programme, which already includes a Presentation meeting on '*Photographing Flowers*' and a technical talk on '*Printing*', as well as a talk on '*A Whitechapel eye: photography from the East End's most famous district*'.

In the meantime, our Chairman Richard Lansdown has been sending out monthly bulletins of interest, including tips, new techniques, and more.

Onion jug, photograph by Richard Lansdowne

Orb, photograph by Richard Lansdowne

We are already considering providing future talks as webinars, if the RSM is not yet open, though we would have to host them ourselves. Some events might even be better over the internet: techniques are easier to comprehend on line, and even member's discussion could be just as rewarding *via* Zoom, though this will require much more preparation and work behind the scenes, by the organisers. One advantage is that more members of the RFS might find it convenient to attend from home; and if their interest is aroused, perhaps even attend our regular meetings when we can resume them?

Recent Advances in Medicine and Surgery

Retired Fellows Society Annual Event

Session One

Chaired by Professor Robin Williamson

The first talk of the day, *Sensorineural deafness and tinnitus* was given by Professor Shakeel Saeed, Professor of Otology at University College London Ear Institute and the Royal National Throat, Nose and Ear Hospital. To set the problem in context he told us that half a billion people worldwide suffer from disabling hearing loss. In adults, it reduces employment prospects, causes social isolation and predisposes to dementia. In children it can seriously limit life opportunities. Helen Keller was reputed to have said that faced with a choice, she would rather hear than see. In common age-related hearing loss the higher frequencies go first. For those who have mild or moderate deafness a well-fitting hearing aid is the appropriate management. For those with severe deafness, cochlear implants have had an enormous impact, spawning a whole new subspecialty of implantation otology. The technology comprises a receiver package and an electrode implanted into the inner ear. This type of electroacoustic stimulation has had its most dramatic benefits among children, in whom a cochlear implant before the age of two can lead to normal speech by the age of five. Nevertheless, cochlear implantation is still a low-volume high-cost intervention, so there is plenty of room for simpler strategies. Most adults can acquire open-set speech recognition, which in combination with a hearing aid may be cost-effective and will preserve the native cochlea for the future. Middle ear implants may be another appropriate alternative for those who are less severely impaired but cannot get on with conventional hearing aids. Professor Saeed and his colleagues at the London Ear Institute are presently involved in the REGAIN trial: REgeneration of inner ear hair cells with GAmma-secretase INhibitors. The drug is injected into the middle ear under local anaesthetic. It is absorbed *via* the round window and stimulates transformation of supporting cells into sensory hair cells that can convey the sense of hearing. Early results of this exciting research are promising, even though many questions remain to be answered. The speaker covered so much ground that he could only mention tinnitus briefly towards the end. I suspect that this topic would have justified another whole talk on its own, a talk that would have received the same

close attention from the audience.

Gastro-oesophageal reflux and its complications, the second talk, tells of another prevalent condition that can impair quality of life, and this subject received detailed coverage by the speaker, Mr Nicholas Maynard. He is a surgeon at Oxford and also President-Elect of the Association of Upper Gastrointestinal Surgery. Between 10 and 20 per cent of the UK population is estimated to suffer from reflux symptoms at least once a week, and upwards of one million citizens take some form of medication to control them. The symptoms include heartburn, regurgitation of food, volume reflux, non-cardiac chest pain and respiratory complaints such as cough and laryngitis. Hiatus hernia is a common but not invariable accompaniment of gastro-oesophageal reflux disease. Standard investigations such as endoscopy and contrast radiology can be supplemented by 24 hour ambulatory pH recording *via* a transnasal catheter or wireless capsule, high-resolution manometry and impedance monitoring. Proton pump inhibitors such as esomeprazole are effective for acid reflux but less so for volume symptoms. The indications for operation are, failed medical treatment (especially in the younger age group), as well as episodes of aspiration. Fundoplication procedure introduced by Nissen in 1955 and adapted for the laparoscopic approach in 1991 has a 90 per cent success rate. Results may be spoiled by dysphagia, gas bloat – the inability to belch – or gradual failure of the wrap over time. There is a 3 per cent operative revision rate, often among the grossly obese. Most alternative procedures have failed the test of time including endoscopic reefing techniques and prosthetic bands, which have a propensity to erode into the lumen. There is current interest in the LINX reflux management system which employs a magnetic ring around the oesophagus to augment lower sphincter pressure. Mr Maynard concluded his first-rate overview of reflux disease by discussing one of its most serious complications, namely development of Barrett's oesophagus. This condition, which represents columnar metaplasia of the normal squamous lining of the lower oesophagus, has a well-known predisposition to eventual development of adenocarcinoma. Short of major surgical resection, potential manoeuvres to deal with Barrett's change and interrupt that evolution are endoscopic mucosal resection and radiofrequency ablation.

The third talk of the morning *Treatment of epilepsy* was given by Professor Matthew Walker, Professor of Neurology at University College London and the National Hospital for Neurology and Neurosurgery at Queen Square. The audience was treated to a masterly account of a condition that remains poorly understood in a number of important respects, not least the mechanisms by which certain drugs act to control symptoms. The speaker told us of one of his eminent predecessors at Queen Square, Edward Henry Sieveking, who read a paper on epilepsy to the Royal Medical and Chirurgical Society (forerunner of the RSM) some 150 years ago. In discussion at that same meeting Sir Charles Locock mentioned his success in treating 15 women with epilepsy using potassium bromide, the first effective drug to be introduced for this condition. (In due course Sir Henry Sieveking became President of the Society and donated a handsome medal in gold and blue enamel that still adorns the presidential neck). Professor Walker described some other pharmacological milestones in the treatment of epilepsy: phenobarbital, phenytoin, valproate, carbamazepine, lacosamide, lamotrigine and, of recent controversy, cannabinoids. He drew attention to the fact that drugs target the seizures not the disease, that freedom from seizures is only obtained in 70 per cent of patients, and that all drugs have potential side effects to set against their benefits. In this regard valproate, although generally well tolerated, is teratogenic, and should be avoided in women of reproductive age. For the 30 per cent of patients with resistant epilepsy there is a 1 in 1000 annual risk of death as well as frequent psychological co-morbidity in the form of depression, anxiety and psychosis. Surgical treatment is suitable for 5-10 per cent of patients with epilepsy, notably those with malignancy, focal dysplasia or a lesion in the hippocampus. Better localisation of the causative focus using PET scanning might allow increased roles for surgical management hereafter. Other prospects for future treatment included gene therapy to revise neuronal activity and disease modification using drugs that can inhibit reactive oxygen species.

Robin Williamson

Session Two

Chaired by Dr David Murfin

Professor Sir Nilesh Samani, Professor of Cardiology, University of Leicester, Medical Director, British Heart Foundation, Consultant Cardiologist, Cardiac Centre Glenfield Hospital, gave a lecture on the *Genetics of coronary artery disease and its clinical implications*. His research interests are particularly focused on the area of cardiovascular genetics and he was knighted in 2015 for his services to medicine and medical research. Familial risk associated with coronary heart disease (CHD), has been known for some time. Historically, screening at-risk individuals with a family history, has been central to medical thinking. Evidence of adverse family history in turn sparked emphasis on regular clinical review of at-risk individuals. Allied to this, the last ten years have, by means of blood DNA sampling, identified some 70,000 variants which in turn led to discovery of the most common ones. Transformation of knowledge in the field of human genetics over recent years has allowed a new platform to study the human genome. This provides momentum across a wide field of associated research. Tracking at-risk individuals annually may allow simultaneous comparisons of changes. The current status of genetic discovery related to CHD indicates some 160 associated loci. Risk variants allied to their frequency of presence are tracked alongside identified common variants. A challenge in current research is to allow clinical translation to occur allied to new findings. Inserting appropriate mechanisms should include therapeutic interventions to take place. Observational studies allow causal inferences to be made in association with cardiovascular biomarkers. This in turn will lead to improved risk prediction. Challenges remain however, as at present fewer than 40 percent of CHD loci have been identified to show specific risk factors, to date. An area of potentially better positive returns relates to the study of biomarkers which are associated with CHD. This may lead to research studies on the role of specific pathogens. Allowing studies on the disease process and pattern of CHD will allow relative risk studies. The way forward may be a combination of tracking individuals with genetic variants, identifying biomarkers, then in turn allow relative risk calculation. A genetic appraisal could define a therapeutic target, based on evidence of genetic variation.

Present studies are concentrating on ‘the flavour’ of genetic variants and as to whether they present a modest or high risk. Identification of these variants could lead to confidence in defining them as causal or merely associated risks, and the speaker indicated that at present two fifths of these variants have unexplained roles. There is powerful genetic evidence for the risk of triglycerides associated with CHD. Elevated low-density lipoprotein (LDL) has focused thinking on pharmaceutical research for many years. New studies on identifying biomarkers have led to investment in drug research on intervention allied to potentially causal relationships. Genetic studies may provide earlier evidence to the clinician, allowing targeted use of specific lipid lowering agents.

Health workers have employed much time and energy in the field of health screening in recent times. This in turn has led to accusations of the imprecise nature of mass screening. We may be about to enter a different phase with screening mechanisms driven by age, and identification of genetic variants and importantly, risk variants. Longitudinal studies in Scandinavian populations have provided helpful guidance. This has allowed a rise in the ability to identify those individuals at risk of CHD. The Framingham Risk Score provides guidance on low, intermediate and high risk but is thought to be arbitrary in nature. Genetic research is well on the path to offering true prediction of risk at an earlier age. The last decade has been particularly promising and, in future, targeted improved therapeutic intervention will reduce morbidity.

Professor Anthony Gordon, Chair in Anaesthesia and Critical Care at Imperial College, London, gave the fifth lecture of the meeting on the subject of *Management of sepsis*. The

topic receives much public exposure at present. Definitions have changed and current understanding is of a disease both life threatening and associated with organ shutdown. It is not sufficient to merely relate to an inflammatory relationship. It is often a metabolic catastrophe as witnessed by rapid reduction in blood pressure. Surviving sepsis has become something of a national campaign and when not possible may initiate controversy. Guidelines are helpful but as with all directives they may vary in initiation and drug treatment. Following identification of an illness, treatment should be early, ideally within one hour if septic shock is suspected. Antibiotics may be governed by protocols but these are not universally popular. An approach to antibiotic management may run alongside a mandatory three-hour bundle, but the key in any approach would appear to relate to early commencement of treatment. Managing fluid infusions is an emotive subject with a background link to potential harm to the patient if incorrectly administered. It is universally felt however that it is fundamentally unethical not to give fluids. One was reminded of historical teaching by carefully assessing the patient as a whole and not merely concentrating on a physiological end point. Drug therapy in sepsis is balanced against safety profiles. Vasopressin may present a risk to renal function and norepinephrine (noradrenaline) has been shown to improve survival in selected cases. Dopamine is no longer used while adrenaline is only used in carefully monitored situations. Choice of drug therapy is based on careful patient selection and is associated with diligent cardiovascular and biochemical observation. Cardiac function requires constant review while use of beta agonists is dropping out of favour. Predictive biomarkers enjoy some use in providing information on cardiac function. Use of inotropes requires intensive supervision and in selected cases may allow cardiac recovery in septic shock. Use of epinephrine (adrenaline) may help cardiac function, but its use is controversial.

