

RFS Newsletter

Newsletter Issue No.58

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The ROYAL
SOCIETY of
MEDICINE

Editorial

Will your watch soon be able to detect that you are ill before you do?

In the last issue of this *Newsletter* I wrote on personalised medicine, taking it to what was an illogical conclusion. Now it is the turn of another technical development; smart health trackers. What, you may ask, are they? I quote from the *Times*, 13 January; "Smart health monitors such as Fitbits can detect when a person is ill before they start experiencing symptoms."

Sensors, fitted to a wearable device, can detect, it is alleged, infections, inflammations, and even insulin resistance. They can also measure sleep, activity and calorie intake, changes in heart rate and skin temperature. The technology could be developed to collect data on blood pressure and body temperature. All this in a smart watch.

So where would this end? "Good morning, doctor, I feel fine but my watch tells me I am going to be ill."

And the technology could, perhaps, be extended.

"Good morning, marriage counsellor, we are quite happy as we are but my watch tells me that I am soon going to be sexually frustrated so I will have an affair and that could wreck our relationship, what do you think we should do?"

Rather more seriously, there is the always present problem of the false positive. Think of all those drugs prescribed to prevent something that is not going to happen anyway.

There is a further underlying difficulty and that is our increasing reliance on technology. Yes, I use a computer and I am grateful for the internet but I do not bank online because I do not trust the security system. There is much talk, justifiably, on cyberwar and it is easy to see what havoc can be brought by hacking into major systems. The entire transport network could be brought down. What would happen if millions of people, not knowing that their smart watches had been interfered with, became convinced that they were due to develop diabetes at any minute?

Forthcoming meetings

Thursday 20 April 2017

Mr Francis Wells: The Renaissance heart - from Erasistratus to Vesalius and beyond

Naissant anatomy is associated with the work of Vesalius and his masterpiece *De Humani Corporis Fabrica* published in 1543. This huge event in the life of anatomy began the move away from Galenic principles and teaching, which held sway for 1500 years to that point, and indeed beyond.

Leonardo da Vinci's work on human anatomy was known about

in his time. Sadly, none of it was published until more recent times and therefore, its contribution was not recognised.

Mr Wells has had the great good fortune to be able to spend some considerable time with the drawings that he did of the heart, along with their accompanying notes. The more he studied them the more obvious it became to him that Leonardo had a very profound understanding of the physiology as well as much of the anatomy.

The lecture will draw upon this experience and also present the results of some work that he did

in reproducing all of Leonardo's dissections of the heart.

Thursday 18 May 2017

Professor Caroline Wilkinson: Facial reconstruction - depicting the dead

Professor Wilkinson is a graduate of the University of Manchester, where she also led the unit of Art in Medicine from 2000 – 2005 and received a NESTA fellowship to develop a 3D computerised facial reconstruction system for use in forensic and archaeological depiction.



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Professor Wilkinson is the Director of the Face Lab, a Liverpool John Moores University research group based in Liverpool Science Park. The Face Lab carries out forensic/archaeological research and consultancy work and this includes craniofacial analysis, facial depiction and forensic art. Craniofacial analysis involves the depiction and identification of unknown bodies for forensic investigation or historical figures for archaeological interpretation.

Her high profile depiction work includes facial depictions of Richard III, St Nicholas, J.S Bach, Ramesses II and Mary, Queen of Scots.

Thursday 15 June 2017

Mr Robert Hulse: Brunel's Great Eastern: the ship that changed the world

Mr Hulse is Co-Author of *The Brunels' Tunnel*, jointly published with the Institution of Civil Engineers. He is Director of London's Brunel Museum, housed in the original Thames Tunnel engine house and winner of The Queen's Award.

He has worked in education and museums for 20 years. He has taught at London University and City University; lectured at Tokyo University, the Royal Institution of Great Britain and Tel Aviv University. He has just returned from a lecture tour of east coast American universities with the English Speaking Union.

He strongly supports museums in their search for a new and dynamic role within their local

communities. He is the first man since Brunel to hold an underwater fairground and is now working on a project to build an underground theatre in the chamber where Brunel began and nearly ended his career.

Extramural events

Tuesday 9 May 2017

Walls, halls and a few stairs, a walk with Sue Weir

This is an opportunity to explore the hidden corners of the City. Passing churches, squares, Livery Halls (see how many you can count) and glimpsing the remains of the Roman Wall which encloses the City, we will also enjoy unexpected gardens and green spaces.

Wednesday 14 June 2017

In the steps of James Parkinson: A historical walk in Shoreditch

Lead by Retired Fellow Dr Christopher Derrett, this walk will focus on the life of Dr James Parkinson as we celebrate the bicentenary of the publication of his description of the 'palsy' as Parkinson's disease was then called.

During the walk Dr Derrett will talk about the medical and social history of Shoreditch but will concentrate on sites associated with James Parkinson including the places where he lived and died, where he worshipped and was buried, and where he worked.

Wednesday 28 June 2017

Innovation and expansion, a walk with Sue Weir

Today we will see the exciting recreation of the former abandoned plots of Somers Town, passing a small museum, large library and the largest biomedical research centre, a rare nature park, a new university and a sparkling concert hall.

Friday 7 July 2017

London Palladium: Backstage tour and afternoon tea

Famed for its concerts as well as spectacularly staged musicals, our two hour tour will explore its architecture and social history. As with all theatre tours, there will be a good few stairs and flat shoes are recommended.

The sumptuous tea afterwards will be served in the refurbished Val Parnell bar.

Monday 10 July 2017

Exclusive Cruise for the RFS on the Lower Danube from Budapest with AMA Waterways (AmaCerto) with Sue Weir. Departing July 10th for 7 nights.

Contact Sally at Go River Cruise: 0800 954 0064

Wednesday 20 September 2017

Elegant Mayfair, a walk with Sue Weir

Walking through the expensive and elegant Grosvenor estate there are still hidden corners and unexpected green spaces in the heart of London to explore and of course a well-known market.



Meeting reports

Camera club meetings

Friday 28 April 2017:
Members' meeting

Monday 22 May 2017:
Harold Ludman -
preparing images for printing

Monday 26 June 2017:
Michael Pilkington –
from click to wow

Thursday 21 September 2017:
Members' meeting

What you may see

A man heard on the news of a murder; a detailed description of the suspect was given.

A few moments later he heard a noise outside and went to look. He saw a shadowy figure which met the description of the man suspected of the killing. He reached for his phone and then saw that the figure outside had a phone as well.

It did not take long for him to realise that the figure was his reflection.

Acknowledgements to Bruno Lansdown

This reminds me of a true story. I was walking down a long corridor in a hotel and saw an old man approaching me. He looked vaguely familiar and I soon registered that I was looking at a mirror.

Editor

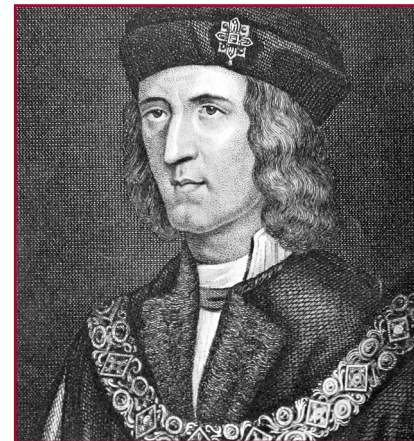
The scientific study of King Richard III

Thursday 20 October 2016



*The Catte, the Ratte and Lovell our dogge
Rulyth all Englande under a hogge.*

This piece of doggerel was affixed to the door of St Paul's Cathedral on 18 July 1484, halfway through the short reign of England's last Plantagenet king. The hogge was King Richard III, whose heraldic device was a white boar. His friends and ministers were Sir Richard Ratcliffe (killed on Bosworth Field), Sir William Catesby (executed three days after the battle) and Francis, Viscount Lovell, who escaped Bosworth but probably died fighting for Lambert Simnel two years later and whose device was a wolf-dog. The King was incensed by the rhyme and ordered a hunt for the author. It was soon traced to Sir William Colyngbourne, who was cruelly put to death for being "in derision of the King and his Council"; lèse-majesté would not be tolerated. Richard, formerly



Richard III

Duke of Gloucester and younger brother of Edward IV, was only 32 years at the time of his own death at Bosworth on 22 August 1485. His body was stripped and draped across a horse en route to Greyfriars Priory in Leicester, where it was displayed in public before burial in the chapel.

Mr Piers Mitchell is a Paediatric Orthopaedic Surgeon at Peterborough who also carries out research into ancient diseases in the Department of Archaeology and Anthropology at Cambridge University, where he teaches on human evolution and health. He is current President of the Paleopathology Association and edits international journals on mediaeval culture and osteoarchaeology. He was thus eminently qualified to tell the Retired Fellows about the scientific work leading to identification of *The King in the Car Park*, this being the title of a television programme featuring Philippa Gregory and the Richard III Society. Greyfriars was demolished in 1538 during the



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dissolution of the monasteries, and Leicester City Council subsequently built a car park over the ruins. The search for the King involved digging three parallel trenches, one of which unearthed a single body lying only six inches beneath the hardcore covering the choir of the ruined church. Clues to its royal identity were the prominent and solitary site of burial, numerous weapon injuries (unusual for the average monk) and radiocarbon dating to the correct 60-year window. To prove the point required studies of mitochondrial DNA, which is passed down the female line, and a genealogical search to find two descendants of the King's sister (he himself had no surviving children) who gave an identical genetic match. The Council has now set up a sign in the car park.



Colyngbourne would have approved.

The King seems to have been buried hastily because he was too long for the grave and his head was flexed upwards, and thus fortunate to have escaped damage. There was a marked

scoliosis, readily apparent in a photograph of the body lying in the grave, with its apex at the level of T8/9; the rest of the spine was straight. The spinous processes of the lower thoracic spine were crooked, and there was arthritis of the facet joints. Reconstruction of the spine showed a spiral twist atypical for a congenital scoliosis. There was no evidence of other skeletal or neuromuscular disorders, so this was probably an idiopathic adolescent scoliosis. It accounts for the eyewitness description by a chronicler in 1490 of a man who was below average height and had unequal shoulders. For all that, the deformity scarcely fitted the crookback monster depicted by Shakespeare in 1593 during the rule of the victorious Tudors.

