Preference is given to letters commenting on contributions published recently in the *JRSM*. They should not exceed 300 words and should be typed double spaced

London medical schools

May I make three brief comments on the interesting article 'The flowering of London pride: finding a name for it' (July 2001 *JRSM*, pp. 355–357) by Professor Crisp, Sir David Innes Williams and Mr Price?

One significant omission is any reference to the 1992 report by Professor Sir Bernard Tomlinson which actually brought about the present configuration of London medical schools.

Secondly, the sentence 'The degrees *for the moment* remain those of the University of London' (emphasis added) calls for comment. While nothing these days can be predicted with any certainty, it should be made clear that the University of London degree is one of the most powerful unifying forces in the federal University and it is a condition of membership that every College, even if it has its own degree-awarding powers, must leave those in suspense and award degrees of the University. That policy, so far as I know, commands universal support across the University.

Thirdly, the authors revive the Flowers suggestion that the new groupings of medical schools within their multifaculty Colleges should be renamed. Tomlinson was wise enough not to venture into this territory, let alone make any concrete suggestions.

It was left to each group to determine their own names. Now, as those institutions are settling down within their new institutions, is hardly the moment to reopen this question. I was very much involved in one of these sets of mergers and know better than most what the difficulties were and not least the sensitivities with regard to name.

Rather than pull out the names of great medical scientists in the history of London's medical schools and teaching hospitals, it is even more important where possible to retain those names of medical schools with a distinguished history and tradition which resonate in the medical world; and the second imperative is to ensure that these new schools become fully a part of the multi-faculty College of which they are now a part. Importing new names and titles would damage that process and create even more uncertainty.

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Evidence-based art?

In his article 'Evidence-based Art?' (June 2001 *JRSM*, pp. 306–307), Professor Michael Baum dismisses the *Exeter Evaluation* as 'Essentially, staff and patients were asked whether they liked the environment and whether or not their life was enriched by the beautiful things that surrounded them'. We did not ask these or any other such ill-formulated questions.

Admittedly we made opinion surveys and not the randomized controlled trials so beloved of clinical scientists. I do not believe that art alone in healthcare settings can treat disease in the way that interventions with drugs, surgery and, indeed, professional art therapy do. Therefore clinical trials are inappropriate in this field. Research and the collection of sound evidence is nonetheless in very short supply and the *Exeter Evaluation* was the first truly independent work to establish a full *factual* description of every aspect of a major hospital art project.

The polarization of 'strict scientific empiricists and fuzzy-logic experientialists' described by Michael Baum is the problem, not the solution he seems content with when he states that 'The value of art and music are givens in our culture'. He offers as examples hospital chapels and the room of Mark Rothko paintings at Tate Modern. Chapels, atrium galleries, entrance halls, corridors, stairways and waiting rooms in hospitals are now commonly adorned with art but these are not places exclusive to hospitals and certainly not the sites of treatment and care. Such places are wards, consulting, examination and treatment rooms, imaging rooms, delivery suites, intensive-care units, rooms for dialysis, chemotherapy, physiotherapy and radiotherapy and so on. Some clinical staff believe that these areas should be clean, sterile and stripped down for high-tech medicine and there is surely a debate to be held about this.

The debate must hinge upon evidence, not merely the assertion in Michael Baum's article that 'the life-enhancing value of fine art is common experience' which, like his references to Mozart and Raoul Dufy, in my view quite misses the point. We will continue to collect evidence with the same objectivity that we recognize and respect in the work of clinical scientists and we are keen that they join with us in constructive debate.

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Arguing solely from an opinion-based evaluation of the Exeter Health Care Arts Project, Professor Michael Baum concludes that 'the notion of evidence-based art is as absurd as an Impressionist school of science'.

It is not evidence-based art but evidence of the responses to art which we at Chelsea and Westminster Hospital Arts are seeking to establish. To that effect, two years ago we set up a research project—*A Study of the Effects of the Visual and Performing Arts in Healthcare*—conducted by RLS, winner of one of the Wellcome Trust's first SciArt awards for her project *Fast Blue, Slow Red: the Brain's Construction of Colour* and with 25 years' experience in

medical research. With backing from our hospital's research committee, we formulated a protocol to conduct a study including physiological and biological responses in the presence or absence of works of art or live music with controlled trials. After the first year the King's Fund, impressed by the importance of the research—the first such scientific evaluation of the arts in healthcare as opposed to the reams of anecdotal evidence of which the Exeter evaluation is an example—has funded the rest of the three-year study, which, it is hoped, will conclude in June 2002, with the findings published thereafter by the King's Fund.

