A 1960's Medical Student

Contents

Fifth Year Medical Student

The core of the fifth year were the three month 'runs' in medicine and surgery, where in groups of three to six, we were attached to one of the medical or surgical teams. The Deanery (one Dean, One Administrative Assistant and One Typist) liked students to get used to one hospital, and so although we 'rotated' between different specialities, we did not 'spin' from one place to another. This meant that we developed a sense of place and belonging, as although we would never have admitted it, being a medical student near qualification is a scary time in ones life, and one needed some essence of 'place' and 'family'.

I was assigned to the Royal Infirmary, a remnant of the Workhouse and Infirmary system, but re-built in Victorian times, to cope with the burgeoning expansion of population resulting from the steel works spreading up the Sheaf and Don Valleys. It was a hard landscape of decrepit factories and still with the remnants of the two-up, two down terrace houses, interspersed with bombed areas from the blitz, some of which now contained ribbons of multistory council flats. The Infirmary nestled near the bottom of the valley and just up from it was an old detached house, possibly originally a vicarage, that was where we lived every fourth week, when we were on call for our 'firm'. This student residence, like those at the other hospitals had been christened by the first generation of Sheffield medical students with an medical name and thus was 'Charcot's Joint' – a joint degeneration resulting from advanced syphilis, first described by Charcot. The residence at Jessop's Women's Hospital was 'Chorionic Villa" - a reference to those parts of the placenta that do the actual work.

'Charcot's Joint, being separated from the hospital and fairly large, was notorious for its parties as there was no on-site supervision, only cleaners who came in daily. Living there was rather like being in a school dormitory (although we had separate rooms) or junior officers' mess, and practical jokes and high jinks were part of the lifestyle and helped with the unacknowledged stress we lived under. It was unwise to let it be detected that you had a companion in your room, as you were likely to find a smouldering newspaper or fire extinguisher nozzle pushed under the door to flush you and your partner out. The common room had a 14 inch black and white television and tea and coffee making facilities, but most evenings, when not on the ward, we spent just around the corner in one of the final examples of a Sheffield workingmen's pub, still with its original Victorian décor, under an impenetrable layer of cigarette and pipe smoke. One student was always deputed to stay at Charcot's Joint to answer the phone if a student was required in casualty, theatre or on the ward, and they would then phone the pub to pass on the message.

Whilst resident, we ate our meals in what was still called the hospital staff canteen and usually commandeered a section with the Student Nurses so that suggestive banter could be batted back and forth. Hospital food at that time was attractive to us as most medical students lived in tiny flats with rudimentary cooking facilities (mine was a single gas burner in the 'wash-house') and so having a range of even institutional cooked meals was like the Ritz to us. Once a month, the House Surgeons and Physicians in the resident doctor's mess held a party and attached students were invited as long as they made a contribution to the kegs of beer provided for the occasion. The kegs were obtained at wholesale prices from the pub and wheeled across to the mess on patient trolleys covered with green theatre sheets.

Life was agreeably busy, just keeping up with the social scene, but we did actually work hard as well, but I never remember being tired or bored. The clinical work, as well as being interesting in a medical sense, meant that you had the chance to sit and talk to a universe of people, all of whom had something interesting about them, if you let them bring it out. Yorkshire people are natural story-tellers, once they have determined that the listener is not from the Home Counties, and you learned about real life from the mixture of tragedies, comedies and unbelievable events, real listening revealed (as opposed to 'taking a case history').

Surgery with a Welsh Wizard

I did my surgical attachment with an outwardly ferocious Welsh surgeon called Clifford Jones. He always implied that he was descended from orthopaedic surgeon, Sir Robert Jones, famous for the first publication of an X ray image and an eponymous compression bandage, but the stories were often confused as they seemed to overlap with the exploits of the famous Welsh bone-setter and surgeon family, the Thomas's.

Cliff was a colourful character who liked to keep his students in their place. His favourite trick was to instruct all of us three students to make a rectal examination, having made sure there were only two gloves on the trolley. As well as these 'humorous' foibles, and his tall Welsh tales, he was a superb general surgeon, despite having become the region's ultra-specialist in surgery for peptic ulcer.

Medical students on surgical runs in the sixties had a slightly different relationship with their consultants, compared with medical or obstetric runs, as a lot of time was spent assisting in theatre and almost as much time in the theatre tea room, waiting with the consultant for patients to arrive and be anaesthetised. Therefore, despite Cliff always letting you know who was the king and who was the dirty rascal, you got to know each other fairly well, particularly as he had a disdain for even senior registrars' surgical skills, and insisted on doing a lot of the team's routine and emergency surgery himself. He liked nothing better than the typical Sheffield Friday and Saturday night mayhem of fights and traffic accidents, which allowed him to exercise his remarkable surgical talents, as well as tell unlikely, and if the duty student was female, often unseemly stories over the

bloodied body. His bluest stories usually commenced after he ripped the modesty sheet off a customer, disdainfully looked down at the 'wedding tackle', and exclaimed "not a Welshman are you boyo?" He was rendered mute on one occasion by an East-End, hard-case female student, when she responded - "No Mr Jones he can't be, he has testicles". He was a little more careful with female students after this.

Cliff had an aversion to yes-men, and seeing as one of my student team-mates was known as 'Creeping Mary' and the other was not available Fridays (and many other days) ostensibly for religious reasons, but actually to pursue some commercial interests, I spent a lot of time receiving Cliff's wisdom, and appropriately refuting it, when his stories became too outrageous. It was therefore not a complete surprise, when the attachment was almost complete, that he called me aside and said I would be spending the last week as locum (stand-in) house surgeon. I never investigated the legality of the Sheffield system of letting fifth year students act as house physicians or surgeons when the qualified house officers were on leave or sick, but it was an established custom, and regarded as a mark of approval. There were always other qualified house staff to call on and countersign drug orders, and if you got beyond your level of competence you could quickly get help in this era when house staff got one night a week and one weekend in four off, so there were always a dozen or so languishing in the Mess Bar.

My week as a house surgeon did not start well. I began on a Friday afternoon and was taken round the patients by Gwyneth (how Clifford Jones had an attractive Welsh house surgeon was not a mystery) and then she formally handed the patients over to me. The team was not on for emergency admissions until the following Wednesday, so I thought that I would have a few days to work myself in, looking after post-operative patients and admitting new pre-operative patients. However, at 2 a.m. I was woken by the telephone, and was addressed by that most august of nursing staff, the Night Nursing Superintendent. This immediately had me worried as student locums were usually only contacted by the lower grades of staff nurses. "Doctor " she said (the sarcasm in this address to an unqualified student cannot be expressed in words) "A patient has hung himself". "I'll be right there, have you started resuscitation?" I replied. "Oh no " she replied "He's quite dead". I was somewhat nonplused by the silence that followed, but eventually plucked up enough courage to ask why she was ringing me as I assumed that the police would need to be called and the Coroner would deal with the matter. Her response confirmed my classification of Night Nursing Superintendents as a species in their own right, as she then said "He has hung himself in the STAFF toilet and I will not have the nurses using the patient toilets." It shows the degree of terror that night superintendents could invoke in junior medical staff, as I was 'persuaded' to go to the staff toilet where the poor chronic alcoholic had ended his alcohol-free hospital stay, by hanging himself from chain of the high level toilet flush of those days. There, with arms folded the night superintendent instructed me and an orderly to cut down the body and "take it away". We did this, and when, sometime later and with some trepidation, I had to appear at the Coroner's hearing to explain the unorthodox proceedings, I was fortunate that that the Coroner was a graduate of my medical school, and I just muttered the words "Night Nursing Superintendent" and he said "I understand' and adjourned the proceedings.