Personal medicine is a term more frequently associated with primary care but Professor Gordon brought us to the arrangements of personalised medicine at a molecular level. Genomic profiling allied to cluster analysis is aiding treatment selection while patient outcome in terms of treatment response, can only aid our store of knowledge for the future. We are seeing the birth of a new era with genotyping at the bedside, which will lead to an age where immunological profiling leads to management decisions.

Artificial Intelligence (AI) is closer than ever to working alongside the physician on a daily basis. What was possibly seen previously as a Virtual World with optimistic hope for the future is now proving more than capable of reaching a diagnosis and organising management. Whether AI can claim to be better at clinical decisions may be open to debate. What is beyond contradiction is the fact a computer can memorise treatments and be programmed to assist decision making. Provided data entry is of high quality, consistent evidence will accumulate on the use of drugs and physiological and biochemical patient changes. Computer evaluation can be programmed to learn from experience as to what went well. A huge database can be accumulated with a growing cluster of material. On a rather morbid note AI offers the statistical chance of predicting a patient dying may well have arrived, although ultimate decision making on management must rest with the physician at the bedside. AI may influence timing of interventions with the computer aiding amendments to management, and even suggesting the alternative might be death. It remains vital, however, that the physician sees the patient under their care as unique. Decisions to resuscitate fall on the doctor, and ethically this should remain the case. A trusted doctor will always be sensitive to change and be open minded regarding new medical frontiers. The human element of decision making must remain notable, given the heterogeneous nature of sepsis.

David Murfin

Session Three

Chaired by Dr Fiona Moss

The final session of the day was a mini-symposium with two speakers, followed by a lengthy discussion moderated by the RSM Dean, Dr Fiona Moss. Many controversial issues were aired, and major concern was expressed about the method of prosecuting doctors accused of serious clinical errors.

Mr James Laddie QC of Matrix Chambers spoke first on *Aspects of safety in modern medicine*. He was Defending Counsel in the successful appeal by Dr Hadiza Bawa-Garba in August 2018 against erasure by the General Medical Council. The case began with the death of a six-year-old boy at Leicester Royal Infirmary in February 2011, when Dr Bawa-Garba was the paediatric registrar on call. She had recently returned from maternity leave, and this was her first shift in an acute setting. The child who had Down's syndrome was admitted with diarrhoea, vomiting and breathlessness, and he died of sepsis later that same day. After an initial decision not to bring proceedings, the Crown Prosecution Service bowed to pressure from the child's family and the press. In November 2015 Dr Bawa-Garba was convicted of manslaughter on the grounds of gross negligence, but in view of contributory hospital failings she 'only' received a suspended sentence. In June 2017 the Medical Practitioners Tribunal service (MPTS) of the GMC decided that she should be suspended for 12 months and not struck off, but the GMC appealed against its own tribunal and the High Court over-ruled the MPTS, leading to her erasure from the medical register. After a crowd funding campaign Dr Bawa-Garba was granted permission to appeal, and that appeal was upheld by The Court of Appeal. The GMC was heavily criticised for its handling of the case, and its Chairman was obliged to apologise.

The second talk entitled *Moving on from blame* was given by Dr Jenny Vaughan, who is a consultant neurologist at Imperial College, and a vigorous medical law campaigner working alongside the Doctors' Association in the UK (DAUK) and the British Medical Association. She articulated the general unease felt about imprisonment of colorectal surgeon Mr David Sellu for gross negligence manslaughter, and she led the successful campaign to get that verdict reversed. The case concerned his management of a patient who died from a colonic perforation at the Clementine Churchill (private) Hospital in London in February 2010. There had been difficulty in obtaining an anaesthetist for the emergency operation, and intraoperative bleeding related to cirrhosis contributed to the fatal outcome. Appeal judges found that the trial judge had not properly directed the jury, but before the sentence was quashed Mr Sellu had spent 15 months in jail. He was also cleared by the MPTS after a six-week hearing which took extensive evidence from many witnesses working at the hospital; not one of the allegations brought by the GMC was proven.

Several points were aired during the panel discussion. Transparency was a victim of the legal process in each case; for example, a root cause analysis at the private hospital was withheld. Systemic errors by both hospitals concerned did not receive adequate consideration during the hearings. Instead all the blame was pinned on the individual treating doctor, never mind the fact that both Dr Bawa-Garba and Mr David Sellu had unblemished previous records. There is a disproportionate rate of black and ethnic minority individuals among healthcare workers accused of misdemeanours. The right of appeal by the General Medical Council is likely to be withdrawn. In particular, gross negligence manslaughter has emerged as an inappropriate criminal charge to bring against doctors accused of serious clinical mistakes. It is notable that there have been no similar cases since the two high-profile ones presented in this symposium.

Robin Williamson

Who owns antiquities?

The Parthenon sculptures and other causes célèbres

On the 21st of November 2019, over 90 fellows and their guests were treated to an enthralling lecture by Dr Dominic Selwood, on the topic of '*Who owns antiquities?*' with examples concerning the Parthenon sculptures and other treasures. This was a wide ranging talk, which addressed ownership of cultural objects in relation to historical time and place. Dr Selwood used his academic background as a lawyer and historian to make a cogent case for the 'Encyclopaedic Museum'. In general, he defined antiquities as premedieval objects, with reference to the fall of the Roman Empire.

He started by demonstrating the balloon which greeted President Trump's recent visit to London, as an object which might have cultural significance in centuries to come. Should that balloon belong to the United Kingdom or to the United States? Does the *Codex Amiatinus*, one of the greatest of all Anglo Saxon treasures, written in England, but kept in Florence, belong to us, or to the Vatican? Is the value of the John Lennon museum diminished or ill understood by being located in Japan? Does the world famous bust of Nefertiti, discovered in 1912 by German archaeologists and kept in Berlin, belong to Germany or to Egypt?

Cultural objects clearly have different meanings in different ages. Destruction of the Temple of Jerusalem in AD 70 and subsequent construction of the Arch of Titus was an act of cultural domination. In recent times, wilful destruction of antiquities in the museum of Mosul and of the ancient city of Palmyra, by the so-called Islamic State, were examples of cultural vandalism, where objects were perceived to have negative value to them. Closer to home he mused over sacking of the High Abbey at Winchester, instigated by King Henry VIII. In the 19th century, people were encouraged to chisel their names into pillars of Stonehenge, and 60 years ago one could stop and picnic there; examples of the interface between culture, time and place.

Lamassu and Balawat Gate in the British Museum. Mosul museum had the other pair of gates, but suffered looting in 2003, and again in 2015 when structural metal bands were taken and destroyed by the Islamic State

Antiquities can be a political tool, with President Macron of France favouring return of artefacts to Africa, and Jeremy Corbyn wishing to return the Parthenon marbles to Greece. We were reminded that it would be illegal for the trustees of the British Museum to return the marbles. This raised a discussion point regarding law and morality. There have been international protocols in operation for the last 40 years in relation to antiquities, however historic collections are lawfully owned by their museums.

Dr Selwood then gave a fascinating account of the history of the Parthenon, rebuilt in 432 BC by the Athenians, following rout of the Persians. Next the Spartans, who regarded the Parthenon as a symbol of Athenian oppression, then tried to destroy it. In 500 AD the Parthenon became a Christian building but the magnificent gold and ivory statue of the goddess Athena disappeared without trace never to be seen again. During this conversion damage was caused, together with loss of even more sculptures. In 1456, the Ottomans captured Athens and the Parthenon became a mosque, while in 1687 there was enormous damage to the building when attacked by Venetians. The Ottomans had used the building as an arsenal for storage of gunpowder, ending by at least 50% of the Parthenon being destroyed by the time of the Napoleonic wars.

In 1799, the seventh Earl Elgin, Thomas Bruce (descendant of Robert the Bruce) was appointed ambassador to the Ottoman court. This was the era of collecting during 'the Grand Tour', but the concept tended to be blocked by Napoleon, who regarded France as the new Rome. Elgin however had ideas about improving the state of the arts in Britain. The Ottomans had no interest in the Parthenon as a cultural object, and indeed used the building for military target practice. However, Elgin was in favour with the Turks following initial defeat of Napoleon by the British, and so was granted a 'firman' (a royal mandate or decree issued by the sovereign of an Islamic state) in 1801 to freely acquire objects from the building.

Parliament was not interested in funding the acquisition of these antiquities so he self-funded, a project which took almost 10 years to complete from 1801 to 1810. This period of intense activity countered suggestions of mission creep or surreptitious theft. A further firman was granted after the French ambassador attempted to acquire some artefacts too. The Parthenon sculptures, now known as the Elgin marbles, were a sensation in London - regarded as the new Athens. This was reflected in the design of buildings such as the Athenaeum club in Pall Mall, St Pancras church, and also in poetry, for example, of Pope and Shelley, amongst others.

It is important to understand that Greece has never sued for the return of the marbles - this would not succeed in international law, thus, a diplomatic/political or cultural route has been explored. Elgin was eventually imprisoned by Napoleon in an attempt acquire the marbles for France, but this failed, and he was released on parole, which heralded the end of his career. Elgin offered the marbles to the British Parliament and the nation in exchange for his expenses. Parliament voted by 82 to 30 in favour of acquiring the marbles for the British museum, but his request for costs of £73,000 were rejected and reduced to £35,000. This was hopelessly insufficient and he sadly died bankrupt, in France.

