RFS

Retired Fellows Society

Newsletter Issue No. 30 December 2007

EDITORIAL

This issue incorporates some of the items from the AGM, such as the Treasurer's and Secretaries' reports and the new committee, but not the most momentous feature of that memorable day, our tenth anniversary celebrations, so the festive season really started two months ago for the RFS. We should, perhaps, particularly celebrate the considerable number of our founder members who are still actively participating in the Society's activities, and indeed four of them are currently serving on the Committee and six more were present on the day. In those far-off early days, the RSM was most insistent on an educational content to our Newsletter, and until a year ago, we religiously included a round-up of abstracts from the medical literature. These became progressively more idiosyncratic, reflecting the tastes of the extremely small number of members who could be bothered to submit them, and it was therefore with some relief that we seized instead the opportunity to include summaries of the papers given at the admirable day-long update of Recent Advances for Retired Physicians organised annually by Ken Citron and Bill Cattell. The last of those from December 2006 appears in this number of the Newsletter, and is happily complemented by a masterly overview of AIDS by Nicol Thin to inform those of us who retired in the earlier days of this affliction.

It could be claimed that most of the material which follows is of a broadly educational nature. As new disorders emerge, so old ones thankfully disappear, from these shores at any rate, and newer members (who are of course getting younger all the time) may not remember poliomyelitis with the degree of horror which it instilled in those of us who were at school or university during the heyday of this dreadful disease. The personal account by Margaret Elmes is not only moving and intensely evocative, but may be very instructive for those who have been spared any encounter with polio closer than the occasional elderly patient with a "withered limb". A few years ago, a lateral-thinking respiratory physician in East Anglia "liberated" several iron lungs which he found languishing in some long-forgotten NHS warehouse, and used them with good effect in a group of patients with respiratory failure, thereby

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EDITOR: Dr Nicholas Coni **ASSISTANT EDITOR:** Dr Shirley Emerson **COMMITTEE:** Dr William Cattell (Chair), Mr G Chambers (Vice Chair) Prof Malcolm Forsythe (Hon secretary), Mrs Sally Gordon Boyd (Hon meetings Secretary), Dame Beulah Bewley (Hon Treasurer), Dr John Ford, Dr Kenneth Citron, Prof James Malpas, in attendance Dr Patricia Last

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validating the ancient truism that "what goes around, comes around". The educational pill is lavishly sugared by Derrick Jackson, who takes us rambling in Burgundy and reminds us of the beneficial effects of wine, which is a most refreshing change from the dire warnings we have become accustomed to. Colin Speirs indicates that there is more to Dubai than reliable sunshine and luxury hotels, and Judith Langfield proves how richly she deserved the honour of playing the organ in St Paul's Cathedral (Newsletter, April 2007). We have recently been reminded what a valuable archive our memoirs constitute, and Shirley Emerson provides a glimpse into hospital life in the 1950s which will strike a chord with all of us. Finally, for those of us who wondered how our colleagues used to find those cloistered hours so entertaining, Ronald Millar provides some further rather disconcerting insights into life in the operating theatre.

The Newsletter wishes you all an excellent Christmas, and, should you experience periods of unaccustomed inactivity, suggests that these may be constructively spent composing an article with which to enrich a future issue.
Nick Coni

Chairman's Report

I am delighted to report that the Society continues to grow and prosper, now having 1275 members. This owes a great deal to the excellent programme of events masterminded by Sally Gordon Boyd and Pat Last and to the skill of our Honorary Editor, Nick Coni, in regularly producing an entertaining and informative Newsletter. I would also like to pay tribute to all of our committee who constantly come up with suggestions for lecturers, extra-mural visits and improvements to the Society. In co-operation with the Dean we had a further highly successful all day meeting on Recent Advances for Retired Physicians last year and are repeating this on the 5th December.

Your committee is also keen to pursue new ideas. One such is to revisit the possibility of having a Photography Club, which had been tried 10 years ago. We feel many members have taken up photography in retirement, or have more time to devote to it. We envisage concentrating on digital photography, with a broad spectrum of activity to accommodate the needs or interests of the very amateur recruit and the more expert photographer. A number of members have expressed an interest so we are pursuing this. Any others interested should contact Sally Gordon Boyd.

There are a number of changes to our committee. Dr Bates steps down, having completed her ex officio year. I would like to express our sincere thanks to her for eight years as committee member, Treasurer and then Chairman of the Society. John Ford completes his tenure as vice-chairman but still has some years to go on the committee. We propose that Mr Gordon Chambers move up to take his place as Vice-chairman. There are no vacancies for elected members on the committee.

I am delighted to report that Ken Citron has been appointed Honorary Librarian to the RSM and will keep us all well informed of what is happening there.

You will remember that we lost Annie Nagem, our administrator, in July. Since then, there have been some hiccoughs in administration and a disastrous mailing of notice for this meeting, for which I apologise sincerely. This was due to a combination of factors including problems with "stuffing envelopes" and the franking machine blowing up, which, with such a large membership, created a nightmare, compounded by the Post Office strike. The Academic Department has worked flat out to sort it all out, so we hope not too many people have been disadvantaged.

That completes my report. Thank you all for your continuing support and enthusiasm and I believe we can look forward to another successful year.

William Cattell

Honorary Treasurer's Report

I am pleased to report that for 2007 - 2008 the RFS is financially sound. Membership has increased to 1275.

Balance	30 September 2006	30 September 2007
Income and Expenditure account	£ 2,184.63	£ 8,491.41
Funds on deposit	£ 7,928.41	£ 8,329.41
Total unrestricted funds	£10,113.04	£16,820.82
Contribution to salary (based on £5 per member)		£ 4,930.00

The surplus made over the period is £6,707.38, this includes £400 interest on the deposit account

A careful review of running costs continues to show a regular deficit on intramural events. Catering costs have increased, so it will be necessary in 2008 to increase the cost of lunches by 5% (approx £1.50)

Postal costs have also increased and will continue with the rise in membership as well as the recent postal charges for envelope size. Apart from the Newsletter it is proposed to use where possible RFS members' email addresses except for those who request us not to do so. 72% of RFS members have provided email addresses. Registration for meetings is easier with email as there is a link straight to the website and to secure meetings registration forms allowing members to pay securely by credit or debit card and will save our members time and postage.

Beulah Bewley

Forthcoming Meetings & Events

INTRAMURAL EVENTS

Thursday 21 February 2008
The Interface between Medicine and Law
- Dame Elizabeth Butler Sloss

Thursday 20 March 2008
A Doctor in the House
- Lord Walton of Detchant

Thursday 17 April 2008
Genetics – title t.b.c.
- Professor Christine Kinnon

Thursday 19 June 2008
Art, Surgery, and Transplantation
- Professor Sir Roy Calne

Thursday 20 March 2008
"Curing" Cardiac Arrhythmia
- Professor John Camm

EXTRAMURAL EVENTS

Monday 19 May 2008
Visit to Fulham Palace (and walks with Sue Weir provisionally arranged for 13 May, 17 June and 8 July)

Thursday 12 June 2008
Visit to Eton College

Thursday 10 July 2008
Visit to Burghley House, Peterborough

RFS/RSM TOURS WITH SUE WEIR

15-21 April
Beautiful Baltics – Riga, Tallinn, Parnu, Vilnius (£1,139)

2-7 September
Krakow (£1,199)

Contact Interchange Croydon Office, 7 Stafford Road, Croydon, Surrey CR0 4NG
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Events Reports

INTRAMURAL EVENTS

Long Case Clocks

17 May 2007

As a subject Long Case Clocks was always going to be enjoyable listening, especially when delivered by a physician whose previous positions included being not only Master of the Court of the Worshipful Company of Clockmakers but also the President of the British Horological Institute. Colin Lattimore started by describing early time-keeping devices including sundials, which were for so long the only way to regulate clocks of any sort. A clockmaker would enquire of a potential clock purchaser whether he had a sundial at least until 1924 when the Greenwich time signal was introduced. Then there were the hour glasses whose use ranged from assisting a preacher on the duration of his sermon (¼, ½, ¾, or 1hr), measuring a ship's watch (4-6 hrs), and as an economical way for nurses to take the patient's pulse in hospitals (15 or 30 seconds), as well as for boiling eggs at home (5 minutes). Mechanical devices came next in the history of timekeeping starting in monasteries/nunneries in the 13th century where they served to regulate the life of the community without having either a dial or hands. Salisbury Cathedral houses one of the oldest mechanical clocks.