Although unsettled by the night's events, as no undergraduate teaching had prepared me for it, I was considerably re-assured when Cliff appeared for one of his unscheduled and

unannounced weekend ward rounds on Saturday afternoon. He immediately had a story of an even worse event he had suffered as a junior, when, still recovering from anaesthetic and confused, a large rugby player had run amok and Cliff's tackle had pushed him out of a fourth story window. Cliff could always cap a tale and a lot of them seemed to be true, and in this case, true or not, it restored my confidence. By Sunday, after clerking-in the patients for routine surgery, I was back in a confident mood and got myself ready for the usual round of theatre lists of peptic ulcer surgery. It's amazing to look back and remember that for nearly 60 years the cause of gastric and duodenal ulcers was thought to be due to high stress causing too much acid to be produced by the stomach, which resulted in the ulcers. We now know that most ulcers are caused by infection with a hidden bacterium, but in those days surgeons did elaborate and difficult operations to cut the nerves that stimulate acid production, and re-routing and widening parts of the digestive tract. Cliff was an absolute master of this sort of surgery and had waiting lists of up to two years, so the lists were often of unmanageable size and I was pretty busy. He also had a side line in performing surgery for blocked arteries to the legs due to smoking, so I clerked-in either "company directors" or 60 cigarette a day, steel-work labourers. Strangely enough these two groups seemed to get on well together on the ward, despite their disparate backgrounds or pretensions. Cliff treated the Sheffield steel-workers with his usual gutter bonhomie, but was noticeably cooler towards the company directors and private patients. I suspect he was really from a background of steel-workers or miners and had not a lot of respect for those with inherited money.

By Wednesday, the teams emergency admission day, I was feeling on top of the job, despite a lack of sleep, which has never bothered me as long as I could get a cooked meal every four or five hours – which hospitals provided for staff in those days. The emergency admissions were mostly the usual collection of perforated ulcers, appendices and abdominal pain - soon popped off to theatre, but one was a real puzzle – a fourteen year old girl with vomiting who was very reticent about her problem. I took her history, performed an examination and found a grapefruit-sized mass in the lower abdomen. Having recently done my obstetrics and gynaecology run, I was well, and correctly, primed to think vomiting and lower abdominal mass in any female of reproductive age, added up to possible pregnancy, and that I should not be x-raying her, and so I let the ward sister know that I would be sending for an O & G registrar for a proper examination. The ward sister, a paragon of the Wesleyan Church, insisted that no fourteen year old girl could possibly be pregnant and seemed to think that only a pervert could make such a suggestion. I asked her to talk with the girl and her mother as to the possibilities but when she returned she could give me no indication either way, so I got the team's registrar, in one of his few moments out of theatre, to make the official request for O & G help. I then spent an uncomfortable few hours (the ward sister had spread news of my perversity) before expert O & G arrived. He confirmed my findings and then performed the appropriate visual and internal examinations and with a smile on his face said I was wrong – but not very wrong, as he thought the girl had acute gonorrhoea which had caused urinary retention, the mass being a bladder not a uterus. For some reason the ward sister felt that was much better than being pregnant, and delighted in dwelling to all and sundry on my misdiagnosis, until Cliff overheard her and said a few short, non-religous words, backing me up in my approach.

I was very fond of Cliff and learnt a lot from him and, of my awards, was most proud of my eventual honours in Surgery, as it

was rarely awarded and totally unexpected, as I thought the 'viva' exam I was given was because I was borderline. I always suspected that Cliff had a hand in it, but when I directly asked him, he tapped his nose and looked Welsh.

Psychiatry Patients, Weedkiller and a Lisp

After senior surgery my group had attachments to Psychiatry, General Practice and to all sorts of specialities which we unkindly labelled 'odds and sods' and mostly involved going to sub-specialty outpatient clinics but had some interesting leavenings, including a week of Forensic Medicine

Psychiatry was one of the important components, but I had mixed feelings about it, as our Fourth Year psychiatry lectures had, to put it mildly, been a 'dog's breakfast'. The Professor and his associates, had given a series of lectures, which to me, seemed totally disease, rather than person orientated. I have always believed that the only reasons for putting labels on people who are ill, are firstly, so that, if there is a specific treatment, they can be given the right treatment and secondly so health carers can easily communicate. However, at that time, much psychiatry was based on abstract theories, rather than close observation and investigation of individuals. The Professor, who was the leading authority on suicide, always liked to produce a label for a person, and had an unusual manner, even for a psychiatrist originally from 1930's Vienna. I was told that when he first came from Vienna he spoke good, and almost unaccented English, and looked normal. However, when I met him in the '60's, he had developed a massive domed brow, central baldness with sprays of white hair either side, brushed a la Einstein, and an almost un-understandable thick Viennese accent. I had always believed the old hack that people grew to look like their dogs, but he was the first definite example I met of medical specialists growing to look like the caricature of their speciality.

We had two mental hospitals in our area, a traditional,

foreboding, Victorian Asylum holding hundreds of mostly long-term patients, and a modified Sheffield Steel Magnate's Baronial Mansion, set in a beautiful park and walkway alongside a stream which burbled its way down from the Derbyshire Hills. We had a few sessions at the Asylum which were almost zoological gardens visits, to observe the mostly institutionalised inhabitants, either frozen in catatonic bliss or making repetitive movements, seemingly designed to annoy their keepers.

Fortunately our proper attachment, where we got to see and take histories from 'new' patients, was at the semi-rural Mansion known as "The Woods". This was a more enlightened place and not really secure and so patients and staff shared a canteen and it was often difficult to tell staff (apart from the Professor, who actually looked like a patient) from patients, as nobody wore uniform or badges. There had also developed a tradition that every now and then, even though there were no legally "committed" patients, a patient or small group would 'escape', often up the valley to a conveniently sited pub. As this only ever happened during opening hours, I believe that there was active collusion between patients and some of the male mental health nurses who, joined by the medical students, would raise the hue and cry. Like a 'hare and hounds' we would all then chase off up the valley to the pub and join the escapees for a drink before returning to 'The Woods' and explaining how well we had done to rescue the patients before harm overcame them.

