



RFS

Journal of the RSM Retired Fellows Society

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Editorial:

Catherine Sarraf



A close look will have revealed to you that our publication has changed its title. No longer the *Newsletter* of the Retired Fellows Society, but the *Journal of the RSM Retired Fellows Society*. This change has been brought about after considerable debate in the RFS Committee, although there was no dispute that the new name is a better, more accurate one. There are two main reasons for the change. First, we all receive SO many newsletters from the various societies to which we belong. Filing them all – whether hard copy, printed out or electronically, they do seem to more or less merge into a mass of print to which we must pay attention. Secondly, this publication is SO much more than just a newsletter. Addressing the first, our RFS publication, thanks so much to the RSM for the efforts of their staff – in facilitating all the stages in publication, administrators, page-setter, printers, posting – we have a very high quality journal to grace the most elegant of coffee tables. Secondly, our publication REALLY IS a journal. Indeed, we include all current information concerning activities of the Society, but also we embrace exceptionally interesting articles, submitted both by Fellows and from outsiders of note, who contribute papers concerning all manner of topics, whether medical, cultural, geographical, biographical, autobiographical and more. Our photography is of the highest order, images frequently taken by Fellows but also as parts of full submissions. In addition, now that our Thursday morning meetings (currently) are hybrid, Fellows unable to attend in person receive a full breakdown of lectures we have attended and events we have

taken part in. Personally, I am a Fellow of the Society not a member of the RSM staff. The journal is for your enjoyment I trust we succeed in our purpose.

Historically, what a troubled two years we have lived through! First Brexit (no matter which side one supported), followed by Covid, and now the distresses of Ukraine. I am a Brit, born after the end of WWII, but interested in history of the second world war and before. It seems that the flat and fertile lands of this region of Europe constantly fall in train to aggression, whether Napoleon's ambitions, failed agricultural policies of the early Soviet Union, then Nazis and Communists. I'm sure we all feel great sympathy for the common people involved and hope that this tragedy will come to a compatible end soon.

As ever Fellows, I invite you all to please submit a few paragraphs to me, about your lives and interests, past, present or future. Everyone has a story in them, and the rest of us are fascinated by the experiences of others. You will all be admiring more of Jeffrey Rosenberg's fabulous collections of animal photographs, acquired in his new hobby at London Zoo. Thanks so much Jeffrey.

An apology to the author of Keith Levick's obituary. Sadly, you didn't write your name on the submission, so it's not there! Please contact me and I can credit you in the August issue of the journal.

There is no peer review for publication here, and 'Information for Authors' can be found on the back cover.

Forthcoming events

Programme Intramural meetings 2022 – 2023

Jeffery Rosenberg

2022

April

21 | Anthony C Davies:
Guided missiles – a pictorial visit to the
surface-to-air missile ‘zoo’

May

19 | Shirli Gilbert:
Music on the brink of destruction

June

16 | Charlotte Brooks:
Worth a thousand words: an
introduction to the botanical art
collections in the RHS Lindley Library

October

20 | Lady Ros Altmann:
Pensions

November

17 | Professor Nick Reed:
The future of transport

2023

February

16 | Dr Sushma Jansari:
The South Asian collection at the
British Museum

March

16 | Professor Andrew Cunningham:
Zoonoses and transmission to *Homo
sapiens*

April

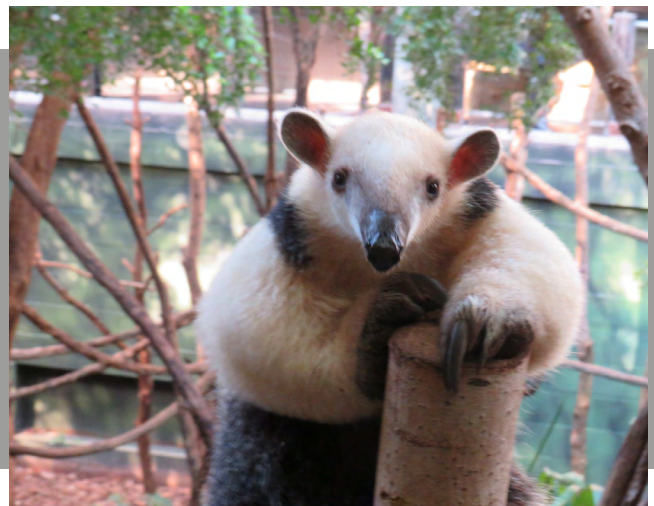
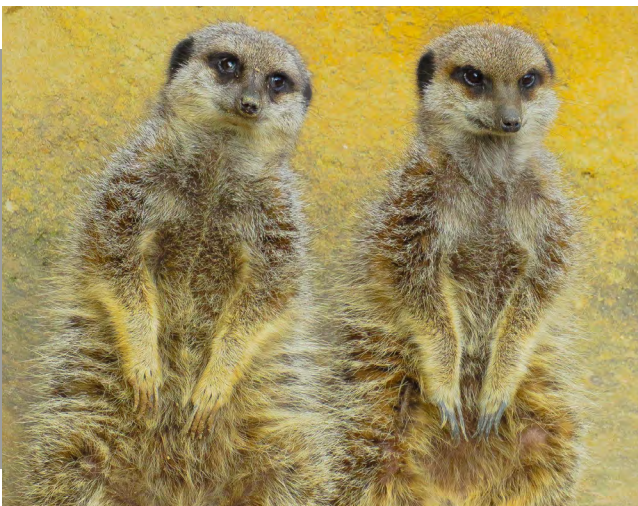
20 | Baroness Sue Black:
The face of death

May

18 | Rosie Lickorish:
The Mayflower autonomous ship
project

June

15 | Jonathan Hall QC:
Counterterrorism



Photos from London Zoo taken by Jeffrey Rosenberg and colleagues

Programme of the Camera Club 2022 - 2023

Memo Spathis and Richard Lansdown

Camera Club Report

The previous January meeting was a presentation by one of our members, Dr Andy Hooker FRPS who summarised his considerable experience walking and climbing in mountainous regions. The photographs were excellent, and the meeting was held by Zoom. However, Members meetings are not really suitable for Zoom, so when not possible to meet in person at the RSM, another type of meeting could be scheduled. The programme is, perforce, fluid!

Members meetings are open and not pre-planned. Members bring in photos, or prints for discussion, including methods or processing that might improve them. Presentation meetings usually consist of two speakers, who each give a presentation lasting between 30 and 45 minutes, with discussion (if on Zoom we encourage shorter timing). Some presentations are technical, others of general photographic interest.

The programme is circulated to all who have expressed an interest, but recently there have been problems with people dropped from the list – this is being looked into. Would anyone who would like to attend or receive the programme, but is not yet on the list or receiving it, please let our me know spathis@doctors.org.uk or Richard Lansdown at rglansdown@yahoo.co.uk

Camera Club Programme 2022

All in house at the RSM, coffee at 10:30am, meeting starting at 11:00am

April

28 | Ian Judson Sailing in the Hebrides – boats, “bonxies” and other birds” (NB in the Wimpole Room)

May

16 | Members’ Meeting

June

23 | Presentation Meeting

September

21 | Paul Sievers: Kew through the seasons

October

12 | Members’ Meeting

November

7 | Presentation Meeting



Photos from London Zoo taken by Jeffrey Rosenberg and colleagues

Extramural Events

Rosalind Stanwell-Smith

Extramural Events Report

In addition to some great walks by Sue Weir (below), we are planning a private tour with lunch at the Royal Opera House on the afternoon of Friday 20th May. This will be an opportunity to see the stunning refurbishment of the oldest Victorian auditorium in London as well as to meet up with other retired fellows. Then on Friday 24th June we shall have an exclusive guided tour of the Foundling Museum. Please check online or your email for booking details. Hopefully the Covid 19 restrictions still in place for many venues will ease over the coming months, so that we can organise more tours and excursions.

Extramural Events Programme

May

20 | Private tour of the Royal Opera House



June

24 | Guided tour of the Foundling Museum



Sue Weir's Spring and Summer Walks

April

27 | Twixt the Strand and the River

A small parcel of land but filled with hidden delights - not only statues but a C15th chapel, small alley-ways and an unusual lamp, but also home to some familiar personalities.

Meet: Outside main entrance to Charing Cross Station - return same

Time: 11:15am and 2:15pm

Maximum number of people: 20

Cost per person: £17.00

Sue's mobile if you are delayed: 07713 402 651

May

17 | Unknown St James

Elegance, fashion, food and dairy maids in the heart of St James - all waiting to be explored.

Meet: Piccadilly Circus underground exit barriers - return same

Time: 11:15am and 2:15pm

Maximum number of people: 20

Cost per person: £17.00

Sue's mobile if you are delayed: 07713 402 651

June

29

Grand and Noble Belgravia

Not only squares and large houses but also a maze of small streets and pubs to delight the eye.

Meet: Exit barriers of Knightsbridge station - to exit east (Harvey Nichols side, **NOT** the Harrods exit) return same

Time: 11:15am and 2:15pm

Maximum number of people: 20

Cost per person: £17.00

Sue's mobile if you are delayed: 07713 402 651

July

15

South of the River - Lambeth Marsh

In its marshy wastes the poor struggled to survive but now Lambeth has changed to a vibrant area of "des res", and innovative restaurants ready for us to explore.