Galileo was regarded as the first person who realised that a pendulum had a constant swing and the first pendulum clock in England was put into Wadham College Oxford in 1668. These early clocks were all made by blacksmiths since iron and steel were the component parts. It was in the City of London where the first "professional" clockmakers began and in 1631 the livery company was set up as a result of a charter granted by Charles 1st.

The case of a long case clock was made separately by a local carpenter if not imported specially. All long case clocks were bespoke which explains why they all look different. The case was to protect the pendulum and early clocks had a glass window to see if it was working. Clocks can be made to go for a very long time and essentially the longer it can go the more likely it is to be accurate. In practical terms a balance has to be struck on the length of the pendulum, and the weight put on it and its chains. Most clocks were 8 days but early ones were 30 hrs. The wood used was originally walnut but in the early 18th century mahogany was imported. Marquetry was also a feature at that time being imported from Holland. Local oak could always be used if mahogany was felt to be too expensive.

There is often logic in the features on the dial and the arch above it. Thus the moon face was to appraise the owners when the full moon would come which would allow either the family or guests to travel at night. A religious motif such as Adam and Eve would alert the owners against evil-doing. The dials were originally made of brass then painted wood followed by enamelled and then painted metal. The hand(s), developed also from steel, started as single, then non-matching to decorative matching. Long case clocks, originally the preserve of the aristocracy, by 1775/1780 had gone out of fashion and were moved out of the lounge to the hall, landing or even the attic. The middle classes sustained an interest until the reign of Victoria.

It appeared, at the end of his talk, which Colin said he had given many times before, that there would be little left to ask, but the questions flowed and we were then told why they shouldn't be called grandfather clocks and that they cannot be expected to go on for ever but instead needed servicing by having their pivots oiled every 5 years.

Malcolm Forsythe

EXTRAMURAL EVENTS

Visit to Buckingham Palace and Clarence House

8 August 2007

We were blessed with warm, sunny weather but the day started badly for me when I discovered, on leaving the RSM after coffee, that my combined travel card and return ticket to Royston had been purloined from my pocket at Oxford Circus Tube Station; but such seems to be par for the course in London today. Anyway, new tickets having been purchased, we made our way to Buckingham Palace and the day got steadily better.

We were surprised not to recognise more RFS faces in the queue at security where we were subjected to the now obligatory search at any public function, another reminder of the hideous world we now live in. For some inexplicable reason the tiniest pocket-knife was confiscated from me at Buckingham Palace but not at Clarence House, such is the illogicality of security procedures.

However, once inside the Palace we entered a new world of magnificence, peace, beauty and security such that one really did begin to wonder how Her Majesty kept in touch with the real lives of her subjects. Be that as it may we were there to admire her house and what a house!

Royal organisation is always impeccable and the arrangements for viewing the Palace were no exception; the audio guides worked perfectly and even I could manage the technology. The commentaries were clear, informative and in a wide selection of languages for those that needed it, which were many judging by the cosmopolitan appearance of our accompanying visitors.

It is hard to find words to describe the splendour of the Palace but the sheer size of it is the first thing that strikes one. Next, I think, is the magnificence of the individual rooms and, in particular, the wonderful ceilings, a visual challenge for those with arthritic necks but well worth the discomfort. We saw, of course, only a small part of the Queen's art collection but that was enough, along with the commentary to each picture on our audio machines to whet our appetite for more.

At the time of our visit there was an exhibition of the Royal Wedding in 1947 to celebrate their diamond wedding. The Queen's wedding dress and many of their presents were on display, bringing back many memories of a day of joyous relief from the austerity of post-war Britain. We admired the views from the windows and made our way to Clarence House via the garden, enabling us to appreciate why this is such a haven for wildlife in the middle of London.

Clarence House was a great contrast. According to the most informative commentary of our attractive young guide there was animosity between the Grand Old Duke of York and the Duke of Clarence, as a result of which York House (now Lancaster House), which was built just across Stable Yard, completely overshadows Clarence House, causing John Nash, who was re-building Clarence House, to have great difficulties with the contractors. This close proximity is one of the reasons that Clarence House seems to be rather dark and dismal, in contrast to the bright airiness of Buckingham Palace.

Although Clarence House is said to have been re-designed to the tastes of Prince Charles and the Duchess of Cornwall, I presume this has been mainly in their private apartments, and those of Princes William and Harry, upstairs. Downstairs, which was the part on public view, still bears the hallmarks of the late Queen Mother, of whom there are several portraits. Many of the other pictures are connected with horses, racing and the war. The paintings of Windsor Castle by John Piper were painted during the war and reflect the gloom of that period. All that part of the house that we were able to see I found sombre, though

not depressing. It was, after all, the home of an old lady who had witnessed and personally experienced some of the most traumatic events our country has suffered in its long history. It was no surprise that the house has not been "modernised" and rightly so. I was pleased that we visited the two houses on the same day; the contrast added greatly to the interest.

It was a memorable day, perfectly organised and full of interest. We felt privileged to have shared a little of the personal world of the Royal Family.

Robin Cox

Visit to Vienna
25-30 September 2007

Our history lessons at school always started with a list of ten dates to be memorised, an exercise which effectively stifled any enthusiasm the subject might otherwise have generated. It was, therefore, with a profound ignorance of Austria's glorious past, that I joined the other 19 members of the group for whom Sue Weir put together a wonderfully eclectic programme in Vienna over a period of five mainly sunny days in September – a programme which went a long way towards correcting this deficit. Every palace, cathedral, church, monastery and museum we visited evoked the events and the rulers of the past 850 years.

In 1156 the Babenberg family were granted the hereditary Duchy of Austria and brought prosperity and stability to Vienna, and constructed the first cathedral of St Stephen. It might have been better for the citizens of England had the wandering minstrel Blondel had a less distinctive voice, since its identification by the incarcerated Richard the Lionheart led to the restoration of his liberty in 1200 for an enormous ransom,

Kaffehaus Demel

which financed the fortification of the city around what is now the Ring Road. The disorderly reign of Friedrich the Belligerent gave way to that of Ottokar II of Bohemia, but in 1278 that in turn was followed by the long rule of the of the Imperial House of Habsburg, who presided over the Holy Roman Empire until its abolition by Napoleon in 1806. This remarkable dynasty had a famous aptitude for acquiring

Let them eat cake

territories such as Bohemia and Hungary by dint of marrying strategically rather than through armed conflict, and after Philip 1 ('the Fair') married Juana 'the Mad' (but even fairer) daughter of Ferdinand of Aragon and Isabella of Castile (*los Reyes Católicos*), their son, born in 1500, became Carlos I of Spain as well as Charles V of Austria. Warfare was a final resort when necessary for the defence of the realm, and two sieges by the Ottomans in 1529 and 1683 were eventually repelled. The early legacy of the Habsburg rule includes the University, founded by Rudolph IV in 1365, who also initiated the conversion of the cathedral to its present gothic splendour. Three centuries and nine or ten Habsburg emperors later, Leopold I (1658-1705) embarked on the construction of the glorious

Hofburg Palace

On the Danube

baroque architecture which is such a prominent feature of Vienna today. It was Joseph II (1765-1790) who commissioned works by both Mozart and Beethoven.

The splendid Imperial Apartments of the palace of Schönbrunn, converted into her summer residence by the Empress Maria Theresa in the middle of the 18th century, reveal much about the domestic life of Emperor Franz Josef – memorably caricatured by Jack Hawkins in *Oh! What a Lovely War!* - who ruled from 1848 until his death in 1916. His beautiful wife Elisabeth ("Sissi") had been assassinated by an Italian anarchist in Geneva in

Ice cream time

1898, and he was succeeded for the last two years of the war by his great-nephew Karl I, since when Austria has been a republic. The current heir to the dynasty, Karl, lives in Austria and has been a member of the European Parliament.

After this thumbnail sketch of the family, an account of our visit will be equally brief. High points of the programme followed by all the party included *The Barber of Seville* at the magnificent State Opera House. They also included a day excursion to the stunning Wachau valley which featured a boat trip down the Danube past steep hills clad with woods and vineyards, past picturesque little towns and forbidding castles such as the fortress where King Richard had been such an unappreciative guest. It was perhaps the Benedictine abbey of Melk which exerted the strongest "Wow!! factor", although animal lovers were enchanted by the Lipizzaner horses exercising in the Spanish Riding School. Independent detachments of the party visited various galleries and museums, and went to a concert in the Mozart House. Another high point

Rapt attention

The monastery at Melk

in a very literal sense was a circuit in the Giant Ferris Wheel (why Ferris? It was constructed in 1897 by an English engineer named Walter Basset, but, like much of Vienna, suffered terrible damage during the war) in one of the cabins so memorably shared by Orson Welles and Joseph Cotton in *The Third Man*.