I met some really nice people at the "The Woods", but had real difficulty fitting them into the categories beloved of the Professor. Although I learnt a lot (but not what the Professor taught) I could not see a humane or scientific basis for the way labels were assigned and therapy given. I still occasionally wake at night with memories of two episodes that confirmed my uneasiness about the 'people-caring' and diagnostic systems used in the Psychiatry of that time.

The first was when the Professor (the world's leading 'expert' on attempted suicide) leant far forward into the patient's space, and as an opener, said to a seventeen year old girl, in thick Viennese accent:- "Vy did you take veedkiller? Did you think you vere a veed?" I had great difficulty restraining myself from telling him that you didn't get a seventeen year old Sheffield girl's confidence or trust by that sort of opening, but she fortunately broke down in tears and fled, so I went after her, found one of the many good nurses in "The Woods" and left her to try and recover a situation which turned out to be un-recoverable, as the girl got her parents to discharge her. I only hoped that the sheer crassness and brutality of the Professor's approach made her never wish to attempt suicide again, in case she had to encounter *him* again. I have often tried to rationalise that he did it for that reason, but have never convinced myself.

The second episode was just as horrifying and left me with nightmares for some time. I had been assigned an already resident, 22 year old patient, to follow through her progress during her course of Electro-Convulsive-Therapy (ECT). As she was already resident and had been diagnosed with 'severe endogenous depression' I never took a full history or fully examined her, and later on discovered that no one else had either. She came from a rich family, and had been diagnosed and referred by the family GP as a sort of private patient. In my later experience I was always distrustful of this sort of arrangement as it meant that the 'normal' routines and investigations often fell through the cracks between the 'private' and the 'public' part of the care. I talked to her a few times before her first ECT, but she was deep in depression and I couldn't really do much except

explain about the ECT procedure and how she might feel during the course.

She was already pre-medicated and very drowsy, when I and a nurse, accompanied her to the ECT room, where an anaesthetist tried to take a history from her about the conditions which can cause a problem with ECT (which he should have done before). She was far too drowsy however and after a cursory examination and measuring of blood pressure, he injected his magic drugs, inserted an airway, and told the ECT technician to apply the electrodes to the head and administer the first shock. As she convulsed, I watched in horror as her face seemed to split open and the upper jaw teeth broke loose and she began to bleed. Despite his previous negligence, in not determining that she had an extensive dental bridge of the upper jaw teeth (broken by the jaw muscle spasm), he quickly did all the right things (although he left someone else to tell her about the 'misadventure'), and she was sedated and taken to the Royal Infirmary Facio-Maxillary unit to have her damaged upper jaw and teeth reconstructed.

As we were still going to specialty clinics at the Infirmary, I visited her at the 'Plastics' ward once she could thickly speak, and found her strangely recovered. She never returned to "The Woods" and apparently made a full recovery from her depression which the psychiatrists put down to a wonderful result, from just one ECT. I was sceptical, and only learnt a more probable explanation years later, when I was doing sessions in General Practice, to augment my miserable salary as a Research Assistant, whilst working for my MD thesis. By chance, the patient of the exploding face belonged to the practice I was working in, and I vaguely recognised her name on the daily appointments list, and got out her brown folder, to have the story brought back to me. I made sure she saw the Senior GP as I doubted that she would wish to be reminded of the events of seven or eight years before. Later I talked with him about her, and he gave some clues as to what had really happened. I asked him to broach with her, at their next meeting, the possibility of seeing me sometime, mainly for my benefit, to understand how she had overcome her problems.

She came in for a routine contraceptive prescription one day, and asked to see me, and so I had chance to ask her to share her story. Only by knowing part of the story could I detect a slight asymmetry of the upper jaw and her slight lisp, both of which added to her attractiveness. She was now married and had had no recurrences of depression and was happy to share her story.

In her late teens she had fallen off a bike and irreparably smashed all her front upper teeth and damaged the upper jaw. For several years, despite extensive but slow restorative dentistry (her facial skeleton would still have been changing, so a permanent cosmetic repair could not be done in one go), she became a recluse. She came from a family where appearance and dress were almost everything and she had been changed (in her eyes) from a beautiful, voluble teenager to a sunken-upper-jawed freak with irregular false teeth, and a funny lisp. She lost all her confidence, felt that people were talking about her, and dropped out of her private school. Gradually, when her restorative work became more natural-looking and permanent and the lisp had almost gone, she re-entered the world, externally normal, but deeply in-confident. She said at that time (her early twenties), she could never bring herself to tell potential boyfriends about her extensive bridge-work, and had a horror that they would discover it, if they kissed her. She tried to make relationships but would never let anybody kiss her, and so her boyfriends (this was the liberated 60's) never stayed around long. She had no

qualifications, did not need to work because of the family wealth, and spent most of her time at home, becoming increasingly inward looking.

Gradually her fears about her appearance returned and she stopped trying to make relationships, although she knew that she was a person who needed to share her life and sexuality with someone. She could not believe, that when people told her that she was attractive, they meant it, and she went into a downward spiral of blaming the world for her accident, and herself for not breaking out of the spiral. Her descent into clinical depression was gradual and she had no memory of the months or medical consultations before her admission to "The Woods". She had no recollection that anybody had asked her about her dental bridge or her fears, and looking back, she said she was sure she would not have mentioned it voluntarily and that it was a 'taboo' subject, so her family would not have raised it with doctors. Nobody had performed a routine physical examination, which should at least have included a cursory look in the mouth, which would have revealed the bridge and then her fears.

I asked "how it was her depression seemed to lift when her appearance, due to the bridge 'exploding' was probably worse than in her late teenage years". She laughed and said:- "Everybody got to know some of what had happened as my parents told people that I had had a medical procedure which had gone wrong, without going into the details." "I couldn't hide the damage in the early stages of restoration, and people would talk to me about it and ask me questions, so I had to face it." "People were really good and came to see me in hospital and then at home, so I couldn't hide any more, so I had to make the best of it" "Eventually I met a nice man who who made a joke about my 'false teeth' and said he would find out whether any of the rest of me was artificially adorned, and we never looked back.

I thanked her for sharing her story and congratulated her on the way she had turned her life around, despite, or perhaps because of, medical malpractice. If her bridge hadn't broken, she might have faced the full course of ECT, with its character changes and probable lifetime of recurrent medication with all its problems. I suggested that she keep as far away from doctors (particularly psychiatrists) as she could in the future, and she laughed and said, with a slight lisp. "I awready know that."

When I reflect on her story (never *her case*), I know that at least part of her problem stemmed from us doctors not giving patients the confidence to tell us their inner thoughts, and another part from us not doing proper, full physical examinations on patients, even if we think we know the 'diagnosis'. I may have an element of obsessional behaviour, but to the end of my medical career, I always did a full physical on any newly presenting patient of any age, including looking in the mouth, testing the cranial nerves, looking at the retina, feeling the hernial sites and, if approppriate, doing a rectal examination. I never felt it was a waste of time and at least a score of times in my career I found something totally unrelated to the presenting symptom, which needed attention, so perhaps my obsession with physical examination was not a bad thing.