Meet: Exit barriers of Southwark underground station, return Waterloo station

Time: 11:15am and 2:15pm

Maximum number of people: 20

Cost per person: £17.00

Sue's mobile if you are delayed: 07713 402 651

RSM: Latest Library Exhibition

Medicine and Literature

An exhibition at the Library of the Royal Society of Medicine which will explore how medicine has inspired literature throughout history.

Free admission

Monday - Thursday:

9:30am - 6:00pm

Friday:

9:30am - 5:30pm

The Library, first floor
1 Wimpole Street, W1G 0AE

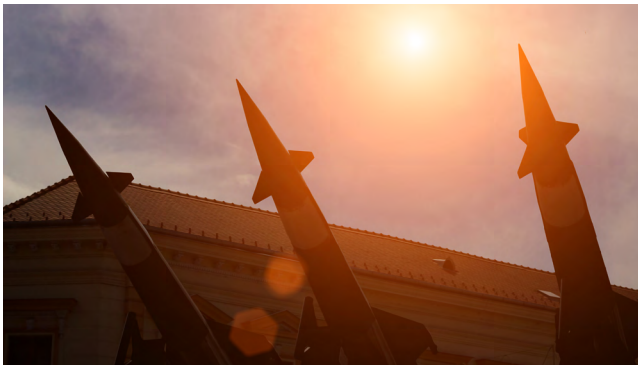


Abstracts and biographies of speakers

Guided missiles – a pictorial visit to the surface-to-air missile ‘zoo’

Lecture by Professor Anthony C Davies

Thu 21 April 2022



Biography

Born in Rainham, Kent, 1936. Military service: British Army, Royal Electrical and Mechanical Engineers (1955-7), trained as Telecommunications Mechanic, and the last year as a Leading Artisan Sergeant. B.Sc(Eng) Electrical Engineering, 1st Class Hons (1963) Southampton University, MPhil (1967) University of London, PhD (1970) City University London. Then, General Electric Co. in Coventry (1961-63): Lecturer (1963), Reader (1970) and Professor and Director, Centre for Information Engineering (1982) at City University London. Professor, Department of Electronic Engineering, King's College London (1990-9). Lecturer, University of British Columbia (1968-9); Visiting Full Professor, Purdue University (1973-4); Royal Society Fellowship, British Aerospace, Army Weapons Division, Stevenage (1987-8). Short course teaching including courses on microprocessors for George Washington University in London, Berlin and Washington DC (1979-1981); Consultant to Admiralty Underwater Weapons Establishment, Portland, Dorset. Former Visiting Professor (from 2002) and now member of Industry Advisory Board, Kingston University, Surrey, England. Fellow IET, Life Fellow IEEE, Member BCS, Chartered Engineer. IEEE Region 8 Director and member of IEEE Board of Directors (2003-2004)

Abstract

This talk will look at the historical development of surface to air missiles: names and types, mode

of operation and methods of avoiding them, to provide an understanding of present status and likely future. The talk will be illustrated with many photos, and an explanation of missiles' operation, but no practical demonstrations are intended. The talk aims to provide an interesting background and to enable the audience to have better understanding of reports they may see in the news/media. A very brief mention of what may be expected in future may be included (such as Directed Energy Weapons).

Music on the brink of destruction

Lecture by Professor Shirli Gilbert

Thu 19 May 2022



Biography

Shirli Gilbert is Professor of Modern Jewish History at University College London and Director of the Sir Martin Gilbert Learning Centre. She holds a DPhil in Modern History from the University of Oxford and was a Postdoctoral Fellow in the Society of Fellows at the University of Michigan. Before coming to UCL, she was Karten Professor of Modern History and Director of the Parkes Institute for Jewish/non-Jewish Relations at the University of Southampton. She has written widely on the Holocaust and its legacies, modern Jewish identity, and Jews in South Africa, and her publications include *Music in the Holocaust* (2005; National Jewish Book Award finalist), *From Things Lost: Forgotten Letters and the Legacy of the Holocaust* (2017; British Association for Jewish Studies Book Prize special mention) and most recently, with Avril Alba, *Holocaust Memory and Racism in the Postwar World*.

Abstract

An extraordinary range of musical activities, both forced and voluntary, took place in the Nazi ghettos and camps, from the earliest internment centres established in 1933 until their liberation in 1945. The musical works created there by prisoners are extraordinary documents of the time: fragments recovered from the rubble of war and genocide. In this talk, Shirli Gilbert will present original songs from this period, including some rare post-war recordings. The songs offer rich insight into victims' experiences, conveying the uncertain and shifting perspectives of prisoner communities as they made sense of lived reality.

Worth a thousand words: an introduction to the botanical art collections in the RHS Lindley Library

Lecture by Charlotte Brooks

Thu 16 June 2022

Biography

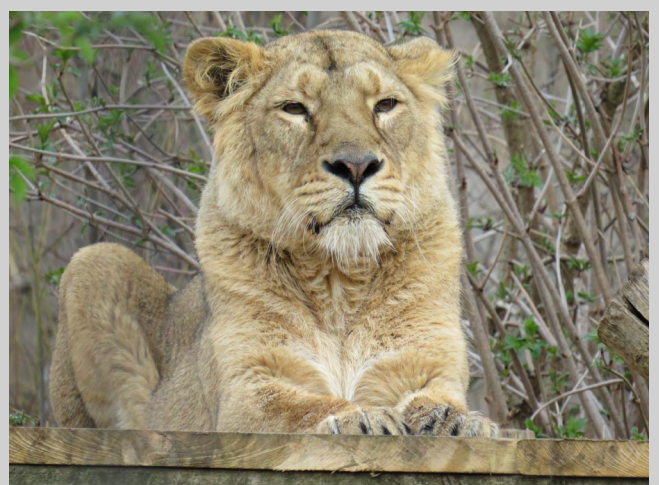
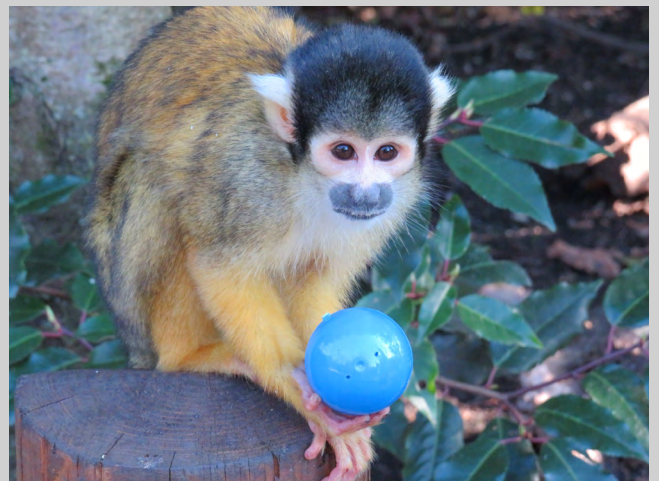
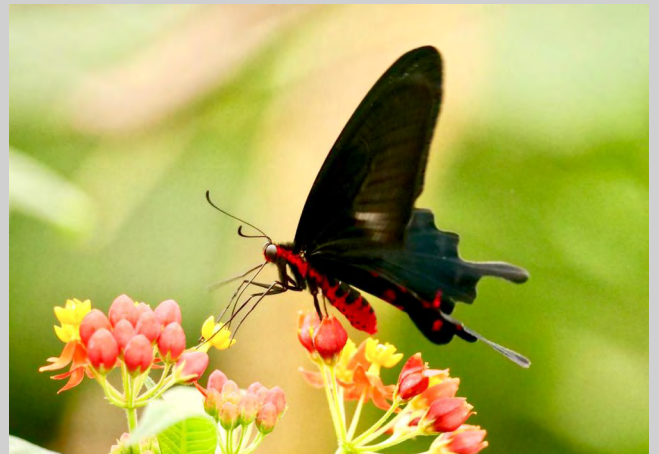
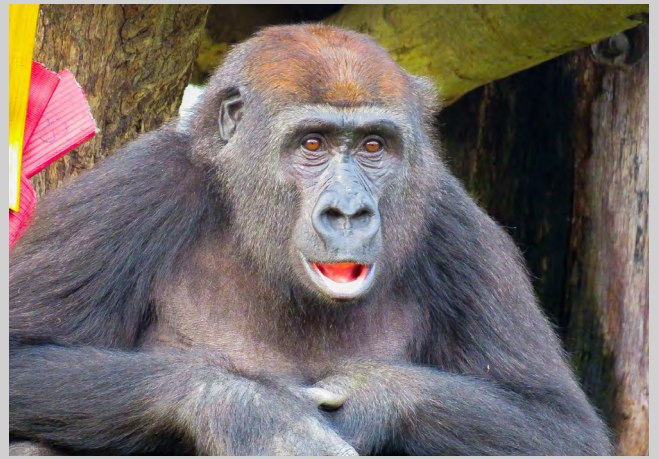
Charlotte Brooks has been working with the art



collections at the Lindley Library for 18 years. She is Secretary for the Botanical Art Judging Panel, which sees artists from around the world exhibit in the hope of gaining RHS medals. Charlotte has contributed to numerous short papers and articles, and her first book *RHS Botanical Illustrations: The Gold Medal Winners*, was published in 2019. Her next book on the RHS orchid paintings is due out in 2022.

Abstract

The worlds of science and art come together in art collections of the RHS Lindley Library. Representing 400 years of botanical illustrations, the heritage collections are complemented by works from contemporary award-winning botanical artists. What are we seeing when we look at a piece of botanical art? What makes a Gold medal picture?



