



The ROYAL
SOCIETY of
MEDICINE



Newsletter Issue No.61
April 2018

RFS

Retired Fellows Newsletter

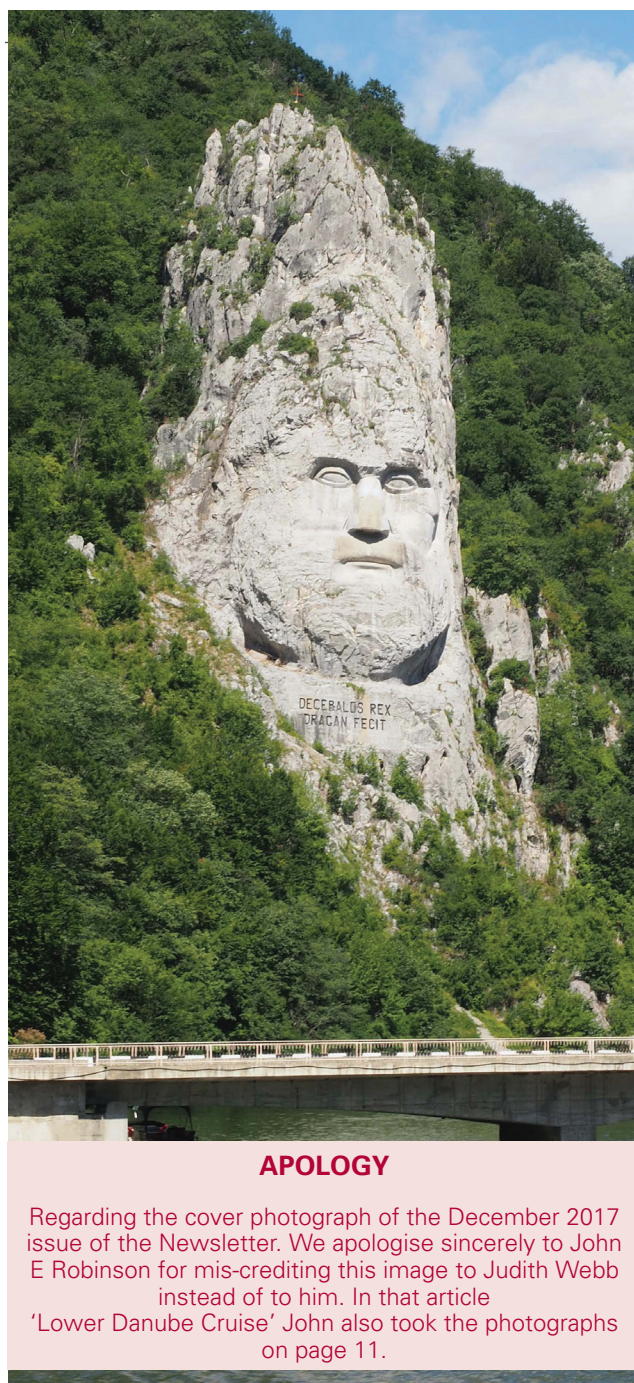


CONTENTS

2

RFS Newsletter issue no.61

| | |
|---|-----------|
| Editorial | 03 |
| Forthcoming meetings | 04 |
| Camera club | 05 |
| Biographies of speakers | 06 |
| Meetings reports | |
| <i>Recent Advances 7.12.17</i> | |
| <i>Age-related macular degeneration</i> | 07 |
| <i>Bone marrow transplantation</i> | 07 |
| <i>Post-traumatic stress disorder</i> | 08 |
| <i>Atrial fibrillation</i> | 08 |
| <i>What is happening to General Practice?</i> | 09 |
| <i>Advances in renal and pancreatic transplantation</i> | 11 |
| <i>The microbiome and health</i> | 11 |
| <i>Earl Grey tea with EM Forster</i> | 12 |
| Extramural report | |
| <i>Elegant Grosvenor</i> | 14 |
| Articles | |
| <i>On Call in Africa (part two)</i> | 16 |
| <i>Four hundred years and four generations at the Apothecaries</i> | 20 |
| <i>The Medical Art Society</i> | 22 |
| <i>Desideratum (part two of 'John Wesley: healer')</i> | 23 |
| <i>A time remembered</i> | 27 |
| <i>The built environment</i> | 29 |
| Credit (John E Robinson, cover image, Fishermen on the Danube. Romania | |



APOLOGY

Regarding the cover photograph of the December 2017 issue of the Newsletter. We apologise sincerely to John E Robinson for mis-crediting this image to Judith Webb instead of to him. In that article 'Lower Danube Cruise' John also took the photographs on page 11.

EDITOR: Dr Catherine Sarraf

RFS COMMITTEE: Dr James Carne, Dr Richard Lansdown, Mr Michael Kelly, Dr Memo, Spathis, Dr Peter Watkins, Mr Harvey White, Dr John Scadding, Dr Rosalind Stanwell-Smith, Dr Catherine Sarraf, Dr David Murfin, Dr Julian Axe, Professor Robin Williamson, Dr Jeffrey Rosenberg, Dr Robin Loveday

**Please address all correspondence to: The Editor, Retired Fellows Society Newsletter,
Academic Department, Royal Society of Medicine,
1 Wimpole Street, London W1G OAE or email: alison.catherine872@gmail.com**

Editorial:

Catherine Sarraf



In this Editorial, particularly for the information of new members who may have just joined us, I would like to talk a little about our Society's (RFS) Committee. The Society has just passed its 20th anniversary, having been initiated in 1998 by Mr Harvey White (Newsletter 60, December 2017). It has 931 members (as of the minutes of the December meeting of the Committee), of whom around 100 regularly attend our Thursday morning meetings.

Amongst all the sections and societies of the RSM the Retired Fellows is the one that proudly attracts the greatest number of accompanying spouses/partners/guests to meetings. The Committee has 14 members, and there are 4 Committee meetings per annum, plus the AGM (which is open to all). There are several tasks to be performed, and over time these rotate. At present, the Chairman is Dr James Carne, Vice-Chairman Dr Robin Loveday and immediate Past-Chairman is Professor Robin Williamson. The Honorary Secretary is Dr David Murfin, Honorary Treasurer Dr Julian Axe, and Honorary Editor of the Newsletter is me, Dr Catherine Sarraf. Dr Richard Lansdown represents the Camera Club, Dr Rosalind Stanwell-Smith arranges our extramural events and Dr Jeffery Rosenberg has the huge task of organising content of all our Thursday morning meetings. There is an element of communal suggestions for subjects of these last two components, but the actual leg-work (or maybe screen work) is very considerable indeed. At our RFS Thursday morning meetings, the Chair of the Day (a Committee member) introduces, then in the end thanks the speaker, and leads the question and answer sessions at the end of the talks. Drs Michael Kelly, Memo Spathis, Peter Watkins, John Scadding and Mr Harvey White are all Elected members, and either have performed many of the rotating duties previously or shortly will do so (possibly both). The annual meetings on 'Recent Advances in Medicine and Surgery' are also under the auspices of the Retired Fellows Society, organising Chairs of the sessions being members of the RFS Committee; the next one will take place on the 6th of December 2018. Here also there is full participation of the Committee in selecting topics to be presented. Many thanks to David Murfin for helping with the facts and figures of the above.

Membership of the RFS incurs a small annual fee additional to the RSM subscription. The Committee represents YOU, and any comments that you would like to be raised, please submit them to Dr Carne (or to our administrator Charlotte Flower), in good time for inclusion into the agenda for the following meeting.

Next meetings are going to take place on:

10th May 21st June AGM 20th September 13th December

Announcement The RSM History of Medicine Society is organising a three day trip to Worcester May 22nd - 24th. Events there will include: A guided tour of Worcester Cathedral, lecture on the Malvern Water Cure, visit to the Old Worcester Infirmary, trip to Malvern and the Priory, and more. Please check the RSM website for details. All welcome.

Catherine Sarraf **Email:** alison.catherine872@gmail.com

Forthcoming meetings

4

RFS Newsletter issue no.61



Lectures

Thursday 19 April 2018

Healthy Prisons? What is happening behind prison walls? Lecture by Professor Nick Hardwick

Thursday 17 May 2018

Addressing global challenges for sustainable food production: Lecture by Professor Sue Hartley

Thursday 21 June 2018

Annual oration - children, parents and society in the family jurisdictions: Lecture by Sir James Munby

Extramural events

Wednesday 9 May 2018

Piggeries and potteries, a race course and of course the market – walk with Sue Weir

Tuesday 10 July 2018

Explore what's new and enjoy the unexpected wildlife – walk with Sue Weir

Wednesday 26 September 2018

More Livery Halls to count but no walls! – walk with Sue Weir

Book your place online www.rsm.ac.uk/RFS

THANK YOU

The Editor and the Editorial Board thank all those RFS members who have taken photographs and/or written reports of meetings and extramural events; your contributions are greatly appreciated.

Equally appreciated are the articles that have been sent in on such a variety of topics, please keep them coming.

Camera club

Presentation meeting - : Madeleine Winston Landscape, a journey into sharp focus, Michael Miller-Jones The Palace on Wheels and the old kingdoms of Rajasthan Ken Citron An AV presentation: People
Thursday 26 April 2018

Edward Wallace, 18 degrees below and counting
Tuesday 22 May 2018 - Chandos House

Members meeting
Tuesday 26 June 2018

Mark and Judy Buckley-Sharp - Images from Turkey: 'There be Dragons' and 'Topkapi Palace'
Thursday 26 July 2018

Harold Ludman Printing materials
Tuesday 25 September 2018

Presentation meeting: Sally Gordon Boyd, Ken Citron
Wednesday 24 October 2018

Michael Pilkington Infra red and black and white photography
Tuesday 20 November 2018

2019

Members meeting
Thursday 24 January 2019

To be announced
Tuesday 26 February 2019

Presentation meeting: Three members will present a variety of topics.
Wednesday 27 March 2019

Richard Schunemann: Title to be announced
Tuesday 23 April 2019

Members meeting
Wednesday 22 May 2019

To be announced
Thursday 27 June 2019

THE CAMERA CLUB

When the club was set up we decided to follow two principles. One was that we would try to offer meetings to appeal to members with a range of expertise, from beginners to the more experienced. The other was that we would, unlike most other clubs, have no competitions. Both have been adhered to.