King Richard certainly died fighting. His skeleton showed a fracture of the right maxilla from an armour-piercing thrust, a vertical cut on a rib, a blade mark on the right mandible, a superficial slice across the cranium and – the lethal injury – a large defect in the occiput. In addition, there was a blade wound to the pelvis which seems likely to have been caused by a vengeful post-mortem thrust per rectum when the King's naked body lay across the saddle of the horse. The scientific study extended to an analysis of the 'sacral soil', which contained roundworm eggs (perhaps from human waste used as fertiliser) but no trace of other common mediaeval parasites, which would suggest that his food had mostly been well cooked. Isotope studies of a tooth and

femur indicated an affluent diet rich in meat and fish. To study the King's ability to fight meant finding a volunteer of similar age with scoliosis, equipping him with custom-made armour and teaching him weaponry. The ersatz king managed very well on horseback but seemed to be at a disadvantage when dismounted. The real king lost his horse in the battle and was slain on foot.

King Richard III was reinterred in Leicester Cathedral on 26 March 2015, and on the following day a new royal tomb was unveiled. Among English monarchs he had a short reign with a violent and untimely end, yet a longer life and later death than that of his nephew, predecessor and alleged victim, Edward V. Mr Mitchell presented a riveting piece of royal detective work. Perhaps most remarkable was the quantity of convincing data that could be gleaned from a single skeleton placed in a shallow grave more than 500 years ago.

Robin Williamson

RSM life membership

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



Retired Fellows Society

Capsules, balloons and screws - new tools in the management of small intestinal disease.

Thursday 17 November 2016

Professor David Cave graduated in London then moved in 1976 to the University of Chicago to pursue his research interests in inflammatory bowel disease. He remains active as a Gastroenterologist at the University of Massachusetts Medical School and continues his research interests related to the small intestine.

Interest in the small intestine was at a very low ebb in 2000. 2001 was transformative, with the FDA approval of the first video capsule endoscope (VCE). Almost simultaneously the double balloon enteroscope was released in Japan. These two tools and their lookalikes have proved to be complementary devices for a variety of applications in the diagnosis and management of small bowel diseases.

Indications for the VCE are for the detection of the cause of small intestinal bleeding, diagnosis and management of Crohn's disease, detection of polyps and tumours, follow up of various polyposis syndromes and various malabsorptive disorders.

The need for preparation of the small intestine is controversial. Ninety nine of a hundred

people are able to swallow the capsule; if not, it can be placed endoscopically into the duodenum as is also the case with children as young as two years of age. Transit time of the capsule through the small intestine is about four hours. Reading of the video from the device takes 20-30 minutes. Contraindications are not absolute and include implantable cardiac devices, pregnancy and small bowel obstruction. Complications are limited. Retention of the device occurs about 1% of the time for more than two weeks due to unexpected strictures and tumours in a general population with indications for capsule endoscopy. Obstruction and perforation are extremely rare and no deaths have been reported in >3 million deployments.

Generically, deep enteroscopy comprises double and single balloon enteroscopy and spiral enteroscopy. These three devices can be inserted via the mouth or rectum to examine the proximal and distal small bowel, respectively. Uncommonly, total enteroscopy is possible. The direction is usually dictated by the results of an antecedent VCE, or CT or MR imaging. All three devices work on the principle of pleating the small bowel over the scope, thereby shortening it. Therapy in terms of cautery or clipping of bleeding sites, biopsy of tumors, polypectomy and dilation of strictures are all possible. Indications for deep enteroscopy are similar to VCE and are complementary to the findings on VCE. Complications again are rare.

The combination of these two technologies allows for the diagnosis and management of many small bowel disorders in a minimally invasive fashion that was inconceivable twenty years ago. The future holds the promise of computer assisted reading, novel scanning modalities with sensors and the use of different wavelength of light. Magnetic control of gastric capsules is possible. A motorized spiral enteroscope is in clinical trials. This device has the potential for complete enteroscopy from mouth to ileo-cecal valve in a single, quick procedure.

David Murfin

Recent Advances in Medicine and Surgery

Thursday 1 December 2016

The Recent Advances in Medicine and Surgery symposium held in December 2016 was the eleventh in an annual series of these meetings. Feedback from the approximately 130 delegates present was excellent. The Recent Advances symposium has become firmly established as a popular high quality academic event at the RSM.

SESSION ONE

Recent advances in stroke

Professor David Werring, from the National Hospital for Neurology and Neurosurgery, and the Institute of Neurology, spoke about recent advances in stroke, focusing on the treatment of acute stroke, prevention of



stroke in patients with atrial fibrillation. He opened with a brief reminder of the epidemiology of the major causes – thrombosis and haemorrhage – leading to neurological deficit. He followed this with a description of the pathology of thrombotic stroke, emphasising the importance of the ischaemic penumbra surrounding the infarcted region of brain, and the potential to restore function in the penumbra by prompt treatment to re-establish the arterial blood supply, thereby improving the outcome of the stroke, sometimes dramatically. Under the heading of “Time is Brain” he went on to describe the outcome of emergency thrombolytic treatment with alteplase and the genetically engineered tissue plasminogen activator tenecteplase, in a number of clinical trials published in the last few years. Evidence suggests that both are effective, and treatment with the tenecteplase particularly is associated with a lower incidence of the major adverse effect of these drugs, cerebral haemorrhage. Successful outcomes from treatment by mechanical thrombectomy have been reported for many years. Professor Werring described the results of five major published trials of thrombectomy, concluding that this treatment doubled the odds of an excellent recovery. Embolic stroke related to atrial fibrillation remains a substantial problem, but trials of the NOACs (novel oral anti-coagulants such as apixaban) have demonstrated a strong preventive effect, with a lower incidence of cerebral

haemorrhage due to the treatment compared to warfarin. Both thrombolysis and thrombectomy need to be undertaken within 3-4.5 hours of stroke onset, and in concluding his talk, Professor Werring discussed the practicalities of putting in place the resources needed to deliver acute stroke care across the UK, together with some of the challenges for future research.

Fatiguing illnesses: Mind or body?

Professor Peter White, from Barts and the London Medical School, discussed the aetiopathogenesis of fatiguing illnesses, focusing particularly on chronic fatigue syndrome (also known as myalgic encephalomyelitis, ME) and confronting the question of whether this is biological (neurological), psychosocial, or both; and whether the clinically recognised syndrome is heterogeneous in its causation and pathological mechanisms. In relation to diagnosis, Professor White drew attention to published evidence indicating that up to 49% of patients referred to a chronic fatigue syndrome (CFS) clinic may not have CFS, emphasising how common fatigue is as a symptom of many chronic diseases, each requiring accurate diagnosis and appropriate management. Epstein-Barr virus infection is a well-recognised cause of prolonged fatigue, and other infective causes of CFS are often proposed. Professor White discussed research on immune factors in CFS, including cytokines and TGF- β , remarking

that the evidence is inconsistent and can often not be reproduced in subsequent studies. The extensive research on the lower cortisol response in CFS raises the question of cause or effect in CFS. An alternative hypothesis is that the central nervous system may by some means become ‘sensitised’, producing a chronic state in which the intensity of pain and fatigue may be experienced out of proportion to any ongoing somatic stimulus. Such sensitisation could also be the basis of the other so-called functional somatic syndromes. There is some evidence to support such a mechanistic basis for these syndromes. Professor White proceeded to discuss psychological factors in the causation of CFS. Recognised predisposing factors include previous functional somatic disorders, previous mood disorders and childhood adversity. Psychosocial mechanisms include fear avoidance, negative perfectionism, attentional bias, and family and spousal beliefs and behaviours. ‘Catastrophising’ is more common in those with CFS; and comorbid depression, or anxiety, or irritable bowel syndrome, or fibromyalgia is present in about 30% of patients with CFS. Professor White challenged himself to answer the question about the cause of CFS: “Which is it – biological or psychosocial?” concluding that it is both, and went on to present a very convincing model of interacting biological and psychological factors leading to the establishment and



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perpetuation of chronic fatigue. Professor White introduced the Cartesian concept of dualism of mind and body using this as the backdrop for a discussion about the treatment of CFS. The PACE Trial compared adaptive pacing therapy, graded exercise therapy and specialist medical care in a large cohort of patients suffering from CFS. This led to the conclusion that behavioural treatments, based on graded activity, are both effective and safe. Professor White finished his talk by suggesting that it is wise to remember that mind and body are indivisible, and that what affects one will affect the other.

Recreational drugs: A growing problem?

Professor Allister Vale from the National Poisons Information Service and the Poisons Unit in Birmingham set his talk in the context of our knowledge of “traditional” recreational drugs including alcohol, opioid analgesics, amfetamines (including Ecstasy), cannabis, cocaine, LSD, ‘magic’ mushrooms and volatile substances. Recreational use of novel psychoactive substances (NPS) is indeed a growing problem. These substances are highly toxic and their use has now reached epidemic proportions in UK prisons. NPS include chemicals of various types, including synthetic cannabinoids, synthetic cathinones, piperazines, phenylethylamines and synthetic tryptamines. NPS, also sometimes referred to as “legal highs” or “research chemicals” often have similar central nervous system

effects as traditional drugs of abuse. However, the ‘street’ name for NPS is a poor guide to identity, and even if the ‘street’ name is the same, the actual chemicals are highly variable in quality and purity, even from the same supplier. The official chemical names of some NPS can be very challenging indeed (for example, 2[[1-(cyclohexylmethyl) indole-3-carbonyl]amino]-3,3-dimethylbutanoate). NPS were available legally, from sources such as the “Headquarters Head Shop” in Birmingham, until May 2016, since when it has been illegal to supply any psychoactive substance if it is likely to be used for its psychoactive effects. Not surprisingly, from a clinical point of view, identification of the NPS involved in a patient acutely poisoned can be extremely difficult. The synthetic cannabinoids tend to produce nausea and vomiting, tachycardia, transient coma, seizures, type II respiratory failure, and agitation on recovery. Other recognised features include ischaemic stroke, myocardial infarction, acute kidney injury and psychosis and paranoia. NPS are often smuggled into prisons by impregnation in letters: Professor Vale provided several examples of the inventiveness involved in such missives, and drew attention also to the use of drones as a means of transport. Synthetic cathinones (substances that mimic the plant extract Khat, which has amfetamine-like properties) include mephedrone (“meow meow”), and mexedrone. These inhibit reuptake of serotonin and dopamine, producing sympathomimetic

effects similar to amfetamine, with predictable clinical toxicity. Piperazines have similar effects. Phenylethylamines have a potent serotonergic effect, as do the synthetic tryptamines. From an acute clinical management point of view, the similarity of the toxic effects of all these substances simplifies matters: the treatment is supportive, usually without the need for prolonged ITU management, and artificial ventilation is best avoided if possible. Although recovery is usually uneventful, there is a significant risk of one of the serious complications mentioned above, and, as Professor Vale concluded, the advice to those considering taking a recreational drug should be: “you only have to play to lose”.