Photos from London Zoo taken by Jeffrey Rosenberg and colleagues

Meetings reports

Recent advances in medicine and surgery

Meeting organised by the Retired Fellows Society on behalf of the RSM, 2 December 2021

Session One

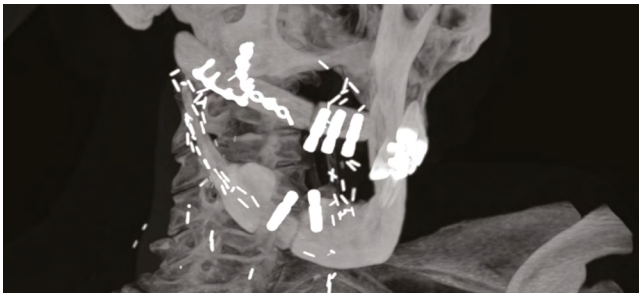
Pulmonary fibrosis in the 21st century



The first talk of the day was given by **Dr Helen Parfrey**, Consultant Respiratory Physician at Royal Papworth Hospital, Cambridgeshire. She started by describing the entity of interstitial lung disease, a large group of conditions characterised by injury to the alveolar epithelium associated with an inflammatory infiltrate and fibrosis which impair gas exchange. In many patients the cause is unknown, and the condition is termed idiopathic pulmonary fibrosis or IPF. In 20% of cases this disease is familial and genetic mutations affecting mucin have been identified. Similar conditions can be seen in sarcoidosis and rheumatoid arthritis. IPF is a progressive condition that can lead to a ‘honeycomb lung’, but its course is unpredictable, sometimes rapid and sometimes slow, but punctuated by acute exacerbations. There is seasonal mortality with infections in winter triggering further damage to the alveolar epithelium. Overall, IPF is generally fatal within three years of diagnosis. There has been a marked increase in its incidence over

the last 20 years. Britain now sees 6000 new cases of IPF each year, and Dr Parfrey described a cohort of 254 patients at Papworth. There are associations with increasing age, the male sex, cigarette smoking, certain occupations (for example, farmer’s lung) and possibly gastro-oesophageal reflux disease. In terms of diagnosis, chest CT (computed tomography) has largely replaced lung biopsy, although biopsy may still be required for indeterminate cases; magnetic resonance imaging can illuminate subtle changes. At present, treatment is essentially supportive and aimed at reducing symptoms of breathlessness and cough. Antibiotics have been tried since patients with IPF have an increased bacterial load, but benefit may be limited to infective exacerbations, and sadly immunosuppressive drugs do not seem to work. Nintedanib, a tyrosine kinase inhibitor, interferes with fibroblast proliferation and can slow down the decrease in forced vital capacity, but side effects are frequent. Pirfenidone, a type of pyridone, may prove to be a useful addition to other therapies, but its mechanism of action is unclear. Lung transplantation may be indicated in younger patients, but it is a major undertaking with its own risks and complications. There are many drug trials under way in the hunt for an agent that is more effective in prolonging survival.

Maxillofacial update



Mr Nadeem Saeed, Consultant Maxillofacial Surgeon in Oxford and also at Great Ormond Street, began by defining the scope of his specialty, which extends from extraction of wisdom teeth to remodelling of the skull. At present, training in the speciality is long and arduous, with its 10-year stretch acting as a disincentive to trainees entering, especially women; some surgeons are now questioning the need for joint medical and dental qualifications in every case. Mr Saeed covered a wide variety of conditions that he encounters in his practice including diseases of the teeth, jaws and salivary glands, trauma, head and neck cancer, craniofacial deformity and temporomandibular joint disorders. The management of maxillofacial trauma and facial deformities has been revolutionised by CT, which allows digital planning and customised prostheses designed to improve the cosmetic result. The worldwide incidence of head and neck cancers has increased, men especially being affected. Predisposing factors include smoking, consumption of spirits, and betel nut chewing. Exposure to human papilloma virus (HPV 16) can lead to carcinoma of the tongue and oropharynx many years later. Minimally-invasive operations can now be performed for some parotid tumours. Arteriovenous malformations can be managed by beta-blockers and by embolisation of glue to facilitate resection. Osteonecrosis of the jaw is a complication of long-term biphosphonate medication. Mr Saeed then concentrated on conditions that affect the temporomandibular joint, which include myofascial disorders and arthritis and which affect up to a third of the population at some stage of life, especially between the ages of 20 and 40. In some patients there is a psychological component. Symptoms include pain, clicking and restricted opening of the mouth. Arthroscopy allows access to the upper component of the joint to help refine the diagnosis. In patients with severe disease, for example an inflammatory arthropathy or ankylosis, joint replacement is now a feasible option. Different types of prosthesis are available for both the mandibular

component and the temporal fossa implant. 3D modelling based on CT imaging helps to determine the amount of bone to remove as well as preparation of a custom-made prosthesis to allow a one-stage operation. At present joint replacement remains a demanding procedure with a number of potential complications, but the results can be gratifying.

Reflections on military mental health practice: it's not just about PTSD



Following the eleventh-hour withdrawal of the previously planned speaker, **Dr Jeya Balakrishnan** generously filled the potential gap in the programme at short notice. He is a forensic psychiatrist who works in primary healthcare for the Ministry of Defence; he discussed the major mind shift needed for veterans transferring from combat back into the community. Previous tactical awareness of such individuals can translate to being on edge all the time in normal civilian life. The adjustment process can be difficult on return from active service, and there is a risk of developing a dependence on alcohol, tobacco or drugs. In 2019-2020 just under 3% of serving military personnel in Britain had some type of mental issue, chiefly adjustment and mood disorders. There were problems also for the families who had to cope with the partner, after having been away for long periods of time. The primary remit for those caring for soldiers is to maintain their occupational fitness. That might necessitate a period spent in a personnel recovery unit, where the outcome would be either that they got better or that they left the military. Post-traumatic stress disorder (PTSD) could follow direct exposure to a threat in combat or indirect exposure, for example in paramedics who witnessed other people's trauma. There was a risk of moral injury, such as distress that impacts on someone's moral or ethical code. A detailed history is crucial to understand the challenges faced by serving personnel. Psychometric tests using self-reporting scales could also be helpful but do not necessarily involve answers to leading questions. Those working in the armed forces may witness suffering at first hand, and this can translate into feelings of anger, guilt or

shame which lead to social isolation (as distinct from PTSD). Important factors that reduce their ability to cope include childhood adversity, lack of support from family and colleagues and disinterest among those responsible for their pastoral care. Dr Balakrishnan helped the audience to appreciate the extent of mental health problems to which those who provide our defence are prone, as well as the close cooperation between mental health and occupational health practitioners needed for their proper rehabilitation.

Robin Williamson, Chair, session one

Session Two

Meeting mind and body: integrating mental health in paediatric and adolescent medical services in the 21st century



Dr Michael Groszmann Consultant in Child and Adolescent Psychiatry at University College London Hospitals NHS Foundation Trust delivered a fascinating lecture, in which he mentioned that he is a consultant at University College London Hospital which is a new glass fronted building. In the old days the psychiatric unit was at the back of a hospital usually tucked away and was a physical separation, similar to the mind and body. He pointed out the Cartesian duality where mind and body were made of two different substances as proposed by Rene Descartes in 1649. Dr Groszmann informed the audience that he is a paediatric liaison psychiatrist and pointed out that 'liaison' is derived from the French 'lier' which means binding and is used in cooking. Liaison changed its meaning during the First World War to indicate an officer who worked between the army, navy and air force. Today a liaison officer works between several services.

Michael informed us of the roles of paediatric liaison and the different areas in paediatric liaison which include acute illnesses such as suicide, psychosis and anxiety, medical illnesses

particularly diabetes, endocrine changes, neurological conditions, gastroenterological and brain injuries. He pointed out functional neurological problems, which are often seen by GPs, including Ehlers Danlos hypermobility, gastroenterological states and chronic fatigue syndrome. There is a large paediatric oncology unit at University College London and the paediatric liaison psychiatric officer works looking at diagnosis and adjustment of mood and anxiety with end of life treatments and the late effects of palliation. There is also a role in teaching, supervision, consultation and staff support.

Dr Groszmann indicated that the point of liaison is to bring a variety of expert views to problems simultaneously, and the importance of multidisciplinary team working was emphasised with everyone in the group seeing the same picture. Integrated care to address child and adolescent health in the 21st century was reviewed, and it was noted that children and adolescents with increasingly complex needs are being managed by paediatric teams and there is better integration of somatic and psychological care. He stressed the importance of co-ordinated care, co-located care and integrated care. There is a proven relationship between mental and physical health. 12% of young people live with a long term condition and people with a chronic condition have a 2 – 6 times higher risk of mental health illness. People with mental health illnesses, such as schizophrenia or bipolar disorder, die on average 16 – 25 years sooner than the general population, and there is a 50% increased risk of mortality in people who are clinically depressed. There is almost double the rate of mental disorders with long term physical conditions. Michael also referred to a paper which showed that paediatricians find it difficult to detect psychiatric disorders and therefore there is a need for paediatric liaison officers to work closely with paediatric units. He finished his talk by delivering several illuminating case studies showing the benefits of child and adolescent mental health services and then took questions. The audience was interested that the suicide and self-harm rates have increased dramatically, but Dr Groszmann thought that this was not entirely due to social media or the pandemic. Various potential reasons were discussed.