This trip posed the medical conundrum of how the Austrians live out a reasonably long life span. They smoke. Their meat is wonderful, but to say they do not seem to be strong on fruit, vegetable and salad is an understatement. They do, however, have their medical giants, and any hall of fame must include the names of Landsteiner, Freud and Billroth.

Finally, it is of scant satisfaction to note that the other Europeans flatter us by copying our habits, and price everything at X euros and 99 cents, so we all returned with pockets weighed down with worthless shrapnel. In the current atmosphere of electoral fever, it is to be fervently hoped that the Monster Raving Loony Party will be resuscitated. The main planks of their platform last time round were eminently sensible – the introduction of the 99P coin, and to hold a referendum the other side of the Channel to see if the French wished to join the pound sterling. Both suggestions get my vote.

Nicholas Coni

News Items

Honorary Librarian of RSM

Dr Ken Citron has been elected by Council as Honorary Librarian, in which role he is spokesman for library matters on Council and serves on several important committees – which is good for us, as he is a previous chairman of the RFS and is on our committee.

Block booking

The committee is looking into the possibility of sending out a programme at the beginning of the academic year with the facility for making block bookings, which the Section of the History of Medicine, for example, finds convenient for its members and economical from the administrative point of view.

Members' widow/ers

We are very aware that the widows or widowers of former RFS members, who had accompanied their partner to meetings, quite often wish to continue to attend meetings/ events in their own right and not only when invited as guests. We would like to accommodate them. After discussion with the RSM officers, the following suggestion has been put to the Membership Committee.

" If a Retired Fellows Society (RFS) member predeceases their partner, the latter can retain their links with the RFS by arranging to take out a Club Membership (currently £50pa) and then also a RFS membership (currently £15pa). Ideally they would already be Club Members on their partner's Fellowship agreement, but if they were not, they would be able to join after their partner dies."

Woodturning

Prof. Jonathan Brostoff writes: "Woodturning has become a serious hobby of mine but woodturners seem to be few and far between in London! - certainly in the NW London area. It would be great to meet up with any of you with this interest who are in the area or nearby." Contact details – j.brostoff@virgin.net. (020 7435 7106) [I hope Prof. Brostoff may be persuaded to contribute an article on his retirement enthusiasm to next year's Newsletter – accounts of what our members get up to seem to be much enjoyed by readers – ed.]

Dubai

By Colin Speirs

Introduction
Most people know of Dubai from television programmes and glossy newspaper supplements. It is presented as a rich, thriving, ultramodern city. Luxury hotels and apartment blocks are for wealthy people. In summer, however, when the temperature is up to 50° C and humidity close to 100%, cheap flights and accommodation at superb hotels are available. Perhaps the most famous hotel is the Burg Al Arab which was opened in 2003. It rises out of the Gulf and resembles a gigantic triangular sail. One night in a room costs $7,500-15,000. It is believed to be the only hotel in the world with 7 star rating.

During the 1990s, a gulf-side area was developed to deal with container ships and a cruise-liner port was constructed A marina was cut out of the Gulf shore to berth large motor yachts. Around it are luxury flats. In 2006, there were 393 hotels and hotel apartments with 35,396 rooms. Construction of more buildings continues day and night. International architects can reveal their skills and fantasies with 60-80 storey buildings. Under construction is a 250-metre building with 54 floors each of which will rotate slowly and independently. The Burg Dubai has currently reached about 450 metres and is planned to be the world's tallest building at around 800 metres. To date, the Taipei Tower is the highest at 509 metres. There are also the famous palm islands and map of the world island.

Dubai has at least 12 shopping centres or malls. The two newest are the Ibn Battuta Mall and the Mall of the Emirates. The first commemorates a 14th century North African Muslim who, like Marco Polo, travelled across many countries to reach China. The Mall is about a mile long and is divided into the architecture of ancient Egypt, Persia, India and China. The Mall of the Emirates has a ski dome at one end. The ski slope is 85m high, 80m wide and 400m long. There are chair lifts to the top. Because real snow is produced, it is possible to ski, snowboard, toboggan and have snowball fights. Warm clothing is hired. The activities can be watched through a glass wall from the comfort of a restaurant. Both of these malls are more than 30 miles from the city centre.

To achieve international recognition, Dubai hosts tournaments for golf, tennis, rugby sevens, power boat racing, dinghy sailing, desert endurance horse racing, and a marathon. The most prestigious event is the annual Dubai International Jockeys' Challenge Meeting. There are six races on one day and total prize money is in excess of $6 million.

Dubai is spreading westwards rapidly. Large plots of sand are sold to developers who erect villas, office blocks and apartment blocks but there are gaps which will be filled. The city boundary is now about 40 miles from the centre. There are light industrial sites and a cement factory. Ironically, Dubai's sand is of the wrong particle size for cement and sand must be imported from other regions. They are building Silicone Oasis for computer hardware production and Academic City for the university, colleges and schools which were in the city centre. There is a campus for Heriot Watt University, UK. Healthcare City has

Correspondence

Forward in France

The lavatory in my holiday home in Italy presents exactly the same problem described by Mike Vickers (April 2007 p.18) and I have had, to adopt the same solution. So FF, FI, BB - would any other readers like to complete this European survey?

John Skinner

an offshoot of the Mayo Clinic and offices for private doctors. Dubailand is planned to rival Disney Land.

This incredible city state could not have been developed without money and outside expertise but how did it happen? I shall review briefly Dubai's recorded history and share my observations over the last 17 years.

History

During the early 19th century the British navy protected from pirates, merchant ships carrying valuable cargoes from India and the Far East as they entered the Persian Gulf. Many treaties were made with and broken by sheikhs on the southern side of the Gulf. A treaty in 1853 was successful. It was agreed that merchant ships would not interfere with pearl diving and piracy would be controlled. It was accepted that this area of land would be called the Trucial Coast and that sheikhs would have their own Trucial States. Dubai was a useful trading post because of its wide creek and wharfs and had also a good annual harvest of pearls.

Oil was found in the Persian Gulf in 1939 but with the outbreak of war this was kept secret until 1945. A consortium of oil companies explored for oil in the sea and desert. To protect them, the British Trucial Oman Scouts were formed in 1954. Large quantities of oil were found off-shore and in Abu Dhabi in 1958. Oil was not found in Dubai until 1966 and the reserves are small. By this time Abu Dhabi was exporting oil. Sheikh Rashid of Dubai decided that his country should concentrate on trade as they already had the expertise. Oil revenue would facilitate expansion.

During the 1950s British Imperial Airways' flying boats landed in the Gulf and taxied up the creek to Dubai. The first airport was opened in the desert in 1961.

In 1971-2 the seven Trucial Sheikhdoms became the United Arab Emirates (UAE). All of the rulers formed a Supreme Council. The roles of President and Vice-President were intended to change every five years but Abu Dhabi has always had the Presidency and Dubai has had the Vice-Presidency and Prime Minister posts. Before India became independent, the Trucial States had been administered by the British India Office and their currency was Indian rupees. Trucial States' rupees were used until the UAE made dirhams their currency.

Personal Experience

My wife and I first visited Dubai in December 1990 to be with our younger daughter who intended to work there for a year. She shared with a girlfriend a Hilton apartment in a 15- storey block on the edge of the main road to Abu Dhabi. The Hilton Hotel was a five- minute walk away. Beyond the block there was only desert. The tallest building in Dubai was the World Trade Centre. From the viewing platform on the roof one could look eastwards across the creek where there were tall business and residential blocks, another two international hotels and near the mouth of the creek, the gold and spice souks. A little old fort was just visible. The creek was busy with wooden merchant dhows and larger metal ships. Water taxis (*abbras*), packed with about 20 people, criss-crossed the creek. Two bridges were for vehicles only. On the nearside of the creek was a jumble of old mud-brick buildings. Many Indian fabric traders were in this area.

My daughter married an Egyptian Muslim banker and over the years had a son and a daughter. I shall give neither a family history nor a travelogue of my annual visits to Dubai. Instead, I shall report the changes in the structures and lifestyle of Dubai over the last 17 years.

The Airport

When we arrived at the small airport in December 1990, we walked from the plane to the terminal building. Our landing cards and passports were scrutinised, we collected our luggage and passed through Customs to be met by our daughter. The airport has steadily increased in size, is now two storeys high and has an integral hotel for those who have an overnight stop. Security checks on departure are very strict: before check-in, at passport control and at the departure gate.

