

SFF

Journal of the RSM Senior Fellows Forum

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Editorial

Catherine Sarraf



Dear Fellows, welcome to the new format of the journal, I hope you all approve. Finance has governed the reason for the change - providing the publication at its customary quality is costly, and we have been obliged to make changes with this in mind. The greatest expenses are printing and postage, thus we need to reduce our overall number of pages. The way to achieve this is to present the text in a lower font and with tighter line spacing. Particularly, in the April and December issues, the Programmes section and the Biographies and Abstracts section need to be reduced in size. The logic here is that these components appear complete for the first time in the August issue, thus April and December are only programme reminders. The journal is still a beauty to behold and looks well on even the finest of coffee tables – instantly ready for browsing and perusal. Our Senior Fellows Forum committee is very interested in your opinions concerning the journal, with its changes, so please let us know (either by emailing me, Catherine Sarraf, or our Chair Jeffrey Rosenberg), your opinions and potential suggestions for the future. All comments are welcome. As ever, we have delightful components concerning our programmes, lecturers, reports on recent events and a varied supply of both cultural and medical-related articles – these will continue. In addition, submissions from our readership are warmly encouraged, let's all share the happiness and fulfilment of our lives.

Catherine Sarraf

Editor

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Forthcoming Events

Spring 2024

Programmes

Internal Events

Jane Reeback

18 April Sophie Scott,

The science of laughter

16 May Simon Spiro,

From snails to sperm whales; pathology across 10 orders of magnitude

20 June Will Palin,

(11.00-11.15 AGM of the Senior Fellows Forum)

Waking a sleeping giant: rescue and repair of the north wing at St Bartholomew's hospital

External Events

Sue Weir

In all cases, should you have difficulties, be late or be unable to attend the event, please phone Sue Weir on **07713 402 651**

Visits

Potential days out, walks and visits are being investigated for 2024 and the future. These might include an autumn outing to Kenwood House on the beautiful Hampstead Heath; Marble Arch with Apsley House - a most unusual museum with exciting views and Wellington's home; tours of John Soane's home and the Hunterian Museum - all at Lincoln's Inn Fields; and a historical outing in conjunction with the Camera Club (to be confirmed).

Walks

Sue Weir

There will be NO afternoon walks. Walks will take place at ONE TIME only, MORNING, meeting at - 11.15 for an 11.30 start, lasting 1hr 30 to 1h 45mins.

11 April Meandering in Marylebone

Explore the small streets, mews, churches and hidden passages of this well known fashionable medical area, finishing at the RSM. Meet: Exit barriers of Marble Arch underground station. Time: **11.15am** for 11.30am start. Price: £20.00 pp.

14 May Secret gardens in the City

The square mile is not only office blocks and high rise buildings, there are many green oases and hidden gardens waiting to be found. Meet: Exit barriers of Monument underground station, return from St Paul's underground. Time: **11.15am** for 11.30am start. Price: £20.00 pp.

7 June Knights, radicals & a hospital

We will venture north of Smithfield to the site of radical movements, innovative ideas and historic records. Some large open spaces where knights were jousting & London's oldest hospital is still on its original site. Meet: Exit barriers of Farringdon station, return St Paul's underground station. Time: **11.15am** for 11.30am start. Price: £20.00 pp.

10 July Rotherhithe to London Bridge - a long walk!

An opportunity to see Wapping on the north bank of the river Thames from the south side - an invigorating walk past well known pubs, a doctor's statue, Fagin's den and old warehouses with a new life. Meet: Exit barriers of Rotherhithe underground station, return London Bridge station. Time: **11.15am** for 11.30am start. Price: £20.00pp.

Camera Club

Richard Lansdown

Friday 17 May Presentation Meeting. Mark Buckley-Sharp will be showing images from the Chiltern Hundreds Members' Exhibition, which is run annually by the Chilterns Association of Camera Clubs. In this event, the images are selected only by the originating photographer and we will be able to discuss how to select our own images for display to others.

Wednesday 5 June The landscapes and wildlife of Svalbard. Edward Hyde. The talk will show images taken from the expedition vessel *MS Quest*, from zodiacs launched from this vessel and some from on land, all from a single trip in May 2023 when the archipelago was covered in snow. The landscape of Svalbard is spectacular, especially at this time of year when there is 24 hour daylight. The wildlife consists of polar bears, walruses, arctic foxes, reindeer and a number of birds (eider and king eider ducks, guillemots, fulmars, kittiwakes, puffins, purple sandpipers and a few more besides). The talk will cover the logistics of the trip and the various other options for a visit to Svalbard.

No matter whether you use a camera or a phone, no matter whether you are digitally savvy or whether you neither know nor care about the difference between an f stop and a bus stop, if you have an interest in photography you will be welcome in the Camera Club. We are unusual in never holding competitions, our aim is to enjoy photography in the most relaxed way. Some members enjoy showing

their work but there is no obligation to do this; we do, however, all gain from constructive discussions of what others have produced. We meet ten times a year, on different days of the week, from 11.00 to about 12.30. Consideration is being given to setting up hybrid Zoom in-house meetings. Our meetings fall into three types: *A Members' Meeting* in which participants bring any topic of photographic interest. This can be a show of their holiday photos, a discussion on any relevant topic, seeking advice on a new camera or phone etc. *A Presentation Meeting* when one or two people present on a specific topic of their choice. A speaker who presents for an hour or so. Usually this is someone from outside the club. *The Atrium exhibition*, which changes every May and November, has been a feature of the club for several years. All members may submit entries and everyone is guaranteed that at least one image will be selected. We also offer one-to-one tuition for anyone who wishes to improve their skills either in using a camera or phone or in editing with Lightroom or Photoshop. Membership of the Camera Club is free for any member of the Senior Fellows Forum.

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ZSL. New baby gorilla, Jeffrey Rosenberg and friends



Dozing baby, Jeffrey Rosenberg and friends

Abstracts and biographies of speakers

The science of laughter



Professor Sophie Scott
Thursday 18 April 2024

Biography Professor Sophie Scott CBE is Director of Cognitive Neuroscience at University College London. She uses brain imaging to ask questions about how speech is processed as a sound, the neural basis of speech and

sound processing and the social roles of vocalizations. She has pioneered neuroscientific studies of laughter. She gave the Royal Society Christmas Lectures in 2017, was awarded a CBE in the Queen's Birthday Honours in 2020 and was awarded the Royal Society Faraday Prize in 2021.

Abstract Laughter is a positive emotional vocalisation which has its roots in mammal play vocalisations. Laughter is often assumed by humans to be an index of humour, but most of the time when humans laugh, it has little to do with humour. Laughter is primarily a social behaviour, and we are more than 30 times more likely to laugh when we are with other people than when we are on our own. In this talk I will address the evolutionary history of laughter, look at its use in human interactions, and explore its neurobiology.

From snails to sperm whales; pathology across 10 orders of magnitude



Dr Simon Spiro
Thursday 16 May 2024

Biography As well as his diagnostic caseload, Dr Spiro teaches undergraduate and postgraduate students at the Royal Veterinary College and engages in clinical research. Dr Spiro holds degrees in pathology and veterinary

medicine from the University of Cambridge, a DPhil in infectious diseases from the University of Oxford and a master's in veterinary pathology from the Royal Veterinary College. He is a Fellow of the Royal College of Pathologists and a diplomate of the American College of Veterinary Pathology. Prior to his work at ZSL he has worked as a molecular virologist at the Pirbright Institute, developing vaccines for oncogenic poultry viruses, and as a diagnostic pathologist for the Animal and Plant Health Agency (APHA).