Dengue and haemorrhagic fevers



The second talk of session 2 was an on-line presentation by **Professor Annelies Wilder-Smith**, who is Professor of Emerging Infectious Diseases at the London School of Hygiene and Tropical Medicine. She is a World Health Organisation consultant and gave her presentation from Switzerland.

She informed us that dengue is spread by the *Aedes aegypti* mosquito, which, unlike the malaria mosquito likes stagnant water and because of the way it bites humans, it likes crowded populations, and urbanisation is one of the reasons dengue fever incidents are increasing. Dengue and dengue haemorrhagic fevers are a threat to more than 2½ billion people in tropical and subtropical regions, there are 100 million infected cases per year with 50,000 deaths. Dengue is the most frequent cause of fever in travellers returning from East Asia and there are clinical diagnoses from non-specific febrile illness, dengue fever, dengue haemorrhagic fever and dengue shock syndrome also. 80% of people who have dengue are asymptomatic, although the rash is distinctive and the criteria for dengue haemorrhagic fever are fever, excessive capillary permeability and a low platelet count. Dengue has an interesting timeline. It takes 4 days from the mosquito bite for the fever to start but viremia and fever stop on day 5. Most people at this time then start to develop noticeable antibodies, but PCR testing is only suitable between day 0 and day 5, after which an antibody test is required. Shock and haemorrhage occur on days 4 to 7. In this critical period there is a drop in the platelet count, rise in the haematocrit and increase in fever. Severe dengue fever is undoubtedly a multifactorial disease, there are epidemiological factors, viral factors and individual risk factors which include age, race and nutritional status.

Annelies mentioned production of homotypic and heterotypic antibodies and also talked about common misconceptions concerning haemorrhagic fever. Dengue haemorrhagic fever patients die of shock and the severe

presentation includes encephalopathy, fulminant hepatitis, cardiomyopathy, severe gastrointestinal haemorrhage and blindness with retinal haemorrhages.

Development of dengue fever is expanding; reasons for this are uncontrolled urbanisation, environmental changes and community behavioural changes. Modern transportation with increased movement of people and animals also is a reason for the increase in dengue fever. There is also a lack of effective mosquito control and climate change may also play a part. Professor Wilder-Smith also spoke about live attenuated dengue vaccines which included the Sanofi Pasteur vaccine, the Takeda vaccine and the Butantan vaccine. In conclusion she pointed out that dengue fever is the most frequent arboviral disease and it is poised to increase further. Unlike malaria and other tropical diseases dengue is increasing, urbanisation being its main driver. Dengue vaccine development has had several setbacks and there are vaccines on the horizon for which policy recommendations are pending.

Annelies took questions from the floor *via* Zoom and her talk was greatly appreciated by the audience.

Humphrey Scott, Chair, session two

Session Three

Multiple sclerosis: disease-modifying treatment



Professor Jeremy Chataway is a Consultant Neurologist and Professor of Neurology, at the National Hospital for Neurology and Neurosurgery, University College London. Multiple Sclerosis (MS) is an enigmatic condition and may present to physicians in primary or secondary care; we still do not understand its cause. Typically, at presentation the patient is in the 'younger adult' age group with presenting symptoms often related to unilateral visual disturbance or balance problems. An early brain scan may reveal changes suggestive of a cerebellar event

or optic nerve changes. Modern scanning techniques allow mapping of the degenerative process either within the optic nerve or central nervous system. It has been long recognised that, looking at a globe of the world, the further from the North or South pole one resides the prevalence of the disease falls. European émigrés from Europe to New Zealand or Australia demonstrate higher incidence of MS than the indigenous populations. The reason for this is still to be fully explained and is probably a mix of genetic and environmental predisposing factors. This disabling disease eventually affects lifestyle and employment with steadily progressive pathological changes. Over the decades it changes from a predominantly inflammatory to a degenerative condition and clinically it may assume a remitting or progressive course. Even first presentation scans may reveal evidence of atrophy and destruction of brain tissue. A series of slides was shown that indicated change in ventricle size after only two years from presentation. Repeat scans indicated that brain destruction occurs at a rate of 0.5% per year compared with 2% per year in Alzheimer's disease. MS progresses substantially for a significant number of patients after 15 to 20 years, despite modern intervention, although a slowly progressive form of the disease is less common. There is a perplexing genetic axis, revealed by studies on twins, due to factors unknown. A huge amount of recent research has focused on the human leukocyte antigen (HLA) locus and seeks to reveal an immunological component. The integral cause of the condition still awaits discovery. Historically, doctors may recall the limitation of their treatments, but steroid use and physiotherapy have provided no hope of disease modification. The modern therapeutic approach to controlling MS revolves around three parts: control of relapses, protecting the axon and the repair of demyelination. Clinical presentation, which varies in relapse rate and severity, is a hallmark of the condition. A number of drugs has been made available over recent years. Clinical efficacy has to be reviewed alongside radiological evidence of change. While the patient may feel benefit subjectively, sadly, each relapse all too often leaves a trail of destruction which provides the National Institute for Health and Care Excellence (NICE) with an ethical dilemma. Beta interferons are capable of succeeding in attaining a 100% to a zero clinical response. The jury remains out as to which treatment regime is the best although longer term trials are leaning to the advantages of monoclonal

antibodies with an early aggressive approach to their use. A stringent review of progress and awareness of potential side effects are central to this approach. The last few years give some reason for hope with new ongoing trials, bearing in mind that therapeutic trials may last many years. The use of algorithms should ensure careful monitoring, not least with regard to treatment costs, and it is essential that modern science remains focused on the patient. The use of modern magnetic resonance imaging (MRI) also continues to advance and ideally evidence will accrue regarding interventions which are truly beneficial. The progressive neurodegenerative changes with each relapse may contribute to further visual and balance deficits. It is important that future research and interventions also focus on neuroprotection. This will include evidence that reducing the rate of cerebral atrophy is allied to the therapeutic intervention. The drug simvastatin has been in use for many years as a lipid lowering agent and it is encouraging that recent trials indicate benefit to MS patients and its effect on the rate of neurodegenerative plaque formation. The disease process on scanning has been described as a premature aging picture with the associated co-morbidity that inevitably follows these changes. Any drug intervention slowing the process is to be welcomed. Professor Chataway also expanded on other research studies. He struck an optimistic note allied to the multiple efforts to aid treatment improvement.

Long Covid



Professor Hugh Montgomery provided the last lecture of the day expanding on 'Long Covid'. He has been well placed to study the disease in his role as Professor of Intensive Care at University College, London and he has been at the forefront of acute management since the beginning of the pandemic. He has also been in high demand for his medical opinions by the media. It soon became apparent that as the virus became established it was a long way away from just causing relatively mild symptoms allied to the upper respiratory tract. This virus is capable of rapidly spilling out to attack many organs in the body and in the early weeks, reports were growing of

the systemic complexity of presentation and management. In addition to respiratory tract infection complications of microvascular disease have been increasingly reported. A number of patients were diagnosed with pulmonary emboli and more sudden deaths allied to myocardial infarcts were noted with evidence of myocarditis rare at post mortem. Cases increased with symptoms allied to brain pathology, often presenting following a fit. Arterial thrombosis was visible on scanning with some patients demonstrating multiple cerebral infarcts despite early anticoagulation. Gut symptoms and renal disease were also described and are now accepted as common, together with peripheral nerve damage, skeletal muscle invasion with profound wasting and sometimes strange skin changes which include hair loss. Increasingly Covid infection and the complexity of multi system invasion was seen as evidence of a targeting of mitochondrial function. The approach to management consequently changed to treating a multisystem disease. The term 'Long Covid' was initially used on social media. This begs the question as to when the term should be instigated. Continuing or worsening symptoms after three weeks have been suggested but there is no agreed time frame. The patient may suffer diverse symptoms while there is evidence of clusters of similar presentations. Cognitive disability is not uncommon and in some patients the brain may become profoundly debilitated with neurological signs on examination. The patient will continue to complain of fatigue and breathlessness while C- Reactive Protein levels are persistently raised. A feeling of exhaustion may continue with brain fog affecting exercise, concentration and sleep. The clinician is presented with a dilemma due to uncertainty as to the exact cause of ongoing symptoms. We should accept that the condition has many pathways and the clinician should view Long Covid not as one diagnosis but a general systemic disease disorder as patients with established Long Covid are experiencing multiple organ involvement. While many patients will improve over time cognitive testing has revealed a longer-term problem for some and there are ongoing studies regarding intellectual impairment. It becomes more complex as some patients suffer symptoms but may not seek medical advice. Other patients managed in ICU for a range of other problems may show evidence of cognitive



Professor Hugh Montgomery

decline which has nothing to do with Covid. Age is no barrier to developing the condition but it is more common in older and overweight patients. A number of patients demonstrate profound alteration to exercise levels. Athletic individuals are not spared, often developing fatigue and breathlessness following exertion. It is not possible at present to be specific as to the numbers of individuals who will proceed to Long Covid. It has been suggested that some ten percent of those suffering from an illness allied to the virus have symptoms at six weeks. Even if it is only two per cent the numbers affected are high. Typically, patient symptoms are diverse, and may include loss of taste, fatigue, breathlessness, impaired concentration and memory problems. While we do not understand the causal agents, we may have to accept that we are dealing with more than one disease. Longer term studies with cognitive testing reveal difficulties which raise the question of an autoimmune condition. Patients suffering at present with Long Covid may describe breathlessness and chest discomfort, the condition is also known to be associated with a fall in blood pressure on standing and breathlessness. It is increasingly suspected that the more one is sick with the infection initially, the more likely one is to develop Long Covid, probably because the worse the infection the greater the immune response. Early body scanning seems to reveal a multi system disease. Reports have also indicated a raised prevalence of postural hypotension, new onset diabetes, thyroiditis, menstrual cycle abnormalities and an effect on testosterone levels. Long term studies seem to reveal the extent of chronic pathology. Is the condition allied to an autoimmune illness? Shedding of faecal RNA remains many weeks after onset and immunological studies are revealing changes at the mitochondrial level. There are pessimistic reports that for some, long term brain function impairment will remain. Current research has led to studying a syndrome attacking multiple organs which despite its complexity is focussing on autoimmune and mitochondrial dysfunction. Professor Montgomery did however advise that early assessment is required, preferably by a generalist approach. Some two thousand years ago Tacitus is quoted as saying that remedies work more slowly than diseases. Let us hope for everyone's sake that this is no longer true.