John Scadding

SESSION TWO

Emerging Infections and Zoonotic Threat

Professor Dilys Morgan has been responsible for developing the portfolio of the Emerging Infections and Zoonoses Agency. The Agency, a multidisciplinary group, meets on a regular basis and acts as forum to identify and discuss infections with potential for interspecies transfer of disease. She was involved in the response to the Ebola outbreak in Sierra Leone and also played a significant role in providing the public health support for Zika infection in the UK.



She described the factors driving the emergence or re-emergence of infections, the systems used for detecting and assessing potential emerging threats and the mitigation of the risk of emerging infections.

These new and previously recognised infections are a continuing public health threat sometimes causing major international incidents. The majority are zoonoses, increasing the importance of having in place robust systems to detect, assess, communicate and manage them at animal and human interface.

Ecological change, human demographics and behaviour and international travel and commerce have greatly increased the risk to the global population. Added difficulties have been poor sanitation in certain areas, microbial change and the breakdown in public health systems. The custom in some undeveloped areas of mixing animals and humans in markets, is also adding to the risks.

Professor Morgan described how the threat was spreading across continents from east to west but equally the danger should be kept in perspective. The outbreak of BSE a few years ago, when millions of cases were forecast based on over-estimated statistical evidence that never materialised, was an example of the dangers of this approach.

The UK was the first to issue guidance about sexual behaviour, and measures to reduce risk from mosquito infestation have been promulgated. Advice to pregnant women and those planning or at risk of pregnancy is encouraged.

Professor Morgan combined her personal involvement and experience of the subject, resulting in adding to our knowledge of a subject that most of us would have read about, but not necessarily recognised the intricacies of the subject.

Man or machine?

Professor Hugh Montgomery is a Consultant in General Internal Medicine, Cardiology and Intensive Care and is on the staff of University College Hospital, London and The Whittington Hospital. Among other specialties he has had an increasing focus on the clinical applications of Artificial Intelligence (AI) and its possible and potential value for medical care in the future about which his lecture focused.

Professor Montgomery started by outlining the increasing problems in providing medical care, both within the NHS and elsewhere. In the presence of more complicated disease, advanced technology and an increasing proportion of an ageing population but with less money to finance these perceived needs, scalar transformative change is required. An estimated 90% of Trusts in this country have declared a deficiency of resources:

in addition the problem is global and in the UK is not only confined to the NHS but also involves the private sector.

He illustrated the nature of the problem by referring to the classical fable of the peasant, rewarded by a grateful emperor, requested that he be given a chess board with only a single grain of rice on the first square, but the number of grains should be doubled on each subsequent square. After an interval, the number of grains of rice required to fulfil the task became impossibly prohibitive, at which point the emperor ordered his execution. Subsequent research has shown the number of doublings that could be coped with is about 32; after this the figures involved become impossible to manage. In theory, this point was reached in world medical needs around 1965, so the need for AI to help in the management and control to satisfy the needs of a worldwide population has become increasingly imperative.

Technological advances in diagnostic appliances has exposed the fact that there are certain things that humans are not good at, or incapable of achieving. For example, interpretation of scans, and pathology reports can only be as good as the person reading them, and it has been shown that AI can very often find abnormalities previously missed by man. Further, it has been shown that humans are



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grossly over-confident in the self-assessment of their ability to be competent in the task being undertaken. Research has shown that whereas a group of clinicians have judged their own competence to be 60% accurate, further investigation (usually at post-mortem examination) has shown a true figure nearer 5%. Given the information, computers have a near 100% success rate. A further problem with humans, that AI has the potential to solve, is their inability to hold images of complicated graphs in their head, which poses no threat to AI.

Finally Professor Montgomery outlined the problems that would be presented if AI played an increasing role in our everyday life. Do we trust other agencies with personal or private facts about ourselves? A number of people are unhappy with the knowledge about themselves other agencies hold in the commercial world. Are we happy with Amazon and other agencies knowing personal details about our behaviour? A small number of people object to medical agencies knowing any of their medical history. Those with a disease they do not want to be universally acknowledged, with its possible legal and social implications, also object.

Unfortunately there was no time to give an answer to all these questions, but we were left with much food for future thought.

James Carne

SESSION THREE

How NICE decides which drugs should be funded by the NHS

Dr Jane Adam chairs one of the four Committees within the National Institute for Health and Care Excellence (NICE). She began her talk by defining some of the criteria that NICE uses to determine the cost-effectiveness of a new drug: QALY = quality-adjusted life years; quality of life means how well you are on a scale from 0 (dead) to 1 (perfect health), allowing for the possibility of a minus value if the individual is deemed worse than dead; ICER = incremental cost effectiveness ratio. In evaluating the potential health gain offered by a new treatment NICE has two objectives: 1) to assess by how much the new treatment improves utility (health-related quality of life), especially whether it is effective and offers long-lasting gain and 2) to calculate the cost of one extra QALY in comparison with existing treatments. If the cost is £ 20k per QALY, then the treatment is regarded as cost-effective. If the cost is £ 20-30 k, then it may still be acceptable if there are tangible gains. If the cost exceeds £ 30 k then a detailed justification is required, save in the case of end-of-life measures that prolong survival by 3 months, in which case the cut-off figure rises to £ 50 k. In reaching conclusions it was necessary to adopt complex (and sometimes contentious) economic modelling so as to extrapolate

from trial data to long-term benefit. ICER was designed to take into account the total cost to the NHS, but not such considerations as whether the individual could return to work as a productive member of society. Dr Adam was at pains to point out that NICE does not look solely at cost-effectiveness but tries to be equitable to society as a whole.

NICE decisions have important consequences. If a new treatment is recommended, then the NHS is obliged to fund it within three months. Thus the Committees are understandably cautious if a drug is very expensive. It is necessary to weigh up its clinical effectiveness against other available treatments. The speaker described the possible outcome of a negative NICE verdict. First, the pharmaceutical company might decide to cut the price to try and get the product approved. Second, there is a right of appeal, which is heard in public and could potentially go all the way to the Supreme Court. Third, there is a special drug fund that might be used in a special case, although the fund is chronically over-spent.

Advances in spinal surgery

Mr James Allibone a Consultant Neurosurgeon presented certain general facts about spinal surgery: it is increasingly expensive, there is a lack of consensus on the treatment of some conditions and there is an ever-present threat of litigation if the patient is



disappointed with the outcome. Bearing in mind that an individual case of paraplegia can settle for as much as £10,000,000, this threat is a constant source of anxiety to the surgeon. There are now a number of providers in the market providing spinal surgery for the NHS, for example private consortia in Dorset and Cornwall. Thus there are lively concerns about the future of training in the specialty and the ability of the present arrangements to produce the next generation of spinal surgeons.

The speaker identified some current clinical challenges including an ageing population with common co-morbidities that affect surgical risk, the frequency of osteoporosis as a cause of chronic pain (for which it was now possible to inject cement – methyl methacrylate – to stabilise the vertebral body) and the growing problem of adult deformity requiring sophisticated radiological measurement and, potentially, the extensive fixation of spinal curvatures. He then outlined several areas of innovation in the field, as follows:

1) New surgical approaches to the spine embracing smaller incisions and minimally invasive techniques, although a fully endoscopic access had not yet been adopted in Britain and its benefits were uncertain. He described an alternative lateral approach to the lumbar spine through the psoas muscle and

avoiding the lumbar plexus, with new equipment designed to protect the nerve roots. Through this sort of approach the surgeon could gain access to the spine, for example to replace a diseased intervertebral disc with an implant of titanium or plastic or to fuse a scoliosis.

2) Current concepts of minimising the amount of muscle damage during access to the spine and maximising the preservation of movement, for example by using artificial discs in the cervical and lumbar spine that can move with flexion and extension. This technology had been applied to horses with equine wobbler syndrome, a compressive myelopathy of the cervical spine for which vertebral stabilisation was an appropriate treatment. In humans undergoing spinal fusion it was possible to use lengthening rods that incorporated a magnetic device with the goal of preventing degeneration of the adjacent segments of spine.

3) Better navigation techniques including image guidance during operation and the use of robotic devices to improve accuracy.

4) A greater emphasis on outcome measures. In this regard he mentioned the British Spine Registry which has been established in the last two years to collect information throughout the country on the results of operations on the spinal column. Hopefully the accumulating data

will provide answers for some of the outstanding controversies in the field.

Mr Allibone covered a wide field in his update on the surgery of the spine. The attention paid by the audience, especially the older members, suggested a personal interest in a number of the novel treatments he described.

Robin Williamson

1945: The myth of rebirth from the ashes of World War II

Thursday 16 February 2017



“History is bunk” said Henry Ford. “History matters” said our speaker, Keith Lowe.

In that contest our speaker won, having given a fascinating, sophisticated discussion of five myths related to the Second World War and how relevant an understanding of myths is today. Each myth helped those surviving to come to terms with what had just happened, somehow giving meaning to the events.

The first was Armageddon. We heard the stories of two young



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people, one was Jewish, she thought that she was the only Jew left alive. The other was Japanese who, after Hiroshima, had similar ideas. The world's population was not wiped out, but somehow we had to make sense of the

horrors of some 60,000,000 dead. There was another dimension: destruction can bring with it satisfaction.

The second was Martyrdom. The story here was of a Korean girl who was raped and made to work in a brothel by the Japanese, a victim who became a martyr. So many countries have set up what have been called lieux de mémoire, from the National War Museum in Amsterdam to the French Oradour sur Glane, a whole village, burnt as the German army was retreating, has been left just as it was when the terrible event occurred.

Third came Monsters, it helps if one can construe the enemy

as somehow not quite human. Ancient hatreds were revived leading to the demonisation of Germans with a degree of personal frenzy. And it was not only Germans who were so treated, Poles demonised Russians and even within communities one group saw another as evil. Examples of the Monster myth can be seen today, a Greek newspaper carried images of Angela Merkel as a Nazi, and Trump has been pictured apparently giving a Nazi salute.

Heroes was the fourth myth. Bill Clinton described how the American army had thundered across Europe, liberating towns and villages, saving the world and



The United Nations



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giving the foundation of a new order. We need heroes to rebuild from the ashes.

Finally came Resurrection, the forgetting of the past and the creation of the new. The British fought to defend traditional values, but once the war was over we abandoned all that and elected a Labour government to build a new Jerusalem. Colonies began to fall like dominoes, there was a massive move towards internationalism, with the setting up of the UN, the World Bank and many other institutions which, together, would enable all people to work together in harmony and hope.

How, though, can we see heroes and villains globally? The answer is the use of sleight of hand, it was not the Germans who behaved so badly, it was the Nazis. Indeed, the Germans were themselves victims of the Nazis. It helps also to fasten on one universal victim: the Jew. There was no doubt that they were singled out, two thirds of European Jews were murdered and there was the advantage, from the point of view of maintaining an international perspective, that they came from a wide range of countries so all can relate to them.