Quite soon we realised that several members needed some help with the basics of using a digital camera and/or with processing images on a computer, and we continue to offer help on both, on a one to one basis.

The present pattern of meetings has evolved over the years and includes talks from outside speakers, members' meetings when images can be discussed, and presentation meetings when members offer short talks on a variety of subjects. We used to meet on the same day each week but now vary our days. All meetings begin at 11.00 and end not later than 1.00.

The exhibition of our work in the RSM Atrium is changed three times a year, all members are encouraged to offer prints.

The best way to keep abreast with what is going on is to be included in our emailing list. If you are not already on it and would like to be, please contact me.

Richard Lansdown
rglansdown@yahoo.co.uk
0207 267 69

BIOGRAPHIES OF SPEAKERS

Healthy Prisons? What is happening behind prison walls? Lecture by Professor Nick Hardwick

Thursday 19th April 2018

Professor Nick Hardwick CBE graduated with an English degree from the University of Hull in 1979. The first half of his career was in the voluntary sector, first working with young offenders for the National Association for the Care and Resettlement of Offenders, then leading the youth homelessness charity Centrepoin before moving to run the British Refugee Council. In 2003 he was appointed to establish and run the Independent Police Complaints Commission as its first Executive Chair. He moved from police to prisons in 2010 when he was appointed as Her Majesty's Chief Inspector of Prisons. Since his term as Chief Inspector ended in 2016, he has combined roles as Professor of Criminal Justice at Royal Holloway, University of London with chairing the Parole Board for England and Wales and some consultancy projects. He is Chair of New Horizon Youth Centre and Vice Chair of Prisoners Abroad. He was awarded a CBE in 2010 and has honorary doctorates from the universities of Hull, Leeds-Beckett and Wolverhampton.

Addressing global challenges for sustainable food production: Lecture by Professor Sue Hartley

Thursday 17th May 2018

Professor Sue Hartley is the director of the York Environmental Sustainability Institute, an innovative inter-disciplinary partnership addressing the key global challenges of climate change, biodiversity loss and threats to food security. Her current research focuses on developing sustainable ways to increase crop resilience to drought, disease and insect pests.

She was the founding director of the £16M HEFCE Agri-Food Resilience Programme, a collaborative project across the N8 group of northern research-intensive universities, and she is currently a co-investigator at the Centre for the Evaluation of Complexity Across the Nexus (CECAN), an Economic and Social Research Council (ESRC), a large centre pioneering innovative approaches to policy making and evaluation where food, energy, water and environmental issues intersect.

Professor Hartley is a member of the Biotechnology and Biological Sciences Research Council's (BBSRC) Strategic Advisory Panel on Agriculture and Food Security, Chair of the Research Councils UK (RCUK) Sustainable Agriculture Research Innovation Club, co-lead of the RCUK Sustainable Intensification Research Network, a Trustee of the Royal Botanic Gardens, Kew, and the president of the British Ecological Society.

Annual oration - children, parents and society in the family jurisdictions: Lecture by Sir James Munby

Thursday 21st June 2018

Sir James (Lawrence) Munby, Hon., Kt 2000, has been President of the Family Division since January 2013. He has an Hon LL.D from the University of Bolton, July 2014. He was Lord Justice of Appeal 2009-2013, Chairman, Law Commission 2009-2012 (on secondment) & Judge of Family Division 2000-09. Sir James was called to the bar, Middle Temple in 1971 (Bencher 2000) and has been a QC since 1988.

Presentations at the RSM RFS Recent Advances in Medicine and Surgery meeting, 7th December 2017

Session One

Following some initial confusion due to two lecturers switching their sessions without the Chairman being told, the first session of our prestigious annual Recent Advances event got off to a good start with a lecture on **Age-related macular degeneration** by Professor Sobha Silvasprasad, Reader in Ophthalmology at Kings College Hospital and Consultant at Moorfields Eye Hospital, where she is the principal investigator of over 30 projects. She is also to be the Editor-in-Chief of the scientific journal 'Eye'.

Those of us who were still struggling to fully understand the concept of, and differences between, the "wet" and "dry" varieties (which can be treated and which cannot), had our doubts put to bed by her clear, well researched and above all, relevant and understandable slides that accompanied her talk. Modern techniques in microscopy have allowed previously hidden areas of the retina to be correctly identified, and their significance in the understanding of, and early recognition of, this scourge of older people. It was with some surprise that we discovered that 'old' included anyone over 50. Although we have not yet discovered a cure for the condition, early diagnosis and treatment can delay its

Although we have not yet discovered a cure for the condition, early diagnosis and treatment can delay its deadly progress, which leads to inevitable blindness.

deadly progress leading to inevitable blindness. Early diagnosis is clearly of importance and our responsibility as health professionals to achieve this aim was described in a clear and positive way. The presence of drusen, seen on ophthalmoscopic examination and previously dismissed as of no significance, has been shown to be a possible precursor of the fully blown disease in some cases and obviously should be carefully monitored. First signs of the developing condition, if present at all, might be some deterioration of night vision, or distortion of central vision. It was noted that optometrists were increasingly using more sophisticated methods of eye examination, and are discovering many of these cases.

At the conclusion of her lecture, I am sure I was not alone in reminding myself that I must get my eyes tested and in particular to check up on drusen, about which I have been so optimistically reassured in the past.

The second lecture was on **Bone marrow transplantation** given by Dr. Richard Kaczmariski, consultant haematologist at Hillingdon Hospital. This is inevitably, given the publicity it receives in the media, a subject about which everyone believes they know all there is to know. Not quite true, as we discovered after listening to this erudite and well delivered presentation on the subject. The source of marrow transplants might be bone marrow itself, peripheral blood or umbilical cord blood. Donors might be related or unrelated to the

Whereas the success rate for finding a suitable donor for some organs may be as high as 70% in this country for a white, native individual, it can be as low as 7% in other ethnicities.

recipient, or come from various agencies, mostly charitable, such as the Anthony Nolan Trust, following publicity surrounding the tragic case of a young boy with leukaemia some years ago. Donor registers have been set up, but there remains great difficulty in finding enough suitable donors for those of some ethnic minorities, particularly those of mixed race. Whereas the success rate for finding a suitable donor

for some organs may be as high as 70% in this country for a white, native individual, it can be as low as 7% in the former categories.

The lecture focussed on the principals, techniques and practical application of stem cell transplantation and consequences for future management, and hopefully treatment, in many serious diseases and at the present time those of the "very little hope" kind. Ethical and moral issues are other obstacles to be overcome, not mentioned, but this could be a major stumbling block to progress in the future. Sexism, however was mentioned, fortunately in the more acceptable zone of males being more suitable than females as donors. However, we could breathe a sigh of relief, that this was only because by its very nature, pregnancy, its management and changes to the body it produces, would have to remain the responsibility of the distaff side of the species.

The final lecture of Session One was given by our distinguished President of the Royal Society of Medicine, recent President of the Royal College of Psychiatry and adviser to Military Healthcare, Sir Simon Wessely. The subject was **Post-traumatic stress disorder (PTSD)**. Delivered, as it was, in his usual witty and quirky style, it came across as some rather pre-prandial light relief. But the subject is neither 'light' nor easy to relieve. My own contribution, described in my introduction of the speaker, that PTSD might be the contemporary word for what had, in times past, had several different names, such as 'shellshock' in World War 1, was quickly sat upon as being completely wrong. The two conditions were quite separate and shellshock had been dismissed as a diagnosis as long ago as 1917. Another seeming misconception is that PTSD is characterised by flashback, but this is by no means the predominant feature. Many of those suffering from PTSD found that merely being reminded of being put in a similar situation as the original trauma could trigger severe emotional distress, which could last for days. Exploitation of its name by some individuals, and the desire for monetary award, encouraged by some maverick agencies, has led to a situation in which many genuine cases have found themselves the victims of being tarred with the same brush, thus increasing their distress. In spite of Sir Simon telling us that my observation had led him to change the subject as programmed, I came away shell shocked, if not quite with PTSD.

James Carne

Session Two

The fourth lecture of the meeting was on **Atrial fibrillation**; when to anticoagulate and when to ablate, was given by Professor Pier Lambiase, Professor of Cardiology at University College London and St Bartholomew's Hospital. The theme outlined approaches to treatment of atrial fibrillation (AF) with particular emphasis on ablation being the preferable choice when appropriate. An electrical disconnect in the heart provokes conversion of the heart from sinus rhythm to AF. The source of this is rapid firing of cholinergic nerves at the base of the pulmonary vein network in the left atrium. This precedes conversion of heart rate from sinus rhythm to AF. Proof of concept has been made possible by pacing studies. There is evidence that AF begets AF and the longer it is sustained there is more likelihood the condition may become persistent.

Paroxysmal AF is usually defined as focal, persistent or permanent. These conditions are often allied to the degree of structural changes in the heart. The clearly defined source

of abnormal firing mechanisms has led to ever-improving methods to ablate the base of the pulmonary veins. Cryo balloon procedures allow a burning process to proceed at temperatures of minus 50 to 60 degrees centigrade; cauterisation is usually completed within two hours. New technology with the use of lasers is gaining pace while studies are taking place using balloon catheters and radio frequency.

