

lack of distraction by other duties, consistency in examination technique and adherence to protocols/guidelines for management. One drawback of this approach, however, relates to the training of junior doctors. To provide optimal care for patients these doctors' involvement should be that of an active observer. The challenges for training of junior doctors and undergraduates are outlined in the same issue (pp 244–246) by Mr Rennie and Ms Seabrook. The trend towards day-case and short-stay surgery has coincided with the removal of housemen from day surgery units. The 'active observer' approach for both junior doctors and students has to be encouraged if their exposure to common clinical problems is not to be further restricted.

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Genesis of the Faculty of Community Medicine

Michael Warren (July 1997 *JRSM*, p 416) correctly presents the origin of the Faculty. The idea came from Jerry Morris, and the opportunity for linkage with the other specialty organizations from Max Rosenheim's broad vision. I did know what was afoot, but believed that action should be seen to be by the profession and not the government. For that reason Henry Yellowlees was an observer on the committee, not a member.

The Health Department's part in this came earlier. The old style DPH was clearly unsuitable for the future, and the London School of Hygiene urgently needed reform. That was achieved after Jerry Morris had been persuaded to move to the Chair. There were, of course, other schools, but only John Brotherston in Edinburgh, before he was persuaded to succeed Kenneth Cowan as CMO Scotland, had organized the sort of programme we needed.

The review of the field of work was undertaken by Robert Hunter's committee of which, also, Jerry was a member. Indeed he joined me in the discussion with Dick Crossman which led to its appointment.

My personal view throughout has been that the initiative should be professional and the CMO's role no more than helping, where necessary, to open doors.

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Lind's clinical trial and the control of scurvy

Dr Thomas commented in his paper (January 1997 *JRSM*, pp 50–54) on the delay between the publication of Lind's monograph in 1753 and the general use of citrus juice in the Royal Navy in 1795. In a follow-up letter (April 1997 *JRSM*, p 238) Dr Bardolph and Dr Taylor emphasized that the delay was due to the impact of the forceful views of those who advocated less effective and less well-tried methods. This is true but one must also consider the real nature of the problem of scurvy, and the way in which Lind chose to present his data and the general climate of opinion at the time.

To take the last two related points first. The tendency of historians to quote the crucial passage describing Lind's clinical trial perhaps obscures the fact that it occupies only two pages of a 454 page monograph¹. The rest was taken up with information on the history, description, diagnosis, post-mortem findings and other methods for the prevention and treatment of scurvy^{1,2}. We focus attention on the trial because of its general historical significance. However, at the time of publication there was no reason why its particular significance should be recognized. The description was short, the trial was small (only two patients per group), and the passage may well have been overlooked or ignored by many. Some may also have been confused by Lind's continued recommendation of traditional and unproved remedies such as onions, cider, and pickled cabbage, all now known to have little or no vitamin C².

The value of fresh citrus fruit was increasingly being appreciated before Lind's clinical trial. However, fruit could only be used on short voyages and on land. The real problem was to provide regular supplies of antiscorbutics on long voyages where stops could not be made to obtain fresh supplies. Lind's answer was to prepare a 'rob', which involved reducing the juice to a concentrated syrup by initial boiling and then simmering for hours², a procedure that would considerably reduce if not destroy the vitamin C content^{2,3}. Lind provided no controlled evaluation of the rob, but instead dealt at some length with ways of making it palatable².

Of other antiscorbutics much attention was paid to 'wort', a fresh infusion of malt, introduced in 1767 by David MacBride⁴. MacBride's trial was not as rigorous as

Lind's and his results not as impressive. However, his commendably brief monograph (62 pages) had a title which mentioned 'ten patients' (c.f. Lind's two per group), and through his brother a Royal Navy captain he obtained Naval patronage⁵.

When Captain Cook went on his three voyages of exploration he was deputed to try various antiscorbutics including rob of oranges and lemons, wort, sauerkraut, and portable soup⁶. Cook's concern for his men's welfare is well known, and he tried to obtain fresh fruit and vegetables at every opportunity. Perhaps because of this, and because he was not well served by his medical staff, no proper controlled trials were made. Although Cook lost only one man through scurvy, the incidence was higher than admitted at the time⁶. Cook concluded that wort was an effective preventative but less certain as a cure for scurvy. He also recommended sauerkraut but thought that the rob, though of some value, was not cost-effective^{6,7}.