Although each of the myths was described in isolation, they are not isolated, rather they amplify and support each other: Monsters are made more monstrous by

the victim myth. But the most important is renewal: Resurrection gives meaning to the others.

Mr Lowe mentioned that he had been asked to give this talk a year ago, recent events have shown him how relevant much of what he had planned to say is today.

The war is over, the nuclear age has been overtaken by the information age and internationalism is threatened: the UN is widely ignored, as are human rights, other major institutions are failing as myths are deconstructed, some, especially Reconstruction, for ideological reasons.

He gave the example of a World War II museum planned for Poland. It was intended to use Poles as the centre but as a microcosm of wider war experiences. Planning was on an international level. But then came a change of government and the new Minister of Culture decided that what was in the pipeline was not Polish enough. The Museum was to be merged with another, which did not actually exist, and so the original idea is likely to fall by the wayside. Nationalists want only to blame their monsters and revere their heroes, reconciliation has no chance.

The British are not immune. We have our heroes, bombers who have only recently been commemorated, but while it is acknowledged that they were carrying out orders it should not be forgotten that we killed some

50,000 people in France and other European countries. Our own Brexit campaigns brought out their favourite myths, with no respect for history. We have fake news and fake history.

Summing up, the point was made that the myths are Jungian archetypes, the whole idea of rebirth was a myth but somehow we have to make sense of war. Who controls the past controls the future, history matters.

Richard Lansdown

Did you know

That Americans take more photographs in two minutes than were taken worldwide in the whole of the 19th century.

That three hundred hours of YouTube video are uploaded every minute.

That on one app alone (Snapchat) 700,000,000 photographs are posted every day.

That in 2014 1,000,000,000,000 photographs were taken.

That roughly half the world now has access to the internet.

Acknowledgements to Nicholas Mirzoeff in the Guardian, July 2015



Extramural visit reports

Flaming June in November

Visit to Leighton House Museum
25 November 2016

Frederick, Lord Leighton, (1830-1896) was one of the most famous British artists of the 19th century. With a useful fortune behind him, he was able to study with the best, travel very widely, become leader of the aesthetic movement, receive commissions from the eminent and end up as President of the Royal Academy.

Leighton built the house in Holland Park to live in, to be his studio, to receive guests, give parties and concerts and house his remarkable cultural collections.

A group of Retired Fellows had a wonderful afternoon on a delightful wander through the amazing rooms, corridors, halls, stairs and studios. Our amusing and insightful guide brought the artist's home and times to life, introducing us to Victorian aestheticism.

The aesthetes were appalled by the general ugliness of contemporary Britain and wanted to introduce a sense of beauty into and from the world through their art. Leighton had Japanese pots standing on a mosaic floor inspired by ancient Pompeii. Nearby, the Arab Hall housed his collection of ceramics, textiles, woodworks and calligraphy. Above you is a large (interior) overhanging wooden balcony with lattice windows from Cairo.

Leighton was well acquainted with members of the Royal Family and with most of the great artists, writers and politicians of the late Victorian era. Thus you will see blue tiles of the ceramic artist William de Morgan, re-created painted panels by the French artist Corot, a painting by John Everett Millais titled *Shelling Peas* and William Morris wall paper (in the bedroom).

Leighton never married, indeed there is only one bedroom in the house, so we are left to speculate, as did his contemporaries, about his relationships. What makes the visit to the house and its treasures even more remarkable is that after his death his two sisters had sold almost all the exceptional collections of fine art, decorative art and furniture which were dispersed round the world. The house itself had an uneasy passage through the 20th century, including bomb damage and unsympathetic restoration post-war. It is, therefore, a huge tribute to the trustees and curators that a long process of restoration and slow re-gathering of contents has made a visit today such a joy. Helped by photographs taken in Leighton's life time along with other physical evidence (paint and wall coverings underlying the post war emulsion) the interiors have re-populated with a combination of Leighton's own pictures and furniture as well as replicas. This work is ongoing; we were shown one returned original that had only been unwrapped on that very day.

Our group was exceptionally fortunate (as were others who have visited before April 2nd 2017) to enjoy a special and rare exhibition. Curator Daniel Robbins managed to re-assemble from the world's collections the paintings which Leighton was submitting to the RA's summer exhibition in the last year of his life. The paintings were photographed on easels in the artist's studio on the day Princess Alexandra came for a private viewing. The exhibition, entitled *Flaming June: The making of an Icon*, tells the story of how this world famous icon of Victorian painting (together with the works that were exhibited with it) was conceived, sketched, painted and first presented here in Leighton's extraordinary studio-house.

Flaming June is indeed extraordinary, not necessarily to everyone's taste. What is undeniable is the now legendary story of how Andrew Lloyd Webber was unable to afford £50 to buy the painting in the King's Road in the 1960s.

What a wonderful afternoon, and our thanks should go to our guide Imogen and to Rosalind Stanwell-Smith for organising our visit on a cold but gloriously sunny November day. I can't resist ending with a quote from curator Robbins: gazing at the sodden garden during one of the wettest Junes on record, he said "It will be good to get a bit of blazing sunlight back in here". We experienced that, enhanced, too, by Leighton's masterpiece.

Mike Vaile



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The treasures and highlights of the British Library

10 February 2017

Buzzing with the excited chatter of a crocodile of school children the light atrium of the entrance hall was a welcome relief from the bitter February drizzle and the Euston Road traffic on the morning we met for the British Library tour.

Once part of the British Museum, this non-departmental public facility, a legal deposit library, meaning it has to receive a copy of every publication produced in the UK and Ireland, houses over 150 million items. With 8,000 new publications arriving every day plus any donated privately published items, the red brick facility designed by architect Colin St John Wilson was full on the day of opening in 1998. Somewhat characteristically of that era, time delays meant construction ran hugely over budget and only one third of the original design, which in profile mirrors a battleship as a homage to the architect's naval past, was completed. Hence the bulk of the library's contents are held in a mechanically operated, temperature controlled, storage depot at Boston Spa in West Yorkshire. A twice daily delivery service bringing requested volumes down to London.

Whilst the collection grows on a daily basis with the addition of all publications be they novels, scientific journals, daily newspapers, "top shelf"

magazines or even the Argos catalogue, the basis of the historical collection was formed from bequests, namely from Robert Cotton, Robert Harley, and Hans Sloane, whose collection amounted to the only one ever purchased by the library in 1753, though the sum paid of £21,000 was a mere fraction of its value then, let alone now. Encased in glass for all to admire in the centre of the building is the impressive 65,000 volume collection of George III. The library struggled to acquire a bust of the said monarch till one was eventually tracked down, in the USA. Unveiled by Nigel Hawthorne it sits on the walkway, with the resplendent gold leaf and leather bound books forming a towering backdrop.

Anyone stating a genuine need to access the library's collection on proof of identity and address can apply for a Reader Pass. This gives access to the reading rooms where requested publications, having been manually located using the unique bar code system, are sent via the mechanical book handling conveyor belt. In addition to the reading rooms seating areas and tables throughout the library abound with people utilising the free Wi-Fi and warmth.

The library houses a dream collection for any philatelist, only a small proportion of which is on display in discreet vertical drawers. An upstairs gallery with oversized tables is for viewing the world's largest collection of maps and cartographic materials, though this, with many of the library's priceless articles, is only available

to be viewed by those with specific scholastic interest and reason. The highlight of the tour and one to recommend for all to visit freely was the Ritblat Treasures Gallery exhibiting the world's most beautiful and important books. Included here are: one of Da Vinci's notebooks; a Gutenberg Bible ironically whilst printed then laboriously hand illuminated; an exquisite jewel encrusted copy of the Lindisfarne Gospels and the amazingly well preserved Codex *Sinaiticus*, a Greek bible written on papyrus in the 3rd century; signed and sealed copies of the Magna Carta and Anne Boleyn's Tyndale Bible. Time was taken at the end of our tour to marvel at these treasures.

Many thanks to the splendid insightful guides Andy and Mark who conducted our tours and to Dr Rosalind Stanwell-Smith for organising the event.

Catriona Head.

The sun never set

It is said that the reason the sun never set on the British Empire was because God did not trust the British in the dark.

Acknowledgements to Robert Hulse





Retired Fellows Society

The RFS Chairman's Prize

The Retired Fellows Society invites submissions of an essay, up to 2,500 words, with the theme and title of *So you want to be a doctor?*

Two prizes of £300 will be awarded, one for members of the Retired Fellows Society and the other for students who are members of the RSM. Final year students who qualify in September 2017 may submit an entry.

The successful authors will be given free registration for the Recent Advances meeting on 7 December 2017 when the prizes will be presented.

Conditions

The submission deadline is 30 September 2017.

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

Illustrations and tables may be included.

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

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

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

Submissions should ideally be sent electronically to rfs@rsm.ac.uk. Anyone who does not have access to the internet may send a hard copy to the RFS Administrator.

A typo too far

An American called Jim returned home from a business trip. First he greeted his wife, then had a look at his email inbox. There he found a mail from his friend and neighbour Bob, who wrote, "While you were away I had a few problems at home and used your wife. I am a bit embarrassed that I can't tell you to your face, but if you let me know the cost I'll pay you straight away."

Jim picked up his gun and went to confront Bob. As Bob opened the door to greet him, Jim shot Bob dead. Returning home, he looked in his inbox again and found a second mail from Bob saying, "I expect you spotted the auto-correct and realise it should read wi-fi, not wife".

Acknowledgements to the letters page of *History Today*, June 2016





Medical Music Society of London

Following a decision in 2012 by the RSM to cease running the RSM Music Society, a group of us decided to set up the Medical Music Society of London as a successor organisation, and the RSM very helpfully supported us in the early years with publicity to RSM members. Now a registered charity and in our fifth successful season, we hold four concerts a year at the Royal Over-Seas League, which has a purpose-built concert hall holding 200 people, and a superb Steinway concert grand piano. We continue the tradition of putting on excellent concerts, combined with an enjoyable social occasion, and with an opportunity for the audience to meet the artists after the concert. The celebrated pianist John Lill gave our inaugural concert on 23rd October 2012, and we have had many enjoyable concerts since, both from rising stars, and from established artists such as Nicola Benedetti, Tasmin Little, Piers Lane, Imogen Cooper and Adrian Brendel. The society is run by a committee of six, of which I am Chairman, and the other members are Dr John Scadding (Secretary), Dr Dave Green (Treasurer), Dr Roy Palmer, Dr Gordon Plant, Dr Michele Sadler and Mr William Edwards.

Our next concerts are a recital for two violins and piano on 6th April by Midori Komachi, Sophie Rosa and Simon Callaghan, and on 19th May we're delighted to welcome the internationally famous violin and piano duo of Alina Ibragimova



Pavel Kolesnikov

and Cedric Tiberghien. On 21st November, we have a solo piano recital by the remarkable young Russian pianist, Pavel Kolesnikov, who gave his BBC Proms debut last year.