David Murfin, Chair, session three



Petty Officer Edgar Evans - Scott's 'giant worker' and 'invaluable assistant'

On the 17th of February 2022, Dr Isobel Williams gave an excellent talk to the Retired Fellows Society. Her medical background is as a respiratory physician but she also has talented and very successful writing skills. She was well placed to give an account of the lecture subject, having previously published books on the same general topics. Isobel trained at St George's Hospital in London which had been associated with Dr Edward Wilson, Robert Falcon Scott's colleague and the physician who accompanied this fated Antarctic Expedition.

Edgar Evans (1876 – 1912) was born and raised on the Gower Peninsula in Wales. The family had a long association with the area, his father Charles (1839 – 1907) having been a seaman – a Cape Horn - brave sailors who travelled to the West Coast of America to obtain copper. Edgar Evans was the fourth son of Sarah and Charles and was raised in very modest financial circumstances, although strong community spirit prevailed which helped to counter many hardships, and he received a basic education leaving school when aged 13. The prevailing disparity in society income of the time was demonstrated later when the salaries of those entering dangerous polar expeditions were released; Evans was paid one ninth of Scott's reward. Swansea is a coastal town and it is probable that he was influenced by stories of local sailors. He decided that a naval career appeared attractive but ability to enter it somewhat hung on precarious assessments such as the state of one's teeth. He was accepted and joined the training ship *HMS Ganges* in 1891 as a Boy 2nd class. He would have been exposed to considerable hardship, but this questionable

toughening up process did not deter him. His training progressed to become a classified Leading Seaman in 1899. There were records of his reprimand for drunkenness which was a problem during his career, although hardly unusual in seamen of his time. He was promoted to Petty Officer 2nd Class on the 18th November 1900 and on Scott's recommendation on 2nd April 1904 to Petty Officer 1st Class. Scott viewed Evans with high regard which Edgar repaid until his death.

The year 1901 saw the commencement of an expedition by the ship *Discovery* to Antarctica and Edgar Evans was chosen amongst many applicants. One of the defined challenges was to investigate the position of the South Magnetic Pole with Robert Falcon Scott being appointed to lead the British National Antarctic Expedition. This was a significant challenge to investigate territory previously thought to be impenetrable. There was also a hint of nationalism, to claim as much land as possible for the United Kingdom. Edgar had previously served under Scott and joined the ship on the 27th July 1901; it left Cowes on the 6th August that year. On the 3rd of January 1902 *Discovery* crossed the Antarctic Circle and entered into pack ice. Skis were tried for the first time and the crew was greeted by penguins. *Discovery* steamed into open sea but was surrounded by increasing ice; a winter base named Hut Point was made, looking across to Mount Erebus. Expeditions into the surrounding area were precarious but Scott held Evans in respect as documented in his records. He became identified as an excellent sledge hauler, Scott describing him as being of 'Herculean strength'.

A group successfully reached the Ferrar Glacier and from there the party was able to view the polar plateau icecap. Following another precarious journey, a trio comprised of Scott, Lashly and Evans discovered one of the amazing dry valleys of Victoria land. This was achieved despite many hardships including Edgar's nose becoming badly frostbitten. *Discovery* returned to England in September 1904 having been away for thirty–seven months. After a period of leave Evans returned to the Royal Navy, but regularly visited Wales and visited his cousin, Lois Beynon, who he married on the 13th December 1904. The couple moved to Portsmouth and soon had a young family of three children; Edgar now trained as a gunnery and torpedo instructor.

In 1907 Ernest Henry Shackleton returned from the *Nimrod* expedition having reached to within 97 geographic miles of the South Pole. This motivated Scott even more to return to the Antarctic and in September of that year a new expedition was announced, the British Antarctic Expedition. Edgar was invited to join in 1910 and he agonised over accepting knowing of the dangers he would face particularly now leaving a young family. He did, however, join the *Terra Nova* expedition which lasted from 1910 – 13. On the 30th of December the ship escaped pack ice in the Southern seas and a new base camp was constructed. In January 1911 Edgar joined a Western Party carrying out scientific and surveying work in South Victoria Land. He was a popular companion with considerable practical skills and when they returned to Hut Point, they had collected samples, made maps and explored the lower parts of the dry valleys for the first time. They also learnt, on re-meeting Scott's party, that the Norwegian Roald Amundsen with his boat *Fram* was also in the area. His boat was carrying nine men but over 100 dogs. The use of dogs and sledges proved decisive allowing Amundsen to beat Scott to the South Pole; Scott's party also had dogs but mainly invested in the use of ponies. Scott continued to hold Edgar in high esteem and the party was more than impressed by his manufacture of ski shoes and crampons. Crucially though, Edgar cut his hand around this time which may have been significant and may have contributed to bacteraemia. Five men including Scott, Bowers, Evans, Dr Wilson and Oates travelled to the Pole arriving on the 16th of January 1912 only to find that Amundsen had beaten them to it. The return journey was hazardous and Edgar's general condition deteriorated. On the 16th of February he collapsed and found it impossible

to keep up with his colleagues. At one point he stayed behind to adjust his shoes but the party continued to move on. When the rest discovered that he was not following they returned to look for him. They found that he had collapsed again and his clothes were strewn around; this odd condition has been mentioned to reflect a state of hypothermia, when the perception is one of overheating. Oates stayed with him whilst Wilson, Scott and Bowers went back for the sledge. Sadly, he died on the 17th of February and the remainder of the party were to die a month later. Three bodies were discovered in a makeshift hut in November of the same year but the bodies of Oates and Evans were never found. Scurvy, malnutrition, dehydration and hypothermia may certainly have contributed to the demise of the group. It is possible that Edgar Evans developed septicaemia following the cut to his hand.

The news was cabled to Britain on the 11th of February 1913, as a message in a letter by Scott had been found in the tent where he died. It may not have been intentional but Scott suggested that Edgar's deterioration had contributed to the death of the party. This led to a class-driven criticism of the man who had held them up in their progress. Unpleasant associations were made to diminish his name with references to class and education, and it was many years later that attempts were made to restore the good name of Petty Officer Edgar Evans. In the meantime, his family not only suffered the sadness of the loss of a loved one but exposure to unfair and nasty criticism after his death. His reputation only recovered many decades later. In 1964 a new accommodation block at the Naval Gunnery School in Portsmouth was named the Edgar Evans Building.

Dr Isobel Williams had ended her book on Edgar Evans emphasising that Scott appreciated him greatly and he reciprocated. 'He died as he had lived – doing his best'.

David Murfin



HMS Discovery

Extramural reports

Sadly, during this session, because of the Covid 19 omicron variant, we have been unable to participate in any extramural events in the period prior to this publication. However, omicron hopefully has passed and we very much look forward to the visits to the Royal Opera House and the Foundling Museum, organised by Rosalind Stanwell-Smith, and of course to Sue Weir's ever popular walks.

Articles

Horatio Nelson's medical legacy: his grandson, Mr. Marmaduke Ward, MRCS, RN.

Ian Douglas Fraser

Despite the plethora of publications on Britain's naval hero there has been less attention paid to his genetic family. Admiral Nelson's scandalous relationship with Lady Emma Hamilton produced a daughter, Horatia, who, after his death at Trafalgar and in her teens, grew up within his wider family. In turn she married and had a large family, one of whom pursued medical training and joined the Royal Navy as a surgeon. His name was Marmaduke Philip Smyth Ward and this is his story.

Possibly it was the significant head injury Nelson sustained at the Battle of the Nile in August 1798 that marks the beginning of Marmaduke's story. On his return to Naples a traumatised Nelson (see figure 1) fell hopelessly for Lady Emma Hamilton, wife of the British Ambassador. In 1800, distanced from his wife, regarded with ridicule, his judgement questionable and with his mistress pregnant they returned to London. Their daughter, Horatia, was born secretly in January 1801. Horatia was Nelson's only surviving child and in his last four years she brought him intense joy. In a codicil to his final will he left the welfare of Emma and Horatia to the nation, a wish largely unfulfilled until the Nelson Memorial Fund was launched in 1850.