Prognosis and the success of treatment are markedly affected by obesity. Scanning has shown that the disease process is allied to degree of pericardial fat with subsequent fibrosis. These changes limit success rates for ablation. Losing ten percent of body weight post ablation may improve prognosis. Size of the left atrium is associated with the heart's degenerative processes and again may influence success rates for permanent reversal of AF.

Risk factors in treatment must be balanced against non intervention. Quantifying risk for ablation procedures should be discussed with the patient. Hypertension is a risk factor while patients with no symptoms also need to be involved in plans for management. Quantifying risk may be challenging but there is evidence that early intervention for paroxysmal AF offers the best results. Persistent AF has a higher chance of recurrence and management must be viewed against patient symptoms.

Use of anticoagulants has become more focused, and historically the treatment of atrial fibrillation has been a potential minefield. The risk to non-valvular AF by using anticoagulants can be established by using clinical prediction rules. Risk of stroke for non-valvular AF can be estimated by use of the CHADS2 vascular score. With a score of two or more, anticoagulation is recommended and use of anticoagulation when the score is one may be considered. The speaker stated that he did not usually anticoagulate if the score is one. Not using anticoagulation if the score is zero can be considered reasonable.

Drugs have their place but evidence is ever accumulating that an interventionist model using ablation serves the patient best. Anti arrhythmic drugs are best avoided but may have a place to control symptoms before ablation. Beta blockers may reduce risk in AF and enjoy some use in paroxysmal AF. Amiodarone should be used sparingly and for short periods.

Randomised controlled trials in selected groups indicate that some sixty to seventy percent of patients with paroxysmal AF are maintained in sinus rhythm following first time conversion. Figures rise to eighty to ninety percent with a second conversion. Most recent trial evidence supports the use of ablation even in more advanced AF. Interventionist ablation methodology is changing the face of management with the probability of less dependency on pharmacological treatment.

Speaking on **What is happening to General Practice?** Professor Roger Jones (Professor Emeritus of General Practice, Kings College, London. Editor, *British Journal of General Practice*) mentioned how he had witnessed enormous changes in his career having worked in a range of practices. There is now a strong research base for the discipline which was not the case when he started. Around ten percent of undergraduate teaching takes place around General Practice. Family doctors work in medical student selection and are actively involved in their preparation for future careers.

Professor Roger Jones mentioned how he had witnessed enormous changes in his career, having worked in a range of practices.

That the NHS is struggling to cope at present is obvious. Great challenges persist in cancer care, obesity and diabetes and the main management burden falls on primary care. Tackling smoking and lifestyle to control metabolic disease remains challenging. Knowledge of genetics seems likely to be able to play a far greater role in the future.

The NHS was formally enacted on July 5th 1948. Pillars of the health model, free at the point of delivery, with a sharp divide between primary and secondary care, persist to the present day. General Practitioners (GPs) were initially classified as self-employed contractors with twenty-four hour responsibility for their patients. The book *The Citadel* by AJ Cronin may have influenced Aneurin Bevan in his great

motivation to put an NHS model in place. Teaching and research previously were virtually totally confined to hospital medicine.

The burden on GPs to maintain the NHS has never been greater, with an estimated two hundred million consultations annually. These numbers have risen over recent years while the interface between primary and secondary care has become more stressed, not least due to difficulties with waiting times to access hospital care.

The challenges of multi-morbidity weigh heavily on the system. Many elderly people have numerous medical conditions resulting in a growing complexity for management. Consultations have become more multi-faceted and it has become difficult to maintain high standards of care; a research base for managing patients with multi-morbidity is lacking. This has resulted in polypharmacy, and challenges arise concerning how to prioritise care. Blood pressure, weight and smoking all need intervention and guidance. The burden on primary care has high resource requirements.

The NHS has sadly been something of a political football. There have only been two Doctors strikes however, one in 1974 and another very recently. A report on long term sustainability of the NHS produced by a House of Lords committee, suggested an Office of Health Care, allowing health and social care discussion, to enjoy improved liaison. Better cross-party agreement would help the future of the NHS. This could aid clarity on future funding decisions.

Motivation for the formation of a College of General Practitioners later became the Royal College. Earlier attempts to formulate such a College had been blocked by consultant colleagues.

The Collings Report published in the *Lancet* in March 1950 in the early days of the NHS painted a bleak picture of General Practice. This motivated the formation of a College of General Practitioners later to become the Royal College. Earlier attempts to formulate such a College had been blocked by consultant colleagues. Rather strangely the discipline has often been best supported by writers from North America. Barbara Starfield has consistently demonstrated that the better the primary care the better are health outcomes. Other literature appeals to stopping a recurrent theme of restructuring the NHS and to value medical care provided in community settings.

Recent published reports about the plight of General Practice are serious and worrying. There are difficulties in recruitment, retention and maintaining standards. It has been estimated that one to two GP practices are closing weekly. There are real concerns about the sustainability of General Practice. Professor Martin Roland in Cambridge claims there are not enough GPs to meet demand and there will not be enough in the immediate future. This raises questions as to whether to expand the role of physician assistants, nurses and psychologists in the primary care setting. There is also a worrying perception that GPs are not supported by professional colleagues in other specialities. There is a need to promote careers outside hospital medicine and to reduce negativity.

Challenges for the immediate future include raising general regard for General Practice in the medical school setting. Career choices made by students may be influenced by exposure to enthusiastic GPs. Practices have become fragmented with more portfolio working. Fewer doctors find the attraction of entering partnerships and everyday pressures have made doctors feel more vulnerable. Changing career structures bring new roles for young GPs while rapid changes in technology are challenging. Retaining optimism about the future of the discipline should be paramount. Restoring positivity by looking beyond the present with an emphasis on the rewards of the discipline may go some way to expansion in numbers.

The business model of small practices may not be sustainable but the intrusion of expansive private enterprise initiatives is disconcerting. Practices working together are becoming more

prevalent. Patient centred research models and high quality care are not incompatible. While the present difficulties provide many challenges, the future of the NHS depends on strong and robust General Practice.

David Murfin

Session Three

Professor Nizam Mamode, Consultant Transplant Surgeon at Guy's and St Thomas's Hospitals in London, presented interesting information on **Advances in renal and pancreatic transplantation**, to illustrate how successful renal transplantation has become in recent years. In attempt to reduce average waiting time for a cadaveric graft (presently about three years), living donors are benefitted from whenever possible. Over 90 per cent of those receiving a kidney from a relative or friend can expect to have a working graft at one year. The surgical 'insult' to the donor is reduced when a laparoscopic approach is used for organ retrieval, although there is still a 20 per cent complication rate. Several hundred live-donor nephrectomies have now been carried out in Professor Mamode's own Department; he estimates that an individual surgeon needs to perform in the region of 50 such operations to be comfortable with the technique. Nowadays there is even a move towards laparoscopic implantation of a kidney into the recipient. Technical difficulties of this procedure seem to be reduced by the use of robotic technology. One fascinating aspect of living donation is the growing number of altruistic donors, that is individuals who are prepared to give one of their kidneys to someone in need, without specifying the intended recipient. Understandably, a detailed assessment is required of both the physical and psychological health of the prospective donor. When an adult kidney needs to be grafted into a child or there is a problem with abnormal blood vessels, the speaker has used 3D printing of the donor organ to assist preoperative planning for the best site for the new organ as well as the most appropriate vascular anastomoses. Turning to cadaveric donation, the speaker presented his experience of normothermic perfusion of the organ using warm oxygenated blood. With this new technique he has been able to resuscitate a number of kidneys that would previously have been discarded after more than 24 hours cold ischaemia. Although Professor Mamode concentrated on renal transplantation in his main talk, he answered a number of questions on pancreatic transplantation at the end, to round off a most instructive lecture.

One fascinating aspect of living donation is the growing number of altruistic donors, that is, individuals prepared to give one of their kidneys to someone in need, without specifying the intended recipient.

Professor Tim Spector, Professor of Genetic Epidemiology at King's College Hospital, is well known for his work with twins, "the best-studied people on the planet", but in this talk he discussed **The microbiome and health** - the mass of micro-organisms that colonise the intestinal tract of a healthy adult. There are 100 trillion of these bacteria, as many as the cells of the human body. Collectively they make up the microbiome, which can be regarded as an extra organ of the body with distinct effects on appetite, bowel function, immune regulation and even mood. A diverse microbiome is a force for good, protecting against a range of conditions such as obesity, diabetes, rheumatoid arthritis and irritable bowel syndrome. According to the speaker, 99 per cent of the gut flora are either neutral or positively beneficial to maintaining health. Various food fads, for example gluten-free diets in non-coeliacs or the complete avoidance of particular items such as fructose, dairy products or meat can have profound effects on the microbiome. Likewise antibiotics, including those used in farming, have deleterious consequences. Professor Spector has shown that a 10-day diet of junk food (a 'burger binge') leads to 40 per cent loss of bacterial diversity, and the lost organisms are only slowly recovered thereafter. Genetic sequencing offers a promising means for identifying bacteria that are often difficult to culture.

Bacterial species such as *Christensenella* and *Akkermansia* previously unknown to this writer (and perhaps to some others in the audience), have acquired cult status in the fight against obesity. The good bacteria thrive on greens, artichokes, bananas and polyphenols contained in foodstuffs such as coffee, dark chocolate, olive oil and red wine. A perceptible lightening in the mood of the audience at this point was dented by the next piece of information, namely that faecal transplants (capsules of 'frozen poo' from a healthy donor) provide an effective means of treating bowel infections. The speaker ended his entertaining and educational lecture by exhorting us all to tend our microbial garden, thereby helping to remove Britain from its unenviable position at the top of the European league for obesity.