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Author's reply

It is my misfortune in life to be misunderstood. I thought I made it clear in my short article that the biological responses to the visual arts were a subject worthy of study. The only thing I take exception to is the demands for 'evidence' to justify the purchasing, commissioning and displaying of works of fine art in the public places within NHS institutions. As a hardened scientist I believe in the principle of 'art for arts sake'. I also believe that, in the fulness of time, experimental evidence will demonstrate that the juxtaposition of certain colours and certain shapes provokes favourable responses in our physiological status. Meanwhile I will let my heart lead my head and urge all your readers to stand for ten minutes or so, contemplating Vermeer's *Lady with a Balance* currently on display at the National Gallery. I am sure they will find a comforting stimulus to the parasympathetic system, a modest increase in endorphin level and an increase in the number of circulating T lymphocytes.

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Carbon monoxide poisoning

As Dr Blumenthal indicates (June 2001 *JRSM*, pp. 270–272), much is known about the acute effects of carbon monoxide poisoning and quite a lot about the long-term sequels of such poisoning. However, much less has been published about the effects of chronic low-grade exposure to carbon monoxide poisoning. This is often extremely insidious and is usually not detected during the exposure but only later after realization that a gas-fired appliance is defective.

During the exposure the common symptoms are headache, nausea and weakness; vomiting and dizziness may also be complained of. Lethargy can be a particularly severe symptom and may result in a misdiagnosis of chronic fatigue syndrome.

Our experience encompasses over 30 such cases. The psychiatric effects of chronic exposure include irritability, depression and lability of mood. Neurological signs are usually absent. The neuropsychological pattern on detailed testing is impairment of attention, short-term memory and executive functioning.

We wish to draw doctors' attention to this syndrome as it is easily overlooked.

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Thyrotoxicosis with heart block

Dr Faizel Osman and colleagues (July 2001 *JRSM*, pp. 346–348) present two cases of thyrotoxicosis with heart block. For the second patient, who responded well only to steroid therapy, they raise the question whether the triad of thyrotoxicosis, heart block and raised erythrocyte sedimentation rate could be due to a single autoimmune disease; yet they do not say whether this was investigated or not.

Sarcoidosis is known to affect both the heart and the thyroid. In the former it can present as a branch block, an arrhythmia, an atrioventricular block or heart failure[1–3] and in the latter as either hyperthyroidism or hypothyroidism[4,5]. In patients who require pacing for atrioventricular heart block and who have no previous diagnosis of sarcoidosis, the prevalence of sarcoidosis, after extensive investigations, can be as high as 11%. Only 4.5% of the patients in the above study had a positive X-ray and a further 13.5% had bilateral hilar lymphadenopathy on computed tomography. Consequently, gallium-67 or thallium-201 scintigraphy would be the preferred method of investigation.

Sarcoidosis could account for the symptoms of the second patient presented by Osman and colleagues. As Flora and Sharma put it: 'any patient with unexplained heart block, cardiac arrhythmia or heart failure should be considered'[2].

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Leechcraft

With reference to Dr Aronson's memoir on leeches in Philadelphia (July *JRSM*, p. 372), may I stake a claim to be the last hospital physician to use leeches in Britain? In late 1950 I was a houseman at Mount Vernon Hospital Northwood when Dr C E Lakin instructed me to apply leeches to relieve a cardiac patient's congested liver. Fortunately the elderly ward sister remembered the technique. The pathology department supplied the leeches, and we introduced five of the beasts through holes in a pad of lint, in a row just below the costal margin. They browsed harmlessly and with great enthusiasm, presumably in the subcutaneous tissue and not in the liver. The patient felt better but his poor condition was unchanged.

Charlie Lakin, born in 1878, was a famous pathologist, physician and teacher at the Middlesex Hospital. During and after the Second World War he served as a physician at Mount Vernon which was a sector hospital of the Middlesex.

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Adverse events in hospital practice

I am getting increasingly concerned for clinicians in the NHS who, having been battered by politicians and the media, now have their own colleagues turning on them (July 2001 *JRSM*, pp. 322–330). In their previous article[1], I thought Dr Graham Neale and his colleagues were too hard in their criticism of the 'failure to manage leg ulcers aggressively'. I now work for Age Concern and have been visiting a woman regularly who has bilateral leg ulcers that three weeks' inpatient treatment and all the resources of a teaching hospital have failed to heal. Some problems defy solutions.

Ten operations over the past decade have given me ample opportunity to observe the difficulties faced by nursing staff. On one occasion my neighbour was Elsie, 92 years old and confused. She absolutely refused to change her posture when a sacral pressure sore threatened: 'I'm a poor old woman. Please, can't I sleep as I like'. She also regularly rose from her bed, ran across the ward leaving puddles behind her crying, 'Oh, I'm so sorry'. Could the nursing staff be blamed if she fell? Can they be blamed for the readmission of Lily, sent out with a care package, but readmitted with an infected wound because the community nurse had failed to appear, or Lizzie, who was reduced to phoning her fishmonger when her carer defaulted. It is pleasant to record that he left her not a piece of fish but a full meal. (I have changed the names.)

