THE AURICLE

UNIVERSITY OF THE WITWATERSRAND MEDICAL SCHOOL

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EDITORIAL

A number of students have remarked, and I must say that I completely agree with them, that our medical curriculum lacks an adequate course in therapeutics. Up to a few years ago the third year students received a detailed and comprehensive course in pharmacology and therapeutics but this was subsequently changed in that therapeutics was done away with. The reasons for this I do not know but I think that the move was a wise one for theraputics can't be learnt in the lecture theatre, the correct learning grounds being in the wards. Although the Registrars do attempt to teach therapeutics on their ward rounds some of the chiefs do not and as the majority of ward rounds are with the visiting chiefs very little is actually learnt in the way of therapeutics.

The average fourth and even fifth year student will, on being asked, be able to relate the actions, site of action, excretory products, etc., of a specific drug about which he diligently learnt in pharmacology, but ask him what drug to prescribe for a specific condition and even more important what dosage of the drug is required, and he is stumped. Dosages of common drugs such as penicillin, digoxin, seconal, aminophyline, etc., etc., are not known.

This situation is made no easier for the enquiring student who wishes to look up the dosages of a drug, for seldom do two books agree on the subject. Either the dosage varies or in one book it is given in grams, in another in grains and yet in another as perhaps units.

Many readers of this article will, I am sure, say that I am making a mountain out of mole-hill in that therapeutics will be "picked-up" along the way between fourth year and final year, or that if the student wanted to he could learn therapeutics by asking the Registrar and houseman and by taking notes of the bedletters in the ward. However, I feel that this is just a negative reply to a positive problem. In my opinion therapeutics should be actively taught at the beginning of the clinical years. The fourth year timetable is not so crowded as not to allow a small amount of time to be devoted purely to the tuition of theraputics.

This problem could be further relieved by the publication of a booklet by the S.M.C. with the authority supervision and assistance of the Medicine, Surgery, Gynaecology and Obstetrics Departments, giving a list of the more commonly used drugs and their dosage. This latter suggestion would I feel, be of considerable benefit to the student and assist in his attempts to acquire some knowledge of therapeutics.

Let us face a basic fact, diagnosis is just one facet of medicine and treatment is another and without the one the other is useless. A Medical Practitioner must have a knowledge and understanding of pharmacology and therapeutics to be a doctor of any standing.

SHERLOCK HOLMES PHYSICIAN EXTRAORDINARY

IT is hardly surprising that of the many characters Dr. Sir Arthur Conan Doyle created, at least one reflected the medical aspect of this very talented man. Visions of that bluff, hearty gentleman Dr. Watson instantly arise in most people's minds. Indeed his true life model was certainly Dr. Doyle himself, but his very apt answer to a critic who asked him about this point was:

"So please grip this fact with your cerebral tentacle,

The doll and its maker are never identical."

I would like to think that Sherlock Holmes was to Conan Doyle the man who most closely portrayed his association with the medical profession, and not Dr. Watson. In fact it is quite likely that Conan Doyle was having a quiet dig at the medical profession. Dr. Watson, who may well have been representative of an average general practitioner of those days, when compared with Holmes, a non-medical, non-degreed intelligent layman appears to be a complete idiot.

Be that as it may Sherlock Holmes made his first appearance in "A Study in Scarlet" which Doyle wrote in 1886 while waiting for patients. In Doyle's own words "I set up practice as an eye-specialist. My rooms in Devonshire Place consisted of a waiting-room and a consulting-room, where I waited in the consulting-room and no-one waited in the waiting room."

The true life model of Sherlock Holmes was a certain Dr. Joseph Bell, surgeon at the Edinburgh Infirmary from 1876 to 1890. Although Dr. Bell once confessed to Doyle that 'You owe much less than you think to me', Dr. Bell was the very epitome of Sherlock Holmes, even down to his physical characteristics.

