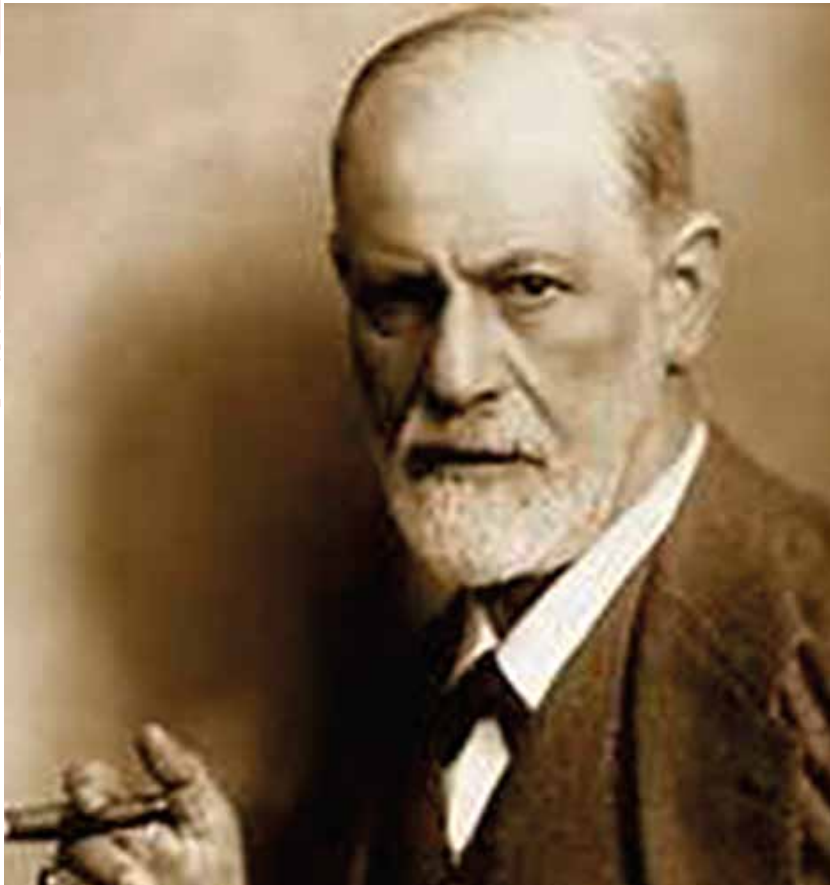


RFS Newsletter

Newsletter Issue No.55

April 2016



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Sigmund Freud, see page 05

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The ROYAL
SOCIETY of
MEDICINE

Editorial

Is the fourth industrial revolution really upon us, I wonder?

The first was steam, iron, steel and all that they brought with them. The second was electricity and, I suppose, radio and television. The third was the internet and the computer and now we have the fourth: artificial intelligence and robotics. I understand that robots are better at some surgical procedures than surgeons, we already have robots that can deliver groceries to people's houses, driverless trains in London and driverless cars in the US.

Since the days of the Luddites we have observed machines taking over jobs from people but now there seems to be a different order of magnitude, no longer are

we worried simply about manual work being supplanted, it is the highly skilled whose livelihoods are threatened. What will happen to editors of Newsletters like this one? Will articles be written by robots, scanned and then corrected according to some predetermined formula? Will the only proper work be for those lucky individuals who know how to program the robots?

But hold on, there is always a danger of predicting the future from the past. Let us consider a GP consultation. Will a robot really be able to interpret the slight twitch in a patient's mouth when a significant point is raised? I suspect not, but this does not mean that we should ignore the possibility of the loss of many jobs.

Work is central to one's self esteem and if all this doom and

gloom really does come about something may have to be done. I can see two possible solutions.

One is to accept that full time work is a thing of the past and encourage the three or four day week. This has obvious advantages but it does not in itself provide any work at all for those who have been totally supplanted by a robot.

The other is simply to create jobs. Go to a theatre and you will buy a ticket. Next you will have to show your ticket to a real human being. He/she will direct you to the correct door where you will be met by another real person who will check your ticket again and direct you to your seat. On the way you will encounter a programme seller, and so on.

Any thoughts?

Forthcoming meetings

Thursday 21 April 2016

Professor Richard Ashcroft: Incentives, nudges and encouragement in health promotion and public health

Professor Ashcroft teaches Medical Law and Ethics at both undergraduate and postgraduate level in the Department of Law at Queen Mary University of London.

Previously he was Professor of Biomedics Ethics in the School of Medicine and Dentistry, and before that he worked at Imperial College London, Bristol University and Liverpool University.

He teaches Medical Law and Ethics at both undergraduate and postgraduate level in the Department of Law at Queen Mary University of London.

He is a Deputy Editor of the *Journal for Medical Ethics*, and serves in the editorial boards of a number of other journals. He is a member of the Ethics and Policy Advisory Committee of the Medical Research Council, Director of the Appointing Authority for Phase I Ethics Committees and a member of the Royal College of Physicians' working party on tobacco.

Camera club meetings

Monday 23 May 2016 - Damien Demolder: My life in photography

Friday 24 June 2016 - Anthony Epes: Title to be confirmed

Monday 25 July 2016 - Mark Buckley-Sharp: What to look for in a photograph

Friday 30 September 2016 - To be confirmed

Thursday 19 May 2016

**Professor Sir Tom Blundell:
Genomes, structural biology
and making new medicines:
Facing the challenges of drug
resistance in cancer and TB**

Professor Blundell is Director of Research and Professor Emeritus in Biochemistry, University of Cambridge, where he was Professor (1996-2009), and Chair of School of Biological Sciences (2003-2009). He researches on molecular and structural biology of growth factors, receptor activation, signal transduction and DNA repair, important in cancer, tuberculosis and familial diseases. He has published 550 research papers including 30 in *Nature*.

He has been a member of the PM Advisory Council of Science and Technology; ACOST (1998-1990); Founding Chief Executive Officer of BBFRC (1991-1996) Chair from 2009; Chair of Royal Commission on Environment (1998-2005); Deputy Chair Institute of Cancer Research since 2008 and President, UK Science Council since 2011. He was knighted in 1997, and is a member of several academies. He has received many prizes and awards and is a Fellow of the Royal Society (1984). In 2014 he was awarded the Cambridge Philosophical Society Prize. He is a Fellow of Sidney Sussex College, Cambridge; Honorary Fellow Brasenose and Linacre Colleges, Oxford; and Birkbeck College.

Thursday 16 June 2016

**Schmaltz and champagne:
All about Viennese operetta -
lecture by Mr Derek Scott and
AGM**

Mr Scott started out with great ambitions to go into the theatre and even got as far as winning a scholarship to RADA; but National Service intervened and after much family pressure (plus advice on a postcard from George Bernard Shaw) and the fact that his girl-friend (now wife after 63 years) was a dental nurse, Mr Scott was accepted by Guy's and St Thomas's Hospital NHS Trust to study dentistry. He practised in London's West End for 40 years; and retired in 1993. But he has always had a passionate interest in popular culture, which he is now able to pursue making up these talks. His time is now spent finding speakers for every Monday morning plus organising their annual three day seminar for his branch of the University of the Third Age - all of which he enjoys much more than dentistry.

Thursday 20 October 2016

**Mr Piers Mitchell: The scientific
study of King Richard III**

Thursday 17 November 2016

**Professor David Cave:
Capsules, balloons and screws:
New tools for the diagnosis and
management of small intestinal
diseases**

Thursday 1 December 2016

**Recent advances in medicine
and surgery**

Thursday 16 February 2017

**Professor Keith Lowe: The myth
of the rebirth from the ashes of
World War II**

Professor Lowe was born in 1970 and studied English Literature at Manchester University. After twelve years as a history publisher he embarked on a full-time career as a writer and historian, and is now widely recognised as an authority on the Second World War and its aftermath.

His books include *Inferno: The Devastation of Hamburg, 1943* and the international bestseller *Savage Continent: Europe in the Aftermath of World War II*, which won the Hessel-Tiltman Prize for history, and Italy's prestigious Cherasco History Prize. They have been translated into twenty languages.