Abstract Dr Spiro is the veterinary pathologist for the Zoological Society of London, where he is responsible for the diagnostic pathology of the society's 23,000 animals of 800 species. He is also the pathologist for the Cetacean Strandings Investigation Programme (CSIP) which investigates dead whales, dolphins, sharks, turtles, and seals in English and Welsh waters. In this lecture, he will guide you through the practicalities of performing post-mortems on animals ranging in size from the tiniest invertebrates up to the largest megafauna, introduce you to some of the fascinating diseases that can be found (some familiar to doctors, others unique to animals) and demonstrate how pathology can contribute to conservation. This lecture will include video footage of images, video and digital pathology from post-mortem examinations on animals as varied as snails, snakes, whales, rhinoceroses and lions.

Waking a sleeping giant: rescue and repair of the north wing at St Bartholomew's hospital



Will Palin
Thursday 20 June 2024

Biography Will Palin was appointed CEO of Barts Heritage in 2019, he is an architectural historian, writer, campaigner and heritage expert. He was a curator at Sir John Soane's Museum until 2007 then served as

director of SAVE Britain's Heritage. Most recently he worked as Conservation Director at the Old Royal Naval College at Greenwich where he led the multi-award winning Painted Hall conservation project. Will has lectured widely on 18th- and 19th-century art and architecture and is a former columnist of *Country Life* magazine. He is a trustee of the Georgian Group and Chairman of the Sheerness Dockyard Trust.

Abstract In 2023, the 900th anniversary of St Bartholomew's Hospital, Barts Heritage embarked on a landmark £9m project to repair, conserve and rejuvenate the Grade I listed North Wing at St Bartholomew's Hospital, including its celebrated interiors, the Hogarth Stair and Great Hall. As well as addressing the historic fabric of the building, the project includes a pioneering programme of events and activities linking heritage and health - in partnership with St Bartholomew's Hospital. In this talk he will discuss the challenges and complexities of the project as well as the exciting opportunities it offers for public access and engagement, both during and after the works.

Meetings reports

Recent advances in medicine and surgery 2023

One-day conference held by the Senior Fellows Forum of the Royal Society of Medicine, 30th November 2023

The meeting was opened by Dr Jeffrey Rosenberg, Chairman of the Society.

Session 1:

Chaired by Professor Robin Williamson

Falling life expectancy in the UK

Professor Danny Dorling, Professor of Geography, Oxford University Centre for the Environment

Professor Dorling presented extensive statistics that made uncomfortable listening. Life expectancy in Britain, which had been gently increasing around the turn of the millennium, came to an abrupt reversal around the year 2010. The speaker stressed the fact that the subsequent decline began well before the Covid-19 pandemic, and he firmly attributed it to austerity. As for Covid, he reminded us that advancing age was the big factor contributing to death, with 1 in 6 of all nonagenarians dying from the effects of the virus. Gender also played a part, mortality rates in men over the age of 50 being higher than those in women; this risk was partly balanced by the fact that men were less likely to catch Covid in the first place. By contrast the effect of the influenza epidemics of 2015 and 2019 on life expectancy has been minimal. Although many countries have seen a similar reversal of the previous trend towards living longer, the effect has been greater in Britain. Our country used to be affluent and to enjoy an effective national health service, but these benefits have largely dissipated. Apparently we pay less tax than most other countries in Europe, while our index of happiness fell sharply in late 2019 as a result of financial instability. One consequence of these trends has been a striking polarisation in ill health and premature death between the haves and the have-nots. Whereas economic inequality is falling across Europe, it is actually rising in Britain. Among European countries we have slipped to 23rd place

(out of 28) in terms of neonatal mortality, with a corresponding 20 per cent rise in maternal mortality last year that was due in part to suicide among expectant or new mothers. Another depressing statistic is the fall in average height of five-year-old boys, a problem that is independent of migration but firmly linked by the speaker, to inadequate nutrition. Reduction in child poverty has improved in former hotspots like Northern Ireland and Scotland but – surprisingly – it has risen in South-East England. In several of these parameters Britain compares badly with countries, notably France and Finland. It is scant comfort that the situation is even worse in Russia and the USA. The average American has a similar chance of long life as people living in the most deprived parts of Britain, with only the richest Americans doing as well as the average Briton. It was difficult to argue with Professor Dorling's conclusion that there is enormous scope for improvement, even if the potential solutions are not immediately apparent or affordable.

Malnutrition in hospital

Professor Marinos Elia, Professor of Clinical Nutrition and Metabolism, University of Southampton

Malnutrition in the hospital setting was the focus of the next talk. It is certainly a prevalent problem, with up to 40 per cent of admitted patients having some degree of malnutrition and 70 per cent weighing even less on discharge than they did on arrival. Malnutrition is both a cause and a consequence of disease. Thus the malnourished are more likely to require admission in the first place and also to spend longer in hospital before they can go home. Malnutrition impairs immunity, delays wound healing, increases the risk of pressure ulcers, reduces muscle strength and thus predisposes to hospital-acquired pneumonia. Underweight patients are also prone to hypothermia and cognitive impairment, as well as psychological problems such as depression and apathy. Malnutrition is a particular problem on certain hospital wards, for example those of oncology, care of the elderly, respiratory and gastrointestinal issues. It doubles the cost of hospital treatment.

The first step in managing the problem is improved detection, and here the *Malnutrition Universal Screening Tool (MUST)* is a useful instrument. The score is based on current body mass index, recent unplanned weight loss and the anticipated effect of the acute illness responsible for admission. The next step involves a full assessment by dietitians. Then comes some form of intervention including special diets, oral supplements, tube feeding (nasogastric, gastrostomy) and parenteral support under the supervision of a specialist team. Supplemental feeding may need to continue after the patient goes home. In this context the speaker discussed the role of home parenteral nutrition (HPN) among those with intestinal failure, which can arise from a variety of causes: short bowel syndrome secondary to surgical resection, gastrointestinal fistula, partial obstruction and malabsorption. At present there are 2500 patients in Britain on HPN programmes, and the figure is increasing by 20 per cent per annum. The level of dependency is very high, with only one quarter of patients being fully independent. Anything that could reduce reliance on HPN is likely to be cost-effective, and here the recent introduction of teduglutide offers some promise. This analogue of glucagon-like peptide-2 acts to reduce gastrointestinal motility while promoting epithelial cell proliferation and absorptive capacity. Current NICE guidelines recommend waiting one year after operation for intestinal adaptation to become complete in patients with a shortened small bowel. Early results indicate that teduglutide can reduce HPN requirements by one day a week and reduce the daily volume of nutrient infusion. Side effects include distension, a higher incidence of stoma problems and a theoretical risk of colorectal cancer. More data are required to determine the long-term role of HPN in both adults and children with intestinal failure.