Doyle was appointed his out-paitients clerk and Bell would treat his firm to this sort of thing:

"Gentlemen, I am not quite sure whether this man is a cork-cutter or a slater." This was due to a slight callus on one side of the patient's fore-finger and a little thickening on the outside of his thumb.

A replica of the room at 221b Baker Street has been reconstructed in a certain building in Northumberland Street. Among the flasks and bottles of chemicals on the small bench is a bottle of Easton's Syrup and numerous bottles of pills. On his bookshelves amongst Bradshaw, files of newspaper cutting and numerous chemical textbooks are to be found Boyd's Pathology, a textbook of bacteriology and also one on chemical pathology. In fact at the time that Sherlock Holmes met Dr. Watson he was engaged in biochemical work in 'a great hospital in the North of London.' Dr. Watson was told just prior to meeting Sherlock Holmes in the chemical laboratory that Sherlock Holmes had been giving people 'a little pinch' of the latest vegetable alkaloid, not out of malevolence, but simply out of a spirit of inquiry in order to have an accurate idea of the effects. He had also been sent to beat the subjects in the dissecting room with a large stick, to verify how far bruises may be produced after death. At their meetings Holmes was only prevented from saying "Dr. Watson I presume," by the fact that he had discovered the Sherlock Holmes test for precipitating haemoglobin. Dr. Watson got off to a great start by a show of ignorance. 'It is interesting chemically no doubt,' he said 'but practically——', "Why, man, it is the most practical medico-legal discovery for years,' said Holmes.

Thus Sherlock Holmes was not only taken from a quite remarkable surgeon, but also appeared to have an excellent grasp of anatomy, biochemistry, pathology, pharmacology and forensic medicine. Holmes also had knowledge of another Hospital, that of Charing Cross itself. In the case of the "Illustrious Client" the newspapers had a small article about an attack upon Sherlock Holmes:

'We learn with regret that Mr. Sherlock Holmes was the victim of a murderous assault, receiving injuries which the doctors describe as most serious. He was carried to Charing Cross Hospital and afterwards he insisted upon being taken to his rooms in Baker Street." One wonders why, as soon as he had entered the hospital, he immediately insisted on discharging himself? After a fruitless search through the Hospital records of that time I still cannot claim that Professor Moriarty was on the staff of Charing Cross Hospital although perhaps Sherlock Holmes, despite his grievous injuries, still had the presence of mind to realise that an even greater evil, malingering force was present in the shape of the R.M.O. of that time.

The point that made Sherlock Holmes a physician extraordinary was his great ability to diagnose with startling accuracy, and also to reveal the cause of death in some cases with not any more than a brief glance. Only the most foolhardy physician would make a diagnosis on a patient without bothering to do a proper examination except in certain well known aflictions. This did not apparently concern Sherlock Holmes and as if to show this complete lack of concern he diagnosed one case of leprosy and another of galloping consumption entirely on negative behaviour evidence; that is, a lack of the patient to conform to normal behaviour patterns.

A notable example of this ability to diagnose in the most adverse conditions occurs in "A Study in Scarlet' In this case he made a

brilliant diagnosis without having seen or heard the patient, and all that he had to work on was a specimen of his blood. This appears to be the closest thing to the self-diagnose black-box of very recent notoriety. On being questioned by Lestrade, who admittedly was not much better than Dr. Watson, as to what the murderer of Enoch Drebber looked like, Holmes replied: In all probability he had a florid face since the blood on the floor is all his own.' He was of course meaning that the murderer probably had hypertension and at the time of the crime, due to emotion had had a terrific nose bleed. In the end Holmes proved correct, but the criminal also had an aortic aneurysm from which he died before being tried.

Sherlock Holmes, in his investigations into the "Sign of Four" shows his remarkable ability as an expert in forensic medicine and at the same time dumbfounds Dr. Watson. Here he ascertains the cause of death from the position of the body and a peculiarly unnatural, fixed grin on the part of the dead body. Holmes of course recognised the grin as risus sardonicus and from the fantastic fashion in which the limbs were twisted diagnosed strychnine poisoning.