Emma, widowed from Sir William in 1803 and lacking Nelson's support after his death in 1805, lost control of her finances. To escape further imprisonment for her debts in 1814,

Emma and Horatia fled to Calais. Emma's health deteriorated and she died in poverty in 1815. Horatia, then 14 years old, returned to England to be taken in by the families of Horatio Nelson's sisters, now Catherine Matcham in Sussex and Susannah Bolton in Norfolk. Horatia had been well-grounded in languages and deportment by her mother so her continued academic and social education prepared her well for marriage. At the age of 21 Horatia Nelson married the Rev. Philip Ward, curate of Burnham Westgate Church on 19th February 1822. In their happy marriage, Philip and Horatia produced ten children. Marmaduke Philip Smyth Ward, their third child, was born on 27 May 1825 and christened on the same day by his father, now the new rector of the Church of All Saints in Bircham Newton, Norfolk.

Marmaduke's education

Marmaduke grew up in the large family where financial security was marginal, all the children being educated by their father. Yet, Marmaduke spent time with his uncle and aunt in Wells-next-the-Sea in Norfolk, especially after his parents moved to Tenterden Kent, for a better living. The marriages of Nelson's sisters, especially that of Susannah to Tom Bolton, established a secure family network. Ann Bolton Girdlestone (Marmaduke's aunt) living in Wells-next-the-sea married James Young, a surgeon who had served abroad in the Honourable East India Company Service. Their son, Henry John



HMS Royal Albert, flagship of Rear Admiral Edmund Lyons

Girdlestone Young was a few months older than his cousin, Marmaduke. Marmaduke became apprenticed to his uncle James and lodged with the family. In this medical environment Marmaduke's ambitions and career were fostered. Cousin Henry appears to have been gifted. He matriculated at University College London (1842), was examined by College and Hall, finally graduating MD at the University of Glasgow in 1846. Marmaduke, perhaps less academic, attended Glasgow University but although without records of him there, he secured enough approved credits to enable him to take the MRCS examination in London which he passed on 30 June 1848, aged 23.

Early naval career

Marmaduke's service record retrieved from the National Archives reveals that he was appointed assistant surgeon on 22 July 1848 when he arrived at the naval medical base in Chatham. He spent over 2 years on board three ships there and in January 1851 he was placed on *HMS Spy* for three years as 'assistant surgeon in charge'. *Spy* was a small brigantine tasked with anti-slave duties off the west coast of Africa. On his return in 1854 he spent nine months ashore at

the Naval Hospital in Plymouth.

Crimean War service (1854-56)

Marmaduke's service record locates him from 23 October 1854 to 7 August 1856 on the muster roll of *The Royal Albert* (flagship of Rear Admiral Edmund Lyons) on 14 February 1855. This suggests that he may have seen action during the siege of Sebastopol. Additionally, he was posted to the naval hospital in Therapia, north of Constantinople on the western shore of the Bosphorus. There Dr John Davidson was the Medical Superintendent, Mr Thomas Bellot FRCS, the senior surgeon and Mrs Eliza Mackenzie, the highly respected matron appointed by the Admiralty. Mrs Mackenzie is accepted as the fine example upon which the Naval Nursing Service, later The Queen Alexandra's Royal Naval Nursing Service (QARNNS) was founded. Marmaduke could not have had better training under such expert supervision, in a fine hospital, in that beautiful setting, during the Crimean war. In August 1856 Marmaduke returned home to become assistant surgeon at the Royal Marine Artillery Infirmary at Portsmouth. Whilst there he presented himself to the Royal College of Surgeons of England on 25 May 1857 and 'passed his examination for Naval Surgeon'. He was promoted to 'surgeon' on 26 August 1857, aged 32.



Figure 1 - Detail from Horatio Nelson by Leonardo Guzzardi, 1799, in the Philip Mould & Company gallery. Photograph by Ian Fraser

Service in the 'Opium Wars' in China.

He was posted next to *Nimrod*, via Calcutta, from February 1858 until August 1861 in the Far East, during the Second Anglo-Chinese (opium) war. *Nimrod* participated in the three battles of the Peiho (Taku) forts; the second battle in June 1859 was challenging and unsuccessful. Marmaduke's medical and surgical journals, with those of his assistant surgeon, William O'Roberts, include documentation of amputations of upper and lower limbs from gunshot wounds. For his participation he received the Second China War Medal. The General Medical Council was set up in 1858 and Marmaduke registered his MRCS at the first opportunity in August 1861.

The remainder of Marmaduke's naval career over a total of 33 years mirrored that of other successful naval surgeons serving abroad as well as on-station. At the age of 47 he was promoted to Staff Surgeon and then to Fleet Surgeon in 1875. After 33 years of service and aged 55, he retired 'with permission to assume the rank and title of Deputy Inspector-General on the Retired List'.

The final years

Marmaduke's widowed mother Horatia moved from Tenterden to Pinner in 1859, which was convenient for family visits. Marmaduke, still a bachelor and nearing retirement, moved in with her. Horatia's biographer, Winifred Gerin, had unprecedented access to the family's records and private papers. She wrote 'In Marmaduke, Horatia found indeed, a companion of exceptional warmth of heart, devotion, cheerfulness and generosity.... he was the most good-natured man that ever lived, unselfish to a fault'. Horatia died in 1881, aged 80 and Marmaduke was with her to the end. He was the sole remaining executor of his mother's will, also the sole beneficiary of her estate. He moved to live with his sister, Horatia Johnson, at 6, Gower Street, London. Characteristically, when he had sold his mother's belongings, he divided the proceeds amongst his remaining relatives, keeping little for himself.

Nothing is documented of his remaining years living in London. He would visit his elder brother, the Rev. Horatio Nelson Ward, the much-loved rector of St. Nicholas Church in Radstock, Somerset. During a stay there in November 1885 Marmaduke became unwell and died, aged 60. Horatio conducted his burial service. Two years later Horatio himself died

and their matching graves lie side by side at St. Nicholas Church, Radstock (see figure 2).

Conclusion

Competition was fierce amongst assistant surgeons in the Royal Navy and preferment based on nepotism was rife. So, did Marmaduke's family history and social connections favour him? Unlike his elder brother, he did not carry Horatio Nelson in his given names. Admittedly, his parents did have influential friends such as Vice-Admiral Sir Thomas Hardy, Sir William Beatty and Sir William Burnett. However, Hardy and Beatty were dead before Marmaduke passed the MRCS and joined the RN. When Marmaduke was promoted surgeon in 1857 Burnett was aged 78 and retired. Also, his mother, Horatia, was always discreet and guarded concerning her parentage, using the link only to lend support to the Nelson Memorial Fund in May 1850 when finances were in a critical condition.

Marmaduke, unmarried, did not have the family interest which might have established a legacy from which we could judge more of his character. There is no image of him in the public sector or in the papers of the Ward family. Despite gaps in his life history this account secures both a medical and naval connection in Admiral Nelson's family history. The record suggests he 'did his duty' as his grandfather might have expected.

Fuller accounts, including thirty-two references, can be found in my paper in *J R Nav Med Serv* 2019; 105 (2): 145-149. And in a webinar presentation on YouTube hosted by the Senior Fellows Society of the Royal College of Surgeons, 7 April 2020.

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Figure 2 - Graves of Marmaduke Ward (left) and Rev. Horatio Nelson Nelson-Ward at St. Nicholas Church, Radstock. Photograph by Ian Fraser

A mystery solved, a mystery created... O'Kelly in Edinburgh



Fr Richard Reid

At six foot by five foot, the painting dominated the room. Whenever there were guests in the house the inevitable question would be asked, 'What's the painting about?' The stock answer was simple, 'I'm afraid I don't know, however there are two schools of thought. One believes this is a valuable piece of art, while the other thinks it is a cheap sentimental religious work.' There was rarely any further discussion after that.

One evening in February 2002 a friend suggested that I should at least be able to tell people the birth and death dates of the artist. This seemed to be a reasonable suggestion as the artist's name, Aloysius O'Kelly, was unmistakable in the bottom right hand corner of the piece. So I promised my friend that this would be on my list of 'things to do' for the following day. Sitting at the computer I typed the name Aloysius O'Kelly into a search engine and to my pleasant surprise multiple entries appeared. Now to the business of finding out something about this man. The first site brought up a painting that looked like a watercolour, of a young woman. Being no art expert, I felt sure that there must be another painter by the name of O'Kelly, as the style didn't seem consistent with the painting in the front room. On closer inspection, thanks to the 'Zoom' command key,

I noticed the signature was identical to that of our painting. I followed the suggested links and these took me to art galleries around the world where O'Kelly's work is exhibited.

After having crossed the Atlantic several times, in a virtual manner, I opened a page of an Irish art journal and to my delight saw a black and white sketch of our mysterious painting. At no point did I think there was anything remarkable about this. Reading the article I was puzzled by the phraseology of one of the opening sentences that read '....Aloysius O'Kelly's *missing* Mass in a Connemara Cabin...'. My initial thought was that this was a strange title for a painting where people are quite obviously not missing mass, but attending with great devotion. Then I realised! In my haste to gather information quickly I had not noticed one important fact. The word 'missing' was italicised. The blood drained from my face as the situation became clear. Our painting, the one no-one knows anything about, has been **missing** for a hundred years, people in the Art World are looking for it, and have been looking for many years.

Not knowing what to do with this information, I left my desk and went around the house calling on Father Ed and Father Michael. Typical, when I needed them they were not in! What should I do? Do I dare tell people the whereabouts of the painting? What would the consequences

be? Whom should I tell? Could this be valuable? So many decisions and no-one to consult! I returned to the computer and decided that I would make contact with the lady who had written the article. At the time she was lecturing in an art college in Dublin. Thanks to another search engine I obtained the contact details and dialled the number. When I asked to speak with Dr Niamh O'Sullivan I was informed that she was on sabbatical and would not be back until after the summer (7 months away). The helpful secretary then informed me that Dr O'Sullivan could be reached at Trinity College, Dublin. All was not lost.