Full details of all our activities and how to join the society can be found at www.mmsol.org.uk and please feel free to contact me at any time by email at londmms@gmail.com or by phone on 07925 885601.

Peter Richardson

Chairman, Medical Music Society of London

www.mmsol.org.uk

Definition of lackadaisical

A bicycle made for one

Thanks to the BBC via James Carne

New, co-opted committee members



Mr Michael Kelly FRCS, formerly Consultant Surgeon at the Leicester University Hospital



Dr Memo Spathis FRCP, formerly Consultant Endocrinologist, St Helier Hospital, Carshalton



Mr Harvey White FRCS, not only a distinguished surgeon but also the founder of the Retired Fellows Society



Articles

Why I became a Medical Ethicist

Sally Gordon Boyd

It looked interesting.

My parents gave me a first class education until the end of my school days, but then seemed to think that was enough. They said I would just go and get married. My father thought some other man should look after me. He insisted I should do a secretarial course and booked me into a London College. The course was awful; I managed to get myself into the graduate section which was shorter, and learned to take shorthand. I was much too impatient with typing and always made errors, which had to be rubbed out or removed with Typex.

Then I had quite an unusual job working with Francis Chichester, who was at that stage a publisher of maps. But it didn't last - he was much more interested in sailing round the world than his business, and I was interested in anything other than being a secretary. I could not obtain a grant for further training until I was 25.

You could say father was right because my next move was to fall madly in love, and marry the guy. The man, whom some of you will know, has fully lived up to my expectations. We both wanted a family and by the time I was 25 we had three children. We had spent

a very pleasant couple of years in Jamaica where Douglas's firm was designing the university, including the hospital and an MRC unit. I did some work with the Polio Centre there and assisted on some field trips with the MRC.

Before the children were very old I was again searching for some sort of career. I'd had a strong interest in medicine since I was seven, when I had told my parents I was going to be a nurse. They did not approve of that at all because they thought it was rough work. Some of my favourite holidays as a teenager were spent going on rounds with the GP father of a friend. My housemistress had done her best and had recognised that I should do medicine, as her own daughter was doing, but to no avail. So at this later stage I settled on Social Studies. I had to do two A levels, and then became an external student of London University and did the necessary course.

While the kids were growing up I worked part time in Child Psychiatry in the paediatric department at Farnborough Hospital. This tended to be more interesting than a Child Guidance Clinic as we had most of our patients referred through paediatricians. I did 21 hours a week and could adapt my hours to do more in term time so that during school holidays I could spend more time with the family. I was very happy doing this and stayed for 10 years.

Children grow up. By the time I was 35, Graham, our youngest,

was ten and at boarding school with the Benedictines, who had been very helpful because he was dyslexic and needed a lot of individual assistance. The two older children were settled at day schools not too far from home. I needed a full time job, and spent two years at Queen Mary's Sidcup. This was the 1970s, the country was in recession, building was restricted and Douglas took early retirement. We moved, first to Sandwich and then to Canterbury where we have lived for 25 years. I had been promised a social work job with Kent but it did not materialise. Again I was left unemployed but was fortunate that I became a member of the Community Health Council and from there was offered a place on a new Health Authority in the reorganisation of 1982.

From this my interest in ethics grew. I became the Authority representative on the Family Practitioner Committee and also a manager of a large mental hospital outside Canterbury. Primary Care particularly interested me and on the FPC I spent a lot of time hearing complaints of patients. This brought me closer to ethical issues again. There were statutory committees known as Service Committees, to hear complaints in the various disciplines - dentistry, medicine, ophthalmology and pharmacy. In Kent we pioneered an informal complaints procedure in all four areas, and I was chairman of that committee. Most people, not all, will bring a complaint largely to ensure that the same thing does not happen to other people.



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That might not seem true to the professionals involved, who could be reading this, but I believe it is likely. Not all cases were suitable for the informal procedure, but it helped, and could save a lot of anxiety for the professional.

Subsequently I became a 'Lay Chair' hearing complaints at regional level. For me that was again interesting and I did not find writing the reports too much of a burden. Eventually, after some years, a hospital was so upset by my findings that it created a big fuss and my appointment was not renewed. As I see it this was wrong, but the closest to an apology was being taken out to lunch by someone from the Region! I was 'kicked upstairs' and offered a place on the Commission for Health Improvement, now known as the Care Quality Commission. It was potentially fascinating and intriguing, but I, together with others, was not impressed by the standard of work they were doing, nor their morality. They gave up having 'lay' members so that did not last long for me.

All this aroused an increasing interest in ethics and I was invited to be a member of the local Research Ethics Committee. I read around the subject a lot and went to an open session at the local university. Fortunately they offered a Masters' degree in Healthcare Ethics and I was accepted on that course. I completed it in about nine months and in the same year did the Intensive Medical Ethics course for one week at Imperial College,

run by Raanon Gillon. I found that endlessly engrossing, and was invited to take part for following years as what they called a facilitator. That was a huge boost to my career as a medical ethicist - although it was only for one week a year I did it for ten years in all, always enjoying that week, and one cannot deny that Imperial College looks good on the CV.

I had several years without any public appointment and settled into a reluctant retirement. Then I was delighted to be offered a place on the Research Ethics Committee at the Maudesley Hospital. After about five years there I am now very fortunate to have moved to the Research Ethics Committee at Great Ormond Street which I find extremely absorbing and which puts to use my belated degree

Baghdad Medical College, my alma mater

Abdulhamid Alabbasi

The college, originally named the Royal College of Medicine, was established in 1927. It was staffed almost totally by British doctors, mostly those who came with the Mesopotamia campaign.

Until 1957 it was a Hospital Medical School. After that, when a university was formed, it became a University Medical School.

The first dean was Dr (later Sir) Henry Sinderson from 1927-1934 and from 1942-1946 and to him is credited the successful

progress of the college, to become the best in the middle East and possibly in Asia and Africa. It had students from many countries. During my time on the staff there were students from all Arab Countries, Africa, Malaysia, Indonesia. Sir Henry taught Medicine and was Dr to the Iraqi Royal Family.

I was a student there from 1949 to 1955. On graduating I joined the army and rose to the position of Chief of Medicine with the rank of Lt Col. In 1964, at the university's request, I joined the staff of the Medical College and became Professor of Medicine. In 1971 I fled the regime to Jordan where I was once again Professor of Medicine, staying there until 1994 when I moved to the UK, taking up consultant locum posts in general medicine, cardiology, thoracic medicine, geriatrics, endocrinology and diabetes.

To be enrolled in that college one had to hold what corresponded to good GCSEs and pass an interview, held in English. That led to an unintended selection of graduates of private schools which put more stress on teaching English and that in turn to graduates belonging to certain communities. This was changed in 1950, the time I was enrolled. There was an interview held in English but priority was given to exam scores, so students from all walks of life and parts of the country had a chance to be enrolled.

Selection by sex was never a consideration, sometimes more



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Sir Henry Sinderson's house

females were enrolled, depending on exam scores achieved.

There were 120 students. Nearly 100 made it to graduation, some repeated a year and some were sacked having failed exams.

The course was six years, probably styled on the Scottish medical school system.

First year: Physics, biology, and inorganic chemistry. You were sacked, if you failed all three in the first sitting of the exam in June.

Second year: Organic chemistry, physiology and histology, anatomy and embryology. You passed to the third year without any exams.

Third year: Biochemistry, anatomy and physiology. By the end of this year the student must have also have acquired knowledge in chemistry rivalling that acquired by graduates from the nearby college of chemistry.

Fourth year: Pathology, medicine, microbiology, surgery and pharmacology.

Fifth year: Public health, forensic medicine, ENT, ophthalmology, anaesthesia and gynaecology and obstetrics.

Sixth year: Medicine, surgery and Ob/Gyn. The students performed all the jobs of a JHO and were expected reliably to perform lab tests: urine, chemical and microscopic, stool, sputum, Hb, ESR, blood film for morphology

and tropical infections

The most sought after lectures depended on the lecturer's ability to make the subject capable of being understood by the student which, to me it seemed later on, depended on whether the lecturer himself understood the subject, at least that is what I found out when I started lecturing. Specifically the OB/Gyn, was boring. That was the feeling when I was a student as it was when I was a professor, as the same man was still teaching OB/Gyn.

On graduation, the graduate should be able to manage common medical problems, make a tentative diagnosis of surgical cases and make the appropriate surgical referral, conduct a normal delivery and spot warning signs, give open ether GA, chloroform or pentothal induction, spinal anaesthesia for most abdominal operations and set simple fractures and dislocations. These were necessary, as graduates were appointed by the Ministry of Health for one year to small



The Dean Sinderson Pasha with First Medical Graduates 1932



towns after graduation without any internship. They had little choice in where they were sent. All had to return to the city to undertake the second phase of postgraduate training, some eventually elected to remain in country districts.

Postgraduates' general preferences were often dictated by the scholarship available. Usually many chose surgery (it was seen as not as cumbersome as medicine, surgeons can make rapid decision, often with spectacular outcome, They cut the body, exert full control of the operating theatre, give orders which others promptly carry out, features which people used to consider as masculine).

Gynaecology and obstetrics was the subject of choice for female graduates. Women preferred to see a female doctor and so did their husbands, but this was not so when Saddam allowed a male doctor to deliver his grandchild.

Graduates were given a higher salary than those from colleges in neighbouring countries or Europe (UK was not in the Euro zone), implying, correctly, that the Baghdad graduates possessed a higher qualification. This caused these graduates of other colleges to join the army medical services with disastrous results. They were poorly trained, sometime even less equipped than the medical dresser of the old days. They often missed serious conditions, did not make health inspections of the army barracks, something which commanders often welcomed.

This weakness was later repaired when the army decided to recruit graduates of the Baghdad Medical College

A bit of history

British formed most of the teaching staff from the start. Among those I still remember with great admiration, was Dr Mills who came with the Mesopotamia campaign, appointed to the department of health in 1922 then to the staff of the college until 1958. I understood that he did not want to leave Iraq, wanting even to be buried there, but he was taken by a relative to the UK. He died at St. Mary's Hospital, in London in 1964. He taught microbiology.

Dr Hargreaves OBE, FRCP, an astute clinician who was highly respected and loved, he taught medicine and was the first to use chloramphenicol in the treatment of rickettsial infections. He was physician to King Faisal, the second. After the murder of the young king it became painful for him to stay and returned to England.