The modern scope of liver surgery

Professor Long Jiao, Consultant surgeon at the Royal Marsden Hospital and formerly at the Hammersmith Hospital, London

Professor Jiao provided a detailed update of the topic. His lecture concentrated on the commonest indication for hepatectomy in Britain, namely metastatic colorectal carcinoma. First performed in Glasgow as recently as 1973, this particular operation has become a standard procedure for selected patients with secondary colorectal cancer confined to the liver. The crucial objectives at operation are: 1) to control vascular input to the liver (that is, from the hepatic artery and portal vein) as well as vascular output (that is, from the hepatic

vein); 2) to preserve blood flow to and bile flow from the liver segments that are due to be retained, and 3) to minimise postoperative complications. Whereas intraoperative haemorrhage and postoperative bile leak are largely preventable nowadays, liver failure can only be avoided by leaving a remnant of adequate size. When faced with unresectable liver metastases the surgeon should not bother to resect the primary cancer in the large bowel unless it is causing bleeding or obstruction. It is better to proceed directly to systemic chemotherapy and then consider delayed resection(s) if the cancer has been effectively downstaged. In the presence of resectable liver metastases, chemotherapy is administered perioperatively and the primary and secondary tumours can potentially be resected at the same sitting. The prime goal with unresectable disease is to prolong survival. To this end, one recent trial (CELIM) of chemotherapy, obtained a 60 per cent response rate and was followed by complete (R0) resection in 34 per cent of patients, with one in three surviving for five years. In resectable liver disease the goal is complete cure. Sometimes chemotherapy will clear all overt tumour, in which case the surgeon can choose either to wait and watch or to proceed to laparoscopy and resect the residual scars to look for viable malignant cells. Radiofrequency ablation (RFA) can be either an alternative or an adjunct to resection in patients with unresectable or multifocal cancer, although lesions >3 cm in diameter will recur. Resection is more likely than RFA to clear tumour cells from the circulation. Preoperative techniques to increase the size of the remnant after right hepatectomy include embolisation of the right portal vein with or without synchronous embolisation of the right hepatic vein. Professor Jiao now uses a robot routinely in liver surgery and would not wish to return to the days of either open operation or laparoscopy alone. He finished his talk by discussing the role of total hepatectomy with liver transplantation in otherwise inoperable patients. An early study from Oslo produced an unacceptably high incidence of recurrence in the grafted liver, but the adoption of more stringent selection criteria has suggested that there may be some role for the technique. A new trial is starting in Britain to carry out a limited number of transplants in patients who have shown a reasonable response to chemotherapy and who have had stable disease for at least two years.

Robin Williamson

Session 2:

Chaired by Dr John Skipper, Senior Fellows Forum, Hon. Secretary

Chronic kidney disease

Professor David Goldsmith, Professor and Emeritus Consultant Nephrologist, Guy's and St Thomas' Hospitals NHS Foundation Trust

Professor Goldsmith informed us that there have been many advances in the treatment of chronic kidney disease in the last five years, its diagnosis and management depend on assessing kidney function using a biomarker for filtration (GFR glomerular filtration rate). For many years this has been creatinine, but he alerted us to the fact that it is not its most reliable index. Among the reasons are that creatinine comes from muscle and there are exogenous sources of creatinine including red meat consumption. Moreover, the level requires adjustment or 'correction' for different populations, races and age. All these factors are problematic. Race reporting difficulties are often encountered, and the debate is ongoing. Diagnosis and therapy are generally determined by GFR, and GFR needs to be reliably estimated so that some drugs can be prescribed at the correct dose. Cystatin C is a more accurate and reliable biomarker of kidney function, but it is a more expensive test and labs are still set up for creatinine. In acute kidney injury (AKI), for example from sepsis, GFR determines therapy, this however is sadly still lacking. Fortunately, one cause of AKI, contrast-induced nephropathy, is now much less of a problem than in the past. Since 2019 drugs used in the treatment of diabetes have been increasingly used in the treatment of chronic kidney disease (CKD), whether diabetes-induced or not. Use of the SGLT2 inhibitor dapagliflozin can reduce hospital stay in chronic kidney disease. It has brought about dramatic improvements in GFR and can delay the onset of dialysis by five years. In the management of diabetic kidney disease, a cardio-renal-metabolic approach is needed in drug production and therapy. Therapy has changed greatly and there are now possible trials which may delay dialysis by up to 10 years. Semaglutide and other weight reducing drugs may benefit kidney function by reducing obesity. Many new drugs are in development and coming at an ever-increasing rate, giving reason for optimism for what used to be a bleak diagnosis. Professor Goldsmith discussed IgA nephropathy where antigen-antibody complexes are deposited in glomeruli, and which exhibits

rapid rate of progression to CKD. Gut processing of food antigens may be a cause as well as various infections. New steroids acting predominately in the gut are often used. Immunosuppressant therapy with mycophenolate may be used. Dapagliflozin is a very effective treatment. The search for the holy grail of complement inhibitors is ongoing. Professor Goldsmith briefly compared haemodialysis with haemodiafiltration (HDF), the latter is more expensive, and dialysis is well established and widespread. HDF may bestow a longevity benefit by reducing sepsis. Finally, we were reminded that there is a shortage of organs for transplantation. Xenotransplantation (porcine) is likely to be useful in the future and is being actively pursued.

Hearing and deafness - why it matters and what's possible in 2023

Mr Joseph Manjaly, Consultant otologist, Auditory implant surgeon, University College Hospitals NHS Foundation Trust

Mr Manjaly informed us that due to time constraints he would be unable to show videos but many informative ones on hearing, deafness, ear disease and surgery can be found on his YouTube channel: Joe Manjaly @earsurgeonjoe. He continued by demonstrating the effect of 30dB hearing loss, asking us to occlude one ear by pressing on the tragus. He then asked us if we had that level of loss would we want an aid or an operation? Hearing technology is now more acceptable, evidenced by earphones being near universal on the underground these days!

Working as part of the biggest ear group in the UK at UCL and the Royal National ENT Hospital, he and his colleagues have been able to subspecialise in different aspects of otology. He began by discussing neonatal screening of hearing to detect the one in a thousand children who is born deaf and who can benefit from cochlear implantation. He noted the importance of recognising the wishes of the deaf community, as some deaf parents who use sign language may prefer their deaf child to be brought up without hearing. He informed us that 78% of children with severe hearing loss now attend mainstream school, and reminded us of the relationship of hearing loss to poor educational progress. Cochlear implantation is an MDT decision. Adults may receive one implant on the NHS, while young children can have two on the NHS. It is now a day case operation and bilateral implants for children are performed at the same operation. Where the cochlea is unsuitable for implantation

a brainstem implant may be considered. It is important to remember that while access to sound is amazing, in cochlear implants it does not provide normal hearing as channels are limited in number. At least one Olympic swimmer has cochlear implants which are waterproof and worn in the pool.

Mr Manjaly stated that approximately 12 million people in the UK have some hearing loss and 70% of those over 70 years of age are affected. Unmanaged hearing loss is associated with cognitive decline. Mild loss is associated with double the rate of cognitive decline, while severe loss is associated with a fivefold increase in cognitive decline. Hearing loss is the biggest modifiable risk factor in dementia. Technology is not the only answer. We should use clearer speech and facilitate lip reading by facing the listener. Sensorineural hearing loss is related to ageing, genetics, noise trauma or it may be drug-induced. There is no medical treatment although drugs to reverse sensorineural hearing loss are being sought. Hearing aids are needed, but the degree of struggle with aids varies. Results are never the same as normal hearing and expectations need to be managed. When conventional hearing aids are not adequate it is important to consider implantable hearing aids, such as the Vibrant Soundbridge implantable aid, which requires specialist referral. Conductive hearing loss can be improved by surgery. In the case of otosclerosis a stapedectomy may be performed. While there is a 1/200 risk of hearing damage, subspecialisation reduces this surgical risk. The operation is often completed while the patient is awake which allows immediate testing of hearing on the operating table. There are many operations for perforations of the ear drum and a variety of prostheses is used in reconstructing the ossicular chain to improve hearing, but there is a variety of bone conduction aids which can be worn on a band or implanted. The bone anchored aid (BAHA) is a very quick and simple local anaesthetic procedure nowadays. Cochlear Osia is a magnetic device rather than having a percutaneous post to anchor the aid, and new devices are constantly being developed.