Interior of King's compound burnt during fire in the seige of Benin City, with three British officers of the Punitive Expedition, seated with bronzes laid out in foreground

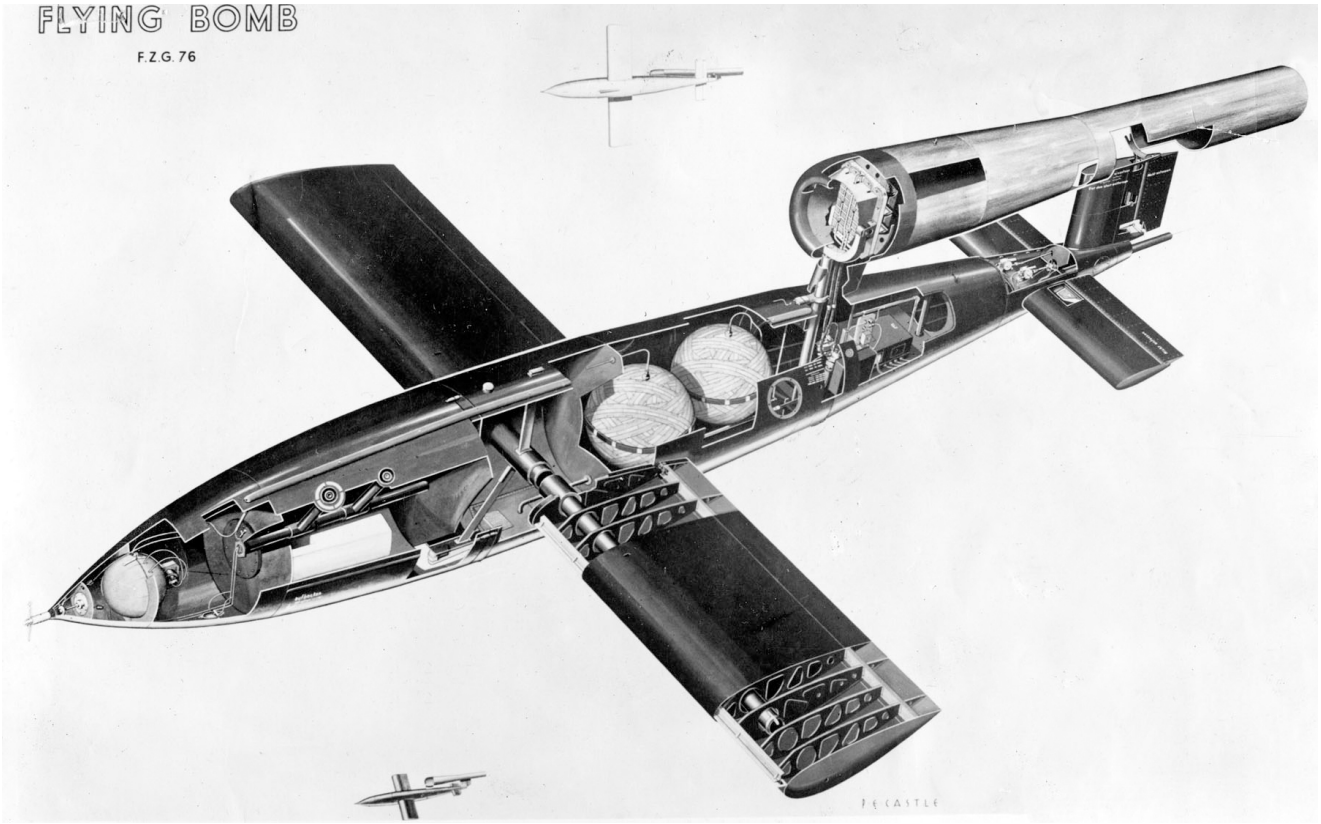
We then learnt something of the Benin Bronzes, which in their original state were caked in human blood and surrounded by crucified corpses, acquired following a trade war with the Portuguese, when British emissaries were killed and an expeditionary force was sent to West Africa. Large numbers of the bronzes were sold to Germany and to the United States to help pay for the expedition. A similar punitive expedition was carried out in 1868 in Abyssinia and again the treasures acquired were sold to defray the cost of the saving expedition. However, some artefacts were sent to the Victoria & Albert Museum.

Also in 1868, *HMS Topaze* transported a gift for Queen Victoria from Easter Island. The Moai (typical statue) of Hakananai'a arrived in England in 1869 and was gifted by the Queen to the British Museum. Currently, the magnificent treasure is seen by approximately 6,000,000 people a year.

We need to understand galleries and museums in the context of the age of Enlightenment. Thus we have the British Museum in 1753, the Hermitage of St Petersburg in 1754 and the Louvre in 1793. These need to be viewed as 'Encyclopaedic Museums', reflecting the entire human story, and as universal rather than vocational or national institutions. But do we want encyclopaedic museums in this age of post imperial guilt? Dr Selwood very much hoped that he had put forward cogent arguments that we do indeed need these Cathedrals of Enlightenment.

Dr Selwood concluded by asking the audience to consider whether the iconic music of Handel belonged culturally to Great Britain or Germany? Such complex considerations need to be addressed globally. I wonder how Handel himself thought of them?

Jeffrey Rosenberg



A total of 9,251 V-1s were fired at targets in Britain, with the vast majority aimed at London; 2,515 reached the city, killing 6,184 civilians and injuring 17,981

The V-1 'flying bomb' of WWII

On the 20th of February, Professor Tony Davies gave us a thrilling lecture on the *V-1 'flying bomb' of WWII*. Most people – including the speaker until he had researched the matter - believed the V-1 was launched in a planned direction whence it flew on until it ran out of fuel, crash landed and exploded. However, as he explained to us the V-1 was in fact an early sophisticated cruise missile. It was known by the Allies as the 'buzz bomb' or 'doodlebug' and by the Germans as 'kirschkern' (cherry stone) or 'maikafer' (maybug). British Intelligence gave it the code name 'diver' as soon as they found out about it. Ideas for the 'flying bomb' arose in the mid 1930s, although they were discouraged by the German Air Ministry as they did not believe the guidance method could be accurate enough. It is possible that ideas came from initial plans in France, from as early as during WWI.

Unmanned radio-controlled planes had been developed by the German Air Ministry primarily for surveillance, but the V-1 by comparison was very fast and very different, yet it was decided not to use radio-control for delivery of precision attacks. It was designed and developed by the Argus Motoren Company and the Fieseler Aircraft Company code name Fi 103, headed by Robert Lusser who previously was chief designer and technical director at Heinkel. The initial test flight took place on 10th December 1942. The first V-1 struck London on 13th June 1944 causing substantial damage next to the railway bridge on Grove Road, Mile End. Eight civilians were killed in the blast. Thereafter around 15 V-1s were launched each day resulting in considerable devastation, although success rates on hitting targets only about 25%, the majority being lost due to a combination of defensive measures, mechanical unreliability or guidance errors.

Main features of the V1 were:

1. A small propeller (vane anemometer) at the front of the missile activated by air speed which drove a mechanical counter, measuring distance from launch, and as the counter was set backwards, distance to the target when reaching zero;
2. On arrival at the calculated distance, the engine would cut-out. This would disconnect tail-flaps and rudder, putting the V-1 into a dive. On hitting the ground, a pin in the nose would detonate an explosive charge;
3. The missile's pulse jet engine flew very fast - roughly 400mph, and consumed one gallon of aviation fuel every 10 seconds, in which time it would have travelled a mile. The fuel tank held up to 150 gallons;
4. The V-1 was launched using an inclined ramp and a mixture of hydrogen peroxide and potassium permanganate, to generate enough thrust and speed for the pulse jet engine to take over. Occasionally the V-1 would be launched from below the fuselage of a Heinkel bomber;
5. An auto-pilot device, powered by compressed air, maintained the height, direction and stability of the missile by controlling mechanically the tail flaps and rudder. A weighted pendulum mechanism helped minimise rolling, and magnetic and gyro compasses maintained bearing.

The warhead weighed 1,000kg and originally contained the same explosive as other Luftwaffe 1,000kg bombs; however, later an aluminised explosive was used.

V-1 on display at the Imperial War Museum, London

Replica V-1 at the Imperial War Museum branch at Duxford, Cambridge

There were nine V-1 launch sites in Northern France, four of which had ramps aligned towards London. The operational altitude was around 4,000 ft and initially the V-1's target was within a circle of roughly 20 miles in diameter, but towards the end of the war accuracy had been improved to about 7 miles. In some cases, manufacture of V-1s was by slave labour working underground in appalling conditions such as at Mittelwerk (originally gypsum mines in the Kohnstein mountains), also called Dora Concentration Camp. This resulted, to some extent, in poor quality, thus many failures.

Launches against Britain were met with a variety of counter measures including RAF anti-V-1 sorties to intercept and destroy the flying bombs, the use of anti-aircraft guns from around the coast and barrage balloons. Some RAF pilots learned to tip the wings of V-1s to cause uncontrollable flight and nose diving. Also, the Allies captured and destroyed a number of launch sites.

Perhaps inspired by Japanese kamikaze suicide attacks, the idea of a manned V-1 arose to enable targets to be hit accurately – with the concept that the pilot would eject just before the V-1 dived. This led to the Reichenberg version Fi 103R of the V-1, named after a town in Sudetenland, now Liberec. Training of suicide pilots was supported by Hitler and a training unit introduced with volunteers, but the Fi 103R was never used in combat.

When it was becoming evident that Nazi Germany was losing the war, Hitler decided only terror weapons would persuade the British to get rid of Churchill, ask for peace and in turn assist in his war with Russia. His last hope was to increase the effectiveness of the V-1 and introduce the V-2 long-range guided ballistic rocket, first vertically launched in September 1944, and also to develop the V-3 'super gun' which was never completed.

Professor Davies's lecture was informative, extremely interesting and hugely appreciated with the added value of some Retired Fellows providing their own experiences of 'flying bombs' and London during WWII, during the questions session.

Julian Axe

Jagadambi and Kandariya temples at Khajuraho, Madhya Pradesh. Chandella. 11c

The Hindu temple

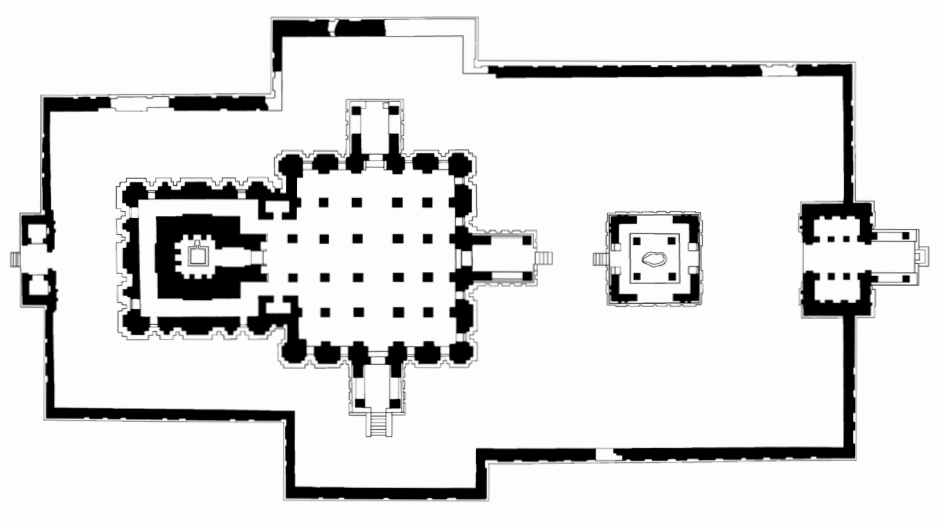
Report on the Webinar delivered by Michael O'Brien

Memo Spathis

The Retired Fellows Society held its first Webinar on June 18th. Our customary annual lecture series had been interrupted by the SARS-CoV-2 virus and Dr Michael O'Brien, one of our committee members, who had been due to give one of the cancelled lectures on *Hindu Mythology* (the planned introductory summary of which is also published in this issue), was asked to give it as a webinar; but, feeling it would be impossible to do justice to so vast a subject in a webinar, instead devised a fully illustrated talk on *The Hindu Temple*. The expertise of the RSM AV department ensured that everything went smoothly.