Much of what Dr Neale and his colleagues write is valid criticism, but failures in patient care are too often blamed on the hospital staff without further enquiry. Readers might be surprised if they knew how many community workers not only fail to do the work they are paid for but also fail to inform their clients. My 'ulcer lady' has had no home help for several days, relies on neighbours and is considering going into a home because her present state is so difficult and stressful. Also, why is it assumed that the hospital staff are always responsible for infections? What about the children, some with patches of impetigo, running from bed to bed, 'Come and give me a kiss, darling'. Couldn't visitors be asked to 'take their litter home' and 'leave this place as you would like to find it' as is done in other places. Overworked nurses should not be asked to clean toilets.

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The Mozart effect

Dr James suggests that some cases of 'road rage' in motorists might be due to an overdose of pop music at the wheel (June 2001 *JRSM*, pp. 316–317). More likely there exist fundamental (psychological) differences between motorists listening to Mozart and motorists enjoying uncivilized music. I should not be surprised if motorists eager to mow down the odd cyclist prefer uncivilized music to Mozart.

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Crutch walker's shoulder

Mr Davies and his colleagues conclude that, in a patient with Cushing's disease or avascular necrosis (AVN) at other sites, shoulder symptoms when crutch walking 'should be enquired about and investigated radiographically' (July 2001 *JRSM*, pp. 348–349). Crutch walking has wider relevance to AVN.

In 1983 I reported the cases of two perhaps osteoporotic but otherwise healthy women aged 73 and 59 who developed AVN of the humeral head as a result of crutch walking following isolated femoral neck fracture treated by internal fixation[1]. In both cases the condition was self-limiting and in one it was detected only as a result of full examination for medicolegal purposes seven months after the injury. I presented also a third patient who had used a walking aid in the right hand for over 10 years after unsuccessful hip replacement and who had developed glenohumeral osteoarthritis, the appearances of which were suggestive of previous aseptic necrosis.

I suggested that the condition probably was more common than appreciated because in those who use crutches for a limited period the symptoms were low-grade and spontaneous resolution takes place. With prolonged crutch walking, however, the condition might lead to glenohumeral osteoarthritis. Some support for this view was provided by a later paper reporting bilateral osteonecrosis of the humeral heads in a wheelchair-dependent T8 paraplegic[2].

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Transition from paediatric clinic to the adult service

Adolescence is a challenging, often traumatic but fascinating time of life whether or not it is accompanied by a chronic medical disorder such as diabetes, cystic fibrosis, arthritis—or epilepsy[1–3], a condition which is in fact more common than the three preceding disorders cited by Professor David in his somewhat pessimistic editorial (August 2001 *JRSM*, pp. 373–374).

In 1991 a specific 'hand-over' or transition clinic for teenagers with epilepsy was established in Liverpool which is supervised jointly by a paediatric and an adult neurologist (both of whom have a particular interest in epilepsy) together with a nurse specialist in epilepsy. The primary objectives of this teenager clinic are to address the unique needs and concerns of this age group and, importantly, to facilitate a smooth hand-over of specialist epilepsy care from paediatric to adult services[4]. The success of this clinic—as assessed by both the teenagers themselves (who have a 'did not attend clinic' rate of $< 3\%$)—and the development of other similar units throughout the UK and the rest of Europe, would suggest that this approach is generally regarded as a 'model' service. Undoubtedly, the success of this service is largely dependent on demonstrating a clear commitment to the young people, the philosophy and personalities of the clinic staff and the teenagers themselves.

In Liverpool, and for teenagers with epilepsy, the future is bright.

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Filmless images for radiology teaching

In his excellent introduction to digital X-ray systems, (August 2001 *JRSM*, pp. 391–395), Dr Shaw reveals many of the advantages of the picture archive communication system (PACS). An additional area of potential benefit is in the teaching of radiology. This idea has been discussed since PACS was in its infancy[1], but it deserves emphasis in view of the limited amount of radiology taught to medical students today. Basic image interpretation is usually taught on the ward, by sporadic and isolated demonstrations of radiological signs. PACS would allow call-up of images from other patients, to emphasize a particular feature, as well as radiological changes on follow-up. Studies on the role of PACS in teaching in the USA have yielded promising results. One report revealed that an electronic final examination for medical students, prepared with images downloaded from PACS or digital teaching collections, was feasible, easy to prepare and cost-effective, and it provided an excellent display of test images[2]. Additionally, teaching in how to prepare and deliver electronic presentations of radiological cases downloaded from PACS was well appreciated by the students[3].