Robin Williamson

12

RFS Newsletter issue no.61

Earl Grey tea and madeira cake with EM Forster

Lecture by Robin Morrish, November 2017

Edward Morgan Forster (1879-1970) wrote novels that have become classics of English literature and popular film/TV adaptations, but this lecture by Robin Morrish focused on how Forster's upbringing and education influenced his writing. Robin was a Cambridge choral scholar in the 1950s and attended Wednesday afternoon teas that Forster provided for the scholars. Morgan, as the students knew him, would serve tea and cake while seated in an armchair at an oval walnut table in his elegant study at 3 Trumpington Street. The table had served in the Forster family nursery since the 18th century and the room was full of other family associations and portraits, including a tall wooden ornament cabinet, designed by his architect father. The elegant surroundings made a change from the 'bursar's bile' colouring of many rooms in King's College at that time – and students were also allowed to 'twang' an Indian musical instrument from his collection.

Morgan was shy, a much better listener than talker. Before studying classics at Cambridge (1897-1901), he attended Tonbridge school – where Robin Morrish, himself, later taught for 30 years. Morgan was not well suited to public school culture and offered to write "How I got out of games at Tonbridge" for an Old Tonbridgian miscellany, an offer that was not taken up. Brought up by his mother and maiden aunts, he was never going to emulate his contemporary Lord Ironside of Archangel, who had a WWI tank named after him. The traditions and architecture of Cambridge enchanted him and he saw King's College as a symbol of England. The central character of his novel *The Longest Journey*, Rickie Elliott, is the closest to resembling Forster himself. It contains descriptions of the university, which was enjoying a philosophical renaissance at the start of the 20th century, led by luminaries such as GE Moore and Ludwig Wittgenstein. Forster was invited to join the Apostles' Society, a discussion group, whose members included Maynard Keynes and Bertrand Russell and formed the future Bloomsbury Group with Virginia Woolf.

VW could not have joined: the Apostles were a strictly men-only group.

Forster claimed later that he seldom understood the discussions, his interest being mainly in the way they said it. Nevertheless he deeply valued the friendships formed, prizing such bonds as more important than marriage, which he likened to servitude and death of the self. The freedom of friendship gave Forster the fusion he sought, hence his much quoted motto (and epigraph to *Howards End*) of "Only connect," a recurring theme in other

The book contains descriptions of the university, which was enjoying a philosophical renaissance at the start of the 20th century, led by luminaries such as GE Moore and Ludwig Wittgenstein.

novels, notably his greatest work, *A Passage to India*. After his student days Forster did not return to Cambridge for 40 years. He served in Alexandria in WWI for the International Red Cross, and made two visits to India, including working as secretary to a Maharajah.

At the age of 66 in 1945 he was elected an honorary fellow of King's College. His rented rooms in Trumpington Street were close by and he was later accorded the unusual privilege of a bedroom within the College. At breakfast time he could be found wrapped in a dressing gown like 'Old Moley' from *Wind in the Willows*: he would then have a two hour bath "having beautiful thoughts," which he said always drained away with the bath water. His favourites among the students included those from India and those with a working class background. He loved music and invited students to attend concerts. Forster strongly believed that undergraduates were the true owners of the university and that fellows existed to induct them into their kingdom. On his 80th birthday, the College honoured him with a literary lunch party, attended by survivors of the Bloomsbury Group and the Apostles. WH Auden sent a message: "May you long continue what you are already, old, famous, loved; but not a sacred cow." Forster had refused a knighthood in 1949, but was awarded the Order of Merit in 1969, the year before his death.

Forster's works echo his passion for uniting society. He felt that, in the west, science didn't harmonise with art, the upper classes didn't harmonise with lower, and public and personal relations were divided. But most of all, modern man needed to link the poetry of the heart with the prose of the head. He explored structure and meaning by contrasting one country with another: English home counties with Tuscan Italy, or British ruling classes with the Muslims and Hindus in India. His characters are complex, usually needing to make an important decision and going on a journey to an often lonely destination. A confirmed bachelor, he also wrote a novel *Maurice* exploring homosexuality: this remained in a drawer, published only after his death.

This report cannot do justice to the detailed analysis of Forster's novels and how they link to the man and his philosophy, however, this was an enthralling lecture by one who had the privilege of knowing him.

Rosalind Stanwell-Smith

Forster refused a knighthood in 1949, but was awarded the Order of Merit in 1969, the year before his death.

I WOULD NEVER HAVE THOUGHT THAT

Per capita, South Korea has the world's highest rate of plastic surgery. It seems that at least fifty per cent of women in their twenties have had some part of their bodies changed; men of all ages make up some fifteen per cent of the market. It is not possible to obtain precise statistics because the industry is not regulated.

A typical high school graduation gift for a girl is either a nose job or double eyelid surgery (making the eyes look bigger).

So-called surgery tourists make up about a third of patients, most coming from China.

Acknowledgements to the *New Yorker*, 23 March 2015

EXTRAMURAL REPORT

14

Elegant Mayfair a walk lead by Sue Weir

The provided itinerary promised we would see the expansive and elegant Grosvenor estate, unexpected green spaces in the heart of London and of course a well-known market. We certainly did all that on a lovely sunny day.

Our group of 9 met Sue at Bond Street underground station and walked away from the noise of Oxford Street into quieter Davies Street where we stopped and admired Bolding's Factory, an elegant and superbly decorated building. At the end of the 1880s it was a sanitary appliances showroom, workshop and warehouse. It is now an antiques centre. Next, we journeyed along Weighouse Street and stopped on top of an electricity substation where a modern cafe, and roof-garden-styled public seating area has been cleverly installed. The substation is surrounded by residential buildings - some of which are owned by the Peabody Trust who provide affordable housing for those living in this "upmarket" part of town. From our vantage point we were also able to admire the Ukrainian Catholic Cathedral on Duke Street.

Grosvenor Square Gardens was our next port of call. We saw the Franklin Roosevelt Memorial Statue, the Eagles Squadron Memorial and the September 11 Memorial Garden. Grosvenor Square has a strong association with the USA and is home to the US Embassy at the moment, this is however due to move south of the river to Nine Elms into new Freehold premises. Even the mighty US Government has been unable to persuade the Duke of Westminster to change the Grosvenor family's "Leasehold only" policy and sell them the Freehold of the property that they so desire.

Passing the Connaught Hotel, with Bentleys parked 'squeezingly' close to the front door, we ventured on to Mount Street, where we were greeted by an impressive array of terracotta facades. The ornamentation was exquisite. We peered through the window of one shop, fascinated by the luminous colouring of the rather weird goods inside. Sue decided to enter to find out exactly what they were selling. Apparently it was an Art Installation.

In South Audley Street we stopped opposite Purdey's gun shop. Built in 1880 to house its workshops and showrooms it remains today as the mecca for game gun enthusiasts. Purdey Gun & Rifle Makers has Royal Warrants and has, until 2007, had a member of the Purdey family at its helm. At nearby Grosvenor Chapel, there were numerous folk in wedding attire and we were fortunate to have the opportunity to enter there, shortly after the ceremony had finished. Scent from the exotic blooms was overwhelmingly lovely.

Then we hit the highlight of the walk. The serene beauty of Mount Street Gardens can only be appreciated by being there. The gardens are almost entirely in the shade of several enormous London plane trees, the long branches of which flirt with the buildings that encircle the space. One of those buildings houses Saint George's Primary School, and happy children's voices could be heard. The Gardens provide a home for a lovely artwork - a sculpture of a horse's head by Nic Fiddian-Green.

We are lucky to have so many fantastic religious buildings in London, and the Roman Catholic Church in Farm Street is certainly high on the list. The beauty of the golden altar, the stained glass and the ceiling in the nave were astounding. I was drawn to the statue of St Andrew - patron saint of lost things and lost people. We will be increasingly calling on his help as we grow older. Then we walked through Hays Mews. Hawks used to be kept in mews -

the word 'mews' describing the sound that hawks make. Chesterfield Street was our next stopping point where we admired the houses where Somerset Maugham, Anthony Eden and Beau Brummell lived. All blue plaqued, of course.

The final attraction, before ending our tour at Green Park tube station, was Shepherd Market off Curzon Street. Historically this is where labourers would congregate in the mornings in the hope of being hired to work in nearby fields. They would have to walk a long way to find any fields today! Shepherd Market is a vibrant mix of nooks and crannies, pubs, restaurants and boutiques. The infamous telephone box, where ladies offering such delights as "sensual massages" post their contact details, is blatantly and prominently at the Curzon Street entrance to this, rather trendy quarter.

Thanks to Sue Weir for a very enjoyable, informative and delightful 90 minutes.

Allen Davey



Romanian countryside with modern electronic relay station - John E Robinson

ARTICLES

16

RFS Newsletter issue no.61

On call in Africa – in war and peace 1910-1932, Dr Norman Parsons Jewell OBE MC MD FRCSI

Tony Jewell

This is the second of 3 articles taken from the book 'On Call in Africa – in War and Peace 1910-1932', compiled by Norman Parsons Jewell's family, from his personal memoirs of the time. Part one appeared in the December 2017 issue of the RFS Newsletter 60: 19-21. These texts and photographs are provided by Tony Jewell and Sandra Jewell.

Episode 2. The East Africa Campaign and Colonial Medical Service in Kenya

The article further reviews the recently published memoir of Dr Norman Parsons Jewell who served in the Colonial Medical Service in Seychelles and East Africa in the early stages of the 20th century.