Mr Manjaly's talk elicited several questions. High street testing of hearing is needed to give quick access, but it is screening and may point to a need for referral to ENT. MRI scanning of asymmetric sensorineural hearing loss is often needed to exclude acoustic neuroma. Tinnitus often improves when appropriate hearing aids are used.

John Skipper

Session 3:

Chaired by Professor Gillian Leng, Dean and President-elect of the Royal Society of Medicine

Targeted therapy in cancer

Professor Andrew Wardley, Consultant in Medical oncology, London

Professor Wardley's excellent lecture focussed on human epidermal growth factor receptor, HER-2, a transmembrane large tyrosine kinase, in breast cancer. The founding theory for targeted therapy to treat cancer is to combine a tumour cell-specific antibody to a chemotherapeutic agent. The tumour cell-specific antibody can deliver the chemotherapeutic agent precisely to the cell type it recognises (the tumour cell), then affect the plasma membrane, enter the cell, and kill it. Antibodies Professor Wardley was most interested in were trastuzumab and pertuzumab, both of which target HER-2, although different epitopes. Pertuzumab prevents HER-2 dimerisation with other members of the HER-2 family and Professor Wardley demonstrated to us activity pathways of the monoclonal antibodies and how their effects are achieved.

Discovering functionality of monoclonal antibodies and chemotherapeutic agents, and eliciting their best potential use in the clinic, in these cases took over ten years. Histopathologically, positive reaction sites of HER-2 are demonstrated by immunohistochemistry on relevant tissue sections, and the gene copy number is estimated. Once the protein's potential has been recognised in animal experiments, sequential clinical trials must follow. Use of pertuzumab and trastuzumab in combination with Docetaxel first provided strongly enhanced antitumour activity in human xenograft models (Scheuer et al 2009) which led to enhanced progression-free treatment later. Trastuzumab deruxtan results indicated that in HER-2 treatment, it was superior when used against pre-treated metastatic breast cells (Modi et al 2019). Treatment addressing a new subclass of HER-2 found in 50% of all breast cancer patients, has shown reduction for recurrence in one to three years. Subsequently, tucatinib and trastuzumab in combination with capecitabine have been shown to improve survival, particularly in brain metastases from breast tumours, where HER-2 positive metastases achieved 52% regression with complete control. For over ten years. Increasing research into HER-2 has initiated results establishing event-free survival compared

to non-survival and more, and an action table was demonstrated, indicating potential pathological complete response to be expected ahead, that would be both prognostic and actionable. A variety of trials performed, comparing pros and cons of treatments can be obtained from:

her2radical-icrctsu@icr.ac.uk.

In conclusion, although using the HER-2 pathway is excellent, metastases remain a problem, particularly those from brain tumours. Also, it has been found that superior results have been achieved by using the combined agent before surgery, then surgery followed by adjuvant treatment. Interesting questions followed, for example, 'is the UK an optional country for trials to take place, are there contrary operational conditions? And is the NHS successful at designing best methods of patient care?' REPLY – it depends on individual conditions. 'What about patients who are not HER-2 positive?' REPLY – this is a different topic, as their treatment is not targeted. 'How much is radiotherapy used in conjunction with surgery these days?' REPLY – minimal of these, these days. 'Some breast cancer patients may have 10 and 20 years survival, then recurrence of the same genotype tumour, What could be the reason for this?' REPLY – Tumour cell dormancy is a possibility, potentially long-lived cells residing in the bone marrow environment.

The curious rarity of ileal carcinoma

Professor Robin Williamson, Convenor of this meeting

Professor Williamson provided us with a thrilling account of the little known fact, that although malignant tumours in the rest of the digestive tract are common, they tend to be uncommon in the ileum, the final portion of the small intestine. It was observed many years ago that judging by length of the duodenum, 'it is more likely to develop malignant tumours than the rest of the small intestine' (Jefferson 1916). Professor Williamson's talk was richly illustrated with photographs of operative specimens.

There are intermediate tumours of the small intestine, such as the villous adenoma (which has high malignant potential) and stromal tumours (whose malignant potential relates to their size). Frankly malignant tumours found in the small bowel include metastatic carcinoid tumours or gastrinomas, malignant stromal tumours (GIST), lesions of lymphoma and adenocarcinomas, the latter being the most common.

The topic here, however, concerns ileal carcinomas, and to state that they are relatively rare, we need to compare their incidence with carcinomas of other areas of the small bowel - the most common malignant tumour of the duodenum being the adenocarcinoma, while the most common in the ileum are carcinoids (at very much lower incidence). Clinical presentation of primary carcinoma of the duodenum, for example, commonly includes obstructive jaundice, epigastric pain, gastric outlet obstruction, iron deficiency anaemia or perhaps recurrent acute pancreatitis, while initial clinical presentation of ileal carcinomas are specific for *these* lesions.

To aim to explain the rarity of small bowel carcinomas in general and ileal carcinomas in particular, several theories have been promulgated, which include rapid transit of food through, relative sterility of the organ here, the contents are still quite dilute while they pass and there is rapid cell turnover in the epithelial lining of the bowel wall in this region, thus removing potentially imperfect cells ahead of malignant change having taken place.

In conclusion, Professor Williamson's suggestions for the rarity of ileal carcinomas included lack of either a predisposing cause (either inflammatory as occurs in Crohn's ileitis, or iatrogenic subsequent to surgery associated with a pelvic pouch) or their development occurring when there is loss of immunosurveillance perhaps due to use of immunosuppressive drugs or presence of an anergic state associated with advanced malignancy.

Catherine Sarraf



To be crippled for lack of means is not economy: hospitals and their mentally ill patients in austerity, 1920s style

On Thursday 16 November 2023 Dr Claire Hilton, Historian in Residence (an honorary post) at the Royal College of Psychiatrists, and Honorary Research Fellow at Birkbeck, University of London, whose MA and PhD are in history and whose current research is on mental hospitals in England and Wales in the 'long' 1920s (1918-1930), gave a fascinating and thought-provoking lecture to the Senior Fellows Forum. Dr Hilton who was previously an NHS consultant and old age psychiatrist (1998-2017), warned us that her talk used some terms common in the 1920s, such as lunatic, asylum, pauper, and Board of Control (BoC). She then proceeded to deliver a tour de force lecture on the 'lived experience' of patients in public lunatic asylums or mental hospitals, in England in that era.

By way of background and setting the scene she explained that after WW1 and the flu pandemic, everyone wanted life to return to normal. But the world had changed. Despite initial euphoria seeing restoration of industry, with optimism for future and a hope for a country 'fit for heroes', economic reality soon set in. In 1919 there was rising unemployment followed in 1922 by cuts in public spending. 1926 saw the General Strike followed in 1929 by the Great Depression and austerity was unavoidable even for the shell-shocked veterans of WW1, who eventually lost their 'special treatment' status, their care merging with that of the 'ordinary lunatics' in the asylums. We were reminded that in this era treatment did not include antipsychotics, antidepressants, lithium or ECT. Public mental hospital doctors had no say over who they admitted under the Lunacy Act of 1890. Families did not banish their relatives into public mental hospitals and whenever possible, patients were discharged. Indeed, patients sometimes sent 'thank you' letters after discharge.