Mr William Wardill, FRCS. I understand that he designed the operation for cleft lip and palate, another example that people often make their spectacular achievements outside the core of their speciality (a testimonial to the saying that one is limited by what he knows). He taught his assistant Dr Naji to master the operation. He was a urologist, taught clinical surgery and used to say that there were Iraqi operators "better than me".

Mr Perkins, FRCS, of UCH, taught orthopaedic surgery. He converted the orthopaedic ward from what looked like a chamber of horrors: people hanged from their legs, necks, arms etc, into an attractive discipline where many graduate went after that to specialise in it. his little book, Surgery for Toddlers, was a masterpiece.

Dr Critchley, the Professor of Public Health in my days revolutionized the teaching of his subject. He used to take students to locations where diseases and public health menaces lived and grew: brothels, overcrowded areas and factories. In one sector in the province of Kerkuk the incidence of TB was 100%. Tanneries were a source of skin anthrax, a condition that was (is?) endemic in Iraq.

He was instrumental in implementing the construction of a sewage system in Baghdad. He was successful in pressing to delegalise brothels (relics of the Ottoman days) in which he was helped by his wife who had pioneered a similar project in London. I remember his saying it was a difficult job for there were important people who, for their own interests, wanted the situation to stay as it was.

By the way he was the brother of the well known Queen's Square neurologist, MacDonald Critchley.

Thanks are due to Dr Fattal for overiewing points in history andfor supplying the photographs.i



In praise of Home Visiting

Tom Madden

Although during the 70s GPs were arguing that home visits were a burden on their time; that many sick persons could safely be brought to the surgery; and although the College supported their view, this former trainee would indicate a loss, in particular for the novice, of intimate contact with homes in which complicated conditions were being managed. In Bow, a considerable portion of the trainee's maturation was outside the office, the experience of home visits a particularly enjoyable part of early learning. Becoming familiar with the circumstances of care in the home was an asset for case management.

Manifestations of disease in a domestic setting were not as they appeared in the surgery; for example, when they affected a multi-generational family, an isolated elderly couple or a lone individual. Households presented a range of capabilities: in nursing skills, cooperative inter-family dynamics or the reverse.

There was the excitement of medical challenge away from the tutor and the resources of the surgery. Complicated cases were now encountered in a different atmosphere. There were the more easily observed behavioural aspects of individual responses and what emerged regarding a family's ability to cope. It was vital to know who would take charge,

who would ensure that grandma's medication was taken on time and could be relied on to spot a change and call for help.

It was a privilege to be the most welcome face at the door. Among those offering the inevitable 'nice cup of tea', there were some who would have failed every Time and Motion study of efficiency, shuffling back and forth between countertop, cupboard and table for each item, milk, sugar, cups, pot - not forgetting cake. These relentlessly mobile individuals were never overweight, these habits supporting recent studies of the blessings of fidgeting. Such experiences led the trainee beyond the surgery's preoccupation with the case to the implications of sickness in the community, its control and eradication.

Far too many were living in inappropriate conditions; the most important factors being social isolation, poor nutrition and a deprived physical environment. To live in their lives, to share them, however briefly, was to understand.

Two observational vantage points

1. People are fascinating; some more than others.

Arriving unannounced: dominant family invalid exposed:

In this case the invalid was upstairs, princess of the

household, carried down by volunteers to every family celebration, and this had been going on for 25 years.

An unanticipated physician visit caught her out of bed, moving nimbly about her room. Considering what little good could be served by revealing this, the discovery remained a doctor's secret.

2. On auscultation: a philosopher revealed:

The thin, dyspnoeic man who opened the door, climbed into bed to be examined. Like his gown, the sheets and blanket were thin from age and use but white as snow.

Leaning forward for inspection, percussion and auscultation of his back, on shelves to his right were to be seen concise editions of philosophers from ancient Greece on, issued by Victorian Collectives of Apprentices, supporting charities and Mechanics Institutes, enabling those who wished to abandon ignorance and catch up on what mattered, such, improbably, as philosophy.

Editor's note: this is an extract from one of the entries for the Trust me, I'm a doctor essay competition.



Religion, spirituality and end of life care

A meeting organised by the Geriatric and Gerontology Section on 24 October 2016

Editor's note: It is not customary to report on meetings other than those organised by the RFS but an exception was made for this one on the grounds that the topic would be of particular interest to our readers. Thanks are due to the Geriatric and Gerontology Section for their kind permission to include the report here.

This was a fascinating and valuable seminar, made essentially apposite by the recent addition of Canada to the number of western legislations that now permit, with restrictions, some form of assisted dying.

The morning panel was chaired by Dr Mashkur Khan, President of the Section, and Canon Alastair Macdonald-Radcliff, Director General of the World Dialogue Network, and consisted of four selected representatives of different beliefs regarding life and death. The secular voice was firmly but gently represented by Maryam Namazie, styling herself 'political activist, campaigner and blogger', and the Jewish one by Rabbi Danny Rich, a senior Rabbi of Liberal Judaism. The Muslim perspective was offered by Dr Usama Hasan, head of Islamic Studies at the Quilliam Foundation and, to all appearances, similarly liberal in his interpretation of Islam. The fourth voice was that of Tom Rhind-Tutt, Anglican

lay-reader, President of the Sunnybank Trust (an Epsom charity providing support to those with learning disabilities) and, at the age of 89, still a convinced but kindly evangelist for Christian beliefs. Each offered a twenty minute summary of his or her approach, followed by an opportunity for audience questions – something which did not seem to have been fully allowed-for in the programming and which led to some hasty re-timings as to lunch and tea-breaks.

It was perhaps unsurprising that the Roman Catholic interest was not represented, and the whole emphasis of the day tended towards shared concepts of humane and decent behaviour rather than specific faiths. Nevertheless, it could hardly escape anyone who heard Usama Hasan's contribution – or read the printed digest of it he thoughtfully provided – how very much Islam, broadly interpreted, parallels Christianity, that other great monotheism with its own Prophet. Concepts of charity, public welfare and concern for others are similar in both faiths, and both have apparently wrestled with some of the same fundamental dilemmas – if God is all-powerful then what of free will? Is hell eternal or temporary? When exactly does life before birth begin? And what exactly constitutes the moment of death? Usama Hasan also emphasised the extent to which sickness and the possible imminence of death are an occasion for the forgathering of families and neighbours in Muslim societies,

as they used to be in Christian ones, but today are less so. Active euthanasia is not tolerated, but the refusal of treatment is, as is the with-holding of medicine or life-support systems. No one, least of all Usama Hasan's friend Danny Rich, was surprised to hear there have been lively arguments in Islam about the acceptability or otherwise of transplanted animal organs (especially those from pigs) since in his experience exactly the same disputes arise in Judaism.

One common Muslim prayer runs "O God, keep me alive as long as life is better for me; cause me to die when death is better for me", and during question-time the Rabbi similarly remarked, with conviction, that 'we need more common sense about Do Not Resuscitate notices' – ie that too often energetic resuscitation is not in a patient's best interests. His own equivocal position he summed up as being 'a reluctant believer in God' on account of a personal experience (unspecified) and that he had 'tried to rationalise myself out of it, but in vain'. He added 'Sometimes I wish I had the faith that Tom Rhind-Tutt does' – a reference to the personal belief that was shingly evident in all that his co-panelist had to say.

Unbelievers in the audience may have felt that the comfort the dying may receive from Rhind-Tutt's visits possibly owes more to his modest and warm personality than to the specifically Christian faith that has supported him through his own life-crises, but



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one could hardly dissent from his criticism of today's 'sterile tide of secular views' that ignores 'the instinctive desire to seek for something beyond oneself'. He stressed the need for the dying, believers or not, to 'let go' of earthly preoccupations, just as, at a slightly earlier stage, they may have needed to abandon most of their worldly possessions to move into a care home. He remarked on the well-intentioned inadequacy of many of today's secular funerals, which constitute no sort of farewell to the body or recognition of death's immensity – a theme that was taken up then and in later question-times by Canon Macdonald-Radcliff. The Canon remarked how difficult it can be to be called on suddenly to produce Christian comfort for a distressed dying person and his relatives, when none of them has apparently ever given a thought to the matter till that moment. 'People say they "don't like organised religion". But there is no cost-free religion... You can't be religious on your own.' It was generally agreed that we live, unlike our ancestors, in a death-denying society, and that this is no help to people, believers or not, when their end really is near or when the death of another is unpredicted and sudden.

During the afternoon session the discussion on specific end-of-life issues became more close-focussed. The Very Rev. Professor Iain Torrance, the Pro-Chancellor of the University of Aberdeen, acknowledged that such eminent thinkers as Desmond Tutu and Archbishop Carey have come round in recent years to the idea

of assisted dying, but said that in his own non-conformist tradition 'cheerful survival is considered a moral service to one another'. He felt that today we hear too much about 'me' and 'my dying' and drew a comparison with the wider context of sexual behaviour - 'In the 1980s Christian moral theology became too lax. It under-estimated the importance of community living'. He emphasised that being human in itself carries some moral import, a 'societal freight', and that, contrary to what some people seem to think, dying is not a private act. He touched on the changes over the centuries in Christian belief regarding death: that at one time Christians believed they would 'sleep' until the day of judgement, whereas by the late medieval period judgement moved to the moment of death or very soon after: hence the necessity to die 'in a state of grace' and consequent anxiety to 'die in full command of one's senses' – which was indeed the title of his talk. He remarked, apropos this, that both the 'pro-choice people' and the 'palliative care people' appear to make common cause on this matter, both favouring a conscious acceptance of death rather than 'a long dwindling'.

Baroness Butler-Sloss described the latest and very recent Bill introduced into the House of Lords by Lord Hayward, in yet a further attempt to change Section 2 of the Suicide Act which prohibits assisting a suicide. The Hayward Bill had just, as she spoke, arrived at its second reading. She herself was not in

favour of it, but admitted to not being well-informed about it. She remarked that the Government remains notably passive over this whole issue, and made the standard references to fear of 'a slippery slope' and of old people being made to feel that they are burdens fit for removal. But when a questioner from the floor raised the equally well-worn anxiety as to whether, if doctors could assist in dying, 'trust in them would be compromised?' Lady Butler-Sloss said briskly that she thought this a red herring. Life, she indicated, is much more complicated than that, and that in general she felt, as did Prof. Huxtable, that attitudes on both sides of the debate were too confrontational.

Richard Huxtable, Professor of Medical Ethics and Law at Bristol, gave a brisk and useful run-down on several prominent legal cases related to assisted dying over the last two decades or so, from the prosecution of Dr Cox in 1993 to the Nicklinson case of 2014. He pointed out that the absolute nature of the Law against assisting dying has, by a series of Court decisions, already been compromised. It is, in practice, gentler than would appear and should not be discussed in black and white terms. He personally favoured, he said, the introduction of a separate, reduced offence unconfused by the traditional implications of the charge of murder or man-slaughter. He mentioned the Oregon experience (generally agreed to be successful) and remarked in passing that the time-honoured 'slippery slope' argument put



forward by those opposed to any form of assisted dying 'tends in itself to be somewhat slippery'.