It is unfortunate that, despite his concern for his men, Cook in effect helped to delay the introduction of effective measures to combat scurvy^{5,6}.

In summary, the general value of Lind's small-scale trial was that it provided the first model of how the efficacy of treatment could be tested by controlled experiment. As far as scurvy is concerned it proved what was generally believed—that fresh citrus fruits were an effective cure. The major problem was to develop reliable methods for preserving the juice. With these available, the rise to power of people such as Sir Gilbert Blane eventually ensured its proper use.

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Swearing off the Oath?

Professor Kessel's editorial, 'Swearing an oath' (June 1997 *JRSM*, pp 301-2) raises several issues. Some of them have lately been discussed elsewhere¹⁻³, so we wish to comment on just two. Although Professor Kessel is right in saying that 'the Hippocratic Oath does not attempt complete coverage of medical ethics', we fear that the emphasis on this point overlooks the fact that the Oath was written for medical students and practising new physicians, not for medical research scientists, biotechnologists or other health care professionals. It is noteworthy that the Roman physician Scribonius Largus (1st century AD), who is considered as the first to refer to the text of the Hippocratic Oath, states that it was written 'to inspire human feeling in the mind of the students'⁴.

Building upon the Hippocratic heritage is a valuable part of medical education for the students. The process of retaining and of developing the Hippocratic spirit of the classic Oath—before the medical graduation ceremony—is more important than its particular structure and formulation. The core meaning of the Oath is clearly against negligence, representing the 'nucleus' for the ethics of medical practice and fostering trust in the physician/patient relationship.

We agree with Professor Kessel that the Oath 'is a piece of medical history which still contains much pertinent wisdom'. The fact that this monumental text offered for the first time in the history of the world a complete separation between *killing* and *curing* could explain why the Oath has endured the test of time and will be pertinent for a long time to come.

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Fever

It is surprising that Dr Blumenthal (July 1997 *JRSM*, pp 391-394) discusses thermometry after Wunderlich without mention of Sir Clifford Allbutt (1836-1925)¹. Wunderlich (1815-1877) began using a thermometer, which was 22.5 cm long and required 20 min to register axillary temperature, in 1851. In 1868, in definitively describing its use as an indispensable clinical tool, he showed² that fever was not a disease, but a sign of one.

Allbutt introduced his short clinical thermometer in 1867³. This was, at first, 6 inches (15 cm) long, but was later shortened to 4 and then to 3 inches, and took four minutes to record axillary temperature. It is still the one in ordinary use, and Allbutt had had it made in Leeds, where he was physician to the Leeds General Infirmary, before becoming Regius Professor of Physic at Cambridge. His short thermometer, faster and easier to use, was surely worthy of mention in a discussion of thermometry in clinical medicine.

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On the shoulders of giants

The otherwise helpful and instructive review by Nicholas Cambridge of Thomas

F Baskett's new book, *On the Shoulders of Giants: Eponyms and Names in Obstetrics and Gynaecology* (June 1997 *JRSM* pp 54-55), suggests that the first part of the book title comes from a letter written by Sir Isaac Newton to Robert Hooke. Whilst this is the common attribution of the famous aphorism, it is worth recording that in 1159 John of Salisbury wrote 'Bernard of Chartres used to say that we are like dwarfs on the shoulders of giants, so that if we can see more than they . . . it is not by virtue of any sharpness of sight on our part but because we are carried high and raised up by their giant size'¹. Unfortunately, the reference for Bernard's comment remains elusive!

Anyone interested in the pursuit of the aphorism could do no better than to read the delightful book *On the Shoulders of Giants—A Shandean Postscript*² by Robert K Merton, who devised and defined the acronym OTSOG—'a close knit narrative that pays its respect to scholarship and its dues to pedantry'.

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Paracetamol hepatotoxicity

I enjoyed Dr O'Grady's review (July 1997 *JRSM*, pp 368-70). May I draw attention to three additional pitfalls in the management of paracetamol overdose. Firstly, since activated charcoal adsorbs and inactivates oral methionine, undertreatment of toxicity may result if they are administered together or concomitantly¹. Second, if slow release tablets, which have a delayed or unpredictable absorption, have been consumed or if a sequential overdose has been taken, then doctors must not rely on the treatment nomogram lines to interpret paracetamol levels before administering antidotes. Third, patients who are infected with human immunodeficiency virus have depletion of hepatic glutathione and are consequently at greater risk from paracetamol-induced hepatotoxicity. These patients should be