In a hospital equipped with PACS, teaching of radiology can be improved with little additional hardware or software. Use of PACS and PACS-derived teaching files

could make a big difference to student confidence and ability in interpretation of radiological images.

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Attitudes to adhesion

Professor Ellis's review of the legal consequences of intra-abdominal adhesions (July 2001, *JRSM* pp.331–332) was timely. We have been investigating surgeons' attitudes to this common problem. Though there is little clinical evidence, barrier agents such as Seprafilm have been shown experimentally to lessen adhesions without importantly reducing anastomotic strength[1]. Perhaps recent adverse events[2] have caused some surgeons to abstain from using such agents.

Three points mentioned by Professor Ellis's article were included in a questionnaire sent online to our Forum for Registrars In Surgical Training (www.frist.org/temp/guynash.html). General surgeons were asked whether they routinely warn patients, before laparotomy, of the risk of adhesions; whether they believe that covering a bowel anastomosis with omentum decreases the risk of future adhesions; and whether they use an agent, if available, in the hope of avoiding further adhesions in a patient with multiple previous laparotomies.

Of the 50 who replied initially, 7 routinely warn about adhesions, 12 favour omental covering and 25 would not currently use an agent such as Seprafilm. On the evidence of this small survey, the lack of consensus on aetiology and epidemiology extends to practical management.

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John Hunter's health

J Rosenberg (May 2000 *JRSM*, p. 260) refers to Everard Home's claim that poor health was the reason for Hunter's enlisting in the Army, and implies that Home's view is endorsed by me. In fact, my text[1] goes on to point out that army service in those days was hardly a healthy exercise, and in my more recent study of the Home family[2] I quote Drewry Ottley's rather similar story, probably derived from Home: 'he was strongly advised to leave London, therefore, and seek a more southerly climate'[3] with the comment that Hunter's enlistment 'took him out of London, certainly, and to a more southerly climate as well, though we would have to wonder just how military service in the eighteenth century rated as a rest cure'.

In fact I am about as sceptical as Rosenberg concerning Hunter's choice of an army career as a cure for his health, though an open-air life may have appealed to him after some years in brother William's anatomy school. But how much ambition influenced him, or friction with William (we know they fell out later) we can only conjecture.

We do need, though, to recognize that Hunter's health in Portugal was less than perfect. In a letter dated 8 September 1762 to Lord Loudon, the British commander-in-chief, the commanding officer of Hunter's hospital, William Young, wrote: 'Mr Hunter . . . does not downright say he is sick but that he is almost knocked up. He has had too much to do'.[2]

That said, Rosenberg's letter still raises a paradox. The syphilitic myth, propounded by Sir D'Arcy Power[4] to his lasting discredit (and parroted by biographers such as Kobler, Gloyne and Gray) should have been forestalled by the evidence of Hunter's necropsy which—as Rosenberg mentions—showed evidence of widespread coronary and cerebral vascular disease. And that necropsy was carried out in 1793 by the same Everard Home who, a year later, wrote the biographical sketch which accompanied the posthumous publication of Hunter's final work[5] and which Rosenberg inclines to ascribe to Home's 'nefarious reasons'.

Even when Home misrepresented Hunter's intentions regarding his *MSS*—thirty years later and after the plagiarism and burning—he did not resort to maligning Hunter in other ways. In 1793–94 he had even more reason not to impugn Hunter, on whom his own somewhat dubious fame would be founded; and he had not yet entered into the friendship with the Prince Regent to which, directly and

indirectly, I am inclined to attribute his later truculent alcoholism.

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Correction

Not pre-eclampsia

In this case report (July 2001 *JRSM*, pp. 351–353) the qualifications of the second author, Dr Sandra Dean, should have been given as FRCP, FRCPGlas.

Once The Eastern Dispensary now *The New Dispensary*

The type of dispensary inaugurated by John Coakley Lettsom in Aldersgate Street, where home visiting and care were encouraged, helped open the eyes of the medical profession to the extent of poverty in 18th century London and its relevance to the incidence and outcome of diseases. By 1800 there were 16 dispensaries in London and many more were built in the 19th century. Few architectural traces remain of such buildings, which were domestic in scale and sometimes elegant in style. The building of the former Eastern Dispensary, founded in 1782 and rebuilt in 1848 in Leman Street (near present day Aldgate underground station), to serve a district once known as Goodman's Fields, is a notable exception. Built by public subscription to 'dispense gratuitously the benefits of medical and surgical relief to the poor of a very extensive and populous district,' it became a crumbling warehouse for much of the 20th century. It has now been restored and refurbished as a pub, and the visitor has a rare opportunity to see the internal structure and layout of a dispensary building. Renamed *The New Dispensary* and now situated in a neighbourhood touched by the eastward extension of the prosperity of the City of London, it provides for the needs of a different clientele.

Denis Gibbs