Michael is an accomplished lecturer. He has a long-standing interest in far eastern religions and temple architecture, having lectured on these subjects at the British Museum, the V&A and The Royal Archaeological Institute, as well as academic courses at London University's School of Oriental and African Studies. He is an accredited lecturer for the Arts Society (previously known as NADFAS) to whose audiences he has lectured, not only in England but also in France, Spain, Australia, and the USA. When taking photographs of temples, he goes to great lengths to exclude people; fortunately, his wife is particularly adept at including them.

The earliest temples in India are the Buddhist cave temples cut into the hillside from the 3rd century BCE. They developed elaborate decorations, even carving out of stone, the shape of



Plan of the Virupaksha temple at Pattadakal, Karnataka. Early Chalukya. 745

wooden rafters, reminiscent of characteristic triglyphs in classical Doric Greek temples. Hindu cave temples date from the 6th century CE. In the 7th century CE, monolith temples were carved from large boulders and by the 12th century had become increasingly massive and carved out of hillsides, every detail of the elaborate decorations being sculpted out of the stone with no detachable figures. Following this we find free standing constructions with styles ranging from curvilinear towered Nagara style of the North to the more rectilinear Southern Dravada style. The former has a disc at the top of the tower, while the latter are square in section, diminishing in size as they rise higher. A further Pagoda style is found in Nepal and the Himalayas, its sloping Chinese-influenced roofs allowing it to shed snow (although the same style is found in Bali where the temperature rarely falls below 20°C!). Uniquely in the alluvial plains of Bengal, many temples take the form of terracotta huts, made of brick and decorated with tiles, each detailed and ornamental. Yogini Temples, product of a secret cult from the 6th-12th centuries, are rare, only about 25 still existing. These circular temples, sometimes with a shrine in the middle, were usually built out in the jungle, never in the middle of towns. Around the walls are images of the 64 Yoginis, female deities.

Hindu temples, integral to the life of the community, at least in villages and small towns, are generally thronged with people, with shops lining the routes to them, even nestling against the walls, selling amongst other things, characteristic flowers and garlands to the devotees. People may visit almost every day to pray, study, teach or sometimes just snooze; they invoke the relevant deity at the start of any enterprise, such as opening a shop or starting to build. Holy men and beggars are a frequent sight. Shoes, sometimes in the thousands, have to be left outside, but they are safe and you will always find yours when you leave.

Temples may be devoted to either Vishnu or Shiva without conflict. Devotees of the former can be recognised by a steep ‘U’ shaped mark, with a central vertical line painted in the middle of their foreheads, while those of Shiva often sport one to three horizontal stripes. The temple tower is over an inner sanctum, which is dark and unadorned, with a figure of the deity in the middle. This may take the form of a Shiva Linga, round at the top representing Shiva (sometimes with a head of Shiva), octagonal in the middle representing Vishnu, and a square at the base representing Brahma. Only the top is visible, the remainder being buried in the Yoni, the female generative element. This incorporates a drain so that when the images are anointed with oils or water, the fluid is conducted to an outside basin accessible to the public.

A circumambulatory, often covered, surrounds the sanctum, and devotees can pass clockwise around the shrine. At the portico they can make an offering (puja), often flowers or fruit, which is accepted by Brahmin priests. In the front of the inner sanctum is the mandapa, a pillared hall, though Hinduism is not congregational, unlike the cases of Churches, Mosques or Synagogues. They vary in size and elaborateness, and may be separate from the shrine and portico. Some of the pillars may be exquisitely carved out of a single stone; even a chain attached to one of them was shown, carved from a single rock. These halls have many uses apart from just a meeting

place, as photographs of people praying, sleeping, being married or being blessed by an elephant were illustrated in the webinar. It is also the site of a 'fire ceremony', dating to Vedic times, to mark special occasions. Not only are the outsides of temples highly coloured but the interiors are often full of murals, usually depicting scenes from the Sanskrit epics such as the Ramayana or Mahabharata.

In a Shiva temple, attached to the mandapa there will be a shrine to Shiva's vehicle, the holy bull Nandi. These vary greatly in size, sometimes a massive monolith, but usually life size. The Nandi is venerated and is the centre of great devotion, often offered portions of rice, or to whispered prayers or requests. In Vishnu temples, the Nandi is replaced by Garuda, the vehicle of Vishnu, an eagle with wings, claws and a beak, but a human body. Garuda shrines may take the form of a stone chariot.

Outside some temples, one might find similar massive chariots, heavily decorated during festivals and carrying an image of the deity, to be towed through the town by hordes of men. In the south, the temples are often enclosed, the entrance gate or gopuram becoming increasingly elaborate, and by the 16th century quite large. One illustration showed first two stories were of stone, then of brick with thousands of plaster figures, rising in all to 65m. Within the enclosure there are often subsidiary shrines, which would include one to the deity's consort. Most temples have a water tank, often with a shrine in the middle, and during festivals the deity may travel around the tank on a raft.

During questions Dr O'Brien explained that he used to travel a lot, and was asked to show pictures, so he would develop a story for the slide show and it snowballed from there. I suspect there is more to it than that - most photographers have to bribe people to watch their slide shows!

Feedback afterwards confirmed this webinar to be a resounding success. The committee was greatly encouraged to consider further webinars, and if they are half as enthralling as the present one, there will be no difficulty in attracting a large audience, both from the RFS and the wider RSM. We are most grateful to Michael for all the effort he put in and for his excellent explanations and pictures.

Trimurti temple (Nagara style), Badoli, Rajasthan. Pratihara. 10c

Sangameshvara temple (Dravida style), Alampur, Andhra Pradesh. early Chalukya 8c

Universities and medical schools of the UK

Catherine Sarraf

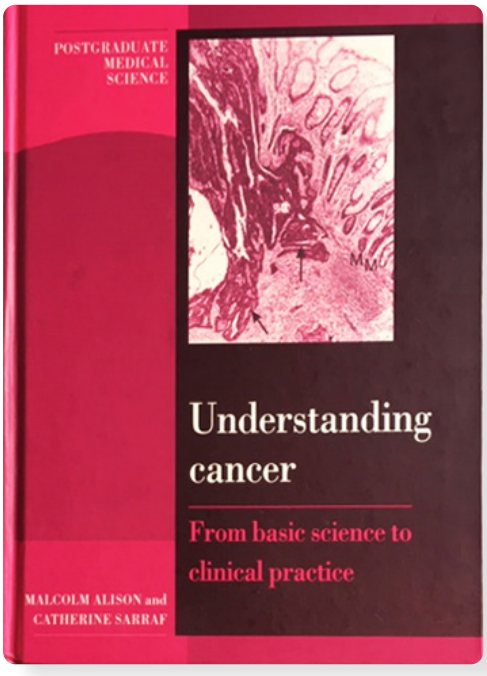
Justifiably, our society is egalitarian, although, we RFS Fellows deservedly compose a kind of meritocracy, by dint of our professional activity and published achievements. However, as time goes by grandchildren/grand nieces and nephews approach or indeed have concluded their university education. Today universities and their medical schools offer something quite different from in our time. Oxford and Cambridge speak for themselves and globally they are ever in the top five (UCL and Imperial College are also often included in this category). In the UK there are 24 Russell Group universities many with their own medical schools; there is also a host of 'new' universities. Let's take a look at all these.

The Russell Group universities are at Belfast, Birmingham, Bristol, Cambridge, Cardiff, Durham, Edinburgh, Exeter, Glasgow, Leeds, Liverpool, Manchester, Newcastle, Nottingham, Oxford, Sheffield, Southampton, Warwick and York: London having five separate Russell Group universities - Imperial College, Kings College, London School of Economics and Political Science, Queen Mary University of London and University College London. Titles of Russell Group universities tend to be simple, for example 'University of Exeter', 'Durham University' (the London ones, though, having more descriptive names). The Group was established in 1994 to represent its members' interests, principally to government and parliament, and it was incorporated in 2007. The Group might be perceived as being composed of the 'best' universities in the country. At present, Russell Group graduates hold 61% of all UK jobs that require a university degree, despite these being only 17% of all higher education graduates. In the 2014 Research Excellence Framework, 68% of world-leading (4*) research and 68% of research with an outstanding (4*) impact was carried out in Russell Group universities. Of the 21 Russell Group universities that have chosen to enter the Teaching Excellence and Student Outcomes Framework (TEF), 10 hold gold awards (48%), 10 silver (48%) and one bronze (5%), compared with proportions across all higher education providers with full awards of 27% gold, 50% silver and 23% bronze.

New universities – in this context I refer to post-1992 universities. Thirty-three of these were former polytechnics or central institutions in the United Kingdom that were given university status through the Further and Higher Education Act 1992, plus institutions that have been granted university status since 1992 without receiving a royal charter. In addition to varieties of college that have succesfully sought university status, there is also a group that were not former polytechnics or central institutions and a single university (University of Wales Trinity Saint David) that results from a merger between a pre-1992 and a post-1992 university. The new universities advertise themselves as providing the more traditional courses plus an exceptionally wide range of topics that previously would not have been on offer at university level. They tend to have to have smaller postgraduate student cohorts thus with the claim of 'offering a more personal postgraduate experience – providing excellent postgraduate options leading to fantastic opportunities'. Often although not always, names of new universities incorporate the name of a famous local historical person, for example 'Liverpool John Moores University' (not to be confused with the University of Liverpool) and 'Edinburgh Napier University' (not to be confused with the University of Edinburgh).