Inside the asylums the culture was often defensive and authoritarian with a steep management hierarchy operating under a safety-at-all-costs outlook. Yet mental hospital standards varied, and local leadership mattered with some having more liberal regimes, for example, unlocked wards. It was not correct

that 'nothing happened' to change things in the 1920s. Complaints were followed up, campaigns, inquiries and a Royal Commission took place. Dentists were introduced into mental hospitals and women began nursing male mental patients. Yet care continued to show a certain lack of empathy, dignity, privacy, or respect. Conditions were often unhygienic with communal bathing and shared towels. Patients were considered untrustworthy with no personal possessions or clothes of their own. Non-compliance might be followed by punishment. The diet was extremely basic, three meals a day, but breakfast and tea often consisting of little more than bread and margarine.

The question of 'aliens' in the hospitals was discussed. About 1/6 patients in Colney Hatch were Jewish, recorded as 'Hebrews'. A kosher kitchen was available with a visiting rabbi, prayer books, sabbath and festival services and a Yiddish interpreter. However, 'the Insane Alien population of London, which yields a large proportion of acute cases, who are noisy, violent and destructive' was blamed for high use of sedatives and excessive pharmacy budgets. With echoes of today's immigration issues, Dr Theo Hyslop, writing in 1925 was quoted, 'aliens have flocked to our shores, and it is a strange irony that once a lunatic is on the sea his only landing-place appears to be England, which has thus become the asylum of the world'.

In 1922 Dr Henry Devine wrote about work for patients, stating the rationale for patients working should be their wellbeing, not the wellbeing of staff or hospital economy; work should help patients to be 'creative and to raise their social esteem'. The BoC eventually encouraged Dr Devine's type of ideas in 1929. Good practices which had been lost were slow to be re-established, depending on innovation and leadership from enthusiastic individuals. Money or tokens as rewards for work gave patients a degree of autonomy and choice about how they were spent.

Dr Montagu Lomax, a retired GP, published 'Experiences of an Asylum Doctor' in 1921, which shocked the public, and raised interest.

The Ministry of Health set up an 'independent' inquiry whose members included a London County Council mental hospital manager with two psychiatrists. In essence, the panel members were judging themselves. Not surprisingly, they reassured the public that Lomax's allegations were false, but they also suggested improvements, although little changed. Lomax though, had political, medical, and philanthropic allies, and the strength of character to persist. A Royal Commission in 1924-6, hearing evidence from patients and front-line staff, reported on 1,000,000 words of minutes. Although much of the guidance was ignored, it gave the BoC confidence to encourage change, and to shift from economy as the benchmark of success to facilitating recovery and discharge, even though this cost more.

The Mental Treatment Act 1930 was passed, amending the Lunacy Act 1890. It permitted (not mandated) local authorities to finance psychiatric community care and out-patients, allowing voluntary admissions to public mental hospitals, and mandated women on management committees and the BoC. Improving standards required some willingness to spend more. As Professor George Robertson noted in 1922: 'financial burden of caring for the insane is not borne by the ratepayers without complaint', and as Grace Eyre Woodhead said, 'to be crippled for lack of means is not economy'.

Some interesting questions from the floor and online audience were then put to Dr Hilton regarding lessons for today. She said that as a historian she will not tell people what to do regarding the politics or policy of provision of services, but that history can be used to generate questions and to rethink ideas, were obvious points of comparison, not least the present top-down, tick-box culture with little continuity of care in our current Mental Health services, which may be working against the development of empathy.

The audience showed their appreciation and Dr Hilton was warmly thanked for her superb lecture and presented with a gift as a token of appreciation from the Senior Fellows Forum.

John Skipper

Comment on the lecture given by Claire Hilton

I found Dr Hilton's talk about '1920's style mental hospitals in austerity' fascinating. She showed us something of the slow dawn of enlightenment during the pre WW2 era. But, as she emphasised, overall change was slow and erratic.

This rang a loud bell for me. Fast forward 40 years and as deputy District Medical Officer I was involved in the 'decanting' (horrible word) of patients from Oakwood Hospital near Maidstone. Founded in the 1830s as The Kent County Lunatic Asylum at Barming, it had impressive new buildings added in the 1850s. These were designed by the architect of Maidstone prison - and it showed. I remember massively thick window embrasures, for instance. During the 1930s there was a euphemistic change of name to Oakwood Hospital, and by the 1940s it housed just under 2000 patients. A slow process of de-institutionalisation had reduced that to around half during the 1960s, by admitting only the most severely ill patients and of course the arrival of new treatments.

The task for the team in the late 1970s was to prepare for total closure. This was much more difficult as many of the residents had been there for many years. I have some striking memories: the immaculate garden of the Medical Superintendent's house; the very impressive cricket ground and pavilion; the depressingly huge but still well kept adjoining cemetery, used for patients and staff; the sometimes difficulty of distinguishing between patient and staff in the chronic wards; the slow crumbling and vandalism of the historic (listed) buildings as they became redundant.

In a brief chat with Dr Hilton after her talk, she confirmed that WW 2 and the subsequent economic problems had resulted in a serious relapse in standards and interest in the asylums and mental health care in general, certainly until the later 1960s.

Michael Vaile

I was not a Blair babe – the ups and downs of life as a Labour MP

On the 15th of February, Judy Mallaber (MP for Amber Valley, Derbyshire 1997-2010) gave us a resounding account of her period as an MP, with vignettes of what might go on behind the scenes in Parliament. She reflected on her life as an MP, although maybe somewhat regretful that her time occurred ahead of the thrills (and spills of) Brexit. However, she recognised that her decade there was an extraordinary one and that she was proud of her and her government's achievements.

First she set the scene of her background and what initially motivated her to run for Parliament. She had been a research officer in the National Union of Public Employees (NUPE) from 1975-85 rising to Head of Research. She described how originally her motivation was care for communities with which she was in touch and how she strove for improvements in lifestyles and qualities of life – particularly of the poorly paid. She had no specific political ambition nor desire for high office. She already enjoyed visiting schools, hospitals and factories, learning about the cares and disappointments of workers and their families, and campaigning socially on their behalf. By the late 1990s it became clear that the best way she could be of service was by running for Parliament, and in the Amber Valley constituency (although being a southerner herself) she found a population for whom she could fight. This area of Derbyshire was suffering from the death of the coal and textile industries, with resultant unemployment.

Arriving in Westminster, she was in her element! Judy described for us the multiplicity of areas in which an MP had the opportunity to be involved. Speaking in the chamber is the most obvious duty, although *via* TV many members of the public wonder why it is often sparsely populated (MP's can follow debates by watching on-screen from their offices). There are also backbench debates, and of course parliamentary questions including Prime Minister's Question Time. Judy also enjoyed being a member of Select Committees, such as those for Education and Employment, Treasury, Trade and Industry, Energy and Climate Change, Arms Control and (for her) The East Midlands Region. Crucial to an MP's role is listening to her constituents in her Constituency Office; she stressed that salaries for the office staff need to come from the MP's expense account. Problems brought to the surgery are not necessarily all of a party political nature, for

example, Judy was always active in Women's Issues, the NHS, public services, local unemployment and difficulties engendered. At this point she addressed the observation that an MP might be considered as just a kind of social worker – which she rejected. As a politician she was able to actively campaign for her constituents to improve the lots in life that seemed to have been ascribed to them.