Housing

Like most newly married couples my daughter and her husband rented a small flat. In Dubai only locals could buy property. Over the years, they moved to larger flats. When they had a son, then a daughter they rented a terraced villa with a communal garden and swimming pool. Around 2004, property laws changed and it

became possible for foreigners to buy houses. My family's current home is a villa in the Green Community almost 40 miles from the city centre. Green does not mean that it is ecofriendly. It was built on sand but with copious irrigation it is possible to have lawns, shrubs and trees. Its meandering streets have names such as Poppy Lane and Acacia Avenue. The shopping area includes a good hotel. There are a lake and a canal. A fence surrounds the community. Security guards are at the entrances and on patrol.

Traffic

This is heavy, fast and dangerous. Day and night, heavy lorries move nose to tail from Dubai port to Abu Dhabi. Roads are four to six lanes wide and lorries must keep to the two inner lanes. To reach exits from the motorway, cars must squeeze in between lorries. Private cars are mainly large German, Japanese or American 4WDs or saloons for safety reasons. A third bridge has just been built over Dubai Creek to cope with the traffic. There is also a bus service which is cheap and usually used by labourers and domestic staff. Taxis are clean, have meters and are relatively cheap. Drivers must wear uniform shirts and speak English. An overhead railway is being constructed beside the main road into Dubai. Any buildings on its route will be demolished.

Education

State schooling is free but is in Arabic and of dubious quality. Many countries with a significant number of nationals in Dubai have their own schools, which use their national curricula. These are English, American, Indian, Iranian and Lebanese (French). Fees are high. Locals can choose to go abroad for free education up to university level.

Socialising

Because my daughter and her husband never worked for British companies they did not become part of the British "ex-pat" set. They have an international group of friends whom they met at work, had as neighbours or met at their children's schools. They know a few minor UAE sheikhs. Dinner parties are usual.

Religion and Culture

Dubai is an Islamic state, predominantly Sunni. In the city there are mosques on many street corners. The call to prayer is blasted out five times a day. If your bedroom is close to a mosque the morning call around 5.30 can be startling.

There is a Christian Compound near the city centre which has buildings for Anglicans, Roman Catholics and Evangelists. Non-Muslims should show respect for their host country but there are unfortunate lapses which would not be tolerated in Saudi Arabia. Many women dress as they might in Ibiza

In 1990, there were still some old mud brick buildings but most were demolished within two years. This was a mistake and in 1996 the authorities constructed the Heritage Village. At the centre is Sheikh Saeed al Maktoum's house, which was the seat of government from 1912-1958. It was repaired with mud-bricks and decorated inside with pictures and local artefacts. Close to the building old women produce local food on open fires and artisans demonstrate their trades. Part of the old town has been rebuilt with mud-brick but rendered with cement. The narrow streets are authentic but the buildings are not.

Around 2004, efforts were made to explain Islamic ways to foreign workers and tourists. The Sheikh Mohammed Centre for Cultural Understanding has leaflets in several languages explaining their religion and lifestyle. Informal talks are given to visitors who sit on carpets and cushions in the courtyard and sip sweet mint tea with Arab sweetmeats. The Five Pillars of Islam are described. The mosque at Jumeira is open for an hour on Thursday and Sunday so that visitors can learn what happens inside. For those who are improperly dressed, shawls and sarongs are supplied.

Shopping

At least 20 years ago, the government built showrooms and shopping malls to attract foreign companies. They were excellent sites for German and Japanese car manufacturers. Ikea had an impact. Department stores were those seen in the UK Supermarkets were mainly French. Family shopping was not cheap because most goods were brands available in the UK. It was possible to buy large unpacked quantities of rice,

lentils and other staple foods cheaply. Over the years, more French, Indian, American and Indian supermarkets opened and competition has been beneficial. More recently, Italian fashion houses have opened exclusive shops for designer clothes.

Eating out
Choice ranges from well-known burger and chicken meals to the cuisines of all countries. Lebanese food is plentiful and cheap but French is expensive. Alcohol is available in hotels and where restaurants are grouped together. There is a state tax of 20% on meals.

Tips for tourists
The best time to visit Dubai is December to late February. Weather is similar to a good English summer and rain is possible. Hotels are expensive but tour operators offer good flight/ hotel deals. They might also suggest tours and facilities. These can also be chosen at the Dubai hotels. A boat trip on the Creek is essential. Dubai fort with its museum and the Heritage Village are interesting. So also is the oil museum in Abu Dhabi. The Cultural Centre and the Jumeira Mosque are educational. Desert Safaris in a Land Cruiser or a desert dinner in a large well-decorated tent can be special experiences and can be booked through a company called Arabian Adventures. (www.arabian-adventures.com) Hotels can arrange for guests to play golf on world-class courses, even under floodlight at night. Most tourists find their way to the gold and spice souks.

Fly Theatricals

By Ronald Millar

"A fly!"...Excited cries relieve the tedium of a long schedule. Practised alarm - to hunt down the intolerable menace to sterility. If anything can throw the operating room nurses into hysterics, it's an entomoid.
"Up there...look...the ceiling", shouts one of them.
"It's a spy-fly from another service", remarks the anesthesiologist, venerable with dry wit and common-sense. "Manoeuvring in the flies..."
"Put out the lights...quick!", the scrub-nurse calls.
"Hey, wait a minute. I'm inducing a patient here." No flies on him, not yet. But the hunt is up, and nobody listens.
"You need an ethyl chloride spray."
"What's that?"
"Before your time", he adds maliciously,as he pushes in the succinyl choline, in two minds about the row. This is an irresponsible insect, and still at large. He must concentrate. But there's scope for a trick or two. Flies in the ointment for these sterility-obsessed honey-pots.
"Turn off the radio", insists a musical nurse. "We need to hear the buzz."
And now, in the gloom, the dipterous demon is on the move, looping downwards, drawn to the light. One bright source, to the common hospital fly, is as alluring as another. A new laryngoscope battery just last week.
"I hear it", someone says, casting about with the latest fly-shooting artillery.
"Careful with that bug-gun. Remember yesterday."
Faulty aim, that was, her least favourite surgeon within practice range, his fly not one of the many thousand species. "Assassin", he had cried. "And don't touch the doctors."
The watching crowd seems larger now, there's a bzzz around his head. It's worth a commentary.
"Here", he suddenly calls. "It's on the blade...surely it won't...oh, no...God... it's gone!"
The room is stunned into silence. No bzzz now, not even a buzz of alarm from the wanton fly-catchers. He puts the tube in.
He says unrelentingly: "I've lost it. Quickly...call an entomologist..."
"Who's that?"
"He means an endoscopist..."
"You think...it's gone...down?"
"Lights", he shouts with authority. "Got it...I think."
He brandishes a piece of tape, messily folded, pointing to a dark speck.
"See - the murderous bug - stuck fast."
No one is sure. But altogether too far this is going. Crowded oppressively, he seizes a nearby bottle of halothane, shakes some onto a piece of gauze, and waves it about. The fly escapes imminent narcotization and the gadflies scatter, fearful of unfounded dangers to offspring yet unborn.
Bzzz...bzzz...bzzz
"There it is...quick..."
And now they are drawn back to primordial obsessions, to sanitise the insect-tainted entirety, to wipe clean this theatre of therapy.
Bzzz...bzzz...
The entomoid, in frantic flight, is splayed into insensibility by the very nurse, who, you might have sworn, wouldn't have hurt one. There is still a purity these girls will kill for.
"Don't forget to send that alleged fly to pathology", the anesthesiologist says laconically. "Can't be sure what happened at this end..."

Human Immunodeficiency Virus Infection and the Acquired Immunodeficiency Syndrome

By Nicol Thin

The acquired immune deficiency syndrome (AIDS) was first recognised in 1981, though it took time to realise that this was the end stage of a chronic infection due to the human immunodeficiency virus (HIV), which was identified in 1983. There are two main types of HIV, HIV-1, and HIV-2 which is mainly found in west Africa and is less aggressive. There are many subtypes and genetic variants of HIV-1, and this causes problems with drug resistance and vaccine development. HIV is an RNA retrovirus, so-called because when it enters a susceptible human cell, viral reverse transcriptase transforms viral RNA to DNA which integrates with cellular DNA. HIV attacks cells with suitable receptors; the most important are the subset of lymphocytes called CD4 helper cells. HIV can enter the body either within cells or as free virus.

Transmission

HIV is present in semen, cervicovaginal secretions, blood, breast milk, saliva and other body fluids. The infection is largely spread through sexual contact. It was first recognised in north America and Europe in homosexual/bisexual males, and then in intravenous drug misusers, and recipients of infected blood and blood products. This last route of infection has been largely eliminated in rich countries by discouraging donations from those at risk, and antibody testing. Heterosexual transmission is now the most common route of transmission worldwide. In the UK this is largely among people who have come from endemic areas such as sub-Saharan Africa. Transmission from mother to baby can occur in *utero*, during parturition and via breast milk. Transmission to health care workers is rare apart from percutaneous hollow-bore needlestick injury with a risk of 3 per 1,000 cases; this is much lower than with hepatitis B.