Considering medical schools, there are thirty three medical schools in the United Kingdom that are recognised by the General Medical Council, where students can study for a medical degree; clearly, there are medical schools at nine non-Russell Group universities, for example, the University of Brighton. There are twenty-five medical schools in England, five in Scotland, two in Wales and one in Northern Ireland. The Bute Medical School (University of St Andrews) and Durham Medical School offer undergraduate pre-clinical courses only, with students proceeding to another medical school for clinical studies. Although Oxford University and Cambridge University offer both pre-clinical and clinical courses in medicine, students who study pre-clinical medicine at one of these universities may move to another university for clinical studies. At other universities students stay at the same university for both pre-clinical and clinical work. Advantages or otherwise of selecting any specific medical school to apply to, depends on the preferences of each proto-student. Potential postgraduate training might be one of these.

Not infrequently I'm asked 'How does a scientist (ie not medically qualified) get to be a Fellow of the Royal College of Pathologists? I can reply with certitude on one specific case – First class honours degree in Zoology from (Russell Group) University of Cardiff, PhD on the topic of Cell Proliferation and Cell Death in Malignant Tumours, total of over 30 years' research and teaching experience and being productively active in Pathology Departments in top London hospitals. In my day as a PhD young scientist working in research pathology, to be able to apply for Membership of the Royal College of Pathologists one needed a portfolio of at least 30 peer-reviewed publications in appropriate, globally recognised journals. To proceed to being a Fellow, further years of successful research, very numerous publications and prolific activity at the highest level of the field, followed. When an acceptable standard was proven, the Fellowship was awarded.



Understanding cancer, by Catherine Sarraf and Malcolm Allison

In conclusion, for bright 'A' level students, selection of a path to follow can be confusing. There is a plethora of choices on offer, but not only ability and future job satisfaction need to be considered. Today, following a university education is exceptionally expensive for the family – particularly when there are a few offspring to consider. Best of luck, to all our youngsters!

Alchemist Sedziwój by Jan Matejko (1867)

Alchemy and medicine, yesterday and today

Richard Lansdown

Ask the man or woman in the street what alchemy means and the answer is likely to be 'the practice of trying to turn base metals into gold' (the word is derived from the Arabic *al kimia* which in turn comes from the Greek *chyma* meaning to fuse or cast metals). The more knowledgeable may mention a 'philosopher's stone' and attempts to create an elixir of immortality which could cure all illnesses. The even more knowledgeable might add the development of an 'alkahest', a universal solvent. There are numbers of examples of everyday alchemy around us if we use the one word 'transmutation' to define it: wine that goes sour is transmuted into vinegar.

Alchemy has a dual nature. Turning base metal into gold was for many of its practitioners, their sole aim, but for others it was far more complex than that. For them, gold personified human renewal and regeneration. These aimed to discover the relationship of humans to the cosmos, encompassing astrology, mysticism, spiritualism and art. This was a world view in which everything around us contains a universal spirit. As base metals could be turned into gold, so impure humans could be purified spiritually. Some authorities argue that this was actually the main preoccupation of alchemists, turning base metals to gold was no more than a metaphor.

As the aims of alchemists varied, so did the characteristics of the 'philosopher's stone', the ultimate goal of alchemy, a condensation of a secret substance that will change common metal into gold and, more importantly, bring immortality, enlightenment and perfection to the possessor of the stone. It is also called 'the tincture', 'the powder', and '*materia prima*'. To some it was a stone from which a dry red powder could be obtained, to others it was a wax or liquid. In spiritual alchemy, it is the symbol of the interior force that conveys perfection.

The earliest days

Alchemical practices were evident in the Far East, the Indian subcontinent and the Muslim world. Alexander the Great (356-323 BC) is said to have discovered the Emerald Tablet which contained the secret of the Stone, later building the Library of Alexandria to house alchemical texts. As the library was almost entirely destroyed in the third century, one can only speculate on what it actually held. More certain is the notion that among the earliest, if not the earliest, known mention in writing on alchemy was that of Zosimos of Panopolis around 300 AD.

By the middle of the 7th century, alchemy was almost entirely a mystical discipline but the 8th century Muslim alchemist Jabir ibn Hayyan produced another theory which, as it were, brought alchemy down to earth. He analysed each classical element in terms of the four basic qualities: fire, earth, water and air. It was then reasoned that the transmutation of one metal to another could be reached by rearrangement of its basic qualities, using the Philosopher's Stone, whatever that might be.

Alchemy in Europe

Introduction of alchemy to Europe has been dated, with remarkable precision, to the occasion when Robert of Chester completed his translation of the *Arabic Book of the Composition of Alchemy*, 11th February 1144.

The basis for Western alchemy is Hermetic philosophy, based on the writings of Hermes Trismegistus, thought by some to have been a wise pagan prophet credited with writing 42 books covering all fields of knowledge. This philosophy affirms the existence of a single, true theology that is present in all religions, given by God to man. Hermeticism gave prominence particularly to the idea of influencing or controlling nature which led many scientists to look to magic and its allied arts to reach this end. A characteristic of alchemical writing was that it usually employed elaborate codes and esoteric symbols, giving a spurious air of the scientific, beyond the ken of ordinary folk. One text describes a 'cold dragon' who 'creeps in and out of caves'. This was a code for saltpetre.

Alchemists were not without favour. A Holy Roman Emperor, King James IV of Scotland, Michael I of Russia, Charles I of England and an Elector of Saxony were among many who contacted them for practical purposes. On the other hand, fake alchemists were common, pilloried by Chaucer in *The Canon's Yeoman's Tale* (no-one who practises alchemy, the narrator concludes, will profit: he will lose everything he puts into it). In 1403 Henry IV banned the practice of multiplying metals, although it was still possible to obtain a licence to make gold alchemically.

Alchemy and chemistry

Originally the terms *chemia* and *alchemia* were used synonymously. In the 4th century an Indian alchemist described the process of zinc production by distillation. The German physician Hieronymous Brunschwig published *Liber de Arte Distillandi* in 1512, hoping to make medicinal alchemy accessible to 'the common people that dwell far from medicines and physicians'. Much of the equipment he described, funnels, flasks and so on, are still standard in chemistry labs today. In the 17th century a German alchemist isolated phosphorus and in the same period a fellow German developed a porcelain material, which broke the monopoly in porcelain production, hitherto held by China.

Robert Boyle (1627-1691) is often cited as the father of modern chemistry. He wrote two papers on transmutation of elements, claiming to have changed gold into mercury by means of what he called but did not describe - quicksilver. In his 1661 text *The Sceptical Chymist* he outlined his theory that all matter consists of varying arrangements of identical corpuscles. Transforming copper into gold is no more than rearranging the pattern of these corpuscles. In less scientific mode Boyle supported the supernatural interpretation of alchemy, believing that the Philosopher's Stone might be used to communicate with angels. Isaac Newton (1642-1726) wrote more than a million words of alchemical notes, including details on how to make 'philosophic' mercury.

Alchemy and medicine

The Middle Ages saw alchemists advance the ancient techniques of distillation, leading to production of strong, often alcoholic concoctions, collectively known as aqua vitae, the water of life. They also developed a range of ways to tap medicinal powers of flowers, herbs, spices and minerals. The Philosopher's Stone also, it was said, produced the elixir of life which would cure all diseases and bring not only health but immortality.

Roger Bacon (1220–1292) a Franciscan monk, who set off by studying medicine, has been credited with a number of alchemical texts; his best known *Opus Majus*, written for Pope Clement IV, cites alchemy and astrology as important parts of both natural philosophy and theology. He attempted

to combine all knowledge into an integrated, universal science. His vision having its roots in his study around 1247 of *The Secrets of Secrets*, a book that spuriously purports to be the occult and most profound teachings of the philosopher Aristotle. This work inspired Bacon's study of medicine, astrology and alchemy. He learned from *Secrets* that medicine, combined with alchemy, teaches how to prolong human life.

Historians of medicine turn to Paracelsus (Philippus Aureolus Theophrastus Bombastus von Hohenheim 1493-1541), for he believed in alkahest, an undiscovered element from which earth, fire, water and air were derived. It was this element that was, for him, the Stone. His version was a universal solvent to be used medically. In his words 'Many have said of Alchemy that it is for the making of gold and silver. For me such is not the aim, but to consider only what virtue and power may lie in medicines'. Arguing against the prevailing Galenic view of medicine (that disease comes as a consequence of imbalances in one of the four bodily fluids: blood, yellow bile, black bile and phlegm) Paracelsus saw the body's organs working alchemically; their function was to separate the pure from the impure. Three controlling substances were seen as necessary for health: mercury, sulphur and salt. He thus treated plague and other diseases with the administration of inorganic salts, minerals and metals.

Alchemy's decline

As late as 1781 one James Price claimed to have produced a powder that could transmute mercury into silver and gold, but the decline of the practice in Europe had begun with the rise of modern science and an emphasis on quantitative experimentation. Around 1720, there came a rigid distinction between alchemy and chemistry. By the mid 18th century the former was generally regarded as fraudulent.

Alchemy in our time

Although a study of alchemy is not part of mainstream psychology, Carl Gustav Jung (1875 –1961), having read the Chinese alchemical text *The Secret of the Golden Flower*, traced a correlation between symbolic images in alchemical drawings and symbolic images arising in dreams, visions or the imagination of his patients. Volume 12 of his collected works is entitled *Psychology and Alchemy*. He wrote 'When the alchemist speaks of Mercurius, on the face of it he means mercury, but inwardly he means the world-creating spirit concealed or imprisoned in matter'.

It is not surprising that alchemy has some place in New Age interests and practices. Three examples come from the United States: Frater Albertus Spagyricus (a German born as Albert Richard Riedel, 1911–1984), founded the Paracelsus Research Society in Salt Lake City, which later evolved into the Paracelsus College. For him, following traditional teaching, all things were made of sulphur, salt and mercury, analogues for soul, body and spirit, or Father, Son and Holy Ghost. Extracting these three from plants and purifying them, he made medicines. One of his students has written of separating the essences of chicken eggs and from the sulphur thereof producing a medicine 'that has proved salutary in incidences of artheriosclerosis'. After his death in 1984 the college ceased operations in the United States but continued to carry on the tradition in Australia.

John Dee Performing an Experiment before Elizabeth I - painting by Henry Gillard Glindoni (1852-1913)

Next, Nicholas D Collette asserted a few years ago that immortality is not a myth. Using his elixir, one can stay young or rejuvenate oneself to a young and beautiful person again. The methods for making his elixir were, he said, taken from a private collection of unpublished 17th and 18th century alchemy manuscripts. We had, for

a fee, a chance completely to eradicate disease. What is more, the Philosopher's Stone would, starting with morning dew, turn lead into gold. He died in 2012 in his early thirties.

