*re*views

BOOKS • CD ROMS • ART • WEBSITES • MEDIA • PERSONAL VIEWS • SOUNDINGS • MINERVA

ART

Pictures of Health

A photographic exhibition from the British Library at Homerton Hospital, London, until 31 July 2001
On the web (www.bl.uk) from March 2000

A picture on the wall is never just a picture. Every captured image has a history, a social context, and a meaning that goes far beyond the confines of its frame. Take, for example, an exhibit called *Surgical Fashions under a Pound*. The photograph shows a page from a 1922 catalogue of theatre clothing made by the Surgical Manufacturing Company of London. The art itself is unremarkable—just a series of simple line drawings. What is fascinating is that the adoption of such clothing was of immense historical importance. It marked the end of a time when surgeons wore an old coat or gown, unwashed and bloody, for every operation, a practice that caused countless cross infections and even deaths.

Pictures of Health, works best when it illuminates our understanding of medical history in this way. One of the themes that it addresses is the work of the healing professions. In *Open Wide Please* we see a dentist of the Middle Ages pulling out a man's teeth with pliers. Why put the hapless patient through such a gruesome procedure? Because the dentist believed that worms in the gums caused dental problems and could be eradicated only by such violent tooth extraction. King Edward III was apparently rather impressed by his services and gave him free lodging as a reward.

Aside from the inevitable picture of Florence Nightingale, the representation of health professionals is refreshingly multicultural and inclusive. A 1975 stamp from Guinea shows a female doctor examining a child, celebrating the role of women in medicine during International Women's Year. In a 19th century watercolour a Chinese doctor feels a patient's pulse to assess his Qi, or life force, from which he makes a diagnosis. The most beautiful image in the exhibition is an Indian painting of a Kan mal walah, or ear picker, removing wax from a man's ear. The figures are placed at the bottom of the picture, perhaps an allusion to the position of the different castes and tribes in Hinduism.

There is much in the exhibition to make you grimace and groan. This is part revulsion, part delight. In *The Hydropathic Doctor*, an 1842 cartoon by Honoré Daumier, a woman is held down and forced to drink gallons of water to purge her of her illness. The cartoon's grim caption reads: "Today 2 buckets will do, tomorrow it will be 4." There are medieval scenes of bloodletting, and of doctors cauterising patients' piles, polyps, and even cataracts (ouch). There are incredible, laughable claims made for various remedies, such as Warner's Safe Cure, a "tonic to cure the kidney and liver, Bright's disease, urinary disorders, female complaints, malaria, and general debility."

Ear pickers were experts in removing wax

Waiting time five minutes: possibly the earliest picture of an emergency department, from a 13th century encyclopaedia

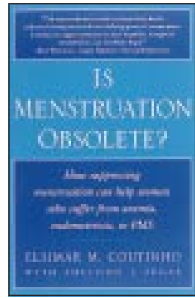
The exhibition closes with a series of health promotion messages. Some are strangely prescient. A Javanese book of heroic tales, *Panji Jaya Kusuma*, published in 1805, promoted the benefits of breast feeding to child health. Other messages must have made sense at the time but seem truly horrifying today. In 1832 the Central Board of Health issued public advice to Londoners on how to abort the early symptoms of cholera. It advised people to first induce vomiting with salt water, then to take laudanum "in a small glass of any agreeable drink," and finally to apply heated plates "to the belly and pit of the stomach." Surely this regime would have finished people off.

In assembling *Pictures of Health*, the British Library has made some of its arcane works more accessible to the public, allowing us glimpses of past worlds that have informed and shaped the present.

Gavin Yamey *BMJ*

Is Menstruation Obsolete?

Elsimar M Coutinho, Sheldon J Segal



Oxford University Press, £15.95, pp 190
ISBN 0 19 5113021 9

Rating: ★★★

Menstruation is one of the most prominent anthropological taboos to have left its mark on present day society. Women who are menstruating have been branded as impure and, in a not too distant past, were accused of turning cow's milk sour or causing iron to rust. Elsimar Coutinho claims that "Recurrent menstruation is unnecessary and can be harmful to the health of women. It is a needless loss of blood." This statement represents the key message of the book. Coutinho advocates an almost lifelong medical suppression of menstruation. This position is obviously controversial but undeniably fascinating.