The East Africa Campaign

Although I (Tony Jewell) was brought up in Mombasa where my father John Jewell worked as a general surgeon for more than 25 years, there was no talk of the WW1 campaign and my grandfather's role in it. We visited National Game Parks such as Tsavo East and West and Amboseli/Serengeti, without realising that they were battlefields and there are still remnants of fortifications in the area. My father had possession of a copy of my grandfather's war diary, which a friend remembers being shown but sadly was lost. Since editing my grandfather's memoir I have learnt a great deal about the East Africa Campaign and how rather than being a 'sideshow' it was a major theatre of war. As Edward Paice, author of *Tip and Run: The Untold Tragedy of the Great War in Africa*, wrote in the Foreword to our book:

'The East Africa Campaign – by far the most protracted and costly of the four on the continent – engulfed 750,000 square miles, an area three times the size of the German Reich. Its financial cost to the Allies was comparable to that of the Boer War, Britain's most expensive conflict since the Napoleonic Wars. The official death toll exceeded 105,000 troops and military carriers.'



Constructing a banda

When the news of impending war reached the Seychelles, Norman determined that he should join the war effort and once he had been given permission he made his way to British East Africa to join up, in December 1914. Mombasa was very different to Praslin Island and he soaked up the atmosphere, the historical buildings such as Fort Jesus built by the Portuguese in the late 16th/early 17th centuries. He ran into European settlers, traders and local colonial officials in the Mombasa Club. He was taken on as

a Captain in the British Army without much of an interview process or skill training, in Nairobi. Wearing his new uniform he was sent to Kisumu on the edge of Lake Victoria, an area where hostilities with neighbouring German East Africa had already erupted. This was a baptism of fire for him and he immediately had to deal with Ross's Scouts, a detachment of irregular troops who had been involved in action some days before. These undisciplined and armed troops were not used to military discipline nor obeying the instructions of a rather young army doctor.

An Army enquiry soon after disbanded the Scouts as it did another group he came across 'Droughts Skin Corps' an African group led by an Irishman James Drought. Many of these European characters ended up in the 25th Legion of Frontiersmen who engaged in the campaign using their firearm and bush survival skills. Norman was asked to be their Medical Officer. One such volunteer was Frederick Selous who joined up as a 66 year old white hunter and was sadly killed by sniper fire in German East Africa in the area of modern Tanzania now called Selous National Park. Selous was the model for Allan Quartermain in the 'Rider Haggard' novels, and films such as *King Solomon's Mines*. He had taken Roosevelt on safaris before the War and met Norman on the campaign trail when they were both admiring and catching some of the beautiful butterflies in the area! Sadly Selous' son was also killed in WW1 on the Western Front.

Sometimes the dressing stations/field hospitals were tented or requisitioned colonial farmhouses, churches or self-build 'banda' facilities.

Assistant Surgeon Zorowar Singh, some European army 'nursing' assistants and African dressers and stretcher-bearers. Remarkably, given the attrition rate from diseases such as dysentery, malaria and pneumonia as well as the risk of war, the team seemed to have some consistency each returning after being invalided out from time to time as medically unfit and sent on convalescent leave. Norman had to train them up and to adapt them to the daily challenges of war and logistics, although they were constantly on the move supporting the front line.

Sometimes the dressing stations/field hospitals were tented or requisitioned colonial farmhouses, churches or self-build 'banda' facilities. These 'bandas' were based on the German design that Norman had noted in the early stages of the campaign which used local wood materials and roofing and were often elevated to keep the patients dry during seasonal flooding. In one of his war diary entries he drew out the design he was building with provision for beds, stores and treatment areas. Mosquito nets were not widely available and there was a shortage of quinine too, which was not always taken as a preventive measure. Norman himself was invalided out on several occasions with malaria and noted once that he took over a German hospital on the march, when he had a fever of 105 degrees and luckily found an English nurse working there. He handed overall control to her requiring the German doctor to keep on his medical duties, which he did including treating Norman!

It was a challenge to keep the troops fed and watered on the campaign trail with few



Motorised medical vehicle

supplies of potable water, primitive sanitation and few washing facilities. Rivers were contaminated by animals (both wild animals and the military horses, mules and oxen used for transport) and often infested with crocodiles. The Expeditionary Force was multi-ethnic made up of African troops from different tribal areas of East and West Africa (with different beliefs and dietary habits), Indians from different parts of India with Muslim, Hindu and Sikh religious beliefs. Dietary habits and religious beliefs made planning the food supply a challenge never mind the difficulties encountered in the supply lines. Carriers could carry loads of up to 50 pounds weight, but that had to include their own water and food supplies. Covering long distances, which they had to, meant the ratio of supplies delivered *versus* supplies for the carriers themselves was evenly balanced. It was no wonder that Norman reports on debilitated and poorly clothed troops and the porters/carriers too.

As in many military campaigns, the senior military leadership can overlook the impact that disease can have on the fighting force while focusing on battle plans. However, several of the regiments were reduced to such dangerously low levels of 'fighting fit' troops that they were disbanded and the remnants returned to India, South Africa and West Africa. The ratio of deaths from disease or of war wounds was of the order of at least 12:1 from official figures but is likely to have been much higher. Malnutrition and unsafe drinking water contributed to the vulnerability to dysenteric disease, pneumonia, cerebrospinal fever and malaria. Norman mentions at one point that he advised his dressers and surgical team to clean their hands with iodine as they were unable to wash them in clean water.

Of course a field ambulance was always trying to keep up with the frontline of the fighting and in one battle Norman reported treating 500 casualties in his unit. War wounds and death also accounted for 15% casualty rate in the Gold Coast regiment at the battle of Kibata in 1916. Norman had to treat some seriously injured men with bullet wounds and injuries to all areas of the body, including head and neck, from gunfire and explosions. This must have influenced his subsequent career decision to get the FRCSI and become a general surgeon in civilian life after the War. The field hospital facilities must have been quite primitive as some of his photographs suggest.



Temporary operating theatre

Colonial Medical Service in Kenya

In 1918 Norman was transferred from the front line back to Kisumu where he had first been. It was there that he had to deal with the 1918 Spanish Flu pandemic, which hit East Africa too. His brave attempt to isolate Kisumu from Nairobi by quarantining the Uganda Railway train proved ineffective and he and his staff were run off their feet dealing with the epidemic. After Kisumu he was transferred to Nakuru where he served the Rift Valley communities including the European settler farmers such as Lord Delamere and had to travel huge distances to visit people. Sometimes this involved

riding a bicycle through the bush and having to cope with meeting wild animals *en route*, such as lion, that were common in the area in those days. He helped establish the Nakuru Memorial Hospital and was establishing himself in the district when he was allowed to return to Britain on leave. The family returned to Dublin where he studied for his FRCSI and completed the Diploma in Public Health.

However, the Irish War of Independence was underway and he was lucky to escape Bloody Sunday in 1920 as he was a named target being in the British Army and Colonial Medical Service. This made the decision to return to East Africa a lot easier than it might have

been, and the family returned to Mombasa where he was Medical Officer in charge of the Mombasa and Coast Province which stretched up past Lamu to Kismayu in present day Somalia and south to the new Tanganyika colony.

As a senior medical officer, Norman had responsibilities for public health and medical administration as well as clinical services (both medical and surgical). As a public health physician myself I reflect on whether I would have been able to orchestrate vaccination and quarantining of suspected cases of smallpox, managing large populations suffering from yaws, outbreaks of cerebrospinal fever, endemic malaria and widespread dysenteric disease. He also reports on his duties as a Port Health doctor having to visit ships with sick seamen. Japanese ships he found to be very hygienic in sharp contrast to the British Merchant fleet!

As a young surgeon he operated on the African, Asian and European populations sometimes doing the anaesthetics for more minor cases as well as operating on the major ones, to help train others. Surgery was gradually gaining acceptance at that time amongst the local population and there was a great backlog of tumours to excise, limbs to amputate and cataracts to remove.

When he moved to Nairobi he continued to be a general surgeon based in the European Hospital, serving the Governor and his distinguished visitors as well as operating on African and Asian patients in the local hospitals. He was ahead of his time when he published a year's surgical audit of his cases – broken down by age, ethnicity, type of surgery and mortality rate – in the London based *Journal of Hygiene and Tropical Medicine* in 1931. He also was an early advocate of using pathological investigations to assist diagnosis, and was a close friend of the distinguished pathologist and medical leader William Kauntze. They published, in London, a textbook called *The Handbook of Tropical Fevers* in 1932. The book received very positive reviews and was aimed at doctors who may have been trained in the West who needed extra support to diagnose tropical fevers.

Norman seemed very content with his work in Kenya but the early 1930s were a time of economic retrenchment on account of global recession and the Colonial Service had budget cuts, which meant that he had to retire from the CMS in 1932. He had received the OBE in recognition of his work in 1929. He moved back to the UK and settled in Pinner working as a general surgeon in Harrow and consulting old friends, colleagues and their families in his rooms in Harley Street.

The book received very positive reviews and was aimed at doctors who may have been trained in the West who needed extra support to diagnose tropical fevers.



Belogradchik, Bulgaria, with the distant Balkans in view - John E Robinson

Four hundred years and five generations in a livery company

Ivan Houghton

20

RFS Newsletter issue no.61

The Worshipful Society of Apothecaries of London that separated from the Worshipful Company of Grocers, celebrated the four hundredth anniversary of its receipt of a Royal Charter from King James I, on 6th December 1617. As such, it is 58th in the order of precedence of its founding, and is the largest of the City Companies. The Apothecaries first bought Cobham House in 1632 originally part of the Dominican Priory of Black Friars. It was burnt down in the Great Fire of London of 1666 but the Apothecaries were the first Livery Company to complete the rebuilding of their new Hall and it is now the oldest extant Hall following destruction caused in the Second World War, fires and other tragedies.