Dr Andrew Hoy, a retired consultant in Palliative Medicine spoke usefully on the complexities, both practical and psychological, of end-of-life care. He pointed out that palliative care can be more tricky than is readily admitted by some of its chief exponents – that some unpleasant symptoms can be hard to control. He spoke of the fairly recent abandonment of the 'Liverpool pathway' (which involved the formal withdrawal of all nourishment and hydration for the dying), and said this had been replaced by 'a set of priorities – a gold standard framework' but did not detail what this is. He pointed out that 60% of our population currently die in hospital, regardless of choice or the suitability of such a setting for life's end, and as a result the dying tend to be 'vulnerable to health care professionals' assumptions'. Many such professionals appear to be scared by the death-care situation and therefore somewhat in denial; yet dying is just one, universal life-event. End-of-life-care should be more mainstream.

The afternoon was rounded off by a sunny but highly apposite contribution from Dr Ann Coxon, a consultant physician and neurologist. She endorsed earlier contributions on the modern denial of death, and more specifically Dr Hoy's remarks about hospital medicine, pointing out that most acute medical doctors on the wards are under thirty - "they are

often too busy to tell the truth. And patients or their families much be prepared to stand up against them." Among her 'tips for managing doctors when they look after you' she suggested firmly telling them what your own life's culture and philosophy has been, and strongly advised everyone not to wait to think about death till serious illness has set in. Preferences and directives should be made clear 'to avoid procedural balls-ups'.

Doctors, for their part, should tell the probable truth early, since the vain hope of some special cure robs people of their proper dying. She remarked that some 80% of doctors and nurses (who may be assumed to know what they are talking about) state a preference for dying at home or in a hospice with only minimal intervention, and that such a route does not necessarily curtail their last days since 'good palliative care in itself tends to improve survival'. In answer to a question, she agreed that there are practical issues to a bed-bound person dying at home with which the present fragmented care system is not geared to cope.

All in all, this was a most rewarding, if rather over-packed day, and your reporter left feeling that some of those present were going to continue the discussion well into the evening and beyond.

Gillian Tindall

Trust me, I'm a doctor

This is an abridged version of the winning essay for the Retired Fellows Society Chairman's Prize 2016. The author, Richard Rawlins is a retired Orthopaedic Surgeon, living in Dartmouth. As a member of the Magic Circle, an expert witness to the courts, and author of 'Real Secrets of Alternative Medicine' (Amazon), he is well used to dealing with deception. The full essay, with references, may be obtained on request from: richardrawlins2@gmail.com.

The contemporary injunction to "Trust me, I'm a doctor" has been used conceptually since physicians parted company with the priests and magicians of ancient days. However expressed, the concept of trust has been integral to medical practice in Western culture since Hippocrates of 400 BC.

Trust is a fundamental need of human existence, encompassing a firm belief that another person will be reliable, that confidence in their honesty and integrity is not misplaced and assurance that they will act altruistically for the benefit of another. There is, however, an important difference between trust based on blind faith and that based on informed mutual understanding.

Elements of suggestion and the engagement of response expectancies accounts for the placebo effects seen in all medical practice. This is how 'alternative



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medicine' and 'camistry' achieves beneficial effects. If there is plausible evidence of useful outcomes beyond placebo effects, whatever methods are employed become incorporated into 'medicine', sooner or later. But can camists, or doctors, be trusted to obtain fully informed consent?

Muhammad ibn Zakariya Razi (Rhazes) wrote a medical book for the public so they could have some guidance as to the diseases from which they might be suffering in 800 AD - a forerunner to Internet information. Nonetheless, physician and law professor, Dr. Jay Katz, found 'no major documents on medical ethics between the time of the Greek city states and the 18th century which revealed even a remote awareness of a need to discuss anything with patients that relates to their participation in decision making.'

Illness makes patients extremely vulnerable. Society has always expected doctors to place patients' interests above their own, but quackery and fraud were never far away. In order to reassure patients that their trust in medical attendants was not misplaced, the United Kingdom passed the Apothecaries Act in 1815 and the Medical Act in 1858. Even so, patients were still expected to trust their doctors.

The theme of trust in doctors has been often been considered in contemporary culture. Variants

of the theme have been used regularly by Dr. Leonard McCoy in Star Trek, - "Dammit Jim, I'm a doctor." Dr Who advised, "Trust me. I'm the Doctor."

The command has now found its way onto tee shirts, badges, mugs and other merchandise in the mass market. The BBC has used '*Trust me, I'm a doctor*' as a title for its medical consumer programme since 1996, though the satirical undercurrent of the first series is now reduced to homeopathic proportions. More recently, other professions have appropriated the term. "Trust me, I'm a lawyer" has been used for over twenty years, and modern alternatives include "Trust me, I'm a magician." Ironically, magicians claim to be honest - they tell you they are going to fool you, and then they do!

The peculiar qualities which mark a modern doctor in contemporary Western society, and which are deserving of patients' trust, have been set out in *Principles of Biomedical Ethics* (2013). Four fundamental principles are stated: Respect for Autonomy; Beneficence; Non-maleficence; Justice.

Respect for autonomy is the most important. The other dimensions can be achieved only if doctors can be trusted to obtain fully informed consent for treatments. 'Any notion of moral decision-making assumes that rational agents are involved in

making informed and voluntary decisions. In health care decisions, our respect for the autonomy of the patient would, in common parlance, imply that the patient has the capacity to act intentionally, with understanding, and without controlling influences that would mitigate against a free and voluntary act. This principle is the basis for the practice of "informed consent" in the physician/patient transaction regarding health care.'

The concept of informed consent has increased in importance since the Doctors' Trials at Nuremberg and the Tuskegee syphilis experiment in the latter half of the 20th century. Katz is credited with drawing attention to the failure properly to communicate with patients.

The doctrine of informed consent has evolved since 1957 when the California appellate court said physicians must not only obtain consent, but must 'reveal any facts necessary for intelligent choice by the patient.' Initially, the UK House of Lord's rejected that requisite. In *Sidaway* (1985) one Law Lord opined that the prudent patient 'was a fairly rare bird, not readily found in his natural habitat on the Clapham omnibus.'

Under Bolam, the standard of medical care was to be determined by medical evidence. The Lords extended this principle to include the quality of information to be provided to a



patient about a given treatment - but that standard itself was determined by medical opinion. Lord Templeman opined, “the provision of too much information may prejudice the attainment of the objective of restoring the patient’s health”

The position in the UK has more recently changed. In *Montgomery* (2015), the Supreme Court, reversing the judgments at first instance and on appeal, has now plainly said that *Sidaway* should no longer be followed.

It has become increasingly clear that the paradigm of the doctor-patient relationship has shifted. Patients are now widely regarded as persons holding rights, rather than as the passive recipients of the care of the medical profession. Reviewing *Montgomery*, Nigel Poole QC opines, ‘It remains true that the manner in which a doctor gives information can strongly influence what decision a patient makes. Many patients are content to be guided by their doctors. Other patients will have strong opinions about their treatment and will make decisions that their doctor thinks unwise. So be it - that is their right. Patient autonomy has to be respected and that is now, unequivocally, the view of the Supreme Court.’

Current professional practice reflects these legal and societal developments. Under the rubric *Good Medical Practice* (2013), the GMC requires that doctors should

‘Work in partnership with patients. Give patients the information they want or need in a way they can understand. Respect patients’ right to reach decisions with you about their treatment and care.’ This instruction applies also to patients taking part in clinical trials, some of whom will be receiving placebos unknowingly. Current regulatory frameworks have recently been questioned as it appears that in many trials, fully informed consent might not have been obtained (*pace Tuskegee*). This is particularly problematic when researching homeopathic and other ‘alternative’ remedies, as basic ethical requirements have often not been met. Even placebos may be associated with risks of harm - a concept rarely conveyed to patients. An article in the *BMJ* of 17th September 2016 emphasises, ‘Openness is vital, both to minimise avoidable participant harm and to maintain public trust.’

Patients should be able to trust their doctors to share all relevant information. Conversely, doctors should be trusted to keep patients’ medical information private and confidential - but there are current concerns that this ancient ethical principle is now being forcibly set aside by inquisitive governments. When asked the question ‘Which profession do you trust the most?’, there is no doubt about which the public consistently places at the top of the list, nor that which is at the bottom.

Issues of trust are critical when dealing with politicians. In the UK, lack of trust about statistics used in support of policies for seven day working in hospitals have resulted in loss of trust in political masters - fuelling the extremes of industrial action presently contemplated. Many doctors no longer feel that patients come first. The GMC originally established the medical profession as self-regulating, but current developments have placed the profession firmly in the hands of government. Although the GMC is supposed to be an independent regulator, the forthcoming appointment of Mr Charlie Massey as its chief executive is inevitably viewed with suspicion and lack of trust by many doctors. *Private Eye*’s ‘MD’ points out: ‘Mr Massey is currently the director-general of acute care and workforce at the Department of Health, working closely with Health Secretary Jeremy Hunt on the junior doctors’ contract and Mr Hunt’s vision of a “truly seven-day NHS.” In the absence of any extra staffing and funding, or indeed a clear definition, this would seem an ultimately futile ambition’. As demoralised ‘junior’ doctors attain senior positions, the corrosive effects of current medico-political mistrust is likely to affect UK healthcare for years.

Although now retired from clinical practice, I am not infrequently asked what to do about an ailment. I am inclined to reply, ‘Ask your doctor the simple question, “If you were me, what



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would you do?” That should elicit a reply based on clinical, ethical and practical healthcare considerations, including issues of commissioning. Options can then be weighed - including, ‘go private’. The doctor should be trusted to be honest and bear Katz in mind: “One of the essential qualities of the clinician is interest in humanity, for the secret of the care of the patient is in caring for the patient.” Doctors should be trusted to offer compassion for a patient’s present suffering, realistic hope for the future, and love at all times. And as St. Paul said, “The greatest of these is love.”

The most important thing that has ever happened in human history?

*Editor’s note: In the last issue David Murfin wrote on Stephen Pinker’s book *The Better Angels of Our Nature*, published in 2012*

Earlier, the late Ronald Millar had sent in a commentary on this book, published now to complement Dr Murfin’s article.

This book merits thesis-length consideration, so that a brief personal review seems not only inadequate but in itself open to misinterpretation. For its *subject* – a history of violence and humanity - maybe, in the author’s words, “the most important thing that has ever happened in human history”.