Coutinho is a widely published Brazilian fertility expert who has gained merits through her contributions to the development of the hormonal contraceptive medroxyprogesterone acetate. Her new book contains a lucid description of gynaecological problems, such as dysmenorrhoea and endometriosis, that will be well appreciated by patients and their partners. Sound medical knowledge is amply supplemented by a historical overview of reproductive biology. Coutinho devotes special attention to the ancient practice of bloodletting. This technique was commonly used to "detoxify" the body, a belief that helps us understand society's view of menstruation. Coutinho adds entertaining anecdotes, linking, for example, the tragic life of Marilyn Monroe to her menstrual problems.

However, *Is Menstruation Obsolete?* somehow made me feel uneasy as it is persistently overshadowed by postcolonialist assumptions. For example, Coutinho interprets menstruation mainly as a control mechanism enforced by a male and Christian dominated society. I cannot shake off the impression that historical events that have little to do with this are moulded to suit the author's position. Findings and interpretations that do not support Coutinho's hypothesis are mostly ridiculed, rejected, or omitted.

Modern knowledge can easily make a joke of old fashioned practices common among those who were pioneers in medicine and who often had religious, political, or economic prejudices. However, rather than representing a premeditated stigmatisation of menstruating women, the early pioneers' theories were often a consequence of a lack of anatomical and physiological knowledge amplified by the absence of modern technology.

Coutinho anticipates criticisms and therefore spends a great deal of her time pre-empting any eventual argument offered by naturalists believing that life should follow the natural course of things. In some instances Coutinho's view is easy to support. The use of hormone replacement therapy to prevent postmenopausal osteoporosis is a good example. On other occasions it is much harder to be sympathetic to her suggestions.

Despite the teleological flaws, Coutinho's alternative view of menstruation deserves careful consideration. To some extent her book may offer a modern replacement for R F Vollman's classic work *The Menstrual Cycle*. Coutinho and Sheldon conclude: "We envisage a campaign involving both the public and private sectors, engaging the medical profession to educate the public about the uselessness of menstruation for women not actively seeking pregnancy." This message also resembles a postcolonial political pamphlet rather than a scientific account, prompting further independent verification of the author's hypothesis.

Carl De Crée *senior scientist in reproductive endocrinology and exercise science, Zaventem, Belgium*

Children as Partners for Health: A Critical Review of the Child-to-Child Approach

Pat Pridmore, David Stephens

Zed Books, £14.95, pp 194
ISBN 1 85649 636 8

Rating: ★★★

"Children should be seen and not heard" is an old adage, probably first uttered as an exasperated last stand by an adult frustrated by the unbridled exuberance of a child. Now like-minded adults have to grudgingly acknowledge that the battle may be lost forever as children triumphantly raise Article 12 of the Convention on the Rights of the Child as their victory flag, with its proclamation that children must be given a voice and their views and opinions respected and acted on.

The "child-to-child" approach, first introduced in the late 1970s, not only affirms this right but promotes its implementation, with children being seen as advocates and not just recipients of health care. This book critically chronicles the changes in the child-to-child movement, from its conception as an international programme aimed at teaching and encouraging schoolchildren in poor countries to concern themselves with the health, welfare, and development of their younger siblings to a programme now implemented in over 80 countries focusing on health promoting schools, assisting children in difficult circumstances, and extending children's advocacy role to educating their families and communities.

Child-to-child is still struggling for legitimacy as an effective strategy for improving health, in common with other innovations in health promotion. The authors objectively review the diversity of practice that characterises child-to-child, the ambiguities and weaknesses of its message as well as its merits and appeal, and the programme's achievements. The flexibility and adaptability of its approach have resulted in many thinly related activities being counted under the programme's umbrella. Until recently, little systematic attempt has been made to analyse what has been accomplished. Ongoing criticisms have included its propagation of a Western notion of the child-adult relationship and its continued overdependence on the influence of its original creators. Nevertheless, child-to-child has notched up notable successes, recognised by an award from Unicef for its leadership role in promoting child rights worldwide.

The book is clearly written and is rich in case studies. I particularly enjoyed the quick, painless ride through modern theories of learning, education, health, health promotion, and development and their interrelationships, provided in an attempt to contextualise the child-to-child approach. It will best be appreciated by individuals involved in child education, primary health care, and human resource development.

This book makes a valuable contribution at a time when innovative approaches in health education are being sought. It provides convincing evidence that children can be strong allies in building health partnerships and can transform their own lives as well as those of adults caring for them. Few people have, however, developed the special skills needed to do this successfully. This is where the challenge lies, and this book helps greatly in at least understanding what these skills are.