One may ask what is the present-day function of the Livery Companies that date back to mediaeval times? Originally the Livery Companies evolved from professional, craft and trade guilds or associations which regulated training, professional standards, working conditions and pay for their members. Boys would be indentured to a Liveryman as apprentices to learn their trade. On completion of the apprenticeship, they would become Yeomen (or journeymen). After a number of years and setting up their own business, they would become Liverymen and be able to take on their own apprentices. The term 'Liverymen' arose from special dress denoting their status in their trade. Currently there are 110 Livery Companies in the City of London with a number of guilds expecting to become Worshipful Companies in the future. Some such as the Apothecaries continue to award professional diplomas whilst others whose trade has died out continue as charitable foundations. Most continue to support their respective trades and practices in various ways as well as being concerned with charitable work. Many Livery Companies require potential members to have an association with the profession or trade of the Company to join. Eighty-five percent of the members of the Apothecaries must have a registrable medical or pharmacists' qualification.

On completion of apprenticeship, youngsters would become Yeomen (or journeymen). After a number of years and setting up their own business, they would become Liverymen and be able to take on their own apprentices.

There are three normal ways to become an Apothecary. The most common way is by redemption - that requires a recommendation from two Freemen of the Society or a member of the Court of Assistants and the payment of a fine to join the Yeomanry. Alternatively where a registered medical practitioner or pharmacist has served an apprenticeship of over four years to a Freeman of the Society, and is over 21, he or she may be admitted to the Yeomanry. The final method to become a Yeoman is by patrimony, for which the applicant must be over 21, having been born to a Freeman of the Society, after his or her admission to the Society.

Promotion to the Livery, usually after about four years as a Yeoman, requires payment of a further fine and requires being admitted as a Freeman of the City of London.

A great great uncle of mine, having read chemistry in London and Bonn, worked as an assistant in the Society of Apothecaries' shop and factory and joined the Society of Apothecaries by redemption, and advised my grandfather, a newly qualified doctor, that he should do so too, and lent him the admission fine. A year or two later in 1913, my mother

Promotion to the Livery, usually after about four years as a Yeoman, requires payment of a further fine and requires being admitted as a Freeman of the City of London.

and I had been born before 1948 when my Mother became a Yeoman of the Society, we could not be admitted to the Society by patrimony. In 1959, my sister, a medical student, and I were indentured to my mother so becoming the first apprentices to be indentured to a female Liveryman. Later my younger brother was apprenticed and both my sister and brother's children were all admitted by patrimony. At the urging of my grandfather who generously paid my examination fees, I qualified with the LMSSA(London). Will there be a sixth generation?

It is relevant to point out that whilst Elizabeth Garrett Anderson was the first woman in England openly to qualify in medicine, in 1865 using a loop-hole in the regulations for the Licence of the Society of Apothecaries (LSA), she was merely taking an examination of the Society which was different from becoming a Freeman of the Society as an apprentice, or Yeoman.

The Society continues to examine for a number of postgraduate diplomas such as the Diploma of Medical Jurisprudence (DMJ 1962); the Diploma in the History of Medicine (DHMSA 1970); the Diploma in the Medical Care of Catastrophes (DMCC 1994) and the Diploma in HIV Medicine (2002). My brother won the Maccabean prize of the Faculty of the History and Philosophy of Medicine, my sister held the Diploma in Venereology and I the Diploma in Conflict and Catastrophe Medicine of the Society of Apothecaries of London.

The Society has a number of official Livery and Yeomanry dinners, a Master's Day on the inauguration of the new Master and a Galen Dinner for the award of its prestigious Galen and other Medals, whilst an official Livery Committee organises a number of social events and visits throughout the year. There are two faculties, one of Conflict and Catastrophe Medicine and the other History and Philosophy of Medicine, which organise public lectures and run courses.

The Society contributes to the life of the City of London taking part in elections for the Lord Mayor and Sheriffs as well as charity in supporting students from every medical school, and offering prizes awarded at the London Medical Schools and some schools of pharmacy amongst others. In 2017, to commemorate the 400 years of its charter, an annual Apothecaries prize was decided to be instituted.

was born and, in 1937, she, like her parents, qualified in medicine. In 1948, the Society was the first of the Livery Companies to admit women. My mother immediately decided to become an apothecary, and being able to join by patrimony, took precedence over all the other men and women joining at the same time, so becoming the first woman apothecary. Although not proceeding beyond the Livery, she was proud to be an apothecary and took a full part in apothecarial functions. Because my sister

At the urging of my grandfather who generously paid my examination fees, I qualified with the LMSSA(London), but will there be a sixth generation?

The Medical Art Society

Jeanette Cayley (Honorary Secretary, MAS) - (photographs of artwork provided)

At a meeting of the BMA in 1934, a group of doctors, including the pioneering plastic surgeon Harold Gillies, arranged their own art exhibition. They proposed forming a society for doctor-artists. By 1951 'The Medical Art Society' had 108 members, (including 17 women, a fact which drew comment at the time). Since then the Society has held its annual exhibition in some prestigious galleries. Its current patron is the eminent artist Tom Coates. The Society has doctors, dentists, veterinary surgeons and students of these professions as its members, from all parts of the UK.

Its major benefactor in the 1970s was a man who had qualified in medicine, dentistry and the law. Baron ver Heyden de Lancey, believed that the society should be linked with the Royal Society of Medicine (RSM) and left a legacy to try to ensure this. For the present the Society's annual exhibition is held in the handsome Atrium of the RSM.

(The Medical Art Society is independent in its organisation and finances so its members are not bound to be members of the RSM). The Baron's legacy pays for two prizes, one for two-dimensional and one for three-dimensional work. Paintings, drawings, original prints and textile art, sculpture and carvings are all able to be shown.



As well as the annual exhibition, the Society acts as a forum for its members through its newsletter and website. Activities such as cultural outings, sketching days and holidays, clay modelling sessions and life drawing are held through the year. There are close ties with a similar Dutch society Pincet en Pencil ("Forceps and Pencil").

There is a growing recognition of the healing power of art and its value in hospitals. Increasingly, medical subjects inspire artists. Works by MAS members may not draw on these directly, but show

considerable skill with form, line and colour.

New members are welcome – they may download an application form from the website: www.medicalartsociety.org.uk or email: jeanettecayley@hotmail.com.

The Medical Art Society annual exhibition will run from Monday July 23 to Saturday July 28 in the Atrium of the Royal Society of Medicine.

John Wesley: healer, (part two)

(John Wesley: healer, Part one appeared in the August 2017 issue of the RFS Newsletter: 59; 11-14)

Richard Lansdown

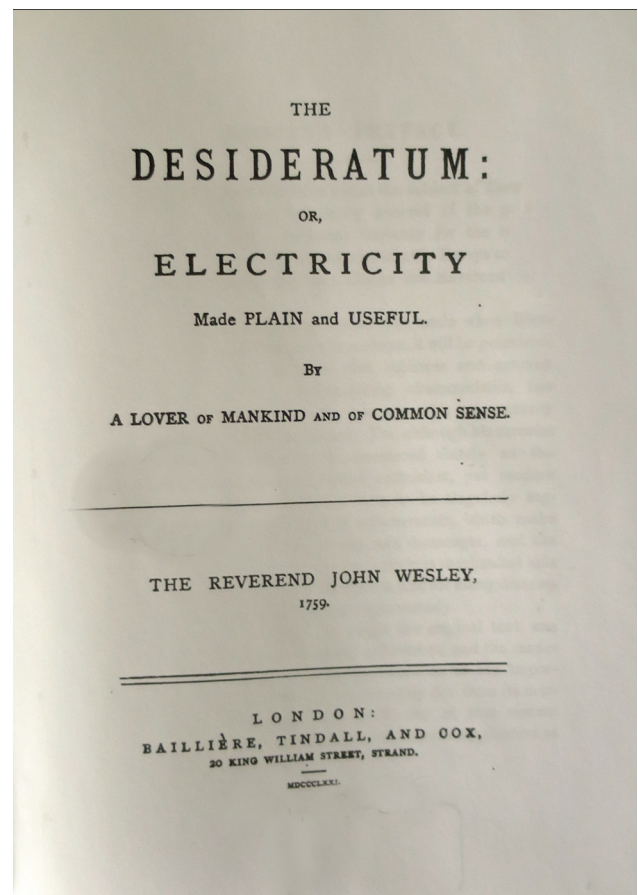
John Wesley (1703-1791) on whose work the Methodist Church was founded shortly after his death, was primarily concerned with saving people's souls but he was preoccupied also with looking after their physical health, with particular reference to the poor who could not afford consultations even with apothecaries. He wrote three books on health care, two of which were discussed in the August 2017 issue of this Newsletter. His third, published in 1759, was *The Desideratum, or Electricity Made Plain and Useful by a lover of Mankind and of Common Sense*. The beginning introduces the reader to electricity, then goes on to its potential therapeutic uses.

The therapeutic value of electricity has a long history. Four to five thousand years ago the Egyptians found that torpedo fish can produce electric shocks, they were placed on the affected part to relieve pain. There are records also of the Romans, around 50 AD, using such fish to cure gout.

By the 18th century portable frictional electrical machines had been developed to the point that they could be used for public demonstrations that amazed the onlookers. Who would not be astonished at sparks from fingers igniting ether and brandy? Electricity became a universal plaything. One lady wrote, in 1747, "Was you ever electrified? We have an itinerant philosopher who will knock people down for the moderate consideration of sixpence and men, women and children are electrified out of their senses. ...The fine ladies forget their cards and scandal, to talk of the effects of electricity."

The appendix to the 1871 edition of the *Desideratum* claims that "It was not until Wesley's original ideas on the future destiny of electricity as a curative agent were promulgated that the science of Electro-therapy and Electro-physiology was recognised." While Wesley's voice was significant, the concept of the therapeutic use of electricity was not new; an amateur scientist, Richard Lovett (1692-1780) published, three years before Wesley, the first English textbook on medical electricity: *The Subtil Medium Prov'd*, followed in 1774 by *The Electrical Philosopher*. His notion was that the sick body contained either too much or too little electricity, and so balance had to be restored. Wesley acknowledged Lovett's work in the *Desideratum*, describing it as "wrote not only with admirable Judgment but with an excellent spirit."