However at the late stage, when I might have examined my lisping lady and found her bridge, she might never have had the 'accident' that allowed her to face up to, and conquer, her darkest thoughts, and so she could have been worse off. Medicine is never simple or straightforward, but it is always interesting and educative. After my experiences I had no inclination to go into psychiatry, but had a lot of ideas about what not to do and say,

whether people were mentally ill or not.

My 1960's General Practice Attachment threatened by WWII

I was looking forward to my months General Practice attachment and felt lucky to be sent a to a well-known Sheffield GP who was part of a two-man practice that had a surgery in the old central city and also out in one of the suburbs towards the Derbyshire Hills, where his father originally had the practice. He was well-known to many medical students as he was great supporter of the Medical School Rugby team, and although I was, and am, the exact opposite of a 'rugger-bugger', my flat-mate Bob, was, and I used to sometimes go to support him, or bring back the pieces after a particularly destructive game. I therefore had met David, my GP, but not formed any clear impression of him.

I soon had a very clear impression of him however, because he was one of the many hidden casualties of the Second World War. He had served as Medical Officer in the West Yorks Regiment (The Prince of Wales Own) and had taken part in the Battle for Imphal in the Burma Campaign. His regiment was one of the many that were surrounded by superior Japanese forces and on one occasion, he and most of the regiment spent five days and nights not being able to move, and face down in the mud, with the Japanese throwing everything they could at them and creeping in at night with knives. When dawn came they often awoke to find a neatly knifed corpse next to them. They were eventually relieved, and Imphal became the victory that stemmed the Japanese advance to India and turned the tide, but at a terrible cost to those who survived. I had heard tales of the Battle for Imphal in my Territorial Army activities, but I did not know that my GP had been part of it, until little clues gradually 'leaked' out from David.

On my second day I joined him at the suburban, after-lunch surgery and was warmly greeted by a hand-shaking David who introduced me to a dear old lady who had come for her arthritis prescription. The greeting seemed excessively warm, as I had only left him the previous afternoon at the City surgery, but I took my chair whilst he and the patient chatted about the old days in the suburb. As he leant to grab the patient record off the corner of the desk, and write the prescription, he fell off his chair, but was up in a moment, laughing about his clumsiness. I was a little taken-aback but the dear old lady was not at all upset and said, in a jocular manner:- "Now Doctor David, you shouldn't have so much in the mornings."

I was not so naïve as to miss the implication of this piece of repartee, but I was astounded that a dear old lady (even a Yorkshire one) would bring such a thing out into the open. She left, another patient came in, and David made no reference to the incident, and I could not detect any problem at all whilst he was sat down. However when he went to the door to call the next patient (no receptionist for most of his surgeries), he had a somewhat rolling gait, that confirmed the old lady's diagnosis. Although, over the rest of the week, there were no further fallings, and his management of patients seemed entirely appropriate, I was in a real quandry. From the old lady's comment and several other odd comments it was obvious that patients were used to seeing Dr David in the next stage on from being 'a little merry', and it was obviously a regular occurrence.

I had two courses open to me. Either ignore a 'failing' that patients obviously knew about, and put up with, or to report the problem to somebody. The difficulty was to whom and how to report it. The way the practice schedule worked meant that I was opposite ends of the City to David's partner in the practice, so I could not quietly talk to him 'by accident'. Even if I did he surely must be already aware of the problem, and tolerated it, so a fifth year medical student confronting him with it, might not be a good idea. If I officially reported it to the Professor of General Practice, I had no actual evidence to present, just that he fallen off his chair. The rest of the week went without any more specific incidents, but I became more and more convinced from his general behaviour and particularly his driving, when we were out on home visits, that complete sobriety was not a common occurrence in David.

Over the weekend I made carefully worded enquiries from the 'rugger-buggers' about David and his background, and was told parts of his wartime story and that his problem was common knowledge. I even thought of approaching the Dean but he had similar tastes to David, and during a rugby dinner, had once come out to the Gents for a pee, and on finding that all the urinals were in use, had exclaimed;- "It's alright to use the hand-basins, boys, as long as both taps are running" and proceeded to demonstrate. This indicated his intellectual abilities were a little short of the full set, even for a Dean, as he was a very short man and consequently had to borrow a tablecloth to wrap round himself to hide the wet patches. It seemed unlikely that I would get a subtle or considered response from him.

I had not solved my dilemma by Monday morning, and when I arrived at the surgery we rushed through the waiting patients quickly, as we had a home visit on a sick child to do. It was misty out on the hills as we drove out, to what fate had determined to be, an isolated pub on the Sheffield Moors, where our little patient lived. Her Publican parents already had glasses out on the bar when we arrived as Dr David was their usual GP, and

David suggested I take the bag and go up with the mother, and see what I thought was the problem, and he would join me soon. In the little bedroom upstairs was a feverish, seven year old girl, and a remarkable bed-full of dolls. This gave me my opportunity, as I said that I would examine the dolls first to see if they were ill. Later in my career I always carried a teddy-bear, so I could demonstrate to unsure kiddies, exactly what I was going to do, and let them use the stethescope and torch on the bear before they were used on them. I asked a few dolls where it hurt, examined them and then asked our patient if she was ready to be examined or should I do *all* of the dolls first. She, of course, wanted to be next and it didn't take long to recognise the cough and the spots inside the mouth, that suggested early measles. We examined a few more dolls played a game of 'I Spy', but there was still no sign of David so we eventually went down and reported my findings.

David said that all sounded OK and gave the usual advice and then said that the mist was becoming thick fog and the publican had invited us for lunch. When I reminded him that there was a surgery he said that we still had time, and he had left a message to say we would be a little late. I had no choice but to join them for lunch which in David's case was mostly single malt. When we emerged David dropped the car keys and I quickly scooped them up and suggested I would drive. He didn't take exception to that suggestion, being what could be described as 'seriously mellow'. There was a waiting-room full of patients, but David, having had a little nap on our way back, was in good form and greeted all of the patients by name. We got through the after-lunch suburban surgery, without any disasters, as the patients mainly needed repeat prescription or sick notes.