Haroon Saloojee *community paediatrician, University of the Witwatersrand, Johannesburg, South Africa*

Reviews are rated on a 4 star scale (4=excellent)

Gods and monsters

It was the kind of build up normally reserved for the launch of a Stephen King novel or a Hollywood horror blockbuster. At a hospital near you, pathology departments would offer up their grisly secrets—tiny human hands and hearts, livers and kidneys, cruelly and secretly snatched, even "harvested," and hoarded in dirty storerooms. This was *Invasion of the Body Snatchers* meets Damien Hirst in his formaldehyde era. The stories had been coming in dribs and drabs for months, but in the two weeks before the launch of the report of the Royal Liverpool Children's Inquiry and the report of chief medical officer Liam Donaldson's survey of organ removal and retention elsewhere, they had reached an almost ghoulish intensity.

Health secretary Alan Milburn's widely reported word for it all was "grotesque." According to the *Times* (29 January), he warned the government that the Alder Hey report was the most shocking that he had read. Also on 29 January the *Guardian* reported a source as describing what took place as "on a scale and in a way that is horrific beyond anything anybody will have seen in this country."

Really? More shocking and horrific than the Moors murders or the Omagh bombing? "The government is braced for violent scenes," reported the *Observer* (28 January). "The contents of the reports themselves are expected to be so disquieting that telephone lines are being set up to counsel the relatives of patients who have died," wrote *Independent* columnist Deborah Orr (30 January).

Without denying the obvious distress that the removal and storage of children's organs at Alder Hey had caused to relatives, wasn't the government, Mr Milburn in particular, getting things a little bit out of perspective? Was it all a cynical ploy to take the sting out of the Mandelson affair, as Brian MacArthur suggested in the *Times* (2 February)? Was it a warm up for the report into the Bristol children's heart deaths, as Mary Riddell suggested in the *Observer* (4 February)? Or did characterising Alder Hey as something dreamt up by Hammer Horror serve the purpose of the health secretary as consumer champion, hell bent on standing up to doctors and shattering the paternalistic culture of the NHS?

Certainly, Mr Milburn couldn't have hoped for a better bogeyman than Dick van Velzen, the "rogue" pathologist at the centre of the scandal. In the *Sun* van Velzen was "Dr Frankenstein," in the *Express* a "monster," and in the *Daily Mail* "Dr Liar" for "deceiving parents." The British press pack hounded him round his native Netherlands desperately in search of a photograph. Only one was taken, and, as in all good horror tales, it was the pursuer who ended up being cornered. *Daily Telegraph* photographer Ian Jones, whose priceless snap was to glare out from every newspaper like the image of an Orwellian hate figure, told the *Sun* (31 January): "It was frightening. I was left shocked and shaken. He came at me and pushed the camera into my face, bursting my lip. I received several blows."

IAN JONES/TELEGRAPH

Van Velzen, aka "Dr Frankenstein"

The *Sun*'s verdict was clear. "This is all about sick and arrogant people in scores of hospitals playing god," said its leader (31 January). So far so good for Mr Milburn, who, in commenting on the reports, had said: "I want the balance of power to shift decisively in favour of the patient." Despite accusations of terrifying patients in the *Times* leader (31 January) and scaremongering in the *Independent* (31 January), Mr Milburn's determination to manage media coverage of the Alder Hey report seemed to have paid off.

At times this determination had bordered on control freakery. To ensure journalists could not break the news embargo set for 3 30 pm on 30 January, they could view advance copies of the report only at a Liverpool hotel and at the Department of Health, where they had to hand over mobile phones and sit, five or six to a table, supervised by an invigilator. And in mid-January the public relations firm that Alder Hey had called in last August to handle the story on its behalf was dismissed. In its place, the hospital would be using COI Communications North West, a direct appointment by the Department of Health.

Unfortunately for Mr Milburn, you can spin a story only so far. Sooner or later it develops a life of its own. In the case of Alder Hey, parents have been reacting with panic—fine if you want to create a consumerist backlash against an overbearing and arrogant culture, not so fine if people stop donating organs. As Mr Milburn was proudly announcing in an exclusive article for the *Sunday Mirror* (4 February) his plans to revolutionise the NHS in favour of the patient, a headline in the *Independent on Sunday* warned "Transplants at risk as organ panic grows." By Sunday evening, Mr Milburn had announced an organ summit to minimise the damage done by reaction to Alder Hey.

And as for Peter Mandelson, it was inevitable that some hack would somehow find a way of linking him to Alder Hey. "Mandy's sister-in-law misled bereaved mum," claimed a headline in the *Sunday Mirror*, ironically on the same spread as Milburn's own exclusive article.