Judy's excellent lecture was followed by a wide range of questions, such as 'at PMQs how does the questioner get selected?' (It's all organised equally beforehand); 'Can educational expenses for medical and nursing students be justified?' (Can additional educational expenses of anyone be justified?); 'Don't we need longer term policies for training medical professionals?' (Yes); 'Can't our politicians learn from history – for example, troubles in Afghanistan, Middle East, Ukraine and so on?' (She profoundly hopes so). The lecture was brought to a close and our Organiser of Internal Events Jane Reeback, warmly thanked the speaker and presented her with the traditional memento for her visit.

Catherine Sarraf



ZSL gorillas. Playing with the baby, Jeffrey Rosenberg and friends

External events reports

A 'behind the scenes' private tour of the Theatre Royal, Drury Lane

February 9th 2024 was grey, damp and drizzly outside, but walking into the foyer of the Theatre Royal all was light, warm and welcoming. Over 20 Senior Fellows gathered there whilst we waited for our guide, David Kirby Kendall. David is a writer, actor, director and tour guide and he put all these skills into practice as he led us around the newly renovated theatre. The first Theatre Royal was built in 1661 and it is said to be the oldest continuously performing theatre in the world, only closing down during the two World Wars and the pandemic. It was rebuilt by Benjamin Wyatt in 1812 and then closed in 2019 for a £60 million refurbishment, largely funded and led by Andrew Lloyd Webber. From the foyer we moved into the rotunda, a beautiful, full height spacious area with a domed glass ceiling (cover photograph) and an enticing bar – one of three well stocked bars we saw on our tour. Up the wide grand staircase on luscious pile carpet surrounded by paintings, statues, mock pillars and lights, we moved into the grand saloon (where afternoon tea can be served, with background music – at a price). The world's oldest tradition takes place here on every January 6th; Thomas Bazali bequeathed £100 on his death in 1794 with the proviso that the interest is used to provide a drink of punch and a themed cake based on the current production at the time – so it was a *Frozen* cake this year. ENSA (Entertainment National Service Association or as David said Every Night Something Awful....) was based in the theatre during WW2.



To the ground floor. Ian Stephen



Portrait of Sheridan, Kings Gallery. Ann Ferguson

Through we went to the King's Gallery. The Royal Charter was granted by Charles II and it was decreed by him even then that women's parts should be played by women. The original Charter is in the Victoria and Albert Museum and is very fragile (a framed copy was indicated to us on our way out at the Stage Door). In the comfort of the King's Gallery we were shown a picture of R B Sheridan opposite a painting of 'his' Theatre burning down in 1809, and we were shown a video of the old sub-stage equipment and the amazing sets they had been able to produce – a live horse race with jockeys, the boat race in real water, a steam train crash and more. All this was removed in 2019 and now the modern stage equipment is completely versatile for whatever is required in a production. Next, on to the Royal Retiring Room: in here George III and the wayward Prince Regent had a heated argument and needed to be kept apart - thus the origin of two royal boxes and labelling of the 'King's Side' and 'Prince's Side' on all the theatre seating. Concerning performances – our National Anthem was first performed in this theatre. In 1702 – was the first pantomime which was mimed only, 1740 saw period costumes

appearing and gender equality in payment was instigated for all the performers – (when did it revert?). In 1800 – dialogue was allowed, mainly in fairy tales, with clowns always called Joeys who had whitened faces. 1880 saw modern pantomime with ‘dames’ – reminding us of the origin of the term drag - Dressed Resembling A Girl.

We then moved into the auditorium in the royal circle. During the 2019 renovation the total number of seats, 1993, had been reduced by 250 to give more legroom and better sightlines. We viewed the stage from this area only and were told that its actual size (40ft wide x 80ft depth) had been reduced by half for the current production of *Frozen*. The Theatre Royal is said to be the most haunted theatre in the world with over 500 ghosts in ‘residence’, including a handsome man in a grey cloak (and we saw him in a box – promise!). David himself was convinced that he was related to someone from the 1800s, with a fascinating tale using a dangling pendant. The boxes on either side were first put in by David Garrick to stop ‘important’ people wandering on to the stage during a performance, as they were apparently prone to do. David Garrick was constantly applauded by our David for all that he did in the theatre world, with gender equality pay to all the performers, regular rehearsals, proper acting, good lighting and true endings to Shakespeare’s plays. It had apparently become the fashion to make all endings happy whatever had been written! Out the other side of the auditorium to the Prince’s Gallery where we heard the tale of an argument between Charles Macklin and Thomas Hallam over the one wig of real hair *versus* all the others of horse hair. Charles was found not guilty of Thomas’s murder and lived to 107 himself still haunted by his deed. We moved back down the grand staircase and out through various security doors to the undercroft passage or tunnel where we saw the foundations of the 1663 building and blocked up arches over tunnels which led down to the Thames. In those days sailors from the boats moored in the Thames used to moonlight as stage hands. This led to the origin of the words ‘crew’ and ‘rigging’ in the theatre, and the reason why no whistling was allowed by the actors, as the sailors used to communicate by whistles for moving the scenery. Our last stop was the war room on the way to the stage door exit where we passed the nose cone of the bomb which only partially exploded in WW2, and a heavy leather chair ‘liberated’ from the Reichstag in Berlin and thought to have been used by Hitler himself. It was presented by ENSA to the Theatre. Back into the Foyer where David said goodbye to us with a farewell ditty:

*I thank you for coming and listening today
I’m glad of your smiles and your laughter
May the stardust of Drury Lane shine ‘ere in your hearts.
And may you all live happily ever after*

A professional to the last – thank you David, a most enjoyable 90 minutes for us all.

Jean Robson



Our guide David Kirby Kendall. Ann Ferguson



Lilac breasted roller, Jeffrey Rosenberg and friends

Articles

Photography and painting

Richard Lansdown

It all started in 1839 when Daguerre in Paris and Talbot in London introduced their versions of photography to the world. Paul Delaroche, a painter whose painstakingly realistic historical subjects made him one of the most successful academic artists of mid-19th-century France, a professor at the École Nationale Supérieure des Beaux-Arts, declared 'From today painting is dead'.

He was of course, wrong - the advent of photography was followed by a series of developments in painting which were either associated with photography or spurred on by that medium to produce something far more varied. Photography, especially that of Daguerre, chimed well with pre-Raphaelite paintings which featured sharp and brilliant lighting, a clear atmosphere, and near photographic reproduction of minute details. The two had a dynamic relationship; Julia Margaret Cameron has been described as a 'pre-Raphaelite photographer'.



Dante Gabriel Rossetti



Julia Margaret Cameron

Then, despising the reality of the photograph, came artists who saw themselves as superior to mere photographers, their work was more than just realism, it was something that no camera could produce.

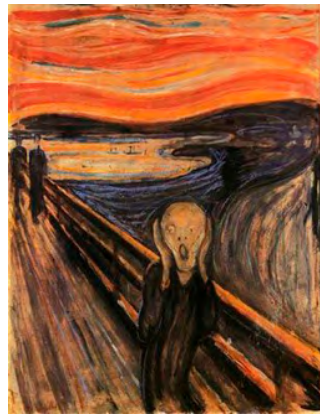


Whistler: Old Battersea Bridge

James McNeill Whistler wrote 'The imitator is a poor kind of creature. If the man who paints only the tree, or the flower, or other surface he sees before him, were an artist, the king of artists would be the photographer. It is for the artist to do something beyond this'.