He regularly lectures at universities and other institutions on both sides of the Atlantic.

RSM life membership

Life membership of the RSM is available to all eligible retirees. For those in their 60s the cost is £2,700, in their 70s £1,800 and in their 80s £900. After that you will pay only £20 (currently) to belong to the Retired Fellows Society.

Retired Fellows Society

Extramural events

Friday 6 May 2016

Day visit to Woburn Abbey and Bletchley Park

This exciting day combines a morning visit to Woburn Abbey and an afternoon at Bletchley Park, the secret location for cracking codes in WWII. During the war the Women's Royal Navy Service workers at Bletchley were billeted at Woburn Abbey.

A chance to see the magnificent gardens, deer park and a tour of the house will be followed by a light lunch. Then we will take the short journey to Bletchley Park, where there will be access to atmospheric soundscapes, recently restored buildings and exhibitions, including the computer used to decipher the enigma machine.

Travel will be by luxury coach (exclusive to us) with pick up and return just by Golders Green tube and bus station.

Tuesday 10 May 2016

Chelsea: Grand houses and small cottages

Although best known for the annual flower show, whose grounds we shall pass, with the army still in evidence, Chelsea still has small cottages and grand houses giving it a very village appeal. The home of writers and artists there retains a bohemian atmosphere.

Wednesday 8 June

Rotherhithe: Exploring our maritime heritage

Going further east on the southern shores of the Thames we will have the opportunity to see how the early docks shaped the lives of those who lived and worked there. We will pass two interesting churches, a tunnel, converted warehouses and a couple of very historic pubs.

Friday 10 June 2016

The Taste of Bordeaux

Seven nights cruise escorted by Sue Weir with an exclusive offer for Retired Fellows.

Information from Sally at GoRiverCruise **0800 954 0064** or sally.collicott@gorivercruise.com

Monday 27 June 2016

Trinity House Tour

The Corporation of Trinity House was given a charter from Henry VIII and since then it has served mariners through its lighthouses, deep sea pilotage and charity work. It is a pioneer of the development of solar and wind energy systems for onshore and offshore installations. Join us for a private guided tour at its magnificent Grade I listed HQ on Tower Hill, which contains antique furnishings, sculptures, paintings and navigation instruments. Rarely open to the public, this chance to share our naval history is not to be missed.

Thursday 14 July 2016h

Southwark: Naughty but nice

This area has long had a disreputable reputation. Outside the bounds of the City of London everything goes, theatres, prostitutes, bear baiting and cock fighting. Exploring this unusual corner south of the Thames we will discover those who attempted to improve the conditions of the poor by improved housing and green spaces.

Friday 5 August 2016

Dennis Severs House

This lovingly preserved house in Spitalfields offers a trip back to the 18th century and the lives of the Huguenot silk weavers, complete with atmospheric sights and sounds. Dennis Severs was an artist who aimed to create the experience of walking into the frame of a painting, with the silk weaver family still present in the house. The number allowed in is strictly limited so book soon for this private group tour.

Friday 16 September 2016

Cutty Sark tour and afternoon tea

The Cutty Sark was brilliantly restored after the devastating fire in 2007 and was awarded Certificate of Excellence as a visitor attraction in 2015. The fastest ship of its time in the mid 19th century, it is the sole surviving tea clipper in the world. Here is a chance to have a welcome talk, afternoon tea under the ship (Cutty Sark blend and all the trimmings) as well as time to explore the ship itself.

Meeting reports

Is Freud still relevant to medicine in the 21st century?

19 November 2015.



Professor Tom Burns has a research history focused on understanding the components of complex psychiatric interventions and the nature of the therapeutic relationship.

He confirmed that medicine does not act in a vacuum and deciding on Freud's relevance extends beyond whether or not psychoanalysis is an effective treatment. An informed judgement should embrace his relevance to i) our society and culture, ii) psychotherapy, iii) psychiatry and iv) medicine.

Freud's personal history as an assimilated Jew in 19th century Vienna was first examined and then set in the context of the development of psychiatry. Psychiatry did not evolve from within medicine. It had two

simultaneous origins, both in the last quarter of the 18th century. The first was that of the care of the mad with the shift from madhouses to asylums. The second was in the care of the disturbed and distressed but not overtly psychotic. The first led to medical classification and the second, stemming from Anton Mesmer's use of hypnosis, laid bare the extent and power of unconscious processes.

Freud's major advance was to treat neuroses by a process that aimed to understand unconscious processes, not manipulate them. Psychoanalysis is based on two techniques – free association (saying whatever comes into your head) and dream interpretation. He initially believed that neuroses were responses to early sexual abuse (traumas) but eventually rejected this and came to believe that the reported abuse was a distorted wish fulfilment. He proposed his theory of infantile sexuality and libido.

His current relevance to society and culture is most marked in terms of our day-to-day ways of relating to each other (the assimilation of Freudian language and thinking into all our social institutions). This impact is generally accepted to be overwhelmingly positive replacing judgemental and punitive practices in schools, hospitals and prisons with more

tolerant and understanding ones. In high culture his influence in literature, painting and philosophy is undeniable.

In psychotherapy, paradoxically, his influence and the status of psychoanalysis have waned markedly in Anglophone settings. However, psychotherapy and counselling are now widespread and current practices are virtually all derived from his thinking and bring enormous relief to countless troubled individuals. As with the cultural developments, whether the rise of Freudian ideas simply reflected inevitable social changes and desire for psychological care, or whether they drove it cannot be definitively settled. Their close association across different cultures makes it difficult to believe that having ready access to the concepts and language has not had some facilitative impact. One possible downside of these developments has been the epidemic of psychobabble and some narcissistic self-obsession.

In psychiatry Freudian ideas undoubtedly contributed to the cementing together of the 'medical' and classificatory approaches developed in the asylums with the more person centred psychological approaches from psychoanalysis. The humane response to shell-shock in WWI was made possible by

slimmed down Freudian thinking and powerfully de-stigmatised both mental illness and the psychiatrists who treated it. However, some academics blame this close relationship for holding back psychiatry. On balance Professor Burns argued that it keeps psychiatry human and avoids some of the more obvious pitfalls that can ambush the doctor patient relationship. It is particularly helpful in providing a vocabulary and mental map that both doctors and patients intuitively accept in discussing their problems.

Lastly, for medicine all the above comments about psychiatry apply equally. Modern medicine, for all its technological sophistication, still relies on a relationship and that relationship can be tortuous and difficult. Neither patient nor doctor is entirely rational at every decision making juncture and Freud's ideas sensitise us to this, making us better aware of what is going on and, importantly, what is not being said. Such a reflective awareness wards off many possible disasters.

In conclusion Professor Burns argued that a familiarity with Freud and his ideas is a necessary part of the training of any well-rounded doctor. Despite writing far, far too much and having a weakness for exaggerated symbolic language he has much to teach us still.

David Murfin

Recent Advances in Medicine and Surgery

2 December 2015

The conference marked the first decade of these meetings, now established as an important annual event in the academic programme of the Retired Fellows Society. This most recent meeting, covering a wide range of medical and surgical topics, attracted more than 100 delegates.

Alzheimer's disease, dementia, or cognitive health – what is the real challenge?

The opening talk was given by Martin Rossor, Professor of Clinical Neurology at the National Hospital for Neurology and Neurosurgery, Queen Square, and the NIHR National Director for Dementia Research. His presentation ranged over both global and specific aspects of dementia. Professor Rossor drew attention to the recent and overdue international political interest in dementia, citing the estimated global costs of managing patients with dementia as being equivalent to the Gross National Product of Turkey, and to the commitment of world leaders including Barack Obama and David Cameron to invest in dementia research, supported by all participants at a recent G8 summit.

The definition of dementia remains a clinical one: progressive impairment of more than one domain of cognitive function,

sufficiently severe to cause functional consequences. But in terms of research and initiation of treatment that might modify disease progression, it is now known that by the time of clinical presentation, in many patients there will already have been substantial neuronal loss, and thus disease-modifying treatment may be too late to alter the course of the disease.