Then came the difficult decision as to what we did till the late afternoon surgery in the City centre. My immediate concern was to keep him away from temptation, and his suggestion, that he needed a little lie down, seemed sensible, until he said he sometimes hired a room at the Railway Hotel, almost next to the City surgery. The problem with the Hotel idea was that if he became a resident, then he could have access to spirituous liquors at any time. I drove him there however, and from the warmth of the reception by the car park attendant and front desk staff, they were very used to his afternoon visitations. I got him into a room and sat with him until he fell asleep, took the car keys, but left his wallet, as his status as a regular, meant he didn't need money to get anything he wanted. I crept out of the room and, from the number in his pocketbook, phoned his home, as I thought that my only hope of avoiding a disaster was to contact his wife. She was out, and the housekeeper or whoever answered the phone, was very frosty, and when I said that David was a “little under the weather” and was resting at the Railway Hotel she retorted: “Not again”. I asked her to relay the whole situation, that I was holding on to the car keys, would stay with him and expected someone from the family to come and take over from me after the late afternoon surgery.

By some miracle he was still sleeping when I got back and so I sat with him till fifteen minutes before surgery started, poured some coffee and soda water down him, and hustled him down the road to the surgery. He was still mellow, but was also becoming vague so I was nervous of what might happen at the surgery. Like many with his condition he had the ability to mostly appear externally normal, even when deep in drink, and also to have enough insight to know what he could not do. When each patient came in he said to them: “I'm testing this medical student today and he is going to do most of the talking and examination.” With prompting from him, and him signing all the appropriate

pieces of paper, we got through through the surgery and walked back up to Station Hotel.

I took him to his room and he assured me he would remain there, which I didn't really believe as I now realised that although he usually had consistently high intake, he was now on what Bertie Wooster would have called a 'Toot' and we know as a binge, and went to phone, first his wife, and then his GP partner. I got no response from either and went back to his room I was not surprised at his absence, and found him in the Bar with a large glass, and already part of of a circle of commercial travelers and other regular imbibers. I hung about for an hour or so, but he had reached the stage of becoming aggressive, and would not listen to my suggestions to slow down and let me take him home. I put the car keys in an envelope, addressed it to David's wife, and made the desk staff promise not to give the envelope to David, and left feeling very worried and powerless. I slept poorly as I tried to think of what other alternatives had been open to me, as I had a sense that the situation would only have become worse by morning, and that I would have to do something to stop David practicing, until he had been dried out.

When I appeared at the City surgery the next morning I was was relieved to find the partner in David's place, but my relief turned into incredulity when the partner accused me of leading David astray, and being the cause of his eventual wrecking his bedroom at the railway Hotel and subsequently being taken away to 'strong lodgings' for the night. I was so hurt and angry at that that I didn't even bother responding, and he then capped his absurd rationalisation by saying I was no longer welcome at the practice, and he would ascribe a 'fail' to my report.

My control broke at that point and said that I no longer wished to work in a practice where they had ignored David's problem, and put patients and David at risk, and that furthermore, if he did any bad-mouthing of me, I would report him to the Medical Council for his cover-up and failure to let me know in advance about David's problem, and give me some support as to how to deal with it. He started to back down after this, and said: “perhaps he had been a bit to hasty and that we could work something out.”

Although it put me at some risk, as I needed to have my GP attachment 'signed-off' in order to graduate, I was so incensed that told him I wasn't interested in “working something out”, told him exactly what I though of his ethical standards, and left.

As with all things in my career however, this apparent catastrophe, actually produced good, as I was lucky enough to have a sometimes girlfriend whose family had a good relationship with a GP, well outside of Sheffield, and therefore was not on the usually full student teaching roster. My friend's parents explained my plight to the GP and he interviewed me and confirmed that David's problem was well-known and that I should not ever have been put into that situation. Although it meant an hour and a half bus ride each way, and I had to set off at 6-30 a.m., it was a really good practice, and as opposed to sitting with, and nurse-maiding David, I was actually taught the important things of General Practice. Most important was an appropriate way to relate to patients, rather than David's way of being overly matey. A lot of my 'relating to patients and truly empathising' skills came from this 'second' GP attachment and I left it eternally grateful that the disaster with David, led me to something I would build on for the rest of my career.

After the run was complete, the 'Ice Lady' Senior Administrative Assistant who actually ran the Medical School (the Dean was a

figurehead), sent for me and wanted to know why I had changed my GP attachment without her permission, and why there was no grade from my initial one. Like a good barrister, she never asked a question without knowing the answer, and so I did some quick thinking as to exactly what to reply, as it was what I *said*, rather than what we both *knew*, that would be recorded officially. I explained that my original GP had suddenly developed an illness which required his withdrawal from practice, and that his partner was too busy to take me on.

The 'Ice Lady', who was a slightly faded, but still beautiful Lauren Bacall, raised her Bacall eyebrow to show she understood what my answer said, and didn't say, and looked at me for a long moment and then said: "Somebody is spreading the story that you threatened a GP. I don't believe it, and will make no record of it, but with your history of upsetting teaching staff I would be very careful of who you take on. Sometimes Medical Teachers have very long arms". She smiled at the end of this (for her) long statement, lit a cigarette (Yes) and having established exactly where we stood, without putting it into words, indicated the interview was over. I breathed a sigh of relief as I left, as we both knew how close I had come to having my career terminated by the GP partner. I was lucky because she had a disdain for what I had heard her refer to once as "small and mean mentalities", and I think, to her, the GP partners behaviour fell into this category. When eventually I qualified, I sent her a small bunch of flowers, to show my appreciation of her discretion and tacit support, and when eventually I became a Medical School Teacher and would see her at Faculty meetings, she would give me the Bacall quizzical look, that suggested she was still keeping an eye on me, in case I was causing trouble.

'Intercourse By Deception' or the 'Too Clever-Dick'

For a week of our 'Odds and Sods" run we had Forensic Pathology, which was one of the courses most popular subjects. The preceding short lecture course has been remarkable, in that out of our year of 90 or so, 140 people turned up and there was standing room only. This interest was not just the in-built attraction to prurient and titillating horror stories, but that the teacher was a good story teller and, unusually for a pathologist, was very popular. One of his stories was, that just after he was married and existing in an attic flat, he and his wife were watching a lightening storm from their garret window, when the wife said they should move in case they were struck by lightening. He, being a newly qualified doctor and therefore knowing everything, responded "Nobody is ever struck by lightening in buildings, only out in open countryside." As the words left his mouth, the garret was struck by lightening, without either of them being seriously injured. When recounting this tale he said: "That this episode accelerated the marriage's maturation, as from then on his wife never believed a word he said, a process which would otherwise might have taken some years." His bonhomie and wit made him an ideal speaker in the same 'rugger' circles as my fallen GP, and his popularity caused many students to bring their girlfriends to his often 'blue' talks.

For forensic pathology we were assigned, if possible, a current case to study, and had to write up a report. The case I was to study, may give the impression of fiction as it is so unbelievable, but its veracity can be checked in court records.