"It means murder," said Holmes, stooping over the dead man. "Ah! I expected it. Look here!" It was a long poisoned thorn stuck in the skin just above the ear. All Dr. Watson could say was that it was all an insoluble mystery which grew darker instead of clearer.

John Dickson Carr brought another Doctor in to the story of The Gold Hunter in his "Exploits of Sherlock Holmes". This doctor, Dr. Griffin, was just as obtuse as Dr. Watson and appears to have little idea of forensic medicine. I think that Dickson Carr realised that Doyle was trying to show up certain classes of general practitioner of that time. In this story Holmes decides the cause of death on seeing a bottle of vaseline, despite the fact that the post mortem was conducted by Sir Leopold Harper, the foremost living authority on medical jurisprudence who failed to determine the cause of death and it had also been far too much of a problem for Dr. Griffin. Holmes proved conclusively that the murderer had smeared vaseline upon the face of his victim and then held a chloroform rag to his nose and mouth for twenty minutes, the vaseline being used to prevent the chloroform burning the skin of the victim.

Holme's brilliance as a medical diagnostician is brought home in the case of the "Blanched Soldier". His client had been trying to trace an old war comrade of his whom he knew was still alive. He suspected something wrong on seeing his companion staring into his room for a brief glance, but was still told by his friend's father that his son was missing. His description of his former friend was enough to satisfy Holmes. "His face was of fish-belly whiteness. It was bleached and as white as cheese."

"Was it equally pale all over?" asked Holmes.

"No it wasn't," replied his client.

Holmes only needed to write the word "leprosy" on a piece of paper for his case to be complete. In this particular case Dr. Watson was not "assisting" Holmes, which is just as well.

In the case of the "Missing ¾" Holmes knew very well that is was only the tragic twist of disease, galloping consumption as he thought, of an as yet unknown third person that would prevent an international Rugby player of five caps missing the Varsity match. It only remained for him to prove that this was the case. The case of the "Resident Patient" would not have been solved by Holmes unless he had extraordinary powers as a physician. In the first place he knew a case of malingering by just listening to his client's story. His client was a neurological diseases specialist.

"I can make little of it, particularly the cataleptic fit," said Dr. Watson.

"A fraudulent invitation, Watson, though I should hardly dare to hint as much to our specialist." His client was not a Charing Cross man.

In the same case Holmes dismissed what appeared to be a case of suicide by hanging as one of murder. This apart from surprising Dr. Watson, was concluded as 'impossible' by Scotland Yard.

The Creeping Man presented to Dr. Watson a quite incredible story. Holmes's client was the assistant to a 'mad' professor. This professor was normal by day, but at night crept around like a three animal and possessed a vicious temper, quite unknown to the professor.

"Well Watson, what make you of that?" asked Holmes.

"Lumbago, possibly — nothing could be more trying to the temper."

"Good, Watson! You always keep us flat-footed on the ground."

Holmes had already decided that the professor was injecting himself with animal extract, but for what purpose he was at a loss to explain. He had thus prepared the way for an answer to the problem.

Many other cases were brought to a successful conclusion by the fact that Holmes had an outstanding medical knowledge. "The Lion's Mane," "The Sussex Vampire," and "The Yellow Face to mention only a few.

Of course forensic medicine has seen great changes since the days of Holmes, but even so I would still place Sherlock Holmes as a particularly able physician, in fact a physician extraordinary.

The Medical School Refectory

EVER since the formation of our University, the University authorities have shown a remarkable lack of insight in their dealings with students and a deplorable lack of understanding in the management of this insittution.

The bickering of Professors for room and finances for research is attended to with astounding alacrity, while the students (who are merely elderly school-children) have their requests and pleas summarily dispatched with, with equal alacrity and far less consideration. Often the only reply to their pleas is a vague promise that something will be done in the future. The "future" to our most reverend authorities can mean anything from a period of 10 to 20 years — which is probably between 5 years and a decade longer than most of us spend in the University environs.