Alzheimer's disease is the commonest cause of dementia, but there are many others, and Professor Rossor briefly described some of these, including vascular dementia (now probably on the decline, with more effective treatment of hypertension); posterior cortical atrophy and frontotemporal dementia, both of which usually present with characteristically focal symptoms, as their names suggest. For example, in posterior cortical atrophy, patients demonstrate an inability to locate a static object in the visual field, but continue to be aware of moving objects, indicating that the neural networks underpinning movement are unimpaired. Professor Rossor showed a video of a patient who could not locate the examiners static hand, but was still able to play badminton.

It is more than 100 years since the hallmark pathological changes of Alzheimer's disease were described – amyloid deposition, and neurofibrillary tangles, which represent breakdown of the neuronal cytoskeleton. But it is

clear that Alzheimer's disease is not a single entity in terms of pathogenesis, and the same is true of frontotemporal dementia. Much has been learnt from familial varieties of both conditions, in which younger age of onset is the rule. For example, serial MR brain scans in pedigrees affected by with familial Alzheimer's disease demonstrate progressive atrophy developing over as long as 10 years before symptoms become manifest, again emphasising the need for early recognition and treatment.

Professor Rossor likened the occurrence of dementia to being the tip of an iceberg. Below the waterline of the iceberg, in addition to those in the pre-clinical stages of Alzheimer's or one of the other recognised dementias, there are many with so-called "mild cognitive impairment" including many older people. Ageing is the major risk factor for the development of the non-familial dementias, but many other factors may have an impact on cognitive performance, including psychological stress, drugs with sedating effects, previous head injury, poor education, poverty, pollution, childhood malaria, cisticercosis in certain parts of the world, and the effects of smoking during pregnancy. These factors broaden the dementia challenge.

Professor Rossor ended his talk by asking whether cognitive impairment is inevitable with ageing, and concluding that it is not, citing some remarkable examples of those in their tenth

decade who are apparently undiminished (Arthur Rubenstein, Pablo Picasso). However, such individuals may be the exception rather than the rule. In relation to his own later years, Professor Rossor said pithily that "I'd like to die as young as possible, as late as possible".

Advances in the treatment of melanoma and implications for other cancers

Martin Gore, Medical Director at the Royal Marsden Hospital, and Professor of Cancer Medicine at the Institute of Cancer Research, followed. He drew attention to the fact that, as with dementia, cancer is not a single disease, and then focused on melanoma, in which two major new avenues for treatment have been discovered in recent years: specific targeted therapy, and immunotherapy.

There are some 16,000 deaths from melanoma in the countries of the European Union and 2,000 deaths in the UK, per annum. It has increasingly become a disease of younger people. Three types are recognised, cutaneous, mucosal and uveal, and distinct molecular subtypes are now recognised. Overall, survival curves have been unchanged until very recently, when, as a result of the developments in understanding of pathogenesis and targeted therapy, described below, there is now, at last, improvement in survival in metastatic melanoma.

The details of the research then presented by Professor Gore

are complex, but in essence, the first breakthrough came with the recognition of mutations of genes controlling cellular proliferation. There are mutations in the BRAF gene in about 50% of melanomas, and in addition in some tumours there are mutations in the MEK gene. Mutations in both genes promote cellular proliferation, and it has now been shown that combination treatment with BRAF and MEK inhibitors, that block the sites involved in cancer evolution, improve survival by about 20% in metastatic disease, though the drugs seem to benefit only some 10% of patients. There have been some remarkable long survivors with metastatic melanoma, up to 4 years, while median survival without treatment is 3-4 months. However, as with targeted agents in many other solid tumour types, therapeutic effects are limited by the development of drug resistance, so the new drugs in melanoma cannot be regarded as curative. In addition, adverse effects are problematic, though interestingly, the incidence of the adverse effects appears to be lower with combined therapy than with single drug treatment.

Immunotherapy, in the form of immune stimulation, developed during the 1980s and 1990s, was shown to benefit only 5% of patients with metastatic melanoma. The exciting breakthrough in the last few years is the development of so-called "immune check point inhibitors". These agents block inhibitory signals within the immune system (immune check points) and by

Retired Fellows Society

releasing this blockade, the host's immune system becomes activated and able to detect tumour antigen and mount an immune response. In melanoma, the immune check points targeted are CTLA4, and PD1 together with its ligand PDL1. Monoclonal antibodies to these have shown very encouraging therapeutic effects, with a clear improvement in survival. It appears that some patients, representing in the region of 20% of those with metastatic disease, are free from relapse after 2-3 years, raising the possibility that they are cured. Further results from ongoing trials are keenly awaited. Toxicity with immune check point inhibitors includes the development of autoimmune disease, which is treatable, and more worryingly a type of colitis that can become resistant to the usual treatments at a relatively early stage.

Professor Gore mentioned the frequent occurrence of cerebral metastases in melanoma, and stated it was notable that both inhibitors of BRAF and MEK, and immune check point inhibitors have been shown to have a therapeutic effect on metastases at this site.

Other solid tumours have been shown to respond to immune check point inhibitors, including breast cancer, non-small cell lung cancer, bladder cancer and some haematological malignancies, and Professor Gore concluded that these agents are likely to change the face of oncological treatment. He also raised the prospect that

other targets in the immune system may also be exploitable therapeutically.

Finally, Professor Gore addressed the issue of the prevention of melanoma. It appears that the risk of developing melanoma is acquired before the age of 18 years. Prevention of sunburn, particularly in young people, is crucial. It has been shown that public health campaigns in Australia have reduced melanoma mortality.

The Future of Primary Care in the UK

The last talk of the morning session was by Dr Clare Gerada, past Chair of Council of the Royal College of General Practitioners and a GP in south London. Her talk was remarkable in many respects. She spoke without notes or slides, basing what she said on both personal experience of the primary care clinical frontline and on her extensive experience as a strong advocate for general practice both as an individual and in her major role at the RCGP. The chairman of this session reminded delegates that her fearless advocacy for patients and primary care had earned both countless supporters (and an appearance on "Any Questions"), but also critics in certain quarters of the national press, and indeed in political circles. The chairman further speculated that it was largely politicians who were responsible for 'politicising' aspects of medical organisation and care, and that those willing to put their heads above the parapet,

such as Dr Gerada, were primarily representing the interests of their patients.

Dr Gerada began with an account of how her father had migrated from Malta to the UK to help in the development of primary care and to meet clinical demand following the establishment of the NHS. As a child, she experienced primary care at first hand, as the surgery was located in the family home, the front room being the patients' waiting room. She emphasised her early understanding of continuity of care, and the knowledge that her father was always on call for his patients and knew them and their families well.

She used this base to speak about general practice in the modern NHS, including the development of group practices and in some areas, even larger working arrangements for GPs. She spoke also about the establishment of a profusion of new categories of healthcare worker, all with direct patient contact, in such number that it is bewildering even for some GPs. While recognising that all those involved in patient care had a contribution to make, she felt that current working practices threaten the continuity of care in general practice, resulting from fragmentation of the service to patients.

She emphasised the need for GPs to have their 'own' patients, and to re-assert the importance of the "sacred space" of the consultation between doctor and patient. She implied that it is possible to itemise the needs of patients to

the extent that it is possible to lose sight of the whole patient.

In the vigorous discussion that followed, in answer to one question, Dr Gerada took the opportunity to refute suggestions that GPs are undertaking less emergency work than previously, emphasising that independent data indicate that the overall increase in patient activity in the NHS is reflected in increasing demands in primary care.

In answer to a final question about how she would like to see primary care in 20 years, her immediate response was to see the re-establishment of continuity of care for individual patients.

Reports by John Scadding

Conservative care in patients with end-stage renal disease

Dr Aine Burns, Consultant Nephrologist at the Royal Free Hospital, London, presented a discussion on the options for treating patients with end-stage renal failure (ESRF). There are now four: the best remains a renal transplant. Donors are scarce and to the other options – haemodialysis (HD) and peritoneal dialysis, should be added a fourth, maximum conservative management (MCM).

The Royal Free Hospital enrolls some 250 patients for HD each year. About three quarters of these are now more than 75 years old. In these elderly patients (>75 years) 30% will have died in the first year, more than 50% by two years and <20% survive five

years.