And so it may be, but also one of the most controversial, received with astonished admiration by an objective minority, but a gasp of disbelief by the rest. For its tenet – that we are living (2011) in one of the most peaceful times in human history – seems an intolerable slight to the currently bereaved, an egregious undervaluation of remembered sacrifice.

But “our times” contribute mere seconds to the decades, centuries, millennia referenced by this optimistic author, and to his conclusion that violence has steadily declined. For this, he has assembled a statistical mountain which mostly relates to *deaths* not in absolute numbers but *per capita of populations*. His sources come from any “...ology” that you can think of, in a text of 841pp, with 1000 plus references and 114 figures (mainly graphs).

For many of us in Western Europe, the two wars in the 20th century have seemed the most insanely violent as any. Yet, although the 75 million lost in World War 2 is a record *number*, it is proportionately much fewer than the million killed by the Crusaders in a world of only 400 million - just one of many religious massacres. And, because of the fifty or more years after WW2, free of conflict *between the major powers*, the overall total of 20th century violence is averaged down to 9th worst. No comfort for many.

Moreover, while most of two generations in Western Europe

can look back on a Golden Age of peace, this callously excludes acts of terrorism, the Korean War, the 375,000 and 183,500 deaths in France’s colonial war in Vietnam and Algeria respectively, the 1.6 million in the US/Vietnam war, the 435,000 in the Russia/Afghanistan war, Stalin’s continuing purges, Mao Zedong’s revolution, Cambodia’s killing fields, the African genocides, and doubtless more.

If mortality per total population (exponentially so much larger now than in past times) is a controversial statistic, the reductions in *all* categories of violence shown in many graphs are of such magnitude as to subdue criticism, even if the range is wide – for instance a factor of 10 to 50 for the fall in Western Europe’s homicide rate from about the year 1300 to today (data from coroners and town records go back centuries). Think of slavery, public hangings, drawings, quarterings. And where, now, are the highwaymen, and the navy’s press-gangs?

The selected period of declining violence is very long, but a mere fraction of the 75,000 years or so in which human life survived as “nasty, brutish and short” (Thomas Hobbes).

As for causes, it is only through thick mists of imagined time that we discern the marauding hunter become peasant-farmer, the coming and going of feudalism, the sepulchral subjugation of free



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thinking by religious dogma, until the slow emergence of reason that is the central achievement of the Enlightenment, wondrously sponsored by a critical mass of thinking brains. Man's inhumanity to man was scrutinised, not least the appalling cruelties inflicted by the state. "You can execute people, but you cannot execute ideas."

But of course "soft" philosophical influences (such as David Hume's "Treatise of Human Nature" and Adam Smith's "Theory of Moral Sentiments"), probably increasing public sensitivity to violence, were but enhancements to the essential creation of, and adherence to political and economic systems, institutions, and legal and moral codes – the substance of "Perpetual Peace" by the ubiquitous philosopher Emmanuel Kant

Reason (as both verb and noun), so central to philosophical theorising since the Greeks, is a recurrent leit-motif for Pinker, and its escalation is perhaps his strongest mantra, at the heart of the decline in violence. Also in powerful credit are The Leviathan (symbolising a state with a monopoly of protective powers); the exchange of benefits through trade; feminization (leading pacifist and humanitarian movements); and of course empathy (overused, misused?). (The conductor Barenboim (wise on the Israel/Palestine issue) said recently on radio that it was not emotional sympathy that was needed, but

compassion, which was *moral*). Pinker's style is not declamatory, he attempts at length to answer the doubting reader, and acknowledges that the decline in violence has been irregular and without future guarantees. He admits to a Eurocentric bias, and the problems with "indirect" deaths (as in the influenza epidemic of 1918, hugely influenced by the inanition of war) and with categories of violence omitted from gross mortality statistics, especially those more personal and non-fatal. And he points out when statistics mislead – for example, the USA's higher overall level of violence, compared to Britain, disguises a much lower incidence in many states

Multiple reviews of Pinker's accomplishment can be read on the internet – mostly favourable, some with fulsome praise. But there is also hostility, expressed in verbal vitriol from at least one (perhaps envious) academic source; and a telling bleakness: "I wish Mr. Pinker lived in an ever growing Indian urban ghetto or lived (as a Dalit) in a North Indian village and made claims about declining violence." And one oddity is picked-on: "There is no indication that anyone but Hitler and a few fanatical henchmen thought it was a good idea for the Jews to be exterminated."

Curiously, the writer was recently confronted with the "terrible twos", that endurance test for most parents. Small child in

play repeats the "orders" written on his pirate's outfit: "Walk the plank!" The game begins mildly, the victim's finger walks along his "thigh-plank", then drops to watery death. But soon the smiles vanish, "walk the plank!" becomes louder, more insistent and, after a dozen or so commands, so alarmingly energised as to require mild physical restraint and serious distraction. And this is a normal, balanced child.

Nothing very remarkable in that, parents would say, familiar with temper tantrums – and perhaps even aware, as referenced here, that the "terrible twos" are the most violent period in a human life? For the human brain shares a violence zone with other species, as vividly shown in electrically-stimulated "Rat Rage".

So, here we have a book of supreme relevance to the civilising of the human condition, and utterly irrelevant to the individual victim. Meanwhile the world watches - resignedly, despairingly - reminded by the hour how thin is the veneer of humanitarian reason covering man's propensity to violence. But wait, for while instinctive behaviour has not changed, it is the human factor - it is men and women alone who have brought about society's structural inhibitions to violence.

In a way, the detail is irrelevant. What we want is a change in human nature.



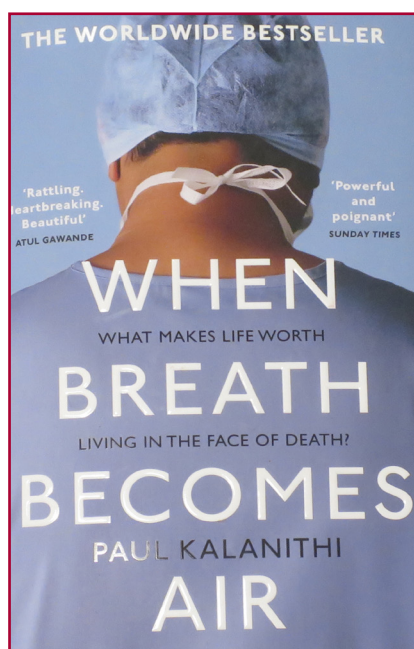
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A book which influenced me

When Breath Becomes Air
by Paul Kalanithi

First published by The Bodley Head in 2016

Available in paperback by Vantage in 2017.



Paul Kalanithi died in March 2015 aged 37 years. The book has been widely applauded as a publication of great sensitivity. The writer was at his death on the verge of completing a gruelling apprenticeship as a neurosurgeon. His initial symptoms were back pain and weight loss. He was diagnosed with advanced lung cancer and died 22 months later. Eight months prior to his death his wife gave birth to a daughter.

Most doctors who develop cancer have a fair suspicion of the diagnosis before formal

confirmation. This was the case with Kalanithi who describes his symptoms vividly. Another book titled *In Gratitude* by Jenny Diski, Bloomsbury Publishing 2016, has received very positive reviews. This book is also an account of living with advanced lung cancer. A recent publication also highly recommended is *Mortality* by Christopher Hitchens, Atlantic Books 2012. He sadly died at a relatively young age of oesophageal cancer. They all differ in style and in all the publications the authors demonstrate the level of disbelief and anger post diagnosis. The unique aspect to Kalanithi's book is the fact that as a doctor he has a profound interest in medicine allied to life's meaning.

The author received a broad range University education. His father was a cardiologist and his parents had emigrated from India. Initially he studied English Literature and human biology. He developed an interest in analysing human relationships and moved into studying neuroscience. He was a late entry into medicine and carried his broad skills very positively. He changed the course of his education partly for philosophical reasons. His literature thesis had studied the work of the poet Walt Whitman. He reflected on issues where sciences and the arts intersect. He spent some time at Cambridge University pursuing a degree relating to the History and Philosophy of Science and

Medicine. He then became a medical student at Yale.

His formal medical training is well described and he experienced unique situations which impressed him deeply. The mysteries of death and the sometimes heroic levels of intervention fascinated him. Kalanithi's broad knowledge base and sensitivity to human feelings shine through in his writing. The choice of neurosurgery as a subsequent pathway is explained by the fact that he felt the speciality presented a great challenge and rather dramatically a 'direct confrontation with meaning, identity and death'. The tragedy of this human story is that the author soon had to face the issues at a personal level.

He took up residency at Stanford to pursue a seven year course of neurosurgical training. He often reflected on aspects of the doctor patient relationship. This is a core issue in primary care training. It seemed unusual and impressive to read of a neurosurgical trainee studying the matter of treating a patient as a person rather than a diagnostic challenge. He still made deference to the importance of acquiring technical excellence. He steadily gained confidence and experience and a specialist career was within reach.

The later stages of the book are based on life following the diagnosis. There are periods of reflection on the reality of being



a patient with a terminal illness. His bravery shines through and is inspiring. The author was occasionally reminded of a dated patient definition of being 'the object of an action'. He was comforted by literature and challenged himself to return to work. He found the strength to pursue his chosen career once again. He was given assistance by a supportive team but after seven months he relapsed and his professional dream was over.

The final chapter of the book is written by Kalanithi's widow and touches on aspects of supportive terminal care. Sadness and admiration for a disease bravely borne permeate through the writing for the reader. It has the power to appeal to a medical or non-medical audience. It is a moving life story which can be highly recommended.

David Murfin

Really?

Terminator style robots are one of the biggest threats facing the future of humanity, a report has warned.

But, good news, the machines could be averted...(here's the really bad part) by asteroid strikes and super volcanic eruptions predicted to spark the end of the world within five years.

The report, put together by Oxford University, the Global Challenges Foundation and the Global Priorities Project, lists all the likely causes of Armageddon, and claims governments must do more to prepare for catastrophes.

The study, *Global Catastrophic Risks*, ranks dangers that could kill off at least ten percent of the human population.

"Deadly engineered viruses, natural disasters, pandemics and nuclear war are the major threats to mankind," said report author Sebastian Farquhar. "There are some things that could completely reshape our world and do so in a devastating way," he said.

"Many risks change and grow as technologies reshape our world. But there are things we can do about risks... International co-ordination is definitely required to tackle these issues," he added.

Acknowledgements to Metro, 29 April 2016

In the next issue

Due to pressure of space the third episode of Felix Bruckner's novel *Death on the house* has been held over. It will appear in the August issue along with the usual meeting reports, articles, photographs and perhaps a letter or two

The Philosopher

A philosopher told his student to question everything.

"Why?" replied the student.





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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 them 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 eye lid 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



Barrie Parker: A family moment

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.