The latest plea put before the authorities to reach a critical stage is the plea for a new Refectory and students' common rooms. The crisis has arrived due to the fact that within the next four to six months the present buildings are to be demolished to make way for a splendid new block of offices and a library. One would just like to digress for a moment to elucidate the history of the refectory and inform the student body of past struggles before continuing with an account of what steps your S.M.C. intends taking to rectify the position.

The refectory and common rooms have long been recognised as two vitally important parts of the students' existence at this school. There are a host of reasons for this statement, not the least of which is the fact that the average student up the hill spends between nine and ten hours on the campus each week day and between three and four hours on a Saturday, and has as his only place of relaxation and nourishment the common rooms and the refectory. It would be a waste of time and effort for one to develop the theme as to why the refectory is important, as almost any clear-minded soul can reason it out for himself.

However, at one stage, many eons ago, it was recognised that a refectory was essential to the welfare of our students and the authorities provided the Medical school with a delapidated, prehistoric building to fulfil this requirement.

For a few years the students struggled on until finally it was decided to request for new facilities, as the upkeep of the building was proving more than the students could bear (even in those days the refectory received no financial support from the University). This first request dates back to 1932! As usual nothing was forthcoming from the University and the students dug deeper in to their pockets to maintain their refectory.

Finally in 1959 after repeated pleas by the S.M.C. the state of affairs became out of hand. Owing to the tremendously high cost of maintenance and the increasingly high price of food and commodities the old refectory became almost unmanageable. Mr. Dawson Maisels together with other members of the S.M.C. (with the backing of Medical school departmental heads) personally approached Professor Sutton and asked him to review the situation. Once again the cold shoulder of the University was turned on the medeical students.

The state of the refectory has been progressing steadily downhill, with increased financial losses until today, when we are faced with the problem of having no refectory whatsoever. Incidentally when this arises we will be the only school in the Republic not to have any facilities for student rest and refreshment.

The S.M.C. has not been idle all this while. The President Mr. Dave Nathan and members of the executive, Mr. Charles Galasco and Mr. David Levy, have had numerous interviews with both the authorities at Medical school and those down the hill. They have discussed the problem with the Registrar and the architects and the only result of their tedious efforts has been yet another vague promise that a new refectory and common rooms will be made available sometime in the future! According to the architects this certainly cannot be achieved within the next six years.

We just cannot afford to take this lying down. We must rally to the cause for if we do not help ourselves let me assure you that no one would dream of helping us. One hopes, therefore, that all students filled their names in on the petition, and that we will all and every one of us support the S.M.C. in its future plans to obtain a brand new, spick-and-span refectory in the forseeable future.

One would just like to quote one or two extracts from a memorandum to the principal issued by Mr. M. Puler (S.M.C. Chairman, 1958).

We also wish to re-emphasize that the decision fails to take into account the deplorable lack of facilities available to both students and staff of the Medical School.

We therefore wish to re-iterate:—

1. That the planning of a new Medical School be finalised as soon as possible;

2. That if the cost of an entire new building for the Medical School prohibits its completion, at least one portion of such a new building be started as soon as possible;

3. This portion should include a refectory, student common rooms, a new Medical Library, and a large, new lecture theatre. Later, when more funds are available, the other parts of the proposed new Medical School could be added.

Medical School students and graduates have in the past pulled their fair weight for the University Appeal Fund, and we therefore feel that the Funds should be allocated in proportion to the needs and to the size of our Faculty.

IAN D. SAMSON,
Chairman, Refectory Committee.

S.M.C. ELECTIONS

The elections held on Monday, 25th September, resulted in the following students being elected to the S.M.C. for 1962:

Mike Welsted, Joe Tiuhuho, Mike Wright, Let we Maar, Khalid Ishmail.