On the off chance that I might get this lady at Trinity, I rang the switch board and again asked for Dr O'Sullivan. The reply made my heart sink, 'sorry, she is in Washington.' I was being thwarted at every turn and was resigning myself to defeat when the secretary offered me Dr O'Sullivan's home number. I was taken aback by this, thinking it slightly unprofessional, but who was I to look a gift horse in the mouth? With this number, a direct line to the O'Kelly expert, I was determined to leave a message and let the matter lie until Dr O'Sullivan returned from the States and got in touch with me. To my surprise the phone was answered and I found

myself talking to Dr O'Sullivan's husband, an eventuality I had not considered. Undeterred I declared, 'I know the whereabouts of a painting that might interest your wife.' He asked, 'Do you know the name of the painting?' I replied, 'Mass in a Connemara Cabin.' SILENCE. After what seemed like a very long time he said, 'Is this some sort of a joke?' 'No, it's in my living room,' I teasingly reported. I then clarified my deliberately enigmatic statement by saying, 'let me explain, I'm a priest....'

Having been with his wife through the many years of her research and her PhD work, it was obvious that Dr O'Sullivan's husband was excited by my claim and himself knew a great deal about our mysterious O'Kelly artist. He explained how his wife had spent years and travelled widely to try and track down the missing painting and had given up hope of ever finding it. As the artist had emigrated to the States at some point in his career, it was supposed that the painting had been destroyed in transit and was lost forever. After a forty-minute conversation with Dr O'Sullivan's husband, during which I learned a huge amount about Aloysius O'Kelly, he promised that he would tell his wife immediately when she phoned from the States.



Mass in a Connemara Cabin by Aloysius O'Kelly, 1883

Now I knew the importance of the painting and the value (which at the time of the conversation was considerably less than we know now), I was left alone in the house; just me and the painting. The phone rang, I answered 'Hello this is Dr O'Sullivan calling from Washington.' And so the roller coaster took off once more. It was clear from her voice that Dr O'Sullivan was excited and a touch sceptical, and who could blame her? With the mobile phone in my hand I was able to stand in front of the painting and describe detail and colour and as I did so, I realised that Dr O'Sullivan did indeed believe me.

Knowing all that there is to know about the painting and the painter, there was one thing Dr O'Sullivan did not know and could not know, as she had never seen it with her own eyes. For years, all she had to go on was the small black and white sketch that featured in her article. So there was one question that was pivotal as it would satisfy her curiosity and prove the veracity of my claim. She asked 'In the centre of the painting, on the back wall of the cabin, there is a picture hanging on the wall. What is the picture of?' Only later did I realise that in the pencil sketch, the picture on the back wall is a blacked out square. The sketch was far too small for that amount of detail. Thinking nothing of giving up this information, that was staring me in the face, I said, 'It's a picture of the Sacred Heart.' 'Of course it is, of course, what else would it have been!' I could hear Dr O'Sullivan saying to herself. At that moment, whatever doubt there may have been in her mind was gone.

That was an eventful afternoon, a surreal few hours, the like of which I have never experienced before or since, and that is how the mystery was solved and the rest, as they say, is history. Today the painting hangs in the National Gallery of Ireland in Dublin, and is by all accounts, one of the most popular exhibits. Attached to wall beside it there is a small plaque that reads, 'On loan from the Trustees of the Archdiocese of St. Andrew's and Edinburgh and the people of St. Patrick's.' It is estimated that the painting is worth somewhere in the region of £500,000.

Our painting has gone home and is enjoyed by thousands after possibly a hundred years of hanging in obscurity in a Scottish presbytery! So the mystery was solved, however, we are now left with another puzzle - how did the painting arrive at St. Patrick's in the first place? Perhaps we'll never know!

V Rev'd Fr. Richard Reid CSsR., is a Redemptorist Catholic Priest, currently the Provincial Superior of his Order in England, Scotland and Zimbabwe. He lives with a community of Redemptorists in their monastery in Clapham, South London. At the time of the story above he was living in a Redemptorist community just off the Royal Mile in Edinburgh and the Church is called St Patrick's. The Redemptorists are a group of Priests and Brothers, 5,000 in total serving in over 80 countries worldwide. They were founded in 1732 on the Amalfi Coast, Southern Italy by Saint and Doctor Alphonsus Liguori. Google "Redemptorists" and you will find plenty of information, or simply [redemptorists.co.uk](http://www.redemptorists.co.uk) and you will find ourselves here at home.

http://www.ricorso.net/rx/az-data/authors/o/OKelly_A/life.htm

[https://www.wikidata.org/wiki/Q77996096#/media/File:Mass_in_a_Connemara_Cabin_by_Aloysius_O'Kelly_\(1883\).png](https://www.wikidata.org/wiki/Q77996096#/media/File:Mass_in_a_Connemara_Cabin_by_Aloysius_O'Kelly_(1883).png)

<http://news.bbc.co.uk/1/hi/scotland/2393667.stm>

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Book review

Uncommon Psychiatric Syndromes

(Fifth edition)



By David Enoch, Basant K Puri and Hadrian Ball. 2021, Routledge, Oxford

Nineteen sixties works of fiction like *A Clockwork Orange*, *I Know why the Caged Bird Sings* and *The Bell Jar* continue to captivate readers to this day. How many medical texts from the same era are still in print? Enoch et al's *Uncommon Psychiatric Syndromes* is one, first published in 1967, and now reissued in an updated fifth edition. Neither textbook nor memoir, I found it as compelling a page-turner as any novel, while commuting to my inpatient ward, after a year working from my kitchen table.

Uncommon Psychiatric Syndromes is unusual in several ways. Unlike standard psychiatric textbooks, the World Health Organization's International Classification of Diseases (ICD-11) and the American Psychiatric Association's Diagnostic and Statistical Manual (DSM-5), the chapters of *Uncommon* address eponymous and other syndromes in turn, which may manifest through a range of diagnoses. It might be argued that Capgras' syndrome (the delusion of doubles) or Othello's syndrome (the delusion of infidelity) do not require dedicated attention, being better characterised under schizophrenia spectrum and other psychotic disorders, for example. However, through up-to-date reviews of the literature and a series of clinical cases, Enoch and colleagues bring together historical, epidemiological, aetiological, psychopathological, treatment, forensic and prognostic aspects of each syndrome, not readily obtained from generic descriptions of schizophrenia, delusional disorder, or depression with psychotic symptoms.

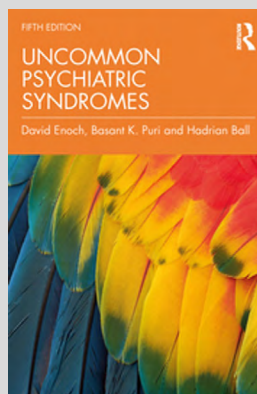
A particular strength is the psychodynamic formulation of uncommon psychiatric disorders, presented alongside reviews of the latest evidence from genetics, neuroimaging, and

functional anatomy, not available for the first edition in 1967. *Uncommon* is of equal interest to clinicians and retired professionals in psychiatry and other specialties, given the frequency with which disorders such as Munchausen's syndrome, Munchausen's by proxy, and Ekblom's syndrome (delusional infestation) present to services outside mental healthcare. In particular, the careful exploration of each syndrome enables aspects of the risk assessment to be explored, which might not readily be identified by clinicians unaccustomed to such unusual presentations. I, for one, found myself reflecting on a range of patients assessed on-call and out of hours, reframing their symptoms in a new light.

Uncommon Psychiatric Syndromes will also appeal to interested students and non-clinicians, and anyone interested in the history of medicine. The clinical cases are written in the parlance of their time, making reference to medications no longer widely used. The book paints a vivid picture of how psychiatry has evolved over the decades since the first edition, enabling reflection on what has been lost, as well as improved.

Uncommon Psychiatric Syndromes reasserts the importance of a comprehensive history and mental state examination, and the dangers of too quickly categorising complex psychopathology according to diagnostic manuals. Above all, *Uncommon* captures the enduring fascination of presentations which have captured the imaginations of psychoanalysts, neurologists, and novelists for centuries. Where else can one contextualise encounters in life and clinical practice through the insights of Gilles de la Tourette, Charles Bonnet (Cotard's syndrome), Freud (possession states), Tolstoy (Othello syndrome), Shakespeare (Ganser's syndrome), Ian McEwan (De Clérambault's syndrome), and James Bond films (Stockholm syndrome)?

Reviewed by Roxanne Keynejad



Uncommon Psychiatric Syndromes
(Fifth edition)

By David Enoch, Basant K Puri and Hadrian Ball. 2021, Routledge, Oxford.