A recently highlighted issue is the intense viraemia shortly after initial infection. There is a suggestion that at this time the patient is especially infectious and likely to be unaware of this.

Epidemiology

AIDS was swiftly recognised to be a major problem attracting great interest and a remarkable volume of biomedical research which has led to general advances in virology, immunology and infection.

The number of cases increased dramatically and the infection is now worldwide. More than 20 million people have died from HIV infection, 60 million have been infected, and five million new infections occur every year of which 800,000 are children. These children are often left as orphans when their parents die from AIDS.

In the UK there are approximately 60,000 infected people, a third of whom are as yet undiagnosed. About 7,500 people are newly diagnosed each year, just over half are infected heterosexually, most of them from sub-Saharan Africa. Very few are intravenous drug misusers and the remainder are homosexual/bisexual men.

Control
Control methods hinge on education. This should cover the importance of stable sexual partnerships, safe sex, correct use of condoms with new partners, sterile methods for intravenous injections, and antibody testing of all donated blood and organs. Co-existing sexually transmitted infections (STIs) such as genital ulcers, gonorrhoea and *Chlamydia* infection increase spread of HIV; education should include advice about STIs and the need for early effective treatment. A major concern is the many infected people unaware of their status. Antenatal mothers are tested unless they opt out, i.e. decline. It has been recommended that opt-out testing should be more widely adopted. Opt-out HIV antibody testing is now policy for all patients attending sexually transmitted infection/genitourinary (GU) medicine clinics but the practice is not universal. It is interesting that it has taken so long to reach this policy; serological tests for syphilis and investigations for the other common STIs have been routine for many years.

Natural history of HIV infection
As the epidemic unfolded, the natural history of HIV infection gradually became apparent. Following acquisition of the virus there is sometimes a short illness resembling glandular fever followed by a period with a mean of 10 years when the patient appears clinically well despite the advance of the infection and gradual reduction in immune competence. A series of minor conditions appear and eventually the patient develops one or more of a range of serious conditions that fulfil the criteria for the diagnosis of AIDS. These criteria have been drawn up over the years by committees of experts.

One unusual feature of HIV infection is that while many years may elapse before severe illness develops, the natural history appears to be universal progression to death. Many other viruses that infect man remain asymptomatic or cause only minor illness in many individuals; only a minority develops serious illness.

Research and development have led to a range of parameters to assess the immune and virological status. The most useful of the former is a count of the circulating CD4 lymphocyte helper cells. These gradually decline over time and it is possible to plot the onset of opportunistic infections and neoplasms against the CD4 count. Until the development of effective antiviral therapy (see below), prophylactic antimicrobials could be started before patients became susceptible to these infections and clinicians were prompted to be alert to the development of complications. The most useful virological investigation is the viraemia or circulating viral load. Serial estimations show a high count shortly after infection followed by a brisk fall and then a gradual increase.

The range of diseases complicating HIV infection is wide, indicating that all systems of the body can be affected. Opportunistic infections vary geographically according to the local prevalence. For example, in many parts of the world tuberculosis is common and occurs with HIV infection. In the developed world *Pneumocystis carinii* (now called *Pneumocytis jirovecii*) pneumonia is the main opportunistic infection. It was a localised outbreak of this infection that led to the first recognition of AIDS in the USA. Skin diseases are frequent at all stages, drug rashes are common, and candidiasis of the mouth and oesophagus occur. Bacterial, fungal and viral infections often appear while tumours in the late stages include non-Hodgkin's lymphoma and cervical cancer. Neurological problems include peripheral neuropathy, HIV-associated dementia and progressive multifocal leucoencephalopathy.

Management of patients
In the UK the condition was first recognised in homosexual males. Many had a past history of other STIs so turned to the GU medicine departments they had already attended. Some required in-patient care. In the early days management consisted of advice on healthy living, plus prevention and treatment of opportunistic infections.

Outpatient care
Initially these patients posed considerable problems in GU medicine departments which were organised for the rapid management of large numbers of patients with relatively simple conditions. In contrast the smaller number of patients with this new infection had complex, time-consuming medical and social

problems. In addition, injecting drug misusers found difficulty in attending outpatient departments for booked appointments, tended to appear unannounced, failed to follow management routines, and could be disruptive, disturbing other patients and staff. Gradually more funding became available, more staff was appointed, and more accommodation was found. At first many general practitioners were reluctant to look after these patients, though this practice is now being encouraged for patients with early disease. Others attended infectious diseases/infection departments some of which had experience of injecting drug misusers.

Community services have helped many patients, while special HIV support groups have sprung up all over the country, especially in those areas with many infected patients. Patient and support groups have raised funds, sometimes substantial, to augment NHS provision.

Inpatient management

When AIDS was first recognized, GU medicine clinics had little access to inpatient beds and lacked medical staff to manage long, complex admissions. A few large clinics organised beds and managed patients with their own medical staff. Others made a variety of arrangements. In some districts the infectious disease/infection department undertook inpatient care. Many cases had *Pneumocystis jirovecii* pneumonia or tuberculosis so were looked after by chest physicians. In other hospitals general physicians managed the inpatients. Co-ordination between inpatient and outpatient care, and community services is vital.

Serum antibody testing

It is a tribute to researchers and manufacturers that soon after the HIV was recognized, sensitive, specific, cheap serum antibody tests became widely available. However their clinical application presented new issues. In most countries in North America and Europe patients were counselled before they were tested, because of the problems that followed a positive result for an ill-understood condition that inevitably led to death after a series of debilitating illnesses. Counselling took time so required yet more resources. Again many patients came to GU medicine departments though some special testing clinics were established. A few general practitioners arranged tests. An exception to pre-test counselling is blood donation where donors sign agreement to a list of screening tests without any detailed discussion. If the HIV antibody result is reported positive, the donor is recalled for counselling and retesting. Organ donors are tested in a similar way.

While for many years a sample of venous blood was required, more recently tests have been developed that only require a finger prick sample of blood or a sample of saliva. Rapid methods can provide results while the patient waits.

Antiviral therapy

The management of HIV infection was revolutionised in 1996 when it was shown that multiple antivirals given together dramatically reduced circulating virus, increased CD4 counts and restored immune competence. This form of treatment, usually with three drugs, is called Highly Active Antiretroviral Therapy or HAART. There was a marked reduction in new AIDS diagnoses and deaths. These antivirals are expensive and at first were only available in developed countries. Gradually they have become more widely available. Management now centres on adjusting drugs and dosages to minimise the side effects. These can be very troublesome and include raised blood lipids and arterial disease, with myocardial infarction and stroke. Renal damage may also occur related to drugs or to a direct effect of HIV. There is redistribution of body fat from the periphery to the centre. While multiple drug therapy minimises viral resistance, this can still appear and careful monitoring of circulating viral load and drug sensitivity remain essential. Patient adherence to complex regimens is vital to minimise viral replication. None of the current treatment regimens eradicates infection, treatment is lifelong, and the disease can still advance due to drug resistance and poor adherence. While life expectancy has dramatically improved, it is too soon to predict survival rates for patients treated with HAART.

Vaccines

Like many other viral infections, the most likely method to control HIV will be an effective vaccine. Since the virus was first identified

scientists have been working on vaccine development, so far without success. As already indicated, HIV is genetically diverse, mutates rapidly and has been described as one of the most complex viruses ever identified. In addition, there are no cases of natural immunity to guide vaccine development and no existing vaccines against other retrovirus infections in humans. There has been a number of developments suggesting that a possible vaccine had been discovered only to find that this was a false hope. The most optimistic prediction is that it will be at least another 10 years before any kind of vaccine is available while pessimists suggest it may be 50 years.

Current situation
Like many other STIs, HIV continues to spread with increasing numbers of cases reported in the UK and world-wide. Education is the main control weapon but requires constant and consistent effort. Clinical care now centres on managing antiviral therapy. HAART regimens are becoming simpler with less frequent dosages but treatment remains life long. Patients are living much longer with higher quality lives.

One positive feature is that the polysystemic nature of the disease has brought together staff from many disciplines. The interchange of ideas is vital to the optimal management of HIV infected patients, enhances the care of other patients, and improves postgraduate training, especially when there are regular multidisciplinary meetings.