Congratulations to these students. The election was strongly contested this year and to those students who failed to gain election we can only say better luck next year.

The following students have already been elected to the new S.M.C.

David Levy — President.
Chiz Smart — 6th year class rep.
Stan Miller — 5th year class rep.
Charles Morris — 4th year class rep.
Keith Kaye — 3rd year class rep.
Keith Wimble — 2nd year class rep.

Next years first year students will elect a class rep and he and the above mentioned members will comprise the total number of voting members. However, the non-voting members (i.e. posts applied for, e.g. Chairman of Cultural Societies, Editor of Auricle, etc.) have not as yet been chosen. These members occupy quite a few seats. They are entitled to enter into any discussion but do not have a vote as they are not elected by the student body. Up to date the only post issued to a non-voting member is that of Chairman of Conference and the task is in the able hands of Mr. Colman.

For years Yehifsky had wanted to meet Abe Bitzer, who owned a big general merchandise establishment out West; but each year for ten years Bitzer had sent one of his sons East to do the buying and each year it had been a different son.

When Yehifsky learned that a Mr. Bitzer was registered at the hotel which the Bitzers always patronized, he rushed over, hoping at last his chance had come to meet Abe Bitzer, who had favoured him with so much business. Learning the number of the Bitzer room and being apprised of Mr. Bitzer's anxiety to meet him, Yehifsky rushed upstairs.

"Is diss de Mr. Bitzer vot owns de beeg depottment store?" excitedly said Yehifsky, shaking hands warmly.

"No," said the other, smiling. "I'm just another one of his sons."

"Gevalt!" cried Yehifsky, in his disappointment. "How many more sons of Bitzer are there!"

THE BALL

My mouth sick with the sweetness of wine and beer;
Shadows moving across a blanket of dark;
Flashing teeth mark
Seductive murmurs, abolishing the politicians' propaganda-scare
Of the encroaching fear.
The metallic screech of jazz from saxophone;
I move amid the crowd, but alone.
Like some conditioned animula
I attend functions of convention
(Social volition rending sanity's retention).
Bowing here, smiling there, saying this and that;
Dancing stiff-legged like a puppet to the notes discordant and flat;
Her breasts pressing insensuously at my chest.
Brain-cells
Brain-cells reeling.
Words crossing lips without feeling,
Poised on the hot air's diaphanous crest,
And then crashing on my muted senses.
The instrumentalists' cacophonous cadenzas
Ending another unsymphonic dance of Hell;
To await Satan's cachectic jest
We leave the floor with the rest.
Sitting in dimensionless recesses of the dark
Are entities, formed by couples coalesced;
My mind more stifled by each nonsensical remark,
That penetrates from her capsule of cras atmosphere.
A screaming trumpet stabs the smoke-ridden air;
Cymbals jangle, splitting the whispering pause
Of a heaving mass of liquor-maddened Man—
Souls hiding behind a feeble narcotic gauze
From the Fear which stands cadaverous and gaunt,
Pulsating each perfidious molecule of matter
With a final sneering taunt.
We walk onto the floor with the rest;
My mind groping to define Life's penultimate, now distorted, quest.
Piano keys thumping, clanking a diatonic conglomeration
By some grim-faced fellow-being,
Whose remaining attributes (likewise his brethren)
Are eating, hearing and seeing;
And perhaps he also prays convulsively in desperate concentration.
And all my life I have (and will) be coerced
By this hated social decree,
Which my inner-self declares perversed.
And yet I crave to be accepted
By that and those from whom I flee.
Frenetic fear claws my being at this thought;
A sexless, unmated life of social blindness,
Slaking my thirst on pathetic drops of kindness.

JACK VAN NIFTRIK

DICK REDDY

A Gentleman's Guide to Girl Pinching

ANTHROPOLOGISTS never tire of pointing out that man owes his place at the top of the evolutionary heap to the fact that his thumb and fingers are in opposition. That is, they can be brought together so as to create and manipulate tools.