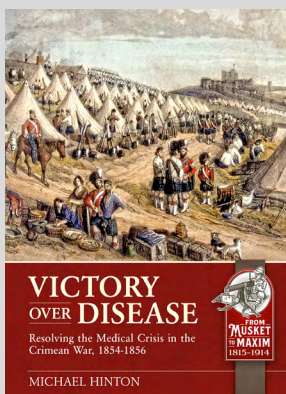
Book Abstracts

Victory over Disease

Michael Hinton

The catastrophic collapse in the health of the British Army during the winter of 1854/55 resulted in large measure from the after-effects of a severe storm on 14 November 1854. This caused havoc at sea, with loss of vital stores, and in the camps, with the destruction of the fragile infrastructure. The army gradually reorganised and this resulted in an improvement in health of the troops, and reduction in mortality from disease. This started early in the new year and was due chiefly to progressive enhancement in the standard of living – by provision of adequate food, clothing, fuel and shelter, including hospital facilities. The principal problems were thus at the front, and not in Turkey, and it was there that matters were rectified. Thus, the improvements in survival of patients at Scutari can be largely explained by an improved prognosis for the patients selected for evacuation. There is very little tangible evidence that Florence Nightingale and the Sanitary Commissioners (who were sent out by the government to investigate matters on the spot), significantly influenced improvement in the health of the main army in the Crimea. Rather, it represented the involvement of many people in many walks of life who worked, possibly unwittingly, for a common purpose, and with such gratifying results.

The lithograph on the cover is of the 93rd Highlanders encamped on the Western Heights, Dover shortly after their return from the Crimea. It is by William Burgess, a well-known local artist, and the neat and tidy look of the camp, and the fit appearance of the men, provides convincing proof of the ‘*Victory over Disease*’.



Victory Over Disease

by Michael Hinton

Bleak Health

The medical history of Charles Dickens and his family

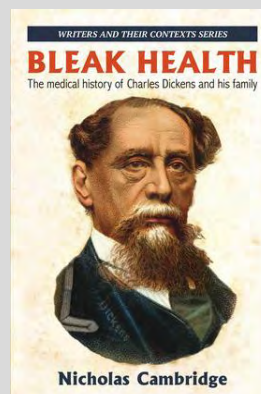
Nicholas Cambridge

Bleak Health - offers an in-depth study of Dickens' life and letters from a medical viewpoint, throwing new light on his world, his medical history, that of his family, and his obsessions. Having read over 14,000 letters by Charles Dickens the author here, has been able to identify many new illnesses suffered by Dickens, and his family.

The Victorians were preoccupied with their health and the connection between mind and body – and Dickens was no different. He tried to keep healthy by going for long walks, taking daily shower baths and keeping abreast of medical issues of the era. Despite these efforts he developed 20 illnesses during his lifetime. These included chronic carbon monoxide poisoning, gonorrhoea, *tic douloureux*, asthma, gout, a painful anal fistula and transient ischaemic attacks; he finally died from apoplexy. To treat his ailments Dickens tried all the standard therapies of the day such as bloodletting, blistering and purging. He was also reliant on medicines including laudanum, Cockles antibilious pills and calomel.

Apart from the family practitioner, he became friends with several leading doctors including the mesmerist John Elliotson and the public health reformer Thomas Southwood Smith. Through these relationships Dickens himself became an expert mesmerist and an enthusiastic campaigner for public health improvements.

Nicholas Cambridge won the first history of medicine prize offered by the History of Medicine section of the Royal Society of Medicine, whilst a medical student, in 1977. He later became President of that section from 2000-01.



Bleak Health The medical history of Charles Dickens and his family

by Nicholas Cambridge

Obituary

Obituary of Dr Keith Levick

1930 - 2021



Dr Keith Levick died at home in Hathersage on 4 January 2021 at the age of 90, finally with Covid-19 but after a long period of failing health. He had been cared for devotedly by his wife and daughters over that time and when I saw him on his 90th birthday he was in good spirits, although obviously frail. He was married to Beti, previously a general medical practitioner in the Hope Valley, and they had three daughters.

Dr Richard Keith Levick qualified in medicine at the University of Wales, College of Medicine, Cardiff, and moved to Sheffield to continue his training in radiology in 1961; in 1964 he was appointed as the first full-time radiologist at the Sheffield Children's Hospital with sessions also at the Jessop Hospital for Women, and the Dental Hospital. There he, along with an initially very small number of colleagues, provided an expert radiology service; he pioneered the use of ultrasound diagnosis in pregnancy and in the management of hydrocephalus, and developed renal isotope scanning. Sheffield became a major centre for training of radiologists in paediatric practice under his guidance, with his international reputation in the field. He was instrumental in the founding of the British Society of Paediatric Radiology and he was respected as a wise, supportive and helpful colleague and teacher. Following his retirement

from clinical medicine, he took on the new and arduous role of Chief Executive of the newly-formed Children's Hospital Trust and ensured the vital continuing independence of the Trust.

His outside interests were many. He was a long-standing member of the Territorial Army which he joined after National Service, and rose to the rank of colonel (holding the Territorial Decoration for long service), and in 1992 was appointed Deputy Lord Lieutenant for Derbyshire (DL). His long association with the St John's organisation led to his appointment by the Queen as Commander of the Order of St John (CStJ). He supported the local British Legion and Hope Valley Probus Club, and was chairman of the Buxton Arts Society. He played snooker regularly in Ashford in the Water with the 'boys', few of them much younger than himself.

His abiding passion was for cars; as a young man he had an old Rolls Royce and told me of going on camping holidays in France with it. He was proudest of his Railton, a long extinct marque which competed in quality with Rolls and which he drove regularly on long trips well into his 80s. He will be very much missed but long remembered by all those who knew him and especially by those who benefited from his immense expertise.

Erratum

Obituary of Dr Jean Ross Colston

The first paragraph of the obituary of Dr Jean Ross Colston (Retired Fellows Newsletter 72, December 2021, page 27), read '... she had trained at the Royal Free Hospital Medical School, then still an all-woman establishment. Jean qualified in 1957 ...'

It has been noted that this is not correct and should have conveyed that the Royal Free had accepted men from 1948 (Dr Pat Last, correspondence).

Dr Michael Shipley, author of the obituary, apologises and agrees that the statement should have read that at that time The Royal Free was 'still a predominantly female medical school'



The War of the Acronyms

Nick Coni

There's an existential danger which mankind has learned to face -
It's Coronavirus planning to destroy the human race;
But we've got three sturdy weapons to defeat this fearful foe,
We've got SAGE, and we've got NERV-TAG, and the third is called SPI-MO.

These noble teams of warriors, whose nerves stay strong and calm,
Are marching off to wage the war, and keep us safe from harm.
So cheers for valiant NERV-TAG, and for SPI-MO and for SAGE,
And may their voices sing out loud (we hope - from the same page).

They're a bit like Covid really, and refuse to stay the same;
Mutation leads to variants, all trying to raise the game.
CO-CIN sounds pretty potent, as do 'See-Mid' [CM-MID] and SPI-B,
So there's a chance, by Easter, we may once again be free.

JCVI holds promise, as does UKHSA,
Whose learned members' musings swell the government's out-tray.
I've made a new one all my own, its name is ABC,
Which is the shorthand for Another Bloody Committee.

But Covid takes no prisoners, else all its plans would fail,
If lumbered with a trillion B-cells languishing in jail.
The conflict thus we can foresee continuing to rage
'Til victory's won by NERV-TAG and by SPI-MO and by SAGE.

Glossary

SAGE: Scientific Advisory Group for Emergencies

NERV-TAG: New and Emerging Respiratory Virus Threats Advisory Group

SPI-MO: Scientific Pandemic Influenza Group on Modelling

CO-CIN: COVID19 Clinical Information Network

CM-MID: Centre for Mathematical Modelling of Infectious Diseases

SPI-B: Scientific Pandemic Insights Group on Behaviours

JCVI: Joint Committee on Vaccination and Immunization

UKHSA: United Kingdom Health Security Agency

EMRG: Epidemiology Modelling Review Group (of the UKHSA) – not mentioned in the verses because I only came across it yesterday.

Information for Authors

There are three issues per year of the Journal of the RSM Retired Fellows Society, 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 Oxford English Dictionary.

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

Authors also please be sure to complete your submission with your name on it.

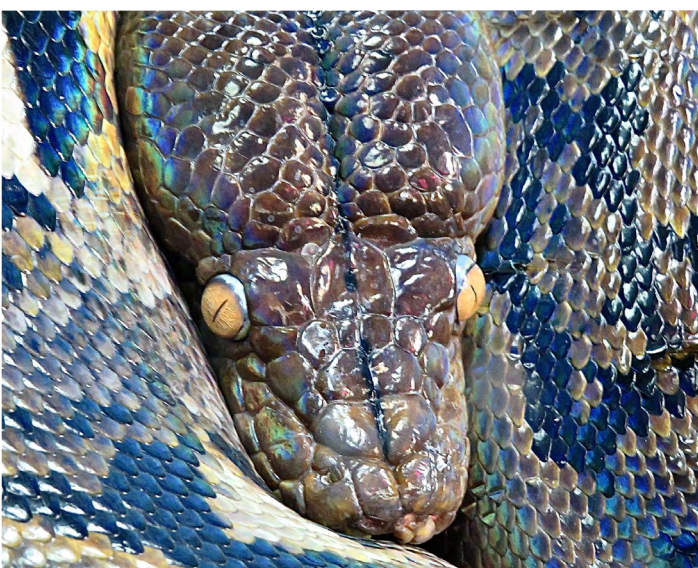
Accepted articles for the *Journal*:

- Solicited articles, 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 - under 200 words.

Imagery:

With reference to submission of images (which is encouraged), it is important that each image is accompanied with a title, description and photographer acknowledgement.

Photographs should be uploaded digitally and be as high resolution as possible.



Photos from London Zoo taken by Jeffrey Rosenberg and colleagues