In the decayed streets that surrounded the steelworks below the

Royal Infirmary, there flourished a thriving trade in, now what we would call alternative medicine, but in those days was, quite correctly, known as 'Quackery' By and large this trade was ignored by the authorities, unless occasionally it came to medical notice as a result of poisoning, a rash of missed or late diagnoses, or sometimes a complaint from one Quack about another when competition got ugly. Just before my Forensic attachment, staff at the Jessop Women's Hospital had become concerned at an increasing number of late, illegal abortions, resulting in complications. This was a difficult area to investigate, as usually, the young women would give no details of the course of events leading to their complications. However the word was spread through our Forensic Pathologist, who was also the Chief Police Surgeon, and through the Vice Squad (who were responsible for tracking down illegal abortionists), that something had changed.

Nothing initially emerged, but then by a stroke of pure luck, and the outspokenness of young Yorkshire Women, rumours emerged that there was someone going round complaining about a 'Quack' whose medicine to solve her 'problem' had not worked, and to cap her chagrin, he had refused too give her her money back. The "Vice Squad" operated close to its sources (and possibly on both sides of the law) and its undercover group soon discovered the identity of the Quack's dissatisfied customer, and it emerged that she had been the victim of one of the most interesting false pretenses scams ever reported. She had consulted the Quack as it was generally known that he could a solve young lady's problem if she "fell" pregnant. I have never understood the mechanics of how the act of falling could result in pregnancy, but the Quack had produced an even more bizarre sexual deception.

When a customer described her problem, the Quack said that he had: "Just the tablet to help, but that it would needed to be inserted into the appropriate place." He then produced what, his customers later said was clearly an aspirin tablet, and attempted to insert it into the appropriate place, but said he could not get it deep enough with his fingers, but "had just the tool about him" for inserting it, *with a bit of effort*, to its' proper depth. There is no need to describe what happened next, but what was most unbelievable, was that many of the young women then handed over money to him, and, as a proportion would not have been pregnant in the first place, and a significant number would naturally spontaneously miscarry, many were satisfied with at least part of his 'service'. News of this spread amongst the community and so initially, his services were in much demand, despite many of his customers subsequently having the late, illegal abortions that ended up in hospital admission.

It was only the outspoken, and unsatisfied (in both senses) needs, of the young woman who eventually spread the word, that allowed him to be identified and eventually apprehended. As the student on attachment to Forensic Pathology I was assigned the case and allowed to observe some of the victim's interviews and the formal interview of the Quack. I was tempted to refrain from describing him as a 'cocky' individual, but that really is the only word to sum him up. He knew that the women had asked him for an illegal procedure, and thought that few would actually stand up to give evidence, and if they did he, was unlikely to be charged with attempting to procure an abortion, because his technique would not have produced one. He also had the honour of having been expelled from a minor public school, spoke and dressed in sleazy-smart manner and thought, being a clever dick, that the police would have difficulty finding a specific charge for intercourse by deception, as the women had 'consented' .

He might have got away with it, if the complainant hadn't been so incensed by his failing to deliver the goods, and the determination of the Police Prosecutor to nail a really despicable character. The Prosecutor managed to find precedents for sexual intercourse by deception to be classified as rape, and the original complainant was such a hoot in the witness box about the Quack's poor and brief performance (in both senses), that the jury found him rapidly guilty and he was, in Sheffield- speak 'sent down the line' for several years.

You may ask what any of this has to do with forensic pathology? I really have no answer for that, as, excepting some individual teacher's aberrations that I have described, our Medical School teaching was based on being able to look at things in depth, and so learn ways of interpreting and then understanding, health and disease and the myriad of ways these happened. I have already stated my objection to spinning students through every discipline and sub-specialty that exists, rather than them becoming comfortable and understanding the principles that underly all medicine, by a smaller number of exposures, in depth. So my forensic medicine attachment was an in-depth study in one of the aspects of the discipline, that gave me an insight into the interface between the police role and the doctor's role, and the bizarre depth of human skulduggery.

Learning Medicine by Accompanying Willie to the toilet

The physician for my Medicine attachment was the exact opposite of the garrulous, improper, ever-present Cliff Jones. Willie …..... was genuinely the son of a Medical Knight, his father having identified the cause of a group of tropical diseases, and then become a well known London consultant. We only ever saw Willie for ward rounds, which began at the door of the Consultant's dining room where the whole team loitered until he had finished his morning coffee, and ended by us accompanying him to the door of the consultant's toilet, a considerable distance from the wards. This 'guard of honour' was the subject of regular ribaldry at each Hospital Christmas Show (see later), which Willie attended, but it seems he never connected it with himself, as the 'guard of honour' persisted until his retirement The ward rounds were highly formal with even the senior registrar only speaking when spoken to, and Willie barely acknowledging the presence of students and rarely speaking to patients. He did however defer to the women's ward, senior-ward-sister, who as the daughter of an earl, was entitled to use a title, but didn't.

Despite his superior attitude and silence, Willie knew his diagnoses and was particularly good at the Physicianly craft of diagnosing rare conditions. On one occasion he was asked to sort out the care of a young General Practitioner, who had life threatening bleeding from a peptic ulcer, but, however much blood was poured into him, his blood pressure could not be raised enough to get him into surgery. The surgical teams were always loathe to call in the Physicians but, Willie appeared, and with hands, eyes and a stethescope, diagnosed that the poor young GP had suffered a massive, silent heart attack about the

time his ulcer perforated and began bleeding. I was the on-call student with Willie and once he had entered, in his precise, purple inked hand, his thoughts into the notes, I asked him what were we going to do, and he replied in his 'official' voice: "Nothing he is going to die". I suggested that he should talk to the distraught wife so she had some idea of what was happening, but he declined with an air that suggested that was not his job. I resolved at that moment, that it would be one of the aims of my life, to try and get doctors to talk honestly to patients about bad news including death, but in a humane way.

It may be hard to believe, but at that short time ago, there were no intensive care units other than a few special post-operative areas run by anaesthetists. They did not care for medical patients and so our poor thirty-something GP was cared for in a side room with me and the other two medical students, 'specialing' him in eight hour shifts. Specialing consisted of sitting with him, taking his blood pressure and vital signs every 15 minutes and watching the ECG monitor (the only one, outside of theatres, in the hospital). He was aware of what was going on around him and subconsciously aware that he was deteriorating hourly, and so all we could do was talk to him about his life, practice and his family, of whom there were two young children in photos on the locker. His wife, who still had not been told anything specific, gradually absorbed from us students that there was not going to be a good outcome, and became calmer and was able to sit by the bed and hold his hand, whilst one of us students sat on the other side of the bed. I watched through the last night with her, and about 3-30 in the morning he quietly died, and I woke his partly dozing wife and let her see the situation. I asked her whether she wanted me to call the resuscitation team, but by this time she knew that the situation was hopeless, and did not want that final indignity, so I slipped out of the room to leave her to her goodbyes. I waited about ten minutes and then let the Night-Sister and the Registrar know what had happened. I expected a bollocking for not having called the crash-team, but the Night-Sister and Registrar seemed to think that what I had done was appropriate, and Willie, true to form, never expressed any opinion, and looking back I would have done the same again.