In patients with ESRF a non-dialysis option, MCM, provides symptom control, correction of electrolyte and fluid imbalances, management of anaemia and end-of-life care.

Elderly frail patients, often with co-morbidities, have a better quality of life (QOL) satisfaction with MCM. This significantly decreases after HD. In these elderly patients on HD life may be extended by some six months but with greater morbidity. They spend more time in hospital, including dialysis (four hours three times each week) and complain particularly of tiredness after a dialysis session. The number of out-of-hospital-free days in patients using MCM is the same as those patients on HD. These patients using MCM have a better QOL with fair performance until their last few days.

However, given the choice only some 10 – 15% of elderly patients with ESRF at present choose MCM. This choice may be influenced by a number of factors, particularly co-morbidities and sometimes cultural and religious issues. In frail elderly patients with ESRF conservative (MCM) should be a considered option.

Report by Tim Fowler

Advances in minimal access colorectal surgery – will traditional surgeons be put out of business?

Miss Rachel Hargest, Consultant Colorectal Surgeon, University

Hospital of Wales, Cardiff, began her talk with a brief history of non-invasive methods of diagnosis and then, at a later stage, of therapy. A vaginal mirror and rectal speculum had been excavated from Pompeii, and at even earlier times Hippocrates had experimented with specula and some form of catheter. The first endoscopic light source had been invented by Aranzi in the 16th century, and laparoscopies were carried out in the first decade of the 20th century (initially on a dog). Gynaecologists took the lead with laparoscopy thereafter, the whole process being facilitated by the introduction of fibrelight flexible endoscopes and video technology. Laparoscopic cholecystectomy began in 1985, soon to be followed by laparoscopic colorectal surgery in 1991. 'Teething problems' for the colorectal surgeon have included the long duration of the procedure, the high rates of conversion to open operation, the risk of 'collateral damage' to other organs, the incidence of positive resection margins and the development of port-site metastases. Over the last 20 years most of these concerns have faded with increasing experience of laparoscopic colorectal resection. The CLASSIC trial has shown that five-year survival rates are just as good as those of open operation, with lower risks of incisional hernia and adhesion obstruction of the small bowel. Training programmes have been introduced for both surgical trainees and established

colorectal surgeons. Thus the procedure can now be offered to most patients with cancer. In practice about half the primary cases of colorectal cancer can be carried out laparoscopically, or at least with laparoscopic assistance, while a 10 per cent conversion rate has become the norm.

The speaker gave a very balanced account of the pros and cons of the new operative technology, avoiding excess enthusiasm while underlining the fact that laparoscopic colorectal surgery is here to stay. All colorectal surgeons need to be conversant with the minimal-access techniques while retaining their skills in open operations: thus the answer to the question in the title of the talk is no. She finished by discussing three recent developments in the field: 1) Single-incision laparoscopic surgery (SILS) via an umbilical port, which has the attraction of only one breach in the abdominal wall but is technically more demanding. 2) Natural orifice transluminal endoscopic surgery (NOTES), in which all external incisions are avoided by removing abdominal organs via the stomach, rectum or vagina but which might best be regarded as a technology seeking a proper use. 3) Robotic surgery for excision of the rectum. The advantage of the robot is to quell the tremor from the surgeon's hand and allow him or her to operate comfortably while sitting at a console. The disadvantage is the cost of the equipment, the lengthy learning curve and the fact that the table is

locked when the robot is docked, making it difficult to convert to open operation in a hurry (e.g. for bleeding); some catastrophes have occurred. At the present time robotic proctectomy has not been shown to be superior to a standard laparoscopic approach in terms of cancer clearance or the maintenance of urinary and sexual function.

Treatment of head and neck tumours

Professor Iain Hutchison, Consultant Oral and Maxillofacial Surgeon, St Bartholomew's and Royal London Hospitals, London, was ideally qualified to give this talk as Director of the National Head and Neck Cancer Audit as well as being a practising surgeon and founder of the charity Saving Faces. He began by challenging the concept that there has been no improvement in survival rates for head and neck cancer in Britain, while acknowledging that outcome data are relatively sparse. There have been marked improvements in the understanding of cancer cell biology, imaging techniques (including sentinel node sampling), radiotherapy in its various modalities and chemotherapy with newer agents such as platinum salts and taxanes plus cetuximab, an inhibitor of epidermal growth factor receptor. Equally important for the patient have been advances in anaesthetic techniques: as the speaker said, and your correspondent can endorse, nothing makes a surgeon appreciate modern

anaesthesia more than having an operation oneself. For patients who have come through a major head and neck resection there can be a major role for speech therapy and also for nutritional support, for example with the use of a fine-bore nasogastric feeding tube or percutaneous endoscopic gastrostomy.

On the surgical front there have also been a number of important developments such as the ready availability of fibreoptic endoscopes, new instruments (e.g. the harmonic scalpel), laser and robotic technology and the introduction of titanium plates for reconstruction of the jaws. Microsurgical reconstruction of small blood vessels allows the use of free flap transfer to cover large defects in the head and neck, while bones such as fibula and scapula can be used to bridge defects in the maxilla or mandible. Lymphadenectomy – radical dissection of the neck – is used increasingly but also more selectively than before. In general the extent of dissection has become rather less radical, with a corresponding decrease in the complication rate. There has also been a trend away from primary radiotherapy for head and neck cancer towards surgical resection with adjuvant irradiation to follow. Professor Hutchison reminded the audience that while surgery is an irreversible act, so is radiotherapy, and osteoradionecrosis remains a potential problem in his field: uncommon but very difficult to treat.

Advances in the management of glioma

Dr Jeremy Rees, Consultant Neurologist, National Hospital for Neurology and Neurosurgery, London has been responsible for the strategic development and integration of care for patients with brain cancer in London. There are some 4,400 new cases of malignant brain tumour in Britain each year, comprising 1 in 50 patients with cancer. The commonest type – glioma – remains largely incurable, with a five-year survival rate of 10-20 per cent, but there have been some straws in the wind to suggest a modest improvement in prognosis. In general survival is rather better in younger patients and, in line with most types of cancer, with earlier diagnosis. In the elderly an invasive biopsy is best avoided and, where possible, radiotherapy as well because of its unpleasant side effects.

There are four types of malignant brain tumour: 1) astrocytoma (notably in children); 2) diffuse astrocytoma or oligodendroglioma (characterised by 'fried egg' cells); 3) anaplastic variants of the same and 4) glioblastoma multiforme, the most aggressive type. The genetic composition differs between astrocytoma and oligodendroglioma. Tumours can also be characterised according to histological grade, I and II being grouped as low-grade and III and IV as high-grade. A major difference among low-grade tumours is that grade II (only) can transform into higher grades,

i.e. they are premalignant. The IDH (isocitric dehydrogenase) mutation, which conveys a better prognosis, is found in low-grade but not high-grade cancers. Modern scanning techniques can usually differentiate between low- and high-grade lesions. In general low-grade gliomas present with a seizure but without neurological signs; typically the tumour is large but non-enhancing on imaging, and it will gradually progress over a matter of years. By contrast, high-grade gliomas present with stroke or symptoms of raised intracranial pressure and there is often a neurological deficit on examination. These tumours enhance on imaging and may show evidence of oedema and necrosis. Transformation of an individual tumour to a higher grade can be detected by accelerated growth on brain scan. Increased tumour perfusion also points to the angiogenesis that accompanies malignant transformation.

The standard TNM system of staging is not applicable to cerebral tumours because they do not metastasise to lymph nodes or further afield. Management depends on histological type as assessed by presenting features and imaging criteria supplemented by a tissue diagnosis from biopsy. A choice needs to be made between surgical resection and surveillance and between early and delayed radiotherapy with or without chemotherapy. Intraoperative imaging – both structural and functional magnetic resonance and ultraviolet light – is used by the surgeon to guide

resection margins in the quest for maximal safe resection. For the many patients receiving palliative treatment, good symptom control is important, but this can be difficult to achieve in those with seizures. Optimal treatment requires a sound grasp of the natural history of the different types of glioma, while future hopes centre on the use of immune checkpoint inhibitors to act synergistically with cytotoxic chemotherapy.