Then an organisation called A New Possibility, founded in 2012, continues the views of the occult schools, common in the 19th century, which interprets alchemy in a spiritual sense. The New Possibility founders thus maintain that 'Alchemy is an ancient tradition whose goal is the transformation of an ordinary person into an extraordinary human being, an everyday life into a life imbued with spiritual meaning, divine purpose and passion. Lead to gold refers to the possibility of a spiritual upgrade, to the miraculous capacity of human beings to evolve to more refined, elegant, potent and complete expressions of their own divine natures. Science and the rational mind are no longer able to resolve some of our most pressing questions about how to heal ourselves and our planet, how to relate peacefully with our neighbors [*sic*], or how to live a spiritually meaningful life'.

These three offer a kind of modern-day alchemy, the art of transforming metaphorical 'lead' - suffering, illness, hardship - into 'gold'- the bright spirit of possibility that defines a meaningful human life.

Conclusion

From Alexander the Great to Nicholas Collette there have been searches for the Philosopher's Stone in all its variations. Perhaps one day someone really will find it.

Acknowledgement: Gillian Tindall kindly commented on early versions of this paper.

Hints to maintain computer hygiene

Michael Kelly

Particularly during a pandemic with Lockdown such as the one we are currently experiencing, the email system becomes an absolutely essential way of people keeping in touch with others. Many, perhaps most, Retired Fellows, will be "working" or at least "functioning" from home, rather than from anywhere else – like me!

I have a PC with Windows-10 and Microsoft Office-16. Often at weekends one or other of these sends out (cursed) Updates that are quite capable of crashing my computer mid-week just when I am in the middle of something, making restorations tedious and often impossible (as well as maddening!)

I have devised the following established daily routine (with occasional "missed days")

- For all of the week, I "close down" my computer each evening by putting it "to sleep"; then next morning I just need to insert the password and I go back to full activity.
- Each Monday afternoon, I try to remember to close it down with a "Restart" and this usually takes care of all the Updates.
- At the start of each day, once I have woken up my computer from its overnight Sleep, I look at my emails, as follows.
- I click on "Unread" and start at the bottom (the earliest) and go through them quickly deleting as I go those that I do not wish to view further.
- I move to my Bin and scan down these carefully (which now contain the above emails) to make sure that I have not made any mistakes (I do find these, and I restore them to my Inbox).
- I then press Control+A which highlights all in the bin and click Delete → they are permanently deleted.
- I then open my Spam and see if anything valuable has crept in there; if so, I restore this to my inbox.
- I highlight all that are left in my Spam* → delete → these appear in my Bin → I delete them as above.

*The reason for taking this step as a separate manoeuvre is that, using my computer, I cannot permanently delete my spam box's contents with one click. When I delete my Spam contents, instead of offering me the opportunity to delete them permanently, it automatically transfers them to my Bin where they now have the potential to become 'lost'. If my Bin is itself actually empty (as it will be, item-6 above) then I can be sure that all of them have been included and then I can delete these as in item-6.

Thus, each day I have checked and emptied both my Bin and my Spam.

I don't often get caught out!

Dr Thomas Sydenham in a 1689 portrait by Mary Beale

Clad in goatskins, Alexander Selkirk (not Robinson Crusoe!) awaits rescue. Sculpture by Thomas Stuart Burnett (1885)

Of doctors and castaways

Catherine Sarraf

Over the turbulent times of the 1600s there lived two notable physicians, the younger having been a student of the elder. King James Ist reigned from 1603 to 1612, Charles Ist from 1612 to his execution in 1649. Following was Oliver Cromwell's Commonwealth until 1660, then the reign of Charles II to 1685 and James II to 1688. In 1688 the Glorious Revolution brought William and Mary (man and wife cousins, both grandchildren of James I) jointly to the English throne.

Embedded in this period was the life of Dr Thomas Sydenham (1624-1689). Initially, his time at Oxford University was cut short by the English Civil War (1642-1651) but ultimately he qualified as a doctor from Pembroke College Cambridge in 1676, having had a Licence to practice medicine in London from 1663. He was author of *Observationes Medicae* which became a standard textbook of medicine for two centuries, plus numerous other learned texts and manuscripts. Sydenham was a successful practitioner and publisher, and fame continued posthumously. During his career he had success with his 'cooling treatment' for smallpox, for his enthusiasm for treatment with laudanum (the first widely used product of opium), and for his advocacy of the use of what was then called Peruvian bark, now recognised as quinine-containing cinchona bark. Nowadays quinine derivatives can be used for treatment of malaria, but in the seventeenth century it was considered as being a kind of wonder drug for just about any inflammation or 'miasma'. With regard to laudanum, Sydenham's seminal contribution to the recipe was derived by experimenting with opium and mixing it with sherry, saffron, cinnamon and cloves, masking opium's bitterness and damaging side effects. It was popular as self/domestic medication, to be found in the home medicine cabinet and was widely administered to children for unimportant reasons, such as fretfulness during teething. Sydenham practiced medicine through the 1665 great plague in London, although his family moved out of the city for its duration. Although seven years after its passing, in 1772 Daniel Defoe (1659 – 1731) wrote *A Journal of the Plague Year*, his account of the catastrophe. Sydenham finally died at his house in Pall Mall 1689, aged 65 and is buried in St James's Church, Piccadilly, where a mural slab was

put up by the College of Physicians in 1810.

Thomas Dover (1660–1742) studied medicine under Thomas Sydenham in London, and also was educated at both Oxford and Cambridge universities. Initially, he contracted smallpox and was treated, apparently successfully, with Sydenham's 'cooling method'. At the time, Dover was noted for his common cold and fever medicine, Dover's powder, and for his exceptional efforts treating the poor in Bristol, following in Sydenham's footsteps at St Peter's Hospital for the Poor. Working in this city of voyagers, however, excited him into a career change – to become a privateer! In 1702, Dover took a trip to the West Indies with two adventurers William Dampier and Woodes Rogers. Subsequently, Dover became part owner and second captain of a ship called the *Duke*, a privateer under the command of Rogers (there was also a further ship called the *Duchess*). The doctor became 'Captain Dover', having contributed £3,312 to the voyage. He also had responsibility for the health and well-being of the crew, although there were a further four surgeons with him. By 1708, the *Duke* and the *Duchess* sailed for South America and on 2 February 1709, off the coast of Chile, a light was seen on a supposedly uninhabited member of the Juan Fernández Islands, Mas a Tierra. Dover led a landing party and discovered it to be a fire lit by a Scottish sailor Alexander Selkirk, abandoned on the island in 1705 with just 'a musket, a hatchet, knife, cooking pot, a Bible and his clothes', because he was something of a misfit amongst the crew and had constantly argued that his ship, the *Cinque Ports*, was not seaworthy. Selkirk's beliefs proved to be well founded, as the ship had sunk one month after with only a few survivors to tell the whole tale! Selkirk, on the other hand was rescued and he accompanied Dover and his ships back to England. His four-year stay on the island and eventual rescue were inspiration for the novel *Robinson Crusoe* by Daniel Defoe, also a friend of Woodes Rogers. One way or another, Defoe heard the tale of Alexander Selkirk, a further suggestion being that while sitting quietly in a tavern he overheard an old sea-dog (Selkirk) relating his tale to some other lags. Be this as it might, seeds were planted in his mind and this was the real-life spur for his creation.

*'This day I did in Drury Lane see two or three houses marked with a red cross upon the doors, and '**Lord Have Mercy upon Us**' writ there – which was a sad sight to me, being the first of the kind that I ever saw.'*

Samuel Pepys, writing during the Great Plague of London, June 7, 1665

Alexander Selkirk was a lucky man, to be discovered and transported home. In the same vein, in the 2000 Tom Hanks film *Cast Away*, the traumatically wrecked hero has to survive by his wits and mechanical ability on a desert island. Eventually he is saved. Life is not always like that. During the second world war, three marooned people were enduring their fate alone, sheltering on a desert island, that many years previously had been inhabited only rarely by a temporary engineer or two. Woody Island is a tiny outcrop of the Paracels Group in the South China Sea, but has fresh water and edible vegetation. Suspicious, but suspecting the presence of human life, on February 3rd 1945 two Australian commandos were secretly landed on it by the American submarine *USS Pargo*. There without revealing themselves, they observed the three castaways, two Japanese and one European living in harmony together, in the remains of a shack, flying a French flag. After the commandos withdrew, the *Pargo* shelled all structures, with the aim of destroying them totally. Just to be sure, on March 8th American aircraft bombed the long-derelict pre-war Woody Island radio relay mast. On July 2nd, a further US submarine, the *USS Cabrilla* arrived. Visiting the bombed out shell of the still extant people's home, the Americans discovered the French tri-colore still flying, but now beneath a white surrender flag clearly displayed above. No doctors were called to evaluate these poor people and nothing was ever heard of them again. The aim of the Americans was certainly not to rescue them.

Full references available on request, in addition to:
Milk of Paradise a History of Opium, by Lucy Inglis 2018, Macmillan
The South China Sea, Struggle for Power in Asia, by Bill Hayton 2014, Yale University Press

What was the ‘Plague’?

Richard J Pusey

Pandemics have occurred repeatedly throughout time. I well remember the 1968-69 Hong Kong flu outbreak in which about 80,000 died in the UK. At the time I was a senior medical student and we were rushed into service to prop up an overwhelmed NHS (anything new?). Throughout history the worst pandemics were caused by ‘Plague’ particularly the Black Death of the 1350s and the ‘Great Plague’ of 1665, in which about 100,000 died in London alone.

‘Plague’ has continued and outbreaks have occurred regularly. The last outbreak of plague in England, confirmed by bacteriological testing, was 1906-18 in East Suffolk, mainly on the Shotley Peninsula . It was cleverly spotted by the local GP because of a massive number of dead rats in the area, and an epidemic of plague was known to be occurring on the continent. It was thought to have been brought in by rats off ships at Ipswich docks. In fact, plague is still endemic in the world, particularly in parts of Africa and I saw cases when I worked in Zambia (1997). It is now treated with antibiotics just like any other bacterial infection, and has low mortality.