Making the Grade

By Judith Langfield

With dry mouth and thumping heart, I climbed the narrow spiral staircase to the organ-loft. Facing me at the top was the examiner, seated at a small desk. She was young and had long, blonde hair. Oh dear, even the examiners these days look as though they are fresh out of school.

She checked my name and that the exam was Grade 6. I adjusted the organ-bench to my height, and sat on it ready. Candidates can choose in what order to take the various components of the exam, and I had elected to start with scales and arpeggios. At Grade 6, all the manual scales have to be known, plus a selection of manual and pedal arpeggios. There is also a pedal exercise, taken from a work by Mendelssohn.

Next came sight-reading. Candidates are given half a minute to look at the music. During this time, I have to select appropriate stops, decide which manuals to play on, work out the key, the time, and then look for any awkward bits. The half-minute goes very quickly! Fortunately, I was playing on a three-manual organ with pistons, which are buttons with a selection of stops already set up. The music had to be played moderately softly on two manuals, so I pressed the appropriate piston. I then just had time to work out the key and time and play a twiddly bit, before the instruction to start came. I thought I was doing all right until the middle, when the pedal part went up high. I got totally confused as to where my feet were, and completely lost it. I kept going, however, with the hands, and eventually retrieved the pedal part. My tutor had impressed upon me, during lessons, the importance of keeping going. After all, in a performance, when playing with a group, or accompanying someone, it is wrong to stop because of a mistake. Everyone has to keep to time.

Transposition followed. I had to sight-read and simultaneously transpose down a tone, a two-line piece of music, on manuals only. Again, I had only half a minute to decide on the stops, the key, and the time.

Then came the three performance pieces, which I had been practising for months. Candidates choose one piece from each of three lists. List A is music from the Baroque period, which is roughly 17th and early 18th century. List B is Romantic, which is approximately 19th century. List C is modern. My first piece was *Plein Jeu*, by Clerambault, an early 18th century Parisian organist. My second one was a beautiful slow composition by Frank Bridge, an early 20th century English composer. My third offering was *Toccata in Seven*, a fast romp in seven time by John Rutter, who is still very much alive.

Lastly, the examiner and I descended to the piano in the church nave, where my musical aural skills were tested. This has always been my

problem area, as I am hard of hearing. However, with my fantastic Phonak Savia hearing-aids, I have been finding it a lot easier. My first test was to sing from memory, the upper part of a two-part melody, played by the examiner. Then I had to identify the type of ending, known as a cadence, at the end of a passage that she played. Next she handed me a line of music, which I had to sing at sight, while she accompanied. Finally, I had to describe the texture of a piece of music that she played, say to what period it belonged, and then, from memory, clap a section of it.

Afterwards, I worked out my score and thought I might have done enough to just get a Merit. Marks are awarded out of 150, with 100 for a Pass, 120 for Merit and 130 for Distinction.

Ten days later an email from my tutor arrived in my Inbox. The subject was "Congratulations!" Phew! - I thought, that means I've passed. Opening the message, I found that I had 131 marks. Distinction! Wow! Me, distinction! Fantastic! Unbelievable! Whoopee!

I found that I had done well in all areas including distinction in the sight-reading and transposition. I had obviously done much better than I thought.

Having vowed, just before I climbed the spiral staircase, never to take a music exam ever again, I think that perhaps I might change my mind, and go for Grade 7 in a couple of years. Despite the agony, it definitely is worth the achievement.

10th Anniversary Celebration - (left) Harvey White with Aileen Adams and Pat Last, (right) Sheila Macvie with Jill Durrant

Verses by Harvey White on the Tenth Anniversary of the RFS

Look at your colleagues
Aren't they all sprightly,
Fit as a fiddle,
Not even a stick.

Over a tankard,
Hospital stories,
Listen a minute
And laugh yourself sick.

Enjoyed our ten years,
We've all had some fun.
Meet up with your friends,
A Freedom Pass home.

Polio, a Survivor's Story

By Margaret Elmes

I was 26 when I fell ill with polio during the last epidemic in England in 1957, the year before Salk vaccine was permitted for use in the UK. I had done my house jobs at Barts and six months at Hammersmith where I met my husband.

We were married in January 1957 and later that year went skiing in Switzerland. On the last day of the holiday I went into some deep snow and sprained my left knee and was unable to work. I became pregnant and in August, on a Saturday after the Bank Holiday weekend, fell ill with fever, weakness and very severe pain in my back. I was due to do a locum GP surgery on the Monday morning so my husband called my sister up from Kent to stay with me while he did my locum. However by Monday morning he had consulted our neighbour, an obstetric registrar at UCH where I was booked for antenatal care who arranged admission to the isolation ward of the obstetric hospital at UCH. I had only noticed difficulty in standing up from sitting at home but by the time I was admitted I found it difficult to lift up the teapot from my tea tray. I was fully aware but whenever I closed my eyes nightmarish ideas and visions appeared before me. Professor Max Rosenheim, the UCH professor of medicine had been asked to see me and on examination found some muscle weakness so performed a lumbar puncture and had me moved to a single ward at the top of the hospital, overlooking Gower Street. I had to be taken through the basement of the hospital and remember seeing the overhead pipes. A nurse was delegated to do regular pulse and respiratory measurements during the night as I later found out there was an iron lung ready in the next room in case my diaphragm failed. I thought I had peripheral neuritis and expected to make a good recovery so it was rather a shock when the registrar told me that I had polio. I was kept on bed rest for the next few weeks but could move my limbs and use my hands.

I was transferred to the Royal National Orthopaedic Hospital at Stanmore for rehabilitation and we were all delighted to find that when put into the pool I could walk without difficulty. Daily physiotherapy by the physiotherapist who had treated Michael Flanders, which always started with painful stretching of all affected muscles, enabled me to go home for two weeks in the month the baby was due but then be admitted to the antenatal ward at UCH because of signs of toxaemia. My daughter was born on December 12 and seemed to have no problems and had a healthy life until her late 40s when she died from an aggressive sarcoma in the same muscle of her left leg that was the most badly affected by polio in my left leg. This is one of the coincidences that intrigues but doesn't give a definitive answer.

I was left with weakness in the anterior deltoids on both sides, left quadriceps, left abdominal muscles and left sacrospinal muscles. However I was able to lead a reasonably normal life apart from sports for the next 25 years, during which time I had 2 more children and went back to work teaching Histology part time at Queens University, Belfast. This led to a PhD in localising zinc in the Paneth cells of rats and the effects of zinc deficiency and an interest in zinc and copper in the body. When we moved to Cardiff I worked on the immunocytochemical detection of the metal-binding protein metallothionein in human tissues with a particular interest in hepatic copper retention and did this for 20 years. I was a member of the British Society of Gastroenterology and the Pathological Society of Great Britain and Ireland. I was an active member of the BMA's Consultants Committee and was elected to BMA Council.

We were keen supporters of Swan Hellenic Cruises from the 1980s and after my retirement went annually until we had visited most of the Hellenic and Byzantine sites around the Mediterranean, been round

the Black Sea twice and been to the Baltic and Scandinavia. I only gave up "doing" the Mediterranean when I found I couldn't climb up to all the ancient cities, most of which were an acropolis on top of a hill.

During my final year of work I found mounting the steps to my place of work was becoming difficult and took a walking stick to work with me as I had a tendency to trip and fall. I had noticed that unusual use of my legs was followed by severe stiffness in those muscles accompanied by muscle fasciculation and became aware of a condition written up in the medical press called Post-polio Syndrome. I prefer to call this Late Effects of Polio as it is complicated by the ageing process and arthritis. It is common among those of us who have had 20 or 30 years of reasonable mobility, and in addition to decreasing strength in the previously affected muscles, is accompanied by increasing fatiguability. There may also be neurological problems due to poor posture and nerve pressure. I have had two quite serious falls in the last three years, the first resulted in hospital admission with a laceration on my forehead needing 15 stitches (I had a head wound and lived alone) and the second led to a sprained ankle and a contusion on my shin that took 6 months to heal.

What concerns those of us with this problem is the ignorance about polio and its sequelae in the younger generations of doctors and ancillary medical staff. There are cases of sufferers being labelled as neurotic until the past history of exposure to polio, which may have been non-paralytic, is discovered, and it can be confused with chronic fatigue syndrome. The problem is that over-vigorous exercise leads to painful and less efficient muscles which may become permanently impaired. A previously energetic person has to learn to live within their capacity, which is contrary to the teaching they received when recovering from the acute illness.

I have joined a support group of the British Polio Fellowship which issues booklets with most useful information that we need to pass on to our medical practitioners who are not aware of drugs we need to avoid, such as statins, and potential respiratory complications such as sleep apnoea.