I never regretted being on Willie's team as I have a belief that learning to be a good doctor depends not on aping and copying a particular role model but observing the way different teachers interact with patients and making judgements as to the value of those behaviours, good or bad. This apprenticeship system, if the exposure is long enough, allows students to identify characteristics *not to emulate*, and so by being exposed to Willie's lack of humanity but technical competence, I learnt what I *would not do*. A precise example came when at a Neurology clinic, a consultant stated to a nice woman patient:- "Madam I do not think you have migraine. Only the intelligent suffer from migraine, and I have it almost incessantly."

The Senior Registrar on Willie's team made up for all of Willie's human deficiencies and was a superb teacher as well as being a nice guy. As the attachment ran almost up to Christmas, we students were much involved in helping plan the traditional Staff Christmas Show and the theme for the Ward Christmas Decorations. The junior-ward-sister of the women's ward was a delightful Debyshire Girl who came from a village famous for its' Well-Dressings and re-enactments of its' history. She was steeped in the tradition of organising such events and a few months before, I had gone to visit her and the Pub at the 500th anniversary of the plague. The visit was platonic, in that *she said* she was spoken for, but mercenary in that the pub was offering beer at the 1460's prices. The pleasure of slapping down two pennies

for eight pints of beer almost outweighed the disappointment of her 'being spoken for'.

I became deeply immersed in helping plan the Ward Decorations which were to be of an Under-Sea theme. We made three foot high papier-mache sea-horses, a massive dolphin to hang from the ceiling, got fisherman's nets to drape and hang everywhere, and had all the patients making cardboard fish, crabs and shells. At the end of the ward we built an underwater grotto from big cardboard boxes draped with painted surgical gauze. The occupational therapists provided lots of materials, paints and ideas, and on one occasion Willie entered the women's ward to be greeted by every bed occupant waving a cardboard fish or crustacean. He was not amused. The wards entrance was decorated by a large lighthouse with real flashing light, courtesy of the hospital electricians.

As we entered the last week of the run, the senior Registrar sidled up to me and announced that, due to terminal illness in the team house physician's family, he had to go home for the Christmas period. I guessed what was coming next, so had a moment to think before he continued "as to how good it would be for your experience, if you would do the locum". I pointed out that my previous locum experience had resulted in me interfering with a crime scene and and also being labeled a pervert by senior nursing staff. "These things happen to all of us." He replied in in calm, friendly way and then, to add to the bait said:- "Sister (she who was spoken for, but who could still exuded attraction when she wanted to) thinks that you would make a good stand-in. I had no commitments over Christmas, as I had looked after myself since the age of sixteen, liked the idea of having good, free accommodation in the resident doctors quarters, had no current special girlfriend, and so was fancy free. I rather liked the idea of spending Christmas in Hospital, and it meant that I would take part in the final decorations of the wards and help out with Christmas Show. I might even be able to tempt 'she who said she was spoken for' to forget she was.

Christmas Week as a 'Locum'- Entertainment, Panic and Reward

I started the locum on the Friday afternoon as usual and was taken round the Christmas Holiday depleted beds by the departing House Physician. One of Willie's interests was in hypertension, and at this time, new families of powerful anti-hypertensive drugs were being tested. Severe hypertension sufferers were admitted to hospital, baseline blood-pressure measurements established and then the new drugs started very gingerly. Only a few of these patients remained, and together with the usual crop of diabetics and miscellaneous medical disorders, would make little call on my time over the holiday. In my enthusiasm to spend Christmas with 'she who said she was spoken for' I had neglected to look at the Emergency Admission roster, and when, too late to honorably back out, I did, discovered that our team was rostered for Christmas Day. Very funny things happen on Christmas Day, and I had a sense of foreboding, un-assuaged by a temporary increase in friendliness from 'my' junior ward sister.

The week started off well, with little work and lots of fun practicing for the Christmas Show, and the whole building seemed to take on a a holiday life. Christmas Trees, Holly and Ivy were deposited at each ward by the Hospital Gardeners, the cleaners added decorations to corridors and even a sprig of Holly to the bust of the hospital's founder, and the whole place had a festive air. Nurses add sprigs of mistletoe to their caps and Doctors tucked one in the white coat buttonhole. Our UnderSea design had forgotten about Christmas Trees but in the end we put it in the 'Grotto' at the back and its fairy light provided an eerie glow through the painted gauze.

The Christmas staff show took place on Christmas Eve and consisted of a series skits, often lampooning the senior staff who were all there with their families. There were an amazing range of talents amongst the 100 or so junior medical staff, 600 nurses and the orderly and maintenance staff, just from their own ranks, could provide an eighteen piece band who could play anything from the Messiah, through jazz to rock. The Hospital had its own hall/lecture theatre, with an adequate stage, and together with the Annual Hospital Ball, the Show was the highlight of the year. My minor role was in a skit performed by a house officer who spoke a version of the old Victorian Monologue “The Green Eyed God”, that would not have passed any of the usual censors. He stood high on a hidden stepladder, swathed in theatre green drapes, stretching to the floor, with his face deathly white and with a modified head mirror on his forehead, out of which glowed a single green 'eye'. Hidden behind him perched on lower rungs, and in the theatre drapes, were three of us (two male and one female) wearing green theatre gowns and white gloves. The turn started with the lights off, and the band playing soft, discordant Eastern Music, and the performer deathly still, as a spotlight gradually came on. The figure apparently had six arms, like the Goddess Kali, which were motionless. After a theatrical pause and 'Oohs and Ahs' from the audience, the figure in a ghostly voice, began to declaim, and, as he did so the arms illustrated some of the things he was saying, using a variety of gestures and inter-twinings, that approximated to what the ghostly voice was saying, but often with added and obscene emphasis.

It was hot under our green 'tent' and the three of us were crammed together and had to synchronise our arm and hand motions to the monologue. We did pretty well except when the owner of the female pair of hands asked somebody to move an

unscripted hand, but the audience thought this was part of the performance, and as the spot faded out, there was thunderous applause.

Several of the skits required some simple scene changes, and to cover the activity in these intervals a highly disguised group performed the 'guard of honour' that I have described, where, at the end of the ward round, all of the team had to accompany Willie …..... to the door of the Consultant's toilet. As the curtains closed, a figure in morning coat, waistcoat, grey trousers and a top hat, would walk onto the stage, followed by the entourage of Senior Registrar, Junior Registrar, House Physician and three students. I never remember Willie actually wearing a morning coat but he almost gave the impression that he did. The party would walk across the stage, and when they were almost off-stage, turn their backs to the audience and then, firstly the fake Willie, and then in strict order of precedence, pretend to unzip, glance downwards towards 'Willie', laugh, shake and then move off-stage. The Christmas show was well received, Willie did not seem to have connected the linking skit with himself at all, and he presented a bottle of Madeira!, to add to the teams store of Christmas drinks. The after show party was very satisfying but not wild, as we had used all our energy up on the performance.