The late 19th and early 20th centuries produced Fauvism, Cubism, Futurism, Constructivism, Precisionism, Expressionism, DaDa, Surrealism, Regionalism and Muralists.

A very well known example of Expressionism, the style in which the artist presented the subjective emotions and responses that objects and events aroused, is given below.



Edvard Munch: The Scream



Albert Gleizes: Man on a balcony

An example of early Cubism, by Albert Gleizes, exhibited in Paris in 1912, is shown below. Modern art took another step, Mondrian is as far from photography as one can imagine.



Mondrian: Composition with red



Gwen John: Self portrait

A modified realism, clearly not photographic, flourished.

The 20th century also saw painters like Norman Rockwell and Edward Hopper producing work so realistic it qualified easily as photographic. Today we have come full circle, some photographs are praised



Richard Lansdown

for being painterly and some painters still imitate photographs. Look at the one below, taken in 2023, is it a photo or a painting?

The UK – a case report

Nick Coni

This great nation of ours is in a fair amount of trouble on several fronts, one of the principal ones being the economy. We have returned to the scenario so familiar during the 1960s and early 1970s known as ‘stagflation’, characterised by stagnant trade and an obstinately high level of inflation. Important aspects of national life wither on the bough, chronically under-perfused with financial lifeblood. Schools lack the funds to employ enough teachers, our beloved NHS is no longer fit for purpose, the armed forces are too under-manned and ill-equipped to continue to fight so gallantly above their weight, and local government is faced with demands it cannot begin to meet. In addition, we have lost almost all of our manufacturing base and thus exports, our governments have been a laughing-stock for the past five years, and our judicial and law-enforcing agencies are struggling to cope with the demands made upon them. The Rev. Astor Carlyle stated ‘We do not live in an economy, we live in a society’, but a more penetrating observation was, perhaps, Bill Clinton’s terse ‘It’s the economy, stupid!’ when quizzed about the crucial issues facing his country as he was being returned as his country’s President all those elections ago. The UK tends to pride itself on its ‘soft power’, although to many of us, it feels as though the nation has certainly gone soft, but we have a hard task working out what has happened to all that power.

One of our major problems seems to be lack of growth in the economy, which, according to Roger Bootle (Chair of Capital Economics) has been, since spring 2016, less than half that of the USA, and below that of France, although greater, he admits, than those of Spain, Italy, Germany and Japan. However, our relative performance has been worse since then, and this is only partly due to Brexit, the damaging effect of which was clearly foreseen by masses of people but may, it seems, have been somewhat exaggerated. Indeed, economists have remained true to form in being unable to agree among themselves about the effect of Brexit on the economy or the cause of the economic downturn, or anything much else, really. It is hard to avoid the conclusion that a number of them must be guilty of perpetrating that most popular of day-to-day sins, ultracrepidarianism, which, as the erudite readers of this publication will know, means ‘the habit, or act, of giving opinions on matters outside the scope of one’s knowledge’, a practice particularly

prevalent in my own home town. It has given rise to the proverb that the cobbler should stick to his last, but we retired cobblers are notoriously prone to pontificate and this aphorism serves as prudent advice to us all, to avoid talking cobblers. On the other hand, A.P. Herbert pointed out that ‘If nobody said anything unless he knew what he was talking about, a ghastly hush would descend upon the earth’. I am therefore emboldened to address the plethora of issues currently confronting us, and will confine my comments to the fields of disease, and social and psychological dis-ease (better referred to as **malaise**), and in particular, the overlap between them which is huge in terms of the numbers of people caught up in this overlapping territory and in terms of the amount of suffering caused and its effects on their productivity. The territory is of a treacherous, boggy consistency, and is therefore fought over by physicians, and social workers, and sociologists, and psychologists, all of whom are fighting not so much to gain ownership of it, as to reject it and to persuade their opposite numbers to accept responsibility for it and for the unhappy humans who populate it and suffer from its afflictions. It could thus be described as a morass (‘an entanglement, a disordered situation, a bog or marsh’) or a quagmire (‘a soft boggy or marshy area... a hazardous or awkward situation’), and there are numbers of afflictions which constitute this morass or quagmire.

They include the following:

Anxiety	Stress
Medication	Poverty
Joblessness	Poor education
Backache	Substance abuse
Chronic fatigue	Depression
Agoraphobia	Obesity
Arthritis	Allergies
Social isolation	Chronic respiratory disease

It must be said at the outset that most of the above conditions or predicaments can denote a variety of underlying disorders, some entirely medical, some serious and potentially fatal. **Chronic anxiety** is key to numerous other problems, particularly **substance abuse**. The **alcoholic** is someone who has discovered that among the range of anxiolytic pharmaceuticals marketed, none is anything like so effective or so readily available, as alcohol.

Stress is currently blamed for a vast variety of medical conditions, but it is impossible to define, let alone to measure, which makes it profoundly unsatisfactory as either a causative or precipitating factor for the onset of any of these conditions.

Depression, deprivation, joblessness, and low educational attainment are all exceedingly prevalent and affect alike those whose lifestyle has contributed in large part to their presence, and those who are entirely blameless and have simply been unfortunate in their choice of parents or place and time of birth. The widespread curse of **backache** as a cause of prolonged absence from the workplace seems to be a reflection on the defective design of the human lumbar spine when caused by mechanical failings, but can be of malignant origin on the one hand, or invented or exaggerated by the ingenious malingerer on the other, with little chance of being challenged. **Chronic fatigue** is a prominent feature of long covid, and also of other post-viral diseases, notably infectious mononucleosis, and **chronic respiratory disease** is commonly a sequel of years of **addiction** to tobacco. **Obesity** is also a form of ill-health related to poor habits often adopted during youth. **Agoraphobia** is a state of mind which can lead to a progressive restriction in the range of daily movement of the subject, who may eventually become effectively housebound, and this may result in a vicious cycle of **social isolation** and an increasingly solitary existence. **Arthritis** covers a wide range of diseases which restrict movement and, when severe, are also likely to impair the ability to undertake regular work outside the home. **Allergies** have been mentioned because the fear of encountering the causative substances can also be extremely restricting, and also because the widespread dissemination of alarming disinformation on dietary and other health-related (or, more accurately, illness-related) topics is liable to induce gullible people to alter their regimes in unnecessary or even potentially harmful ways.

The conditions under discussion can have undesirable consequences extending beyond the person immediately affected by them. 'There can be few physicians so dedicated to their art that they do not experience a slight decline in spirits when they learn that their patient's complaint is dizziness', as the author of a textbook on neurology wrote, memorably and accurately, and exactly the same applies to the symptoms associated with the morass. It may tell us more about doctors than their patients, but all these conditions share a couple of characteristics; undertaking a full history and examination and x-rays or blood tests is unlikely to lead to a definitive diagnosis, and they are

ever-present, and unrewarding. They are the 'slow horses' of three disciplines – pathology, psychology, and sociology, and beyond the skills of exponents of these disciplines to alleviate. They are the converse of that rather less ubiquitous complaint, polymyalgia rheumatica, with its single physical sign. 'Go away and take these tablets', orders the physician who has proposed this diagnosis, carefully writing out a prescription for prednisolone in a very cautiously reducing dosage, 'and come back and see me again in a fortnight's time'. Two weeks later, all is good cheer and sunshine. The patient's *joie de vivre* has been miraculously restored, as has the physician's belief that his knowledge and training are capable of improving the lot of at least one small segment of humanity. And the physical sign? A bottle-shaped gift-wrapped package protruding from the bag of the smiling patient. Further physical signs will later emerge, those of long-term steroid use, but those are bridges to be crossed as and when they are encountered. The honeymoon of the patient-physician relationship is worth the seven-year itch which follows it.