Trevor Jackson *BMJ*

WEBSITE OF THE WEEK

Persistent vegetative state This week, two articles discuss the problems encountered by relatives and professionals caring for people in the persistent vegetative state (pp 352 and 372). This high profile and ethically challenging form of coma has thousands of web pages devoted to it, some crankier than others. If you want a professional view it's always best to start at the top, and the US based National Institute of Neurological Disorders and Stroke has an information page plus links to care organisations at www.ninds.nih.gov. It's also the starting point for an interesting diversion to the National Library of Medicine's new register of clinical trials at www.Clinicaltrials.gov.

It's hard to think about the persistent vegetative state for long without considering the nature of awareness, since these patients are defined only by their lack of it. David Chalmers' website at the University of Arizona (www.u.arizona.edu/~chalmers/index.html) is a wonderful resource for beginners. As a professor of philosophy and an associate director of the university's centre for consciousness studies, he is a good guide to an emerging discipline that links many others, including philosophy, cognitive science, and neurophysiology. Browse through some of his 722 online papers to appreciate just how controversial it can be to define abstract concepts such as awareness.

Many of these articles were originally published in the *Journal of Consciousness Studies*, which has a web presence, including full text articles, at www.imprint.co.uk/jcs/. The journal's editors claim it is written in plain English, and some of it is. But for stopping conversation at a dinner party, try saying: "A self, according to my theory, is not any old mathematical point, but an abstraction defined by the myriads of attributions and interpretations (including self-attributions and self-interpretations) that have composed the biography of the living body whose Center of Narrative Gravity it is" (*Journal of Consciousness Studies* 1996;3:350-6).

Alison Tonks
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NETLINES

- For a good example of a well designed and informative organisational website, look at www.fphm.org.uk, which is the home page of the UK based Faculty of Public Health Medicine. Easy navigation allows you to explore the site rapidly, and there is something of interest for most visitors. It has all the services you would expect plus some added extras, including a huge article entitled "A chronology of state medicine, public health, welfare and related services in Britain 1066-1999."

- There are many sites about evidence based medicine, but www.cates.cwc.net is particularly good. This is the work of a general practitioner with an interest in the subject, and he provides some information about his own work that shows what can be done at the front line of healthcare delivery. A simple menu guides you to the various offerings. This is not an in-depth site, but it does show that evidence based medicine can be practised at the coalface.

- For a home page that is packed with features, www.ncemi.org/ certainly stands out. This has been designed with the emergency doctor in mind and acts as a portal to a wide range of relevant resources. Despite the number of facilities and reference guides on offer, it is user friendly and certainly not overwhelming. There is enough here to interest doctors in many specialties, not just emergency medicine.

- The Canadian Library of Family Medicine has put together a well laid out links page at www.uwo.ca/fammed/clfm/sites.html. It has plenty to offer, but, like many links pages, it needs a fair amount of scrolling. As well as a good range of primary care material, it also has some good general links.

- The Scientific Electronic Library Online (www.scielo.br/) offers a well integrated collection of Brazilian scientific journals. This allows you to access the full text of journal articles in more than one language through one interface and provides some really good content. The information can also be looked through by journal title and topic, and, of course, you can use the in-house search engine to interrogate the whole site.

Harry Brown *general practitioner, Leeds*
DrHarry@dial.pipex.com

We welcome suggestions for websites to be included in future Netlines. Readers should contact Harry Brown at the above email address.

PERSONAL VIEWS

Listen to the voices

Education and debate p 352

The nurses and doctors were of different minds about what they were seeing and what was to be done. Now it is over. It was not easy for any of us. It was hardest for the people who provided the direct care. Fifteen nurses and nursing aides have asked to talk with us, the members of the ethics committee: the doctor, pastor, social worker, the nurse. They ask how we could have let this happen.

By now we all know the story. An 84 year old man, a professional, a bachelor, self-contained, orderly, and self-assured, had used the 20 years of his retirement to see the things that we can only dream of seeing and had lived a life of health and vitality until the accident. With cane in hand he was taking his dog for a walk. The street was wet from morning rain. The dog pulled on the leash and the man tumbled too quickly to brace the fall with an arm or hand. He fell, toppling backwards, landing on his head.

It has been two weeks since he was admitted to the hospital. A nephew and niece, his only living relatives, told us who he was, how he lived, and what he had wanted and expected out of life. The patient is no longer the man whom they had known. The result of the fall: significant trauma. The respirator that we originally used temporarily to help him breathe is now the only way for him to take a breath. His only source of nutrition and hydration is hung in clear plastic bags and delivered through tubes to his body.