Reports by Robin Williamson

Conclusion

Delegates at the conference judged the presentations to have been both useful and stimulating, and this was confirmed in the written feedback from the meeting. Thanks are extended to all those who participated in the meeting. The presentations given by Professors Rossor and Gore should shortly be available as RSM Videos, and viewing is highly recommended. Planning for the conference to be held on 1 December 2016 is well in hand.

Pavarotti is said to have said

“One of the very nicest things about life is the way we must regularly stop whatever it is we are doing and devote our attention to eating.”

Articles

Becoming a guide

Editor's note: The extramural walks guided by Sue Weir are deservedly popular among RFS members. Here she, and two others, tell what it is like to be on their side of the visits.

A Blue Badge guide

Sue Weir

Many of you may have noticed this phrase: 'a tour led by a Blue Badge Guide' and wondered perhaps exactly what made this particular tour so different from other guided tours when you just pitched up and followed the unknown leader. There are green and yellow badged guides but the Blue Badge is the icing on the cake as the internationally recognised professional qualification which enables a guide to conduct their guiding business in Great Britain and abroad.



I did not set out to be a guide – starting life as a nurse at Westminster Hospital and later marrying a doctor, I enjoyed my many years of nursing and family life, but eventually the unpredictability of rotas was making life difficult. With the renovation of a small house in London for student sons I now had a base from which I could indulge my love of history. The application even to be accepted for the Blue Badge course meant many hours of rediscovering the whole range of British history, the geography of our isles and of course general knowledge. After the interview, when I had to take the examiners on a virtual tour of Covent Garden, and two written papers later I was accepted!

In the late 80s the course was run for one academic year on Thursday & Friday evenings for class work, with the practical coach work every Saturday travelling not only around London but a 100 mile radius visiting all the well - known tourist hot spots – Windsor Castle, Hampton Court, Oxford, Stratford, Bath, Stonehenge – the list goes on. Many of you will have taken such trips both home and abroad with the endless chatter of the guide showing you the HVP (high visible priority) spots, together with knowledge of the agriculture, trees, flowers, wildlife, farm animals, art, architecture, the education system, religion, health provision, towns, battlefields and the salient points of interest in the places you are to visit. You can talk going to a place but let

everyone sleep on the way home. On one such trip when stuck in traffic, I went through the high points of the entire monarchy when one of the passengers came forward to see if I was reading from some notes – I was not but had recalled the poem: Willy, Willy Harry Steve, Harry Dick John Harry 3 etc! He was most impressed. The learning curve was steep, so I dropped my nursing and concentrated on the course. The summer of 1988 came with six exams – three with practical knowledge of every part of Westminster Abbey, St Paul's Cathedral, the British Museum and a London walk and three written papers. The walk is intended to show how you cope with a large group from crossing the road to finding quiet spots in which to deliver your knowledge. Many of you will be familiar with my mantra – 'you cannot walk and talk' (ie look where you are going) and 'we will walk swiftly and with purpose' (no dawdling or ambling), this last has even passed into the folklore at Harvard. I was thrilled to have been given a prize out of the 42 students who were with me. Today the course is run over two years at a cost of over £6,000.

Then it was out into the big wide world of guiding. The shock was having to sell oneself – with a nursing agency finding a job was never a problem – but with over 1,000 guides in London and not speaking a foreign language I had to start with the general London bus tours. By the end of day four with three tours a day – hoping you were going to

complete the high light tour in two hours – I brightly said when passing St Paul's "buried here are many famous people like Welson!" A mistaken combination of Wellington and Nelson which did make the coach driver laugh but, I think, passed over the heads of the passengers. To make sure they were still alive on the top deck – we are not allowed to stand on the top - I asked them all to stamp their feet – the noise was deafening.

It was clear I needed a niche topic to sell myself and the obvious answer was medicine. Attending the DHMSA course at the Society of Apothecaries gave me all the background history to medicine and so began my Medical History Tours and what fun they have been. There are now 24 museums of health and medicine within the M25 and the guide book I wrote in 1993 published by the RSM, before the age of the internet, brought in other museums throughout the country. Combining guiding and tour managing I have been fortunate enough to take groups of medically interested people to places as diverse as Glasgow, Budapest, Rouen, Riga, Krakow and even further afield to Cuba and China. Whilst in Amsterdam last year having coffee in a small café, I walked nine sturdy ladies who told me they were trainee guides for the city – when I said I was a Blue Badge Guide much exclamation and admiration and swapping of notes and chat about mutual colleagues – it is truly international.

I have very much enjoyed leading many walks for the Retired Fellows Society and also tour leading on both river and sea going cruise ships – acting not as a guide but as a concerned if sometimes bossy nurse leader which included ward rounds of prostrate sea-sick passengers, tending to scrapes and bruises, fractured wrists, bicycle falls and those who went an interesting shade of pale after a long cycle ride rewarded with a large beer in the hot sun! And yes, the unexpected happens, planes cancelled which involved much ringing of taxis and relatives in the UK, planes deemed to be full and our group kicked off – in the end we did fly home on the right plane on the right day. Absence of pick-up coaches in countries whose language I do not speak, passports lost (& found), AV that does not work for lectures – all the usual hiccups of being a guide.

The interest as always is in the research and I have so much enjoyed my time exploring and discovering many of the hidden and out of the way places in our great capital. Where does this road/alleyway/street/square lead to? Who lived here, what was this building used for, was it a hospital or dispensary, is it of interest to others? I have spent many happy hours tramping the streets in search of unusual nooks and crannies. The difficulty is later remembering the exact route and especially dates to put it all in context. As with all guides I try to inform and entertain but above all to have FUN. So thank you

RFS members for joining me and your fellow travellers in exploring not only London and the UK but also many European countries, however there are still many we have not visited so the great adventure is not yet over.

Guiding at St Paul's Cathedral

Celia Goreham

In 1666 the Great Fire of London destroyed not only houses and shops in the city of London but also St Paul's Cathedral. It was to be 1711 before Sir Christopher Wren, both as architect and builder, had completed his masterpiece, which is now just over 300 years old. Christopher Wren was a natural philosopher. At the time he drew up the plans for the new St Paul's, he was a Professor of Astronomy at Oxford University, a scientist, a mathematician of note and an excellent draughtsman. His engraving of the brain was included in Thomas Willis's 1681 *Medical Works*. Whilst at Oxford he performed a splenectomy on a dog and later, watched by Robert Boyle, inserted a cannula into a dog's leg vein into which injected a warm solution of opium in white wine. The dog apparently survived and became both fat and famous. Wren was also one of the founders of the Royal Society.

Even before St Paul's was finished it attracted visitors; it was mentioned in the 1693 *Le Guide de Londres*. Initially it was

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thought that the Dean's Library and The Great Model could be visited free of charge, but it wasn't long before the sum of 2d or more was charged depending on what visitors wanted to see, a fee that remained until the Great Exhibition. Early on the virgers had taken the role of guides and the fees formed part of their salary, adding as much as £100-£130 per year. Visitor numbers may have been as many as 71,000 in a good year. Indeed, there were so many visitors requiring tours of the cathedral that the virgers employed assistants, one of whom is known to have been employed for 47 years. I can't find any record of how the virgers or their assistants were trained as guides but no doubt they went on tours with more experienced virgers and read the guide book. The earliest book probably dates from 1770, was four pages long and gave visitors an introduction to the "Dimensions and Curiosities of St Paul's Cathedral".

Guiding visitors remained the role of the virgers until after the Second World War, when some



Christopher Wren

of the Friends of St Paul's acted as volunteer guides to help them. Soon after this volunteers took over all the guided tours as virgers found they didn't have time for guiding visitors. Initially training of the volunteer guides was on a "Sitting by Nelly" basis - a single tour with an experienced guide, reading guide books and listening to others. Later they went to occasional lectures and eventually guide training was formally organised by an experienced guide.