One of the (many) saving graces of the UK of recent years has been the low level of unemployment. The availability of jobs is what has made this country so attractive for immigrants, which, until Brexit, was highly advantageous. Then Brexit happened, and then covid happened, and now we have a damaging labour shortage, the cause of which can be summed up by that intensely useful explanation of poorly understood phenomena – 'multifactorial'. The reason for labouring the problem of ill-defined ill-health is the number of people in the UK who are economically inactive – that is, of working age (16 to 64) and neither employed nor seeking work. The number is 8.7 million, or 21% of the working-age population. The unemployment level has declined steeply since 2011, the economically inactive level has been declining very slowly, and the number of vacancies is around 9.5 million. Unemployment is running at around 4.2%, or 1.45 million. The rise in economically inactive people – over half a million since the start of the pandemic - has been among previously full-time working men and part-time women, and has been caused largely by early retirement (some of which is due to poor health, and some, simply a 'lifestyle choice') and by long-term sickness. (In younger age groups, being a student is a leading cause of being economically inactive). Among European countries, England has a fairly average economic inactivity ratio, but it is lower than that of the other UK nations.

Our labour force is under strength, and a significant proportion of its members have become benefit claimants instead. Most of this absence from

work is due to long-term ill-health, causing untold unhappiness and also untold lack of productivity and the UK's recently dismal GDP. It should be added that our dismal productivity is almost confined to the public services, and especially the NHS, the private sector representing the cavalry waiting to charge to the rescue, were it not for the heavy burden of taxation levied in order to keep our welfare ship afloat.

The conditions I have referred to as the morass, or quagmire, are often very difficult to define, or to analyse in terms of causation or mechanism. They do not, in the main, correspond to the illnesses described in medical textbooks or journals. They are numerically very important and are important also

in the amount of misery they cause (or, sometimes, being closely inter-related, are caused by) and also in the amount of damage they inflict upon the economy of this country. It would be of huge national benefit if biomedical scientists could lower their boredom thresholds sufficiently to devote their energies to the investigation of these humble medico-psycho-social forms of malaise. We need to classify them much more accurately, and we need to know much more about their natural histories in terms of their aetiology, their epidemiology, their prognosis, and above all, of course, their prevention and their management.

Tribute to Dr Aileen K Adams CBE for her 100th birthday

Ann Ferguson



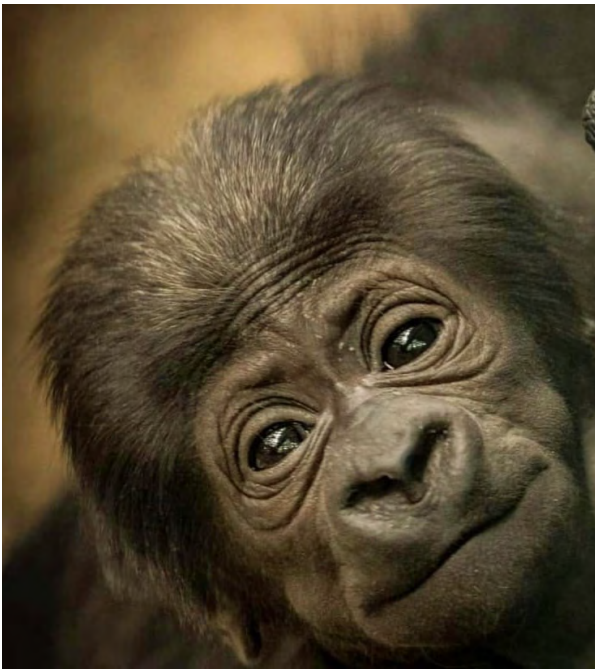
Aileen Adams. Photograph provided by Ann Ferguson

One of our Fellows has achieved her century. Aileen Kirkpatrick Adams was born in 1923 in Sheffield, where she qualified in medicine in 1945; she was awarded an honorary MD there in 2016. Aileen trained in anaesthesia at various hospitals in London and Oxford, and at the Massachusetts General Hospital. Eventually, she was appointed Consultant anaesthetist at Addenbrooke's Hospital Cambridge, where she became known as the 'Iron Maiden' by certain of her junior staff, although she could also be very kind. On one occasion when the situation in the anaesthetic room became tricky, she told the very junior anaesthetist that his role was to tell her firmly if she did anything silly. Elected to the Council of the Association of Anaesthetists in 1964, she was active in promoting aid to developing countries - visiting Zambia in 1966, and then was the first woman to be elected as an Officer of the Association of Anaesthetists in 1967, when she became Assistant Honorary Secretary, proceeding to the full role for 1968-70. She rekindled interest in aid in the field of anaesthesia, for developing countries in 1977 when she was Chair of the International Relations Committee. Aileen Adams was the first woman to be elected Dean of the Faculty of Anaesthetists at the Royal College

of Surgeons in 1985. She served for three years until 1988 and was closely involved in negotiations with the Royal College of Surgeons for the transformation of the Faculty of Anaesthetists to College of Anaesthetists. The conferring of Collegiate status occurred on 19 October, when Aileen's successor as Dean, Michael Rosen, became President. The success of the negotiations had much concerned with Aileen's fine quality of leadership, combining firmness with tact and friendship. Uniquely qualified to write about the evolution of the College of Anaesthetists, she published several papers on this. Deservedly she was appointed Commander of the Order of the British Empire (CBE).

During her time on Council, she did a series of council visits to Departments of Anaesthesia, these being feared by those being inspected. She surprised many of them by being very supportive of their needs for improvement. Remarkably, while Dean, she was also President of the Section of Anaesthetics of the Royal Society of Medicine for 1985-86. In retirement Aileen was President of the History of Anaesthesia Society 1991-2. This was a busy job, involving arranging meetings twice a year in various locations, ending her presidency with a very successful meeting in Cambridge. She celebrated her eightieth birthday at the British Society for the History of Medicine, during her presidency of it. She led the society brilliantly, increasing the membership.

She is now being expertly looked after at Cambridge Manor Care Home.



Photogenic baby gorilla, Jeffrey Rosenberg and friends



Crowned pigeon, Jeffrey Rosenberg and friends



Mum and baby gorilla, Jeffrey Rosenberg and friends

Information for Authors

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

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

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

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

Accepted articles for the *Journal*:

- Solicited articles, on a topic agreed with the editor, and should be 1,500 to 2,000 words in length.
- Articles submitted by readers - 500 to 1,500 words.
- Reports of presentations at meetings of the Senior Fellows Forum - 500 to 1,500 words, the author invited by the Chair of the corresponding day.
- Reports of extramural events of the Senior Fellows Forum - 500 to 1,000 words, the author invited by the leader of the event.
- Reports of Senior Fellows Forum tours - 1,000 to 2,000 words, the author invited by the leader of the tour.
- Short 'fillers', text and/or photographs. Poems, quotes, amusing items, brief - under 200 words.
- Submit to Catherine Sarraf:
alison.catherine872@gmail.com

Imagery:

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

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