I am now a pensioner and have needed to find my way through the Social Security support system. After the death of my husband I was awarded an Attendance Allowance to enable me to have a weekly bath and general assistance with personal care, I have difficulty in reaching my feet, and I have a personal alarm issued by my local authority. I have a Blue Badge entitling me to use disabled parking which is a godsend at supermarkets with their narrow spaces. I have a scooter and a hoist to put it into the back of my car.

I cannot apply for a Mobility Allowance to put towards a car from Motability because I'm over 65, one wonders whether when you become a pensioner you are meant to stay at home and lose the freedom of your own car. Fortunately I can still drive a car with a high seat and can go to retail and entertainment venues with a disabled car park within 50 yards of the entrance. Since the Discrimination Act many venues have installed ramps or lifts but there is often a problem with small businesses such as dentists and opticians and some listed buildings have to take years before obtaining permission and finance to make necessary changes. Some venues forget that the toilets need modification, if only grab rails on each side, and I have been proudly shown one with three steps up to it!

I manage to lead an interesting life by using taxis or a driver when it is too far for me to drive myself and by using a walker in the Wales Millennium Centre to go to opera and ballet. I'm a patron of the National Museum of Wales, which organises excellent tours and talks. I was able to go to English National Opera at the Coliseum with my eldest son to celebrate my 75th birthday in June. I have daily domestic help and a gardener who is a real treasure enabling me to stay in my home which I have occupied for 25 years so I am much more fortunate than many other "survivors" even though I can't walk more than a few steps without sticks or a walker or sit in a low or armless chair. One just has to regard it as an inconvenience to be overcome.

Rambling in Burgundy

By Derrick Jackson

Just over half way between the north French coast and the Mediterranean Sea lies the city of Beaune in Burgundy. The first houses were built by the Gauls around 52 B.C. and they named the town after their sun god Belen. The elegant old centre of Beaune is surrounded by ramparts and contains the Hôtel des Ducs de Bourgogne built during the 14th - l6th centuries and which now houses the Musée de Vins de Bourgogne. The Hôtel Dieu, founded in 1443 by Chancellor Rolin of Burgundy, designed by Jehan Wisecrère the Flemish architect, provides a fascinating glimpse of social history. The building is attractive with its elaborately tiled roof and contains two religious masterpieces, the Christ-de-Pitié statue, carved in wood and Rogier van de Weyden's polyptych *The Last Judgement*. The inscription under this painting states 'Depart from me, ye cursed, into everlasting fire, prepared for the devil and his angels'. It was perhaps seen as a warning to the inmates.

The Hôtel Dieu was a hospital until 1971 after which time part of it was converted into an old people's home staffed by nuns and funded by the profits from its Côte de Beaune vineyards. One of the hospital wards remains, still in its original form with lines of beds, each for 2 people. Its pharmacy contains some unusual pharmacological agents, woodlouse powder, vomit nut powder and shrimps' eyes, each housed in its own earthenware jar. The Collégiale Notre-Dame to the north is well worth a visit. The splendid large tapestries, five in all, depict in nineteen scenes the life of the Virgin Mary. Presented to the Church by Archdeacon Hugh Lecocq in 1501 they have been beautifully restored. Magnificent as they are, perhaps most impressive is the accurate depiction of the wild flowers and small feral animals that grace the Virgin's path. They are only on display during the tourist season.

It is attractive motoring country with interesting tours. To the south-west through Pommard, Volnay and Puligny Montrachet or northwards along the 'Côte d'Or' towards Dijon through Nuits St Georges, Gevrey Chambertin etc. The rolling hills in this part of France have many wooded areas between the vineyards, the latter with their golden reddish brown soil (hence Côte d'Or). In addition, there are many green fields in almost all of which the greyish white Charolais cows so typical of central and southern France graze. The majority seem to spend a large part of their time sitting or lying down. In the spring, there are abundant cowslips in the fields. Cows are reputed to produce as much if not more so called greenhouse gases than the motor car. They should undergo an annual MOOT like motor vehicles.

The area seems to typify the so-called French Paradox with the source of some excellent wines next to the producers of saturated fat. A lthough the existence of this paradox had been noted in the early nineteenth century, it became the subject of much debate and further research after the publication a paper from a MRC research group[1]. Originally, the claimed beneficial effect was attributed to red wine but subsequently it has been shown, thank goodness, to be an 'attribute' of most alcoholic drinks[2]. In parallel with this research into the claimed properties of alcohol, similar beneficial effects have been claimed for high fruit consumption. Perhaps it would be the same if one just ate a lot of grapes[3], Italian pizza[4] or chocolate[5].

Beaune has so many fine restaurants that one is forced to the conclusion that it is necessary to consume adequate quantities of their wine in view of the amount of animal fat consumed, particularly that derived from cows. Is this really a paradox or is it the milk that provides the claimed reduction in cardiovascular disease in France? In Burgundy the cows are different from those found in many other European countries, they are a greyish white in colour and according to some researchers their milk contains Al beta casein as distinct from cow's milk from northern Europe much of which contains A2 beta casein.

There are experimental animal studies to support the hypothesis although no definitive information from human studies at this time. Is this the 'Milk Paradox'?

An interest in milk, wine and health is featured in Arbois, a short and pleasant drive to the east of Beaune. This is a wine centre near the Jura mountains, producing two distinctive wines, *vin de paille* and *vin jaune*, quite unlike any others in France. It was also the home of Louis Pasteur. Did he know about the milk paradox? Is pasteurisation the first step in the manufacture of a prophylactic medicine containing A1 beta casein? Pasteur's house is situated near an old ford over the River Cuisance and it has the original furniture and wallpaper from Pasteur's time. In the billiards room with its French billiards table, without pockets, there is a painting of Jean-Baptiste Jupile trying to prevent a mad dog from attacking his friends. He was the second person after Joseph Meister to receive Pasteur's anti-rabies treatment. Even after all Pasteur's work on the preparation of vinegar and the prevention of wine contamination, in the Jura they still treat wine with sulphur, at least according to the local guides.

North-east of Arbois lies the town of Orans, some 40 miles from Beaune and the birthplace of Gustave Courbet (1819-1877), which recently held an art exhibition entitled Histoires Vaches. The French obviously appreciate their bovine friends. You may say 'pull the udder one' but remember that the consumption of dairy products will protect against gout[6] thus enabling one to take adequate quantities of alcohol - some paradox! Milk consumption may also protect against colon cancer[7]. Additionally, a recent publication[8] challenges the assumption that milk drinking is a cause of stroke and ischaemic heart disease, at least in the Caerphilly area of South Wales.

The French Paradox is most unlikely to be the result of excessive garlic consumption[9] as this has little or no effect on plasma lipids - or is it associated with the deleterious effects of antioxidant supplements in the UK and USA[10]? According to Minerva[11] there are nations who have a low consumption of fat e.g. the Japanese and nations with a high intake of fat, e.g. the Mexicans. Both races suffer fewer heart attacks than the British and Americans. It seems speaking English is the cause of the problem. The answer is simple, order your meal in French. If in doubt ask for *le rosbif*.

It will be interesting to see the next comparison of death rates from cardiovascular disease. Despite the massive increase in wine production each year resulting from the European Common Agricultural Policy, the French consumed 5% less wine in 2003 compared with the previous year. The average consumption of wine per person in France has fallen from 100 litres per year in the 1960s to 58 litres in the early part of this century and only 37% of the French consider themselves regular wine drinkers compared with 61% in 1980. Perhaps they are drinking more milk! For example, in 2004, 19% more wine was produced compared with the previous year and this together with a falling export market has led the French to consider the reclassification of wine as a food, as in Spain, and thus facilitate its sale. Wine appreciation sessions have been advocated for schools. These figures might be distorted by the observation that the lower level of heart disease mortality in France is simply a time-lag phenomenon as the French did not start consuming the quantities of fat typical of some American and British diets until relatively recently and therefore it will be some time before they catch up[12].

To return to the travel details, Beaune is about five hours by road from Calais along the A26 motorway. There are many interesting places en route e.g. Reims and Troyes and also many within driving distance of Beaune. To the north-east lies the Abbé Citeaux, the Roman name for which is Cistercium and this gave the Cistercian Order its name. Citeaux was founded by Robert on the Day of St Benedict, 1098. The ancient building is beautifully restored and adapted to modern use including an appropriately discreet tourist shop where an ever-patient monk will even struggle with the intricacies of credit card shopping! But most surprising within this ancient setting is a beautiful modern church. Its design and the use of proportion combined with a sensitive adaptation of light allows for a very fair comparison with the effect achieved by Brunelleschi

in the lovely Pizzi Chapel in Florence. Both are remarkably peaceful places.