St Paul's

By the time my own guide training took place in about 2012 the whole programme was formalised and validated by the Institute of Tourist Guiding. Even before being accepted on the course I had to give a five minute talk on an aspect of the cathedral.

I attended a day a week for a term which included a session on a specific part of the cathedral, e.g. the dome, and a guide showed us how to guide the group of visitors, so combining theory and practice. We had sessions on pronunciation from an actor, with the support of our mentor were drilled in the route of the formal guided tour, visited places in the cathedral visitors never go to, e.g. the roof, not good if you have vertigo or find climbing difficult, but what a fantastic view, up the bell tower and the clock tower. We climbed up to the triforium above the nave to see the library and the Great Model, all of which can now be seen by booking a triforium tour. To help with learning we were each given a comprehensive and very heavy file of information about the cathedral along with an extensive reading list. The major shock came towards the end of the course when we took a one and a half hour written exam. This took place in the Education Department in the crypt which is used for primary school children. The small chairs at low tables together with the fact that most of us had not taken any form of written exam for at least 20 years added to the stress. Those who passed the written had to take the practical exam. In groups of four we had three examiners, one from

the Institute of Guiding, and went on the prescribed route round the cathedral. We had to cover specific areas as if taking visitors. Throughout the tour the examiners were reviewing their clip board sheets which they proceeded to mark. We had a long wait for results but what bliss when we were awarded our St Paul's Guiding badge and let loose on visitors.

To book into guided tours all visitors come to the volunteers' desk in the nave. One of the most frequent questions is "Where is the rest room?" What is it that makes people come into the cathedral to look for a toilet? We encourage visitors to ask questions, which at times can be dangerous: "Where is Poets' Corner?" Sorry you need Westminster Abbey; "Do you ever have services here?" Yes, three a day, St Paul's is not only a visitor attraction. Others are confused as to what religion St Paul's is. It was in fact the first Anglican/Church of England cathedral to be built after the Reformation. On being told this one visitor asked "Where is the Church of England?" "I am sure the Archbishop of Canterbury would like an answer to that question.

Americans are a notable group of visitors who ask lots of questions or ask for specific graves or memorials in the crypt. One asked to see Hornblower's tomb. The guide suggested he was looking for Nelson's tomb, but no, definitely Hornblower. He had read all the books and had come all the way from America to see his tomb.

The guide tactfully told the visitor that Hornblower was a fictional character. Another visitor asked if Christopher Wren designed the previous cathedral. As Wren was 91 when he died in 1723 and the previous cathedral was started in 1087... Another wanted the memorial to Ponsonby. We all had heard of his but nobody could remember where it was so we consulted "the list". There are over 500 graves and memorials in the crypt, and we eventually found his huge memorial outside the café in the crypt. A couple of years later a group of relatives came over from America to see the memorial.

Being a guide at St Paul's is never dull and often very busy. My training was fantastic. Do visit.

With many thanks to my husband and all the members of the Tuesday team for their help support and encouragement in writing this.

Volunteering at Kenwood House

Barbara Goldstein

In 2013 I decided to increase my post-retirement volunteering to include helping at some of the historic houses in London. Among these was Kenwood House, on the edge of Hampstead Heath, at that time undergoing a refurbishment funded by the National Lottery Fund. Because, like most of the volunteers, who work either in the house or as greatly-valued gardeners, I am in thrall to this place, so I shall begin with a brief history of Kenwood and a description of just a few of

the more spectacular things to be found there.

Originally an unimposing Jacobean house, it was bought in 1754 from the Earl of Bute by William Murray, a young Scottish lawyer who went on to become Lord Chief Justice and 1st Earl of Mansfield. With the ambition of seeing Kenwood House as the jewel we know today, he engaged the famous architect, Robert Adam, to remodel and extend the house into a neo-classical villa. As part of this project, Adam created the Great Room on the east side of the house as both a library and a reception room.

He was particularly proud of the ceiling, an imitation of a flat arch and decorated with classical-themed paintings by Antonio Zucchi; the stucco of Roman motifs was the work of Joseph Rose. At each end, forming part of a circle are coved-ceilinged apses, fronted by Corinthian columns, restored to their original white by the recent refurbishment as were Adam's pastel colours for the rest of the room. It was the 2nd earl, nephew to his predecessor, who employed Humphry Repton to design the very attractive gardens with the lake on the south side of the house and who built the two extensions on the north-facing front of the house, to provide a Dining Room and a Music Room, where now are hung some of the pictures in the remarkable collection which Kenwood House is home to.

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The Library

We now move to a new chapter in the history of Kenwood. In 1922, having rented out the house to the Grand Duke Michael of Russia and other private tenants for many years, the Mansfields decided to return to the family home, Scone Palace in Perthshire, Scotland. The contents of Kenwood House were auctioned off and the house and estate put up for sale. Fortunately, the buyer was Edward Cecil Guinness, 1st



The Library ceiling

Earl of Iveagh, who had sold his shares in his family's brewing company and was now in search of a place to hang some of his remarkable collection of paintings. He died before he was able to live at Kenwood but he bequeathed the house, the estate and the paintings to the Nation, who are allowed to come and enjoy them, free of charge, on almost every day of the year. The Iveagh Bequest has been in the care of English Heritage since 1986.

through the generosity of the Art Fund and other charities. Upstairs there is the Suffolk Collection, portraits left to the Nation by the last duchess in 1974 when the line of the earls of Suffolk and Berkshire ended.

A volunteer goes on duty full of anticipation about the room he or she will be covering for this shift. We are now more than 300 in number, most working a 3-4 hour half-day shift once a week. Many of us are retired from a variety of professional backgrounds; many of the younger volunteers are recent graduates or students, sometimes from overseas. Following our Induction course, we are offered lectures by the Curator or other English Heritage employees at the house. The numbers for these are limited by room size and it is always advisable to put one's name down quickly. Apart from this, it is up to the volunteers how much training



Rembrandt Self Portrait, c 1665

The collection includes works by Turner, Gainsborough, Reynolds, Romney and several Dutch Old Masters, among them Vermeer and Rembrandt. There are some fascinating artefacts, clocks which capture the attention of school parties, and pieces of the original furniture from the Mansfield house, spotted by collectors around the world recognising their provenance and brought back

they seek and it is my experience that most read or find other ways to supplement their knowledge. I was fortunate this term to find an excellent course at Birkbeck, University of London, entitled Art and Society in Eighteenth-Century Britain but at a cost of £625 for eleven lectures it was not cheap. Of course, there is no financial help from English Heritage for such courses.

Our uniform of a beige-coloured shirt and black jacket, however, is supplied by English Heritage. We act as room guides although our official title is Explainer. I would say this role is pursued with determination. We love talking about the place. I have seen visitors, before moving on to explore the house, stand for a good twenty minutes in the entrance hall, listening to a volunteer telling them about the history; about some of the 1st earl's more important cases,

usually coming down on the side of the Abolitionists of slavery; about Lord Iveagh's first encounter with the art dealers in Bond Street; about why they should be willing to buy a Guide Book, since the Bequest needs financial support but charging to view it is not possible; even about topics for PhD theses worth considering by anyone interested in Kenwood! To answer a visitor's question, I am still trying to find out exactly how the stucco work was put up on the library walls.

So if you have time to spare, whether a morning to view the house, a day to spend exploring the estate, including a snack at the cafe still housed in the Brew House built by the second earl, or a half a day a week to come and volunteer, either in the house or the gardens or elsewhere on the estate, you would be most welcome and would feel part of something very special.



The house, rear view

The RFS Chairman's Prize

The Retired Fellows Society invites submissions of an essay, up to 2,500 words, with the theme and title of Trust me, I'm a doctor.

Two prizes of £300 will be awarded, one for members of the Retired Fellows Society and the other for students who are members of the RSM. Final year students who qualify in September 2016 may submit an entry.

The successful authors will be given free registration for the Recent Advances meeting in December 2016 when the prizes will be presented.

Conditions

The submission deadline is 30 September 2016.

It should be original, appropriately referenced (up to 20 references) and typed double-spaced in Times New Roman or some other universal font.

Illustrations and tables may be included.

Students and retired practitioners may be from any clinical specialty but should state their particular specialty.