No one was surprised that he had thought about the possibilities of his death, and named his nephew and niece to speak for him in matters of his care if there came a time when he could no longer speak for himself. His direction was clear. If he were ever in a physical state where his quality of life was significantly compromised and there was no hope, he did not want to be kept alive by extraordinary means or mechanical devices. The family waited, and when they were convinced, long after the doctors were convinced, that the damage was permanent and irreparable, they, in their own voices, spoke their uncle's words and the respirator was disconnected.

Now the waiting. Not easy for the nursing staff, whose hands provide the most intimate and comforting care. Not easy for the doctors, whose training involves providing cure and giving hope. And not easy for these relatives, who could not bear to watch their uncle die, and kept in touch through their daily telephone calls.

And nothing happens. He breathes without the machine, receives nourishment through the tubes, stares without seeing, and listens without hearing. His body is in this world, but the part of this man that made him who he was is no longer with us. Day in and day out, each shift of each day, his nurses turn him, bathe him, and tend to his feeding and medications. While they are there, they talk to him. No matter that he can't answer. This man has become part of this nursing unit's family.

> The nurses provided the care. Now they felt that they were starving this man

Eight days have passed. The niece and nephew have told the doctor that they knew their uncle didn't want to be fed this way. They will produce the affidavit for the ethics committee. The nephew cries at the thought of withholding food from his uncle. The niece comforts him. They ask us to proceed.

Our patient died three days ago, nine days after feeding and nutrition were discontinued. For each nurse and nurse's aide meeting today with the ethics committee, those were nine tortuous days. Nurses were always there and saw him waste away. The doctors came every day for their 15 minute exam. They made loud noises, passed their hands in front of his eyes, touched and poked his skin. No response: chronic vegetative state. The doctor ordered. The nurses provided the care, the food, and the comfort. Now they felt that they were starving this man.

The nurse places a damp gauze pad to his lips and he sucks at it. He appears to be hungry and asking for food. The doctors say this is a reflex. The aide sees greater levels of consciousness: a blinking of the eye when a question is asked, tracking when she moves from one side of the room to the other. The doctor observes and reports random and not purposeful movement. The family stays away.

The nursing staff has asked to meet with us to let us know how hard it has been for them. This man starved to death. They saw him suck the moisture they placed on his lips and they watched him wither. When he finally died, they touched his body as they bound him in a sheet, feeling the paper thin skin, almost touching bone. They were part of his dying. Not for what they did, but for what the doctors wouldn't let them do.

They are here to let us know that they are in pain, that they are struggling. They speak. We listen. We are all made wiser from this experience.

Frederick Nenner *director of social work and member of ethics committee, Lutheran Medical Centre, New York*

If you would like to submit a personal view please send no more than 850 words to the Editor, BMJ, BMA House, Tavistock Square, London WC1H 9JR or email **editor@bmj.com**

Learning to let go of our organs

See pp 309, 371

We don't need to live next to a faulty crematorium to inhale bits of dead people. On an atomic level, every breath we take contains stuff that was once someone else.

So what claim do we have, during the period between death and atomic recycling, on the physical material that used to be ours?

For those who believe in literal resurrection of the body the claim is total. The body must be buried complete or it won't work properly next time. But few truly believe this. Even the ancient Egyptians preserved the body's external appearance while removing organs and replacing them with sand and cloth. Throughout history the emphasis has been on preserving appearance, leaving the messy inner details to the gods.

So why should most of us care what happens to our livers when we've finished with them? Mine can go to the worms, or preferably to one of my desperately ill fellow humans who needs a transplant. My friends can say goodbye to the bits of me they knew—the face, the skin, the outside. None of them has been particularly familiar with my internal organs during life, so I don't really want them to start worrying about these things after my death.

The body and its components have gained the holy quality previously reserved for relics

There is a desperate shortage of organs for transplant. Before Alder Hey there was a growing campaign to allow organs to be removed without explicit consent, providing the dead person never objected. This already happens in some countries. The level of consent leading to a body being buried without some organs could be low, or even absent, because someone else would be helped. If the organs were not used, or failed, the family would not expect them to be returned, or given a funeral, any more than they would expect it for an appendix removed during life.

After Alder Hey there is no more debate. It would be wrong to take even small parts of those organs to help others by education, research, or transplant.