So what is plague? It is infection by the *Yersinia pestis* bacterium, described by the Swiss/French bacteriologist Alexander Yersin in 1894 and named after him. The bacteria are carried by black rat (*Rattus rattus*) fleas which infect the rat which dies (see above). The fleas then have to find another host, which might be a human, and bacteria from an infected flea-bite spread along the lymphatics to the regional lymph nodes in the groin, axilla or neck depending on the original site of the bite. These nodes become swollen and inflamed (a bubo) and can break down and suppurate infected pus if a surgeon hasn’t incised the abscess beforehand. This disease is called Bubonic Plague. Many cases then fully recover, particularly if antibiotics are given. However, in a number of cases the infection can enter the blood stream and spread to the lungs causing severe damage with secondary pneumonia and respiratory failure, frequently ending in death. This is called Pneumonic Plague. Patients cough up highly infected sputum which can transmit the disease to other people as large droplets, but contact has to be close unlike a small particle droplet viral infection. During this acute phase the patient can develop sepsis which results in DIC (diffuse intravascular coagulation). DIC can result from severe infection following bacterial and viral infections, major trauma and many other conditions. It causes clotting in tissues and blood vessels resulting in a rash, peripheral gangrene (I have had to amputate limbs because of this) and bowel infarction (death of gastrointestinal tissues). Once the clotting factors are used up major haemorrhage occurs particularly into the flanks with blackening from massive bruising. This might be why it became known as the ‘Black Death’

So did this cause historical cases of 'plague'? Experts have argued that there are many inconsistencies with this theory. It spread around the whole of the country much too quickly. The Suffolk outbreak shows very clearly how slowly and limited the spread was in this case, taking into account how much slower travel was in the past. In Suffolk, there were only 9 fatalities spread over some 12 years without any isolation procedures or antibiotic treatment. Furthermore, the black rat is a timid creature only found on ships and around ports, in warehouses and so on, and wasn't found around the countryside in historic times. The ubiquitous brown rat (*Rattus norvegicus*) didn't arrive from Russia until the 1750s but it is interesting that the Suffolk outbreak was spread by the brown rat. Large numbers of dead rats have never been recorded in past 'plagues'. Also the disease was found in other animals in the Suffolk outbreak - hares, rabbits, ferrets and one cat – when these were analysed, and infected animals were found in North Essex also. So could historical 'plague' have been spread by rabbits or other vectors? It is interesting, cats and dogs were thought to spread the 'Great Plague' and were destroyed and thrown over the London City Wall (hence Houndsditch). Also Iceland has had the 'plague' - but Iceland has never had any rats!

The rich and those that could (including King Charles II and most doctors), fled London at the start of the plague in 1665 (they had second homes in Cornwall even then but perhaps not caravan sites in Wales!) but some brave doctors stayed behind to attend to the sick. Nathanial Hodges was one such and he had some interesting remedies such as ground up bezoar (hairball from the stomach), unicorn horn and dried toad! He is buried in St Stephens Walbrook and a plaque to his memory can be seen in the church. The doctors wore long protective gowns and curious pointed masks containing smelling salts to keep away the 'miasmas'. They were called 'Quacks' because these resembled duck beaks, and the name for doctors has stuck ever since! I suspect, however, they were of more use than some of the masks being worn at present!

We have seen how quickly Coronavirus can spread around the world by droplet infection (although aided by modern air travel). So could the historical plague have been a viral infection? Certainly something like the Spanish flu virus of 1918 which killed about 200,000 in the UK or the more modern Ebola virus would fit the bill very nicely. It is common to get DIC with these infections and the term 'Black Death' could equally apply. However, perhaps the only good thing to come out of Crossrail (until now anyway!) is that it has unearthed old graveyards and in particular the old Bedlam graveyard near Liverpool Street station. It is thought 'plague' victims were buried there and MOLA (Museum of London Archaeology) staff have been able to perform DNA analysis of teeth of skeletons (during the septic phase blood vessels of the dental pulp become invaded). Interestingly this has proved positive for *Yersinia pestis* in a small number of cases tested. So perhaps Mr Rat was to blame after all!

But there could be another explanation. It is common to see two infections co-existing. A good example is the present HIV/Aids pandemic in sub-Saharan Africa which has reduced general immune states of the population and allowed an opportunistic infection like tuberculosis to devastate those sufferers. Could a minor outbreak of true plague have spread panic in the population with quarantine restrictions, economic collapse and famine, resulting in a lowered immune state? This would allow a massive opportunistic viral infection to decimate numbers and do the real damage. Sound a bit familiar?

Present modern medicine and care, particularly in the developed world, has resulted in a huge increase in the elderly with chronic underlying conditions (meant factually and in no way maliciously) and low immunity; the present Covid-19 outbreak demonstrates how a viral infection can seriously affect this sector. There are many parallels with our present crisis and past 'Plagues'.

Could the 'Plague' even, have been a strain of Coronavirus??

Further Reading and References

Black J and Black D, Plague in East Suffolk 1906-1918. Journal of The Royal Society of Medicine Vol 93 Oct. 2000

Scott S and Duncan C, Return of the Black Death. Wiley 2004

Brahma, Vishnu, Shiva (Trimurti), Cave 27 Ellora, MH Kalachuris 7th century

Hindu mythology

Originally planned as a preview to have been given by Michael O'Brien on May 21st 2020

There are numbers of misconceptions in the Western world about Hindu mythology. Why do some images of the Gods have multiple heads, multiple arms and animal heads, and what about the plethora of deities? Hinduism is usually perceived as polytheistic, but it is in fact monotheistic, with the concept that all things are derived from Brahman, an all pervading, self-existent power, the supreme entity, uncreated, eternal, infinite, transcendent, the cause, the foundation, the source and the goal of all existence. So, if a deity is to be seen by us, it must assume an appearance which can take any form, usually determined by the story behind the manifestation.

Hinduism today evolved from about the 2nd century before the current era (BCE) and was derived from Vedic religion. The Vedas are the holy books of Hinduism, the Rig Veda being first written in Vedic (a precursor of Sanskrit), in about 1500 BCE, recording a much earlier oral tradition. The spread and influence of Vedism began to fade after about 600 BCE. It is possible that Vedism was in turn derived from the Indus Valley civilisation, which flourished from about 6000 BCE to 1300 BCE, with major towns at Harappa and Mohenjo Daro. Neither had constructed temples and Vedic religious practice incorporated open air fire ceremonies.

There were large numbers of Vedic deities, the most important being Indra - God of war and storms, Surya - Sun God and Agni - God of fire. The Vedic deities did not disappear with the advent of Hinduism, but came to assume a minor role. Indra, Agni, Kubera, Varuna Vayu,

Yama and Nirriti became Dikpalas – the guardians of the eight directions. Surya (Sun God) and Chandra (Moon God) became Navagrahas – two of the nine planets. Rudra is thought to be the origin of the fierce form of Shiva. Brahma became a major Hindu deity, forming the Hindu Trinity with Vishnu and Shiva. Brahma rather receded in importance in the 6 -7th century CE, to be replaced by the great Goddess. Although images of Brahma can be seen on the North side of many Hindu temples, there are only two major temples in India devoted to him. The great Goddess, Mahadevi, is perceived as the origin of all female deities.

The two main divisions of Hinduism are worship of Vishnu and Shiva, with numerous sects within each tradition. Vishnu is the preserver of established law, order, stability and continuity, while Shiva is a more complex deity, embodying a wide range of personalities. This is reflected in over one thousand names, which represent his different activities, the mythologies with which he is involved and the locations where he is worshipped. As the Indo-Aryan incursion spread down through India from the North West, local Gods were assimilated into Hinduism, usually with Shiva acquiring their characteristics and adding another character to his persona.

Hindu Gods have a number of attributes and each has a transport vehicle, and it is these characteristics which often clearly identify a particular God. For example – Vishnu carries a discus and rides on Garuda, a mythical bird with a human body, beak, wings and feet of an eagle. Shiva carries a trident and rides on the bull, Nandi. The Gods also have consorts and Shaktis, which may be the same, fulfilling different roles. Consorts are 'wives' and often have children. Shiva's principal wife is Parvati who has two children, Kartikeya, a warrior and Ganesha, the elephant-headed God. The Shakti of a God is the female personification of the divine force, the power and the energy of a deity. The Saptamatrikas (seven mothers) are the Shaktis of their deity. Brahmani (Brahma), Maheshvari (Siva), Kaumari (Kartikeya), Vaishnavi (Vishnu), Indrani (Indra) and Chamundi (Shiva).

Vishnu appears in various forms (avatars) to restore law and order to the world. There are ten principal avatars. The first two are Matsya a fish, and Kurma a turtle. The next two are part

Nandi (a megalith) at the Virabhadra temple, Lepakshi, Andhra Pradesh. Vijayanagara. 16c

Shiva and Parvati
Brihadishvara T. Gangaikondacholapuram TN, Chola 1035

animal and part man, Varaha, human with a boar's head and Narasimha with a lion's head and claws. The next four have human form, Parashurama, Rama the hero of the Ramayana, Krishna and Buddha. The last is Kalki, a horse who has yet to appear. Two notable stories about Vishnu are the Creation myth (Anantashayana) and the Churning of the ocean of milk.

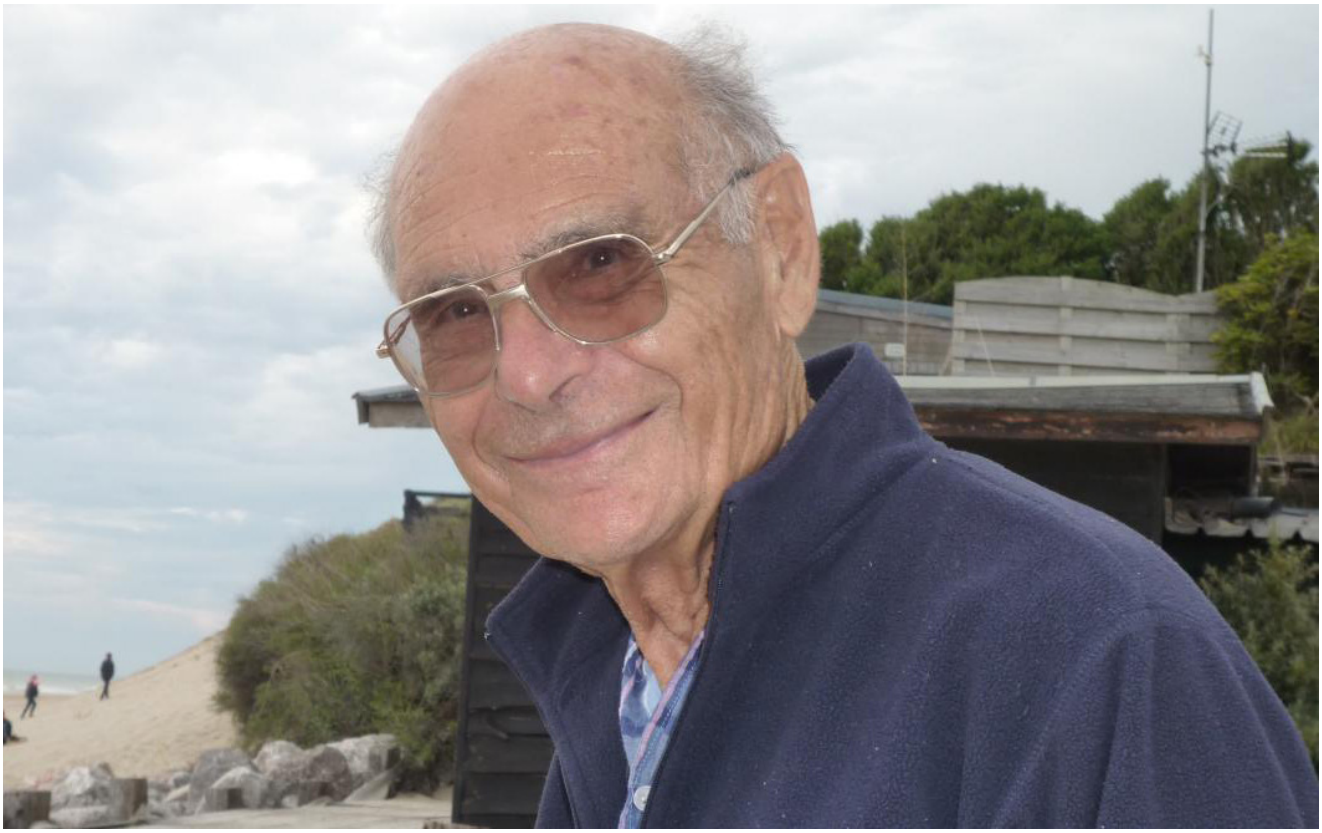
An expression of the common origin of Vishnu and Shiva is Hari-Hara, the left half is Vishnu and the right half is Shiva, both with their characteristic attributes. Shiva's iconic features include matted dreadlocks, skulls, a crescent moon, third eye, tiger skin/ elephant hide and snakes.