Successful and short listed applicants may be asked to précis their essay for inclusion in the *RFS Newsletter*.

The essay will be judged by a panel convened by the RFS Committee, whose final decision will be announced on 31 October.

Submissions must be sent electronically to rfs@rsm.ac.uk

Cardiopulmonary resuscitation – 45 years ago

James Carmichael

My youngest grandson is now ten years old, a very happy young man. He has an allergy to dairy products, I deliberately do not say “suffers”. His attitude is a matter of fact one: “I can’t have that”. Fortunately there is a brand of ice cream, “Swedish Glace” which is dairy free, and it is a joy to see him scoop a large (too large) chunk of it, add sprinkles and sauce, and then march off in triumph. Thank you to Messrs Tesco for stocking it.

A few months ago I picked him up from school and one of the other grandparents said to him “what are you going to do when you grow up?” The reply, very prim and proper, was, “I am thinking of following in my parent’s ‘footsteps’”. His father is a Consultant Geriatrician with a particular interest in dementia. His mother is a Consultant Rheumatologist, and I am a well-retired Radiologist. I graduated in 1945, began radiology training in 1949 and became a Consultant in 1954. His wish to study medicine was at that time unknown to us – but we have taken it seriously.

A few weeks ago, he expressed a wish to learn about cardiopulmonary resuscitation, so he has joined the St John Ambulance cadets. Here the teaching has been excellent and he is enjoying it, and this brought back to me

some of my own experiences in those days long ago, when life was “different”. In particular I should like to tell you two stories, each with different points to emphasise.

The first case was about 1970, on 1st April, All Fools Day. My hospital included the Regional Thoracic Surgical Unit, with five top notch thoracic surgeons. These colleagues performed clinics up to 100 miles away, bringing in cases for further investigation. One of these was a young man of 16 who had suffered a spontaneous pneumothorax and then torn some adhesions, which led to a haemopneumothorax. He was not prospering and he was due to take his O-levels in the summer. The boss ordered a sonogram to see the size of the cavity. Whilst the contrast medium was being injected, he collapsed and sustained a cardiac arrest. This was presumably due to pleural shock, with fluid injected into a non-distensible cavity.

Whatever the cause, we had an arrested heart in a 16 year old, in the X-Ray department, not as easy to manage as on the ward. The Cardiac Arrest Team arrived promptly; I had been involved in the early external massage before the team arrived, as had some good radiographic staff. However, we couldn’t get a spontaneous heartbeat. The pure oxygenation was satisfactory in the hand of a Consultant Anaesthetist from the Thoracic Unit, but a heartbeat eluded us. In those days, we had only internal defibrillation and this involved opening the chest

which was not to be undertaken lightly (particularly in an X-Ray department). We kept going for over an hour. Then the Surgical Registrar, Zoi, a very nice Greek surgeon (who later insisted that his beloved daughter came back to England, where she had been at school for six years, so that she could graduate with an English degree in dentistry), decided to open the chest and internally defibrillate. This worked; we now had a spontaneous heartbeat after 75 minutes of external massage. So off he went to the IT ward, but for obvious reasons we were worried about brain damage.

However he never looked back, he was discharged in two weeks and took his O-levels six weeks later, with good results. Two years later, he took his A-levels and achieved an Oxbridge entrance. It was very obvious that he had no residual cerebral damage. From then on I lost track of him.

The second case was at the other end of the spectrum, and it illustrates some of the difficulties you encounter if the cardiac arrest takes place away from the ward.

The patient was an elderly man (probably 70-75) and he arrested in the X-Ray room. Now the only information we possessed was on the X-Ray request form and this merely said “Pneumonia left lower lobe” although we knew that he was on a surgical ward and that would not be the whole story. So external massage commenced. We rang the ward, and were told that he probably had an advanced carcinoma, so we stopped

resuscitation. Within half a minute we had the case notes, and found out that the “advanced carcinoma” was very uncertain. We started external massage again and got a spontaneous heartbeat. We took him back to the ward in a semi-conscious state. In spite of the difficulty of not really being able to assess his overall condition, we had succeeded in doing the right thing, at least so I thought at first. Later that night he re-arrested and died. So had we merely put him through a second death? Would it have been better to die the first time? Fortunately his family told us the answer. The patient was a Roman Catholic and between the two arrests, he had received the last rites of his Church. Now I don't know if this comforted him - I hope so. But it certainly comforted his family and so I was relieved that our actions in resuscitating him had been so well received.

Now my grandson is learning about other forms of collapse, particularly anaphylaxis which could mean so much to him with his allergy. Eventually he may read of my experiences of cardiopulmonary resuscitation in the dark ages

Enjoying country house opera

Elizabeth Bradshaw

The answer is to go alone. Last night I had one ticket for Handel's Saul on the penultimate night of the Glyndebourne Festival.

The weather forecast was for heavy showers, especially late



Glyndebourne garden

afternoon and evening. I packed my homemade salmon and cucumber sandwiches and a half bottle of the Queen Mother's champagne “Bertie's favourite”.

The car park attendant was checking whether we had front wheel drive cars and supervising the parking for maximum traction on the expected mud. I decided on caution and made my way to the marquee. As I put down my picnic, I overheard the dinner jacketed man saying “If everyone was tested for HIV the NHS would be bankrupt.” I wanted to say ‘it is bankrupt’, but moved on.

I read my programme in the rose garden and followed a couple who seemed to know dahlias from cosmos, to view the saturated herbaceous borders.

The orchestra began with Handel's lively introduction, oblivious of snores from the stalls. As the curtain slowly rose on the severed head of Goliath centre

stage, they could snooze no more. The singing of the chorus and principals was superb and the countertenor Iystyn Davies as David sang like an angel even in a homoerotic tangle with the tenor, Jonathen. What happened to giving David his cape and sword as an example of generous friendship in contrast to the jealousy and envy of Saul?

In the long interval unbelievably, not a drop of rain, and the temperature was positively balmy. I found a bench, opened my champagne, listened to the sounds of laughter and corks popping, I texted my opera-loving friends “wish you were here”, but did I? I remember previous visits, retreating to cars, balconies, and a falling out forever near the mulberry tree. The opera that evening took place in St Trinians but it was Handel.

As I left Saul after the second act I heard a man behind me whinge “too much Peter Sellars”. Goodness, gracious me.

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I passed the pavilion, hopefully to be dismantled as it dominates the tree planted to commemorate the first Mozart opera at Glyndebourne. Its foliage is impervious to a drizzle and under it a retired Edinburgh born Professor of Anaesthetics beguiled me with Shakespeare:

'How sweet the moonlight sleeps upon this bank!

Here will we sit, and let the sounds of music

Creep in our ears, soft stillness and the night

Become the touches of sweet harmony'

Which play?

Which retired Fellow?

Psychotherapy and counselling in a university setting

Penny Hayman

29 years ago, in 1986, as a fairly newly-qualified counsellor, I took a part-time job in the Counselling Service at Nottingham Trent University. This was a new world to me, as it was to my two colleagues, one of whom had worked for Relate and the other at an FE college in Cumbria. Our little service was to be found in a creaky old building sandwiched between the secretary downstairs and the Chaplaincy above. In those early days of student counselling we had a fair bit of

discussion with the chaplains – after all we were dealing with the same pastoral issues and our training and personal conviction gave us a passionate belief in the value of counselling. But nevertheless we were still finding our feet within the university structure and hoping the students would find us and agree that we were useful.

What I remember from that time was leisurely working days, seeing perhaps three or four clients during sessions lasting 50 minutes, punctuated by soul-searching meetings among ourselves. In many ways this was the Golden Age of University Counselling. Funding was plentiful, students in many cases received three years of ongoing consultation, i.e. for the whole of their undergraduate period. There was a plethora of new ideas, as we tried out different ways of applying theory to practice e.g. setting up and trying out different kinds of counselling groups.