We are now told that taking tissue may be a criminal act. Do not education and research save lives? Shouldn't pathologists investigate deaths fully? We are in danger of encouraging duality in a public that is only too happy to see doctors as both villains and saints.

Death, like eating roast chicken or going to war, is an area in which no absolutely kind or wholesome things happen, only those that are perhaps not as bad as the alternatives. If we really want to know all that happens concerning death, then, as with slaughtering birds or killing people, with that knowledge comes responsibility we might not want.

Few would want to be asked whether a dead relative should have her orifices stuffed to prevent leakage. I would not want to be offered instead of a coffin the small bag that was enough for the remains of a friend following a fire. I don't want anyone to ask whether I want the road scrubbed to pick up the last bits of brain, or whether the little they found on the tyres would do. Traditionally the public has seemed not to want to know, and doctors, along with undertakers, crematorium and cemetery staff, clergy, nurses, and others, have been happy not to raise these issues.

Somehow, though, the body and its components have recently gained the holy quality previously reserved for saintly relics. Perhaps beatification of the physical parts, rather than of the spiritual person, reflects a belief that the physical is all there is. Perhaps it is a denial of death itself. The alternative, that the current climate is founded on materialistic ideas of ownership, theft, and control, is too sad to contemplate.

Like most things concerning death, the thought of tissue being taken from a corpse is uncomfortable. Medical politics is a fairy tale world with simple problems and simple solutions. Questioning and informing public attitudes to death and the body are far too difficult compared with endowing dead organs with the same legal protection as a living child.

So now we enter the era of the two-page autopsy consent form. Perhaps the public will relish responsibility for all those choices: "So, you don't mind an autopsy, and tissue samples can be taken for research but not teaching, provided they are less than one centimetre and no more than ten pieces, and that they are used within six months. Now what would you like to do with the bits after we've used them? You're not going to change your mind or worry later are you? Oh, sorry, the transplant team has just dashed through. They've taken all the organs anyway."

As for me, how would I want my body to be disposed of? Well, the transplant surgeons can take what they need. If anyone wants an autopsy I hope my wife will be able to sign a form saying, "Do whatever is of any use, but spare me the details." Then, if I am cremated, and even if I am not, I want to be scattered over Tony Blair at his party conference. If that might get someone into trouble I really don't mind where or how I am buried, incinerated, or flushed, or if I am kept on the shelf for the education of others. I can't, after all, hang on to this physical stuff forever.

Derek Roskell *consultant pathologist, John Radcliffe Hospital, Oxford*

SOUNDINGS

Goodbye Vesalius

They were not humble. Their subject, they told us, was by far the most ancient of medical sciences yet still the foundation of all modern clinical practice.

They were not, however, all-powerful. Their curricular time had just been cut from 900 to 500 hours: a setback they bore with fortitude, simply teaching the same stuff almost twice as fast. But they were still, they told us quietly as exams loomed, the gatekeepers of medicine. No one could proceed without knowing vast amounts of minute detail about the bedraggled, reeking corpses over which they presided.

Fresh from a year in sub-Saharan Africa, I thought I detected, as might any modest 19 year old amateur anthropologist in the circumstances, a rite of passage. That helped. Our cohort would be stressed, mystified, bullied, degraded, and eventually—with a few exceptions—found worthy.

Meanwhile, we trooped to practicals and lectures. A sad woman with a prosthetic right upper limb explained the mitral valve. "Just like a bishop's mitre . . ." She held up a normal hand and a metal claw. ". . . as those of you with two hands can easily demonstrate." A retired surgeon confided to small groups the convoluted secrets of the greater omentum, using folds in the lapels of the lab coat of the nearest student—somehow always female—to make his point.

A smiling junior answered all questions by quoting verbatim whole chunks of the official textbook in response to the stimulus of key words—anticipating the principles of the CD ROM by some 25 years. And daily the star lecturer launched upon his late morning peroration via sentences that lengthened steadily, the approaching release signalled by the most breathtakingly audacious grammatical construction of all—encrusted with ornately worked parentheses and featuring not only serried flying buttresses of subordinate clauses but echoing transepts of noun phrases in apposition too—which led at last to a dying fall, mass exit to the Men's Union and lunch: pie, beans, and chips.

Gone, all gone. A brief note in the university's financial recovery plan indicates that the anatomy department is no more. Elements of the subject will be taught in context as the need arises. But recent advances in anatomy, by Vesalius and others, will all no doubt still be freely available on CD ROM.

Colin Douglas *doctor and novelist, Edinburgh*