Under the third Abbott, the Englishman Stephen Harding, Citeaux started to prosper particularly after the arrival of the young French nobleman, Bernard of Fontaines and in due course further settlements were established including the Abbey Fontenay about 40 minutes drive to the north west of Beaune. Fontenay contains the statue of Our Lady of Fontenay from the end of the 13th century. The abbey has been owned by the Aynard family since 1906 and in 1981 it was classified in the UNESCO World heritage list. It is well worth a visit.

Beaune is a pleasant and interesting place to stay, there are many good hotels and of course wine shops. These are beautifully kept and the owners obviously love their wines. In one of these shops the proprietor will show you, on a plan of the vineyard, which vines produced any particular bottle of Gevrey Chambertin. I keep looking in the vintners for a good Chateau Lait but until I find it I shall stick to the old favourites and have a glass of whisky and a piece of Wensleydale cheese after dinner.

(Readers requiring the references please contact the editor, preferably by email.)

Tuberculosis

William Cattell

(Recent Advances for Retired Physicians, 4 December 2006)
Many of us believed in the late 50s and early 60s that tuberculosis had been conquered and its management consigned to history. Sadly, as Dr John Moore-Gillon of St Bartholomew's Hospital noted, this was far from the case. Not only was the condition not eradicated, but it was increasing in prevalence. This he illustrated dramatically by showing CT scans of patients recently diagnosed with tuberculoma of the brain and tuberculosis of the spine. A recurrent theme in his talk was "back to the future". We were seeing again what we thought had vanished.

An increase in tuberculosis is a global phenomenon with a reversal of the previous downward trend. In the UK there was an increase in new cases of 11% between 2004 and 2005, with 8000 new cases instead of 1000 cases if the previous downward trend had continued. There is , however, a huge regional variation in the incidence of new cases. London, like other large cosmopolitan cities has a high rate of new cases while rates are low in other parts of the country. There is also a big difference as between UK- and non-UK- born individuals, the incidence being little changed in the former, while much higher in the latter. This is true for white citizens, but black non-UK born Africans have an especially high incidence.

Turning to the much publicised emergence of drug resistance and the spectre of "untreatable TB", Dr Moore-Gillon pointed out that multiple drug resistance (MDR) is not yet a colossal problem in the UK, accounting for about 1.5 % of cases. Resistance to at least one first line drug occurs in about 9%. Again there are regional variations with one hospital in North London having isoniazid resistance in some 20% of cases. Examining the nature of the problem, Dr Moore-Gillon reviewed the natural history of tuberculous disease, emphasising that the vast majority of primary infections healed spontaneously and very many individuals have calcified pulmonary lesions. He calculated that some 30% of the world population had been infected with tuberculosis. Only some 5% of initial infections progress. However, active disease may develop, months, years or decades later. Extra-pulmonary disease may occur initially or during later reactivation.

Many factors condition the development of active tuberculosis. It is ten times more common in poorer areas than in the richest. Malnourishment, HIV positivity, coexistent diseases such as diabetes or renal failure all predispose to active disease, whether on initial infection or in individuals with "healed" primary lesions. Spread of infection is also more likely in the malnourished, living in crowded accommodation. There is a close correlation between the incidence of tuberculosis and the Jarman index of social deprivation. Of special importance is the diagnosis of latent subclinical cases who may both progress to serious

active disease and be a source of infection for others. Similarly, supposedly healed lesions may reactivate and prophylactic treatment of these should be considered. It is thus important to have effective diagnostic tools to identify individuals still harbouring tubercle bacilli. Dr Moore-Gillon considered the Mantoux test too non-specific and it could not distinguish the continuing presence of tubercle bacilli from some historic healed lesion or previous BCG immunisation. Instead he recommended the more specific in-vitro gamma imferon test which only identifies the continuing presence of tubercle bacilli in the body.

Turning to the problem of MDR, Dr Moore–Gillon dismissed the myths that MDR organisms were more infectious or more aggressive. MDR was a real problem, usually the result of ill-chosen or innocent mistreatment with drugs to which the infecting organism was already resistant. Treatment was difficult but not impossible, sometimes requiring weeks or months of inpatient care – "back to the future". Treatment required both old-fashioned drugs such as streptomycin and PAS, and the judicious use, in combinations, of quinolones, cycloserine, prothionamide etc. Concluding with a series of dramatic illustrations of various presentations of tuberculous disease, Dr Moore-Gillon emphasised what we were all taught as students – there must be a constant alertness to the presence of tuberculosis in all its disguises. A stimulating, witty and informative presentation.

Nineteen-Fifty-Eight

By Shirley Emerson

The absolute chaos of the Medical Training Appointments System and the tremendous problems of the young doctors involved, reminds me of my appointment as house physician nearly 50 years ago. My experience appears to be like a very gentle episode from the ITV production *The Royal*.

Today's graduates seem to be very organised, knowing exactly what branch of medicine they are aiming for. I was in limbo, qualifying as a doctor was my ambition and a personal triumph. Starting medical training had been difficult. Our next door neighbour, in company with many others, said it was a waste of time and money, as I would get married. My neighbour even offered to help me get a good job at Parsons Factory as a draughtswoman (I didn't know what this was). Even the careers teacher at my school said I had no chance, because I didn't know Latin, but I had read the regulations and proved her wrong.

After Finals, my friends had all been interviewed and accepted in various departments of the teaching hospital in Newcastle. I had made no attempt to find a job. My thoughts were distracted by saying goodbye to my boyfriend of several years, who had just left to become an intern at Queens in New York. Always having lived in the north, I thought I would move south, as for some quaint reason, I felt nearer to my boy friend in America or at least Heathrow, where I had waved him goodbye. How my southern move ended up with a job in North Yorkshire requires explanation.

My parents went to visit some old friends in north Yorkshire and I, having nothing better to do, elected to accompany them. On the way home, late on a Sunday afternoon, I saw a sign to the Friarage Hospital in Northallerton. There was a large old building - the old workhouse - and lots of prefabs (I am told it looks very different now) and a porters' lodge with two porters. They looked surprised when I enquired about vacancies, but without further ado, promptly phoned the hospital secretary. I was interviewed in his sitting room and after a phone call to the consultant, I had a new job. I was to be house physician looking after two wards – as was the custom in those days - very much separate male and female with 30 patients per ward.

Having just left a large teaching hospital where there was an extensive retinue of SHOs, registrars and sundry attached postgrads apart from the consultant, I was quite shocked to find I was the only doctor apart from the two consultants. I was kept very busy admitting and discharging patients and taking bloods. The nights were also busy. I would examine a new admission and, as these were pre-computer days, and to hide my ignorance, I would run back to the residence, through the hospital grounds to consult my Davidson on what step to take next and then run back to the ward. It kept me pretty fit.

What I did not know when I joined the staff was, that when the obstetric house surgeon was on his night and weekend off, I was his cover! The maternity unit was some distance away from the hospital across the main road and the level-crossing of the main east coast railway line. Any patient needing surgery had to be transferred to the main hospital, which sometimes caused exciting times, especially when the crossing gates were closed. The more simple techniques like forceps deliveries were done in the maternity unit. These "simple" procedures were something I had watched but never carried out, although, as was the rule at that time, I had delivered over 20 babies. The big problem came one night when I was called to a patient needing a forceps delivery. The consultant was several miles away and so it ended with me giving the anaesthetic and the on- call anaesthetist did the delivery.

Other specialties needed my care at weekends and nights. There was a TB ward and a paediatric ward – I learnt a lot. Major accidents on the Great North Road were very common and in emergencies, I was required to help out. One other specialty I learned was to become a translator - all the other junior staff were from India. Their English was very good, but they found coping with the dialect of shepherds and farmers from the Dales was beyond their understanding.

At Christmas, as was the way, the wards were quite full and a full Christmas dinner was served. It was then, that I discovered an extra duty. On Christmas morning, all the staff visited the various wards having a glass of sherry at each stop, so by lunchtime I was feeling a bit vague. I then discovered that the consultant and the houseman were expected to be at the patients' lunch, the consultant in the women's ward and me in the men's ward, where we would then carve the turkey. This was another task I had never ever carried out and what was worse I was surrounded by all these Yorkshire Dalesmen shouting encouragement as I completely wrecked the large turkey. Dinner was quite delayed and cold by the time I had finished.

I did move much further south with my next job and fortunately met and married a very practical man, who is very good at carving turkeys!

Photos of visit to Vienna by John Ford: 10th Anniversary Celebration by Sally Gordon-Boyd