It was a time of intellectual ferment and passionate discussion around our different "orientations": whether we were informed by psychodynamic thinking along the Freudian lines set out by Professor Burns in his talk at the RSM recently, or the more 'humanistic' thinking of the Human Potential Movement as it is known, which originated in the States with people like Fritz Perls'

Gestalt Psychotherapy, Eric Berne's Transactional Analysis, or Carl Rogers' Person-Centred Therapy. (By the way, all of

these people were originally psychoanalysts). Crudely speaking, they seem to place individual autonomy and power to become the person they choose, over the more deterministic views of Freud. I have found that there is a sort of north/south divide here: the Freudian/Jungian way seems to dominate in the south while from the Midlands northwards, humanistic views prevail. Interesting. But of course in practice, the efficacy of an approach depends largely on the personality of the counsellor and the relationship between counsellor and client.

At that time I remember attending monthly local counsellors' meetings where colleagues could share concerns. Also there was the setting up of the Association of University and Colleges Counsellors which met annually at different universities for conferences lasting two or three days.

Let us now leap across 17 years to 2003 when I took a job at Cambridge University Counselling Service as Group Co-Ordinator. My job also included individual counselling and acting as supervisor to less experienced colleagues: it is part of the ethical guidelines of the British Association for Counselling and Psychotherapy that all its members receive an hour's supervision at least once a month. As my first task I chose to chat individually to my new colleagues and find out what their enthusiasms were, and to

encourage them to set up groups accordingly. That seemed to work and by 2015 the list of counselling groups available for students to join include the following: Managing Panic Attacks, Food and Mood, Self-compassion, Lesbian, Gay and Bisexual Support Group, Healthy Self-Esteem, Perfectionism vs. Healthy Striving, Assertiveness, Cognitive Behaviour Therapy for Self-Help; Understanding and Managing Procrastination. Most people would agree that this inspired list would benefit the general population if only the NHS could afford it or would wear it.

Let us now go back about 40 years. Cambridge University was one of the first to set up a service dedicated to helping students with their personal problems. It was the brainchild of Dr Graham Petrie. He writes "I came to practise in Trinity Street in the autumn of 1960 at a time when there was considerable competition between the central practices for the registration of undergraduates. I soon found myself, as no doubt my colleagues did, with a large undergraduate practice, and the recognition that among these young men and women there were many psychological problems not easily helped in brief consultations. This view was held by several other GPs in the town and we began meeting regularly to discuss the question of a University Counselling Service."

But establishing a counselling service was a controversial proposal and negotiations were

protracted. The colleges saw the welfare of students as their responsibility and some were concerned that their responsibility might be compromised by this new form of proposed support: in the words of the first Head of Service, they were afraid of 'poaching, pinching, and pandering'. Some local psychiatrists were concerned that their workloads might be increased by what they viewed as untrained people meddling in this area. At the time counselling was a very new profession, not well understood, and there was a stigma attached to using such a service.

However, the service over the years has inspired great loyalty in its staff, several of whom worked here for many years. Graham Petrie later provided psychiatric consultation and supervision until 1979 while he was Director of the Young People's Service. Although in many ways the Service has grown beyond recognition, the concerns that preoccupy us today are very much the themes of the past: confidentiality and its boundaries; balancing resources with need and expectations; and the relationship with the colleges and funders.

By April 2009 the University Counselling Service (UCS) had been in existence for 40 years, one of the oldest university counselling services in the country, and one of the largest. When it first opened in 1969 as Cambridge University Medical Counselling Service, 115 undergraduates were seen in the first year

By 2015 a team of 28 people are employed here, comprising therapists, secretary/receptionists, a financial administrator, a computer officer and two cleaners. Our clients number almost 2,000 staff and students, seen individually, in groups or in workshops each year.

A few observations on changes in students over the years: the way people express their sexuality seems to have become more fluid. From being clearly heterosexual or, more rarely, homosexual, they may move from a heterosexual relationship to a homosexual one and then back to a heterosexual one. And latterly the transsexual phenomenon has appeared and is becoming increasingly common, with its attendant social confusion. At Nottingham Trent unlucky students feel lonely, confused and unnoticed by their tutors. They may take illegal drugs as well as alcohol. Since the disappearance of grants, many students now cannot get by without taking part-time jobs. At Cambridge on the other hand, colleges tend to give financial support; they crack down on illegal drugs but turn a blind eye to massive alcohol intake which causes health and social problems. At both universities I remember students reporting feeling tired of an alcohol-fuelled social life and longing for a quiet space where they could sit and talk. A gratifying memory for me was of a counselling group where students connected so well that over the weeks many of them stopped taking their anti-depressants.

Retired Fellows Society

Let me finish on a clinical note. The type of therapeutic relationship that develops between client and counsellor is very different from the relationship between doctor and patient. We use concepts of transference (the redirection of a patient's feelings for a significant person from the past onto the therapist.) countertransference (what am I feeling in response to this person?) as diagnostic tools. Imagine me sitting in a room for a 50 minute session with a student who is depressed, or anxious, with a difficult family background, perhaps of sexual abuse, who has been neglected, never listened to....the list goes on and on. The way I respond may be very different from the response of a colleague; this is what makes counselling an art rather than a science.

A few years ago we established a method of evaluating the effectiveness of our work objectively by issuing feedback

forms which are analysed statistically by separate companies. Much of the response is positive.

The pressure on our services is now so great that we all have waiting lists. While Cambridge University may be able to offer six sessions to a distressed student, at Nottingham Trent University a student will be offered only a one-off session with the theme: "The Way Ahead".

Did you know

Roger Bacon, in his *Cure of Old Age and Preservation of Youth*, argued that a good outburst of rage warmed the body and slowed the ageing process, giving zest for life and a youthful glow.

Acknowledgements to the Guardian.

Can you really believe this?

An article in a recent *New Yorker* magazine (Feb 23 & Mar 2, 2015) discusses the issue of "fighting the belief that our children are in constant danger from creeps, kidnapping, germs, flashers, frustration, failure, baby snatchers, bugs, bullies, men, sleepovers and/or the perils of a non-organic grape."

It is asserted, in this article, that if one actually wanted a child to be kidnapped, and he/she were put outside, it would take 750,000 years before he/she was abducted by a stranger.

The context is that a Washington father was reprimanded by the police (it took five squad cars) because his two children aged ten and six, had been allowed to walk alone from a nearby park to their home.



Hellebores by Harold Ludman

Two poems

Thoughts on Heaven

And when I die I do not hope to see
A choir of angels on some marble steps
If I get into heaven it will be
By creeping round the back until I see
A little crooked door left half ajar
Among the dustbins and the mangy dogs
It couldn't last too long, one day I'll find
Myself at some tribunal where the judge
Is reading from a list of all my sins,
Sins of commission, hopefully quite few,
But oh the list of things I might have done.
Kindness I should have shown but walked away,
Times when I should have spoken but stayed dumb
Some I remember well but many more
That make me hang my head though long forgot.
Trembling I wait my fate - what will it be?
Perhaps a thousand years of washing up.

Mark Pitman

Regret

Turn the situation over again in the mind.
Re-live the circumstances, sequences, and
wonder how, why?
Whether in a moment's crass impetuosity,
impatience,
or stubborn, wrong-headed misjudgement,
regret takes hold, gnaws with every
reminder.
Fans into life the willing embers
of sadness, guilt, remorse,
which flare up searingly bright.
Amends can't now be made, too late by far.
Though Time's supposed to heal,
her protective capsule's too thin, fragile,
will never wall off and numb
the torture pain of regret when probed by
memory.

A. Baskerville

In the next issue

Nick Coni reflects on a book that has influenced him.

Tom Madden writes of a time when there is but a little life left.

Gillian Tindall takes the pulse of time.

We have the first instalment of the second in Felix Bruckner's trilogy on the life and times of Edwin Scott, now qualified and in his first post.

And reports of meetings and visits and even, if you write any, letters to the editor.

Retired Fellows Society

The **Camera Club** welcomes new members, beginners or advanced. See the RFS website for the programme. Contact Sally Gordon-Boyd (sgboyd@btinternet.com) for more information.



Anne Folkes: Chicago Skyline



Leonard Glaser: Man holding cat



Mark Buckley-Sharp: Pelican look out



Clive Harmer: Trooping the colour



Richard Lansdown: Tree alone