Wesley's concern with electricity began when he observed a public demonstration of this wonder in 1747. His journal entry expressed great interest but also confusion: "Who can comprehend how fire lives in water and passes through it more freely than through air?..... It is all a mystery."





In 1751 he obtained an electrical machine and experimented, successfully, by shocking himself to cure his lameness and neuralgia.

His machine consisted of a hollow glass cylinder supported on two wooden uprights through which ran a metal bar to which a handle was attached, by means of which the cylinder could be rotated. A piece of silk was fixed to a leather pad which was pressed against the cylinder. On an attached platform, mounted on a glass insulating column, was a metal arm with a thin rod attached to it, at the end of which is a small metal ball. The whole was mounted on four glass insulating legs. This was a friction machine, emitting current in one discharge. By storing current in Leyden jars it was possible to vary the amount of shock given.

By 1756 he had become convinced of the therapeutic value of what he called this surprising medicine and he ordered that several people, presenting with different disorders, be, in his

words, electrified, with great success. Indeed, such was the success that three years later the treatment was available in all his London clinics and one in Bristol. He was able to claim that hundreds, perhaps thousands of his patients had received "unspeakable good" with "none receiving any hurt."

There was more than a degree of care in his use of such machines. Wesley said that shocks should not be too violent, it is better to give several small ones, and they should not be given to the whole body, only to the part affected.

Despite his admiration for Lovett's work, there was one point of disagreement. Lovett saw the future of electrotherapy to be in the hands of the medical profession, Wesley said that if society had to wait for medics to embrace electricity they would wait in vain, the professionals were too committed to making money by prescribing expensive drugs. In the event, as is evidenced by the advertisements at the end of the 1871 edition of *Desideratum*, at least some of the medical profession appeared to embrace electricity wholeheartedly.

In the *Desideratum* Wesley listed those disorders in which electricity had been "of unquestionable use".

The following sixteen pages are devoted to examples of cures, from his and others' work.

Some examples:

From a Gentleman in Newcastle upon Tyne: "The Cure of the blind man in Newcastle has spread thro' all the Country; in consequence of which, I am, much against my Will, become an Oculist."

"Mary Osgathorp had her foot bruised by a Stone falling on it, which occasioned a running Sore. It continued, tho' frequently healed for a Time, upwards of eight Years: But was entirely healed a Month ago by electrifying, and has never broke out since."

"A Girl of Seven, born deaf, (who consequently could not speak) began presently to hear Words which were spoken very loud in her Ear, and could repeat some of them in a few days."

"A man of Bromsgrove, afflicted for near a Fortnight with a violent and constant Head-Ach, was twice electrified by a few light Shocks with half an Hour's interval, and entirely cured."

Table: Disorders in which electricity has been of unquestionable value.

| | |
|---------------------------|--------------------------|
| Agues | Fistula Lacrymalis |
| St Anthony's Fire | Fits |
| Blindness | Ganglions |
| Blood extravasated | Gout |
| Bronchocele | Gravel |
| Chlorosis | Head-Ach |
| Coldness in the feet | Hysterics |
| Consumption | Inflammations |
| Contractions of the limbs | King's Evil |
| Cramp | Knots in the flesh |
| Deafness | Lameness |
| Dropsy | Leprosy |
| Epilepsy | Mortification |
| Feet violently disordered | Pain in the back |
| Felons | Pain in the stomach |
| Ringworms | Palpitation of the heart |
| Sciatica | Palsy |
| Shingles | Pleurisy |
| Sprain | Rheumatism |
| Surfeit | Ringworm |
| Swellings of all kinds | Throat sore |
| Toe hurt | Tooth-Ach |
| Wen | |

Mr L " (I assume this was Mr Lovett.)

Wesley goes on to comment that a great part of these problems "are of the nervous kind" adding that perhaps there is no nervous distemper which would not yield to a steady use of this remedy.

An analysis of these reports suggests a range of conditions for which a cure was effected, to be rather broader than this comment would suggest. Of the 85 cases noted, 35 are pain related, 14 are of rheumatism, 7 of deafness, 6 of fits, 4 of swellings, 4 of sight loss, 3 of palsy and 3 of 'ganglion'. Along with these, 2 cases of loss of limb and 2 of sprain are noted and 1 each of ague, inflammation, dropsy, fistula, kidney stones, felony paralysis, the effects of stroke and a sore throat. Only two cases of hysteria are mentioned.

Wesley was not alone, in 1767 the Middlesex Hospital bought an electrical machine to train physicians and in 1793 the London Electrical Dispensary was set up "to administer electricity for all complaints in which its application may be useful."

Wesley was, however, not without his critics. Joseph Priestley, the author of a definitive book on electricity, wrote "This account of the medical use of electricity by Mr Lovett and Mr Wesley is certainly liable to an objection which will always lie against the accounts of these persons, who not being of the faculty (i.e. not being physicians) cannot be supposed capable

of distinguishing with accuracy either the nature of the disorder or the consequences of the seeming cure.”

After Wesley’s death, interest in electrotherapy continued well into the 19th century. A series of advertisements appeared at the end of the 1871 edition of the *Desideratum*, singing the praises of a Medico-Galvanic system of Flexible Voltaic Batteries devised by a Mr J.L.Pulvermacher who patented the battery in the US in 1853. This device was soon followed by the wearable chain battery belt, or ‘electric belt’. Early models had to be soaked in vinegar before use but later on models that worked purely by galvanic action with body sweat were introduced.

Electric belts were made for every conceivable part of the human anatomy: limbs, abdomen, chest, neck – sometimes all worn at the same time.

No fewer than seven eminent medics, including four who were physicians to the Royal Family, testified, in the advertisements at the end of the *Desideratum*, “with much pleasure”, that these appliances were of great importance to scientific medicine. There follows some dozen testimonials or reports of cures from other medics, dated from 1850 to 1865. The conditions cured included rheumatism, paralysis, violent agitation of an arm, vertigo and general disturbance, paralytic tremor of the whole right upper limb, neuralgia, sciatica, ear ache, nervous pains, chronic hoarseness, obstinate sinuses, euralgic affections, toothache, sciatica, epilepsy, hysteria, cramp, spasm, tetanus, gout, dimness of sight, deafness and asthma. Dr C Garratt, of Boston, USA, wrote “This greatest force of nature, viz electricity, which also holds such varied and powerful influence over life, health and disease, does assuredly command our more attentive study, in connection with other rational medicine.”

A complete set of apparatus for the treatment of general debility, central paralysis, epilepsy and functional disorders, with a Volta Electric Belt for restoring vital power, cost £5.

Gradually the enthusiasm for this device waned. The College of Dentists had investigated its possible use as an anaesthetic during tooth extraction in 1859 but found no benefit, in their view the device frequently added to the pain and eventually it was seen as of help to no one

“This greatest force of nature, viz electricity, which also holds such varied and powerful influence over life, health and disease, does assuredly command our more attentive study, in connection with other rational medicine.”

other than quacks.

Today’s readers immediately think of the placebo effect. Wesley had possibly not read of the Oxford academic, Robert Burton, who in 1628 observed “An empiric and often times silly chirurgeon doth more strange cures than a traditional physicianbecause the patient has confidence in him.” But given Wesley’s awareness of Benjamin Franklin’s work, he might have known that in 1748 Franklin carried out a placebo controlled experiment in Paris to debunk Mesmer. It was the same Franklin who wrote that his (Franklin’s) patients benefited more from the exercise they got in reaching him than from the electricity applied to them.

Apparent ignorance of early 19th century physicians and surgeons who so ardently supported the electric belt is harder to explain. The word ‘placebo’ had entered medical jargon in 1772 and in 1800 John Haygarth had published his study on a popular medical treatment called Perkins tractor, concluding that the results from a dummy remedy were just as effective as the alleged active one. Perhaps there was an element of wishful thinking, perhaps the reported cures were wild exaggerations, perhaps the testimonials were fabricated? Perhaps even eminent physicians did not read the literature that widely.

Whatever one may think about the claims by Wesley, we can conclude with W.J.Turrell's words, written in 1938: "Clearly we find a man of conspicuous ability, of indomitable energy, of reckless and fearless impetuosity, of science and fixed convictions, and of outstanding Benevolence to Human Kind."

Acknowledgements

I am indebted to H. Newton Malony, whose article in Perspectives on Science and Christian Faith (1995) raised a number of the topics discussed above.

Gillian Tindall kindly commented on an early version of this paper.

Thanks are also extended to the Wesley Museum in London for kindly allowing me to photograph an electric machine situated in the Wesley House.

All photographs by Richard Lansdown.

A Time Remembered

Heather Montford

At a recent meeting of the History of Medicine Society of the RSM, Dr Catherine Sarraf (President of the Society) gave an excellent talk about Axel Munthe, the Swedish doctor whose book *The Story of San Michele* was a world-wide success almost a century ago, and remains well known today. The talk was of particular interest to me having written, some years ago, about a memorable visit to Axel Munthe's house (Southside House) close to Wimbledon Common at the invitation of his son and daughter-in-law. This is my story :-

A memorable evening, a missed opportunity and time of regret.

Some forty years or so ago my husband Harold Edwards and I were invited to dinner by a couple who lived in a historic house in Wimbledon close by. She was an acquaintance of Harold's from the past and had recently sought his opinion about a medical matter. Perhaps the dinner was by way of saying 'thank you' since we were surprised to find that we were the only guests. Her husband was a distinguished and highly decorated former army officer and spy, but it was the fact that his father was Axel Munthe the doctor, the author of the much celebrated book and a collector, and had lived in that very house, that greatly interested me. The book, *The Story of San Michele*, was published in 1929 and had sold millions of copies world-wide. I had read it in my teens and having thoughts of becoming a doctor myself, had been enormously impressed.