The many aspects of Shiva are frequently seen on outer walls of Hindu temples, but in the inner sanctum (the garbhagriha) Shiva is represented by a linga embedded in a yoni, which represents the female generative element. The linga maybe plain or have one to four heads of Shiva, representing different aspects of the God. Shiva is often shown with his principal wife, Parvati and also in images where the left half is Parvati and the right half is Shiva (Ardhanarishvara).

Notable stories about Shiva include his emergence from the pillar of fire (Lingodbhava), dancing Shiva (Nataraja), as a teacher sitting in the deer park (Dakshinamurti), as a wandering mendicant (Bhikshanatamurti), and dancing inside the hide of an elephant just killed (Gajasuramurti).

The Goddess appears in many forms, as the consort and/or the Shakti of a deity. Most major rivers in India have an associated Goddess and they may also appear as individual Goddesses, such as Durga and Kali. Numerous female figures adorn the external walls of many Hindu temples showing a wide range of activities.

All these stories are graphically expressed in Hindu temple sculpture. The lecture would have used these images as a vehicle to explain the Hindu pantheon, the iconography and the mythology.



Obituary

Dr Kenneth Citron, 2.4.25 to 11.9.19

Dr Kenneth Citron, who died at the age of 94 last September, was a founder member of the Retired Fellows Society (RFS) and contributed much to its development and current high profile at the RSM. Ken's insatiable inquisitiveness and interest in medicine was pivotal in ensuring that the RFS established a strong profile consistent with academic aims of the RSM. Indeed, through the annual *Recent Advances in Medicine and Surgery* conference, which he developed together with the late Bill Cattell, he ensured that the RFS contributed to the theme of research and innovation now rightly regarded as so important to medicine.

Ken was devoted to the RSM and played a prominent role in many of its academic activities. He was President of the Section of Clinical Allergy and Immunology in 1974 and, in addition to being a member of the RFS Committee for many years, was elected a Trustee of the RSM, then Honorary Librarian, and in these roles served on Council of the RSM for several years. His carefully considered and well-balanced views and judgments were widely respected, and, at some critical moments in the RSM's history in the early 2000s, he was influential in the deliberations of Council. As Honorary Librarian, he strongly and effectively promoted the role of the Library and the need for development of Library Services.

Ken trained in chest medicine at the time when tuberculosis was outstandingly the dominant disease of our country, and witnessed the introduction of streptomycin and subsequently all the anti-tuberculosis drugs now used. He was appointed registrar at Brompton Hospital in 1953, where he worked as my father's registrar and later his senior registrar. He was involved in the early MRC clinical trials of streptomycin. Finding drugs that could cure tuberculosis and Doll and Hill's work, leading to the publication of the first report on smoking and health put a new focus on other chronic lung disease, and stimulated the development of research and establishment of respiratory disease as an academic discipline. This in turn led to the recognition of many 'new' respiratory diseases. At the Brompton, Ken played a part in the development of academic chest medicine, being provided with laboratory space in the

enlarging Institute for Diseases of the Chest (later becoming the Cardiothoracic Institute in 1971 and then the National Heart and Lung Institute in 1989). He contributed to understanding the importance of allergic lung conditions, working with Jack Pepys and publishing a substantial number of research papers.

Ken was appointed consultant at the Brompton and at the Wandsworth Chest Clinic in 1959. Tuberculosis, the principal reason for the existence of this and all other chest clinics at the time, remained an important component of the work of the clinic for the rest of Ken's clinical career. Ken seized the opportunity to develop the chest clinic, through close liaison with local GPs and with support and back-up facilities available at Brompton. This new outreach model reaped benefits for patient care, training of junior staff, research and teaching. A new Wandsworth Chest Clinic building was completed in 1960, opened by Enoch Powell. This served a population of some 300,000. Clinics were also held in Battersea and at Wandsworth Prison, where the emphasis was on TB and smoking-related diseases.

Ken was passionate about teaching and training. His reputation as a meticulous clinician, regarding history and physical examination as the starting point in all diagnosis, was well-known. Countless junior staff, many of whom became leading lights in other specialties, benefited from this clinical grounding. A Diploma course at Brompton, later evolving into an MSc degree course, owed much to Ken's initiative and energy.

Ken's involvement in the treatment of tuberculosis spanned his entire career. Following his participation when a trainee at Brompton in the early 1950s, and then appointment at the Wandsworth Chest clinic, he was involved in the later clinical trials of PAS, isoniazid, rifampicin, pyrazinamide and ethambutol. At the Department of Health, he was an Adviser in Respiratory Medicine and chairman of its BCG Vaccination Committee. In 1987 he was awarded the Weber Parkes medal by the Royal College of Physicians in recognition of his contributions to respiratory medicine and tuberculosis.

Ken travelled extensively, advising and teaching on respiratory disease, and particularly tuberculosis, in north and south America, Hong Kong, Poland, with multiple visits to countries in the Middle East (Iraq, Libya, Iran, Saudi Arabia and Egypt), India, Pakistan, Bangladesh, Indonesia and the Philippines. He recalls being whisked away from his hotel in Tripoli late at night, without warning, under armed guard, to be taken to see Gaddafi and his family in the desert.

Ken retired from the NHS in 1990 but remained active on the front line of medicine in retirement. For several years he was closely involved with *Crisis*, and particularly in the problems of TB in the homeless, organising diagnostic services in this migrant population. A *Crisis* publication, *Out of the Shadow* owed much to Ken's expertise and input.

Ken achieved everything with a self-effacing, quiet modesty, but with great effectiveness. The matter at hand was always more important to him than his own part in it or any form of self-promotion. He was measured in his public and private communications, logical in his arguments, a good companion and ally whatever the circumstances, calm under pressure, and a great raconteur at times of relaxation. He had a truly warm, caring nature.

Tall, slender, handsome and impeccably dressed, Ken was concerned with his physical fitness. Having purchased a rowing machine for his son Peter when Peter was an undergraduate at Cambridge, Ken then took it over and became the British National Champion in the over-80 years category, winning in a British (and possibly world) record time.

Ken married Sue, whom he met at Brompton Hospital, in 1979. He is survived by Sue, his son Peter from his first marriage to Mary, and four grandchildren.

John Scadding

31st March 2020

INFORMATION FOR AUTHORS

There are three issues per year of the Retired Fellows Society Newsletter, which appear in April, August and December. Articles may be submitted at any time, and accepted ones are compiled into the next available issue space.

Each manuscript should bear the title of the article, name, address and email address of the author. Please write in Arial Narrow, 12 point, 1.5 spaced and do not justify the text. Spelling needs to conform to the Concise Oxford English Dictionary.

Text MUST be submitted electronically, as a 'Word' fully editable document.

Several types of article are core to the journal:

Solicited articles, these are on a topic agreed with the editor, and should be 1,500 to 2,000 words in length.

Articles submitted by readers – 500 to 1,500 words.

Reports of presentations at meetings of the Retired Fellows Society - 500 to 1,500 words, the author invited by the Chair of the corresponding day.

Reports of extramural events of the Retired Fellows Society - 500 to 1,000 words, the author invited by the leader of the event.

Reports of Retired Fellows Society tours – 1,000 to 2,000 words, the author invited by the leader of the tour.

Short 'fillers', text and/or photographs. Poems, quotes, amusing items – brief – less than 200 words.

Illustrations:
With reference to submission of images (which is very much encouraged), it is ESSENTIAL that each image is accompanied with a title of what it is, and the name of the person who actually took the photgraph.

Photographs should be uploaded electronically and meet the specifications of 300 DPI and minimum size of 297 × 210 mm (A4 paper size).

Hot spoon treatment for mosquito bites

Michael O'Brien

My wife is exquisitely sensitive to mosquito bites, which produce a large weal and extensive surrounding erythema. While on holiday in Spain she was bitten several times on one ankle while sitting out in the evening. Later, she turned around in the shower and accidentally knocked the tap to full hot, getting a blast of very hot water on her ankles. Expecting this to make the intense itching much worse, she was surprised that it was completely relieved. So, after the next mosquito bite, she heated a spoon in boiling water and briefly touched the bite - with complete and immediate relief. This has been repeated many times. I was initially sceptical, but I tried it with my next mosquito bite and could confirm its efficacy, provided the spoon is really hot. The relief is not only immediate, but also long lasting, many bites not requiring any further treatment. It is much more effective and cheaper than the local application of anti-histamine creams.

RSM Update

From Monday 3 August, the RSM will be re-opening facilities at 1 Wimpole Street in a phased approach. Here's what you need to know before you visit.

Our aim throughout your visit is to keep our members and staff safe, while providing our usual friendly and efficient service.

All our staff have received rigorous training for our new hygiene, safety and cleaning standards.

Please help us by following our new way of working and please do not visit if you have Covid-19 symptoms or feel unwell.

For more information, check online at:
www.rsm.ac.uk