Christmas day dawned bright and clear and the resident staff and nurses got into the costumes designed for their ward themes and then staff breakfasted with the patients. Presents left by patient's relatives and some staff gifts were retrieved from under the tree and distributed and we did a quick, early ward round to check everybody was well enough for the rest of the day's programme. The ward round was a little hampered by costumes as 'my' junior ward sister had constructed a mermaid outfit with a tight, glittering hobble skirt as a tail, and I was arrayed as King Neptune in long robes, crown and beard and carried a trident.

Just after our early breakfast all was ready for the important visitors who were to judge the ward decorations and award a prize. The judges consisted the Board of Governors headed by Alderman Mrs Grace Tebbut, who seemed to have run Sheffield since time immemorial. By this time the rest of the team arrived with their families and they, Willie and the registrars were wisely taking sherry and not the unspeakable Madeira, in Sister's Office. At that moment my bleeper went off and somewhat casually I picked up the phone to be told that an emergency message had come in from the Ambulance Service to say that they were bringing in approximately 20 inhabitants of an old folks home, who had been found unconscious from a gas leak. Having said to the switchboard operator (who I knew well) “to pull the other one”, she insisted that the message was genuine and that Casualty wanted all our team immediately to receive the old folk as they arrived. My statement to the team was also initially disbelieved, but within a few minutes, but without time to change out of costumes (the registrars were also costumed), the senior registrar had mobilised extra help from the off duty, but resident staff, and had orderlies move the remaining patients to one end of each ward and create as much of an intensive care area as we could in those days. The orderlies then set off in relays to bring Oxygen cylinders to the ward (no piped oxygen then), as that was really our only treatment for coal-gas poisoning.

Junior sister, three nurses, the Junior Registrar, and eventually Senior Registrar and myself dashed down to casualty, although the costumes somewhat hampered us, particularly the mermaid skirt and my robes. Casualty staff had already made a space in

the reception area and cleared most of the cubicles and we formed a line at the door with the Junior Registrar at the front who lighteningly assessed the recumbent figures on trolleys into 'critical', 'needs some help' and 'park somewhere as will be OK'. Senior Registrar took charge of the registrars who had assembled and supervised the 'critical' patients, senior house officers and casualty staff looked after the 'needs some help' category and I, Junior Sister and our three nurses tended to the 'will be OK' group. This mostly consisted of re-assuring them and getting them cups of tea.

After the first chaotic moments had passed and I had time to look around and assess the overall situation and was surprised to see a distinguished, waistcoat-clad figure helping distribute cups of tea. I had never seen Willie without a correctly buttoned jacket, and I had never expected him to come and help, but there he was, passing out cups and giving a cheerful word here and there. His presence was a great calming influence on the conscious patients as most of the rest of us were still in fancy dress, and the poor bewildered and gassed elders had difficulty understanding the surreal situation they had been dropped into. In fact, when I had chance to talk later to them, one of the gassed elders was convinced that he had 'passed over' and that he was in some peculiar ante-room to hell, and it was only when the ever urbane Willie passed him a cup of tea that he realised it was a hospital rather than hell.

As soon as we knew the 'will be OK' customers were stable, we arranged a possee of orderlies and took them back to the wards and started the immense task of properly admitting them and clerking them in. As the situation calmed down in casualty, house staff dribbled over to the ward as they knew that I would not be able to admit and examine all of this Christmas windfall.

One of the dangers of coal-gas (carbon monoxide) poisoning is that it displaces oxygen from the blood but makes the sufferer look pink and healthy, so it was very important to fully examine and monitor even the well-looking ones. Administering Oxygen, washes out the carbon monoxide gradually, but if too much is is given to elderly people, they may stop breathing. Our only way of ensuring that these healthy looking people were safe was to have someone sit by the bedside and monitor their vital signs and consciousness level. The house staff and senior nurses rallied round and by ten o-clock that night all 21 'gassees' were in the wards, each with an accompanying 'special' nurse or house staff member. The registrars and SHO's had done a remarkable job on the 'critical' and 'needs some help' categories, and had not lost one, and all were breathing on their own.

At this stage a reaction had set in as we had not eaten anything all day (we never even saw the Christmas Lunch) and we were a tired lot as most of the early shift nurses had stayed on at the end of shift and had worked a 15 hour day. We had not even been able to show the judges our decorated ward, but it was appreciated by the gassed elderly, so it was not a waste of effort. After most of the staff had left, 'my' Sister and I sat in the office trying to get the paperwork finalised, so we could make a tidy hand-over to the night shift nurses and the volunteer who was going to relieve me for the night.

We loitered over the final paperwork, as although we were tired, we were still hyped up from the days events and the knowledge that we had done a good job. There was also a feeling of unfinished business. Then the office door opened. The ever helpful Senior Registrar had come back to do a final check that all was well, and congratulate the team on its' performance. As he was leaving, he showed his real understanding of people, by

putting a bottle of good brandy on the table and saying he thought we both deserved it.

When he left, Sister and I looked at each other, picked up Willie's indescribable bottle of Madeira and poured it down the sink. We opened the brandy, got two medicine measuring glasses, and filled them to the brim and toasted each other. "I'm glad I'm spoken for" she said: "As *you* attract trouble." After a little more brandy and a long silence she said: "But I won't be going home tonight". I could only respond by collecting the brandy bottle, opening the office door and pointing the way to the resident doctor's quarters.

The remainder of my locum with Willie's team passed off uneventfully, and I had the pleasure of discharging all the gassing victims gradually over the week, after they had been vetted by Willie and the team. They actually left in better shape than before the gassing, as we managed to diagnose and treat some of the minor and annoying conditions suffered by the elderly. Willie actually spoke to some of the patients whom he had provided tea for, and when he said goodbye to me, even went so far as to say that I might have some potential as a Physician some day: "if I quietened down". He was visibly astonished when I said that I was already spoken for by Paediatrics, which he regarded as a very inferior speciality.

Over the years I have tried to work out what made Willie behave in the way he did, and I have concluded that he was very shy man, but overly self-important, and that towards the end of his career he fell behind in understanding new techniques and developments, and retreated into virtual silence so as not to risk showing his ignorance. His coming to Casualty, and then handing round the tea was the indicator that he wanted to help, but that the hands-on medical involvement was really now beyond him – a tragic end for a man who had superb clinical diagnostic skills.

The Christmas Night events were never referred to again by either Junior Ward Sister or myself (until now). Eventually she married the registrar 'who had spoken for her', who in my eyes, had all the makings of an eventual Willie …....., and who would never be any trouble to her. However, our friendly Senior Registrar spent the rest of my locum time, with an apparent twitch in his left eye whenever Junior Sister and I interacted on the ward. I think he partly made his diagnosis of the Christmas Night events, from the fact she invariably addressed me as 'Trouble' rather than the 'Doctor', that, by custom, a student locum was entitled to.