The book, *The Story of San Michele*, was published in 1929 and had sold millions of copies world-wide. I had read it in my teens and having thoughts of becoming a doctor myself, had been enormously impressed.

On a winter evening we walked up the short stony drive and climbed steps to an elegant front door. There we received a warm welcome from our hostess, but on entering the cold and darkened hall were immediately struck by the feeling of damp, scarcely covered by the faint smells of dinner cooking in the kitchen below. As she led us through to the drawing room to meet her husband we marvelled at the wonderful antique furniture, pictures, statues and fascinating objects but all set against a background of crumbling plasterwork and walls streaming with humidity. Later in the dining room, where we ate at the end a long heavy oak table, it was the same and I wondered whether it was our host's lack of money or a wish to

keep the house remaining exactly as it had been in his father's day. Each part of the collection clearly had significance and was chosen with care and I wondered what that told me about the man whose work I had revered so much. Meanwhile my feelings of curiosity were further aroused, and with some fear also, as our host told us of his pet owl that he even took abroad with him by air on regular trips to Europe hidden in a special pocket of his overcoat or in a special compartment of his luggage. Since childhood I had suffered an extreme phobia of birds, particularly of their fluttering wings close by - and his story filled me with terror. Then after dinner (and by that time in a state of some conflicting feelings) we returned to the drawing room and there came what proved to be the most memorable moment of the evening when our host turned to us and said:

"I must tell you that you haven't yet seen our greatest treasure of all. Upstairs in a cabinet in my study are the pearls worn by Marie Antoinette when she went for execution. How my father came by them is a long story but there is no doubt they are real "

My excitement rose.

"Come with me and I will show you and, by the way, you will also see my pet owl. He likes to fly around my study at this time of night. "

Terror gripped me once again and my heart sank.

"I'm sorry I can't cope with flying birds "

It seemed the owl was not to be caged so Harold alone went with him.

Afterwards I asked Harold what it was like.

"Amazing, like living a piece of history. But no blood on them!"

He didn't mention the owl.

I cursed myself for my weakness and my regret at not seeing those pearls stayed with me.

And then came a second chance.

When Harold died I moved to Richmond. A local society of which I was a member announced that there was to be a visit to this very house, now in the hands of a Trust and open to the

We saw the dining room with the table as I remembered it but no longer the wet and streaming walls. All was beautifully restored, painted and full of light. The guide then led us upstairs where we crowded into the study.

public. I signed up immediately. Would I see the pearls at last?

It was summertime and our guide led us into a beautiful garden, not seen in the darkness of my previous visit. There was a grave and a memorial to the pet owl. No more fluttering birds. We went through the hall to the drawing room where he described the wonderful pictures and statues. We saw the dining room with the table as I remembered it but no longer the wet and streaming walls. All was beautifully restored, painted and full of light. He then led us upstairs where we crowded into the study.

"Here in the cabinets you will see various objects of interest "said our guide. We shuffled past each other to try to see each piece that he described.

"And now that brings us to the end of the tour" he said. "Will you please follow me downstairs and will the last person please close the door."

But what about the pearls? I waited until everyone had gone. I looked through each cabinet

and then at last I saw them, in a corner with a small label "Pearls worn by Marie Antoinette " I gazed in wonder then quickly left the room, closed the door and ran down stairs.

"Excuse me", I said to our guide who was just leaving. "You didn't show us the pearls"

"Pearls?" he said " What pearls? Oh you mean the ones supposed to belong to Marie Antoinette? Just a story. No evidence for it at all. All the things I showed you are far more interesting"

How often in life does the thing we greatly long for turn out to be false? Was my regret not so much at not seeing the pearls but allowing my weakness to stand in the way? And could the pearls have possibly belonged to Marie Antoinette after all? Our host believed they did. Whatever the answer there is nothing that can change the memory of that visit now long ago.

Effects of the built environment on health and wellbeing

Derek Clements-Croome

The built environment affects our physical, mental and social wellbeing. Medics are rarely consulted in advising on these matters in the design of buildings or cities and yet the issues significantly affect the nation's productivity, and indirectly NHS costs. Briefly I describe here some of the reasons why this is an important area of interest for the RSM, to ensure that designers of buildings and cities have the best information on health as impacted by physical, psychological and social environments.

For an organisation to be successful and to meet necessary targets, performance expressed by productivity of its employees is of vital importance. Today, technology allows people to work while they are travelling or at home or in other places, and this goes some way to improving productivity as people feel more free to work, best suited to their needs in time or space. There are still, however, many employees who have a regular workplace that demarcates space for quiet work alone but which is linked to other collaborative workspaces as well as social and public spaces. People produce less when they are tired, have personal worries, or are suffering stress due to dissatisfaction with the job or organisation. Physical environment sets the landscape and this can enhance an individual's work by putting them in a better mood, whereas an unsatisfactory environment can hinder output.

This indicates a need to shut off the ever-increasing speed and volume of information-flow bombarding us every day. Digital technology affects our brains and everyday lives in terms of thinking patterns and lifestyles.

Mental concentration is vital for good work performance. Absolute alertness and attention are essential if one is to concentrate. There is some personal discipline involved in attaining and maintaining concentration, but again the environment can be conducive to this by affecting one's mood or frame of mind; however, it can also be distracting and can contribute to loss of concentration.

Many surveys of offices show occupants requesting more break-out spaces where they can think, reflect, meditate or contemplate. This indicates a need to shut off from the ever-increasing speed and volume of information-flow bombarding us every day. Digital technology affects our brains and everyday lives in terms of thinking patterns and lifestyles. Various studies at Ball State University Centre for Media Design for example, show that the amount of screen-time people spend on mobiles, computers, tablets and television can be as much as 8 hours per day. How we use our brains

can lubricate our well-being, so a balance of screen-time, enjoying a stroll in the fresh air, enjoying music or a myriad of other non-screen activities is generally healthier. This means that breakout spaces for office workers are particularly important to allow them to use multitudinous parts of the brain not just a few of them.

A number of personal factors, which depend on the physical and mental health of an individual, and a number of external factors, which depend on the physical and social environment besides the work-related systems of management, influence level of productivity. Essentially, good health and well-being are drivers to improving not only productivity but also creativity.

Recent research has looked at associations between transmission of infectious diseases, respiratory illnesses, allergies and asthma, sick-building syndrome (SBS) symptoms and effects of the thermal environment (ventilation, lighting and odours) have on such illnesses. In the USA, total annual cost of respiratory infections was in the order of \$70 billion and that of allergies and asthma \$15 billion in 1999. It has been shown that a 20–50% reduction in SBS symptoms corresponded to annual productivity increase of \$15–38 billion and, for office workers, there is a potential annual productivity gain of \$20–200 billion. In the USA, respiratory illnesses alone caused the loss of around 176 million workdays and the equivalent of 121 million days of substantially restricted activity.

Losses in productivity are not only due to absenteeism but occur also by people present at work but not feeling at their best due to environmental factors - this is called 'presenteeism', and sickness presenteeism costs in the US are over \$150 billion per year and account for 71% of the total cost of lost productivity. There is now a growing number of wellness programs, as companies become more aware of these. It can be concluded that socially responsible companies that invest in health and wellbeing have greater business success than those that do not.

The UK has a similar problem where work absenteeism plus presenteeism, waste the nation around £100 billion per year (Clements-Croome 2018).

Any measures that reduce sick-building syndrome, musculoskeletal problems or mental stress, save companies and potentially reduce National Health Service costs. In 2013 there were 131 million working days lost through sickness absence (Labour Force Survey 2013; CBI UK Report 2014) due to the following illnesses:

| Million days per year | |
|--|-------------|
| Musculoskeletal disorders (neck and back problems) | 30.6 |
| Minor illnesses | 27.4 |
| Other | 21.7 |
| Mental stress | 15.2 |
| Respiratory conditions | 5.3 |
| Eye, ear, nose, throat | 5.2 |
| Heart, circulation | 5.0 |
| Urinary problems | 3.2 |
| Headaches and migraines | 1.7 |
| Serious mental health | 1.0 |

Illnesses are due to several causes but the environment is a significant one. Lighting, whether lack of daylight or poor artificial lighting, can be depressing and also lead to headaches. A lack of fresh air can affect respiratory, nose and throat conditions. Poor furniture design can cause backaches.

Comparing data across countries for different years is difficult but one can conclude that those available show at least that in the US and the UK (with working populations of 200 and 30 million people respectively) that lack of health and wellbeing are significant problems which impact productivity of a nation.

The World Green Council Report 2014 states that:

Costs of ill-health vary by sector and country, and are rarely comparable, but the impact is clear:

- Annual absenteeism rate in the US is 3% per employee in the private sector, and 4% in the public sector, costing employers \$2,074 and \$2,502 per employee per year respectively.
- Cost of sickness to the employer is estimated at an average £595/employee/year in the UK, while poor mental health specifically, costs UK employers £30 billion a year through lost production, recruitment and absence
- The aggregate cost to business of ill-health and absenteeism in Australia is estimated at \$7 billion per year, while the cost of 'presenteeism' is estimated to be \$26 billion.

It is time that architects and engineers who design buildings and cities understand the impacts of what they do on health and wellbeing. Medics need to be part of this change of culture as architecture becomes more focused on people and economic benefits to the nation of affecting this, are realised.

REFERENCE

Creating the Productive Workplace ,2018, Chapters 1,2 by Clements-Croome on Health and wellbeing (Routledge) which includes an extensive literature review



River Danube, Iron Gates gorge - John E Robinson

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 + the name of the person who actually took the photograph.

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