This is very useful, especially if you happen to be handy around the house, but to a select group of connoisseurs of life's little extras it is chiefly interesting because it enables them to seize, smoothly and deftly, a small amount of female anatomy and compress it with light but unmistakable pressure. This is known as "The Pinch" and ranks somewhere between the posterior love-pat and the **mano morte** as a token of masculine appreciation of pulchritudinous padding.

According to the dictionary, to pinch is "to squeeze between two hard edges of bodies, or between a finger and thumb." If you think, however, that all you have to do to be a girl pincher is to run around grabbing damsels by the slack of their skins, you would do better to stick to whistles, **sotto voce** comments, or whatever the low fashion is in front of your local drug store. You simply aren't ready for the finer things.

In order to give you an authoritative picture of contemporary girl pinching, I consulted six respected practitioners, all of whom had been recommended to me through various reputable sources. Two are Americans, one a Latin-American, the others are European.

All agree that the classical pinch is quick and precise and should always be executed with the thumb and forefinger held fairly straight and parallel, the tips of both digits approaching each other firmly and deliberately, without fumbling or hesitation. As the affected area is seized, it is given a momentary compression that is just sharp enough to cause the subject (pinchee) to jump slightly and to utter some small exclamation of surprise rather than alarm (it is hardly the purpose of pinching to cause the subject to leap two feet in the air with a howl of terror). In short, the whole thing should be a nice combination of the casual and the complimentary — breezy, with just a soupcon of the caress. It goes without saying that outright grabbing or worse, attempting to make the fingernails meet, is the act of a peasant and cannot be excused, even on the grounds of inexperience, panic, or imminent interception.

Aside from the physical action itself, there is what we might call the metaphysical aspect of pinching. In other words, why? To what end? Is the purpose the pleasure of the pincher or pinchee; the sensual gratification of the male, or the agreeable flattering of the female ego? Here my experts differ: All but one maintain that the pinch is chiefly a means of establishing quick, intimate and gratifying contact with an attractive woman — a snatch, as it were, at passing wulfilment. One of my pundits, with a nice turn or phrase, termed it "an outward manifestation of an inner igle."

There was a boy in our school who was neither intelligent nor particularly handsome. Yet, he had an easy assurance, a come-day, go-day, God-send-Sunday impertinence that seemed to give him **carte blanche** with the fair sex. He was, naturally, a gifted pincher and many's the girl had a tender spot for him.

Finally, frankly envious of his devil-may-care success, I determined to emulate him. I followed him until I saw him execute a particularly deft pinch. His subject was a young lady noted for her easy-going, rather ingenuous disposition. As he concluded his leisurely, almost absent-minded work, she giggled and cried (I quote her verbatim), "Oh, **you**!" and went her laggard way, looking back invitingly.

At my earliest opportunity, I manoeuvered myself into position to her left (I am right-handed) and slightly to the rear. I flexed my thumb and forefinger, even snapped them a few times to make sure that everything was in perfect working order. I took the range mentally, raised my hand slowly, made contact and pinched. She hollered bloody murder.

Was my pinch too hard, my contact too abrupt? I think not. My private opinion is that I was just one of those people who betray, through a pinch, an uncertainty of soul, an infirmity of purpose that alarms rather than flatters. Instead of my pinch being an admiring little attention, it was a species of assault, an affront to the rear. My subject, I feel, detected a complexity in my motives that made her feel insecure. I haven't had a chance to discuss this matter with a psychiatrist, but an acquaintance of mine who happens to be a veterinarian suggests that the problem is closely related to the well-known fact that dogs tend to tear the pants off people who betray uncertainty towards them, whereas they will roll over and thump a friendly tail at bluff, contemptuous types who poke them familiarly in the short ribs.

I can give no hints on how to find out whether or not you have the makings of a pincher: I can only suggest that you make a try. If you have a surplus of female friends, by all means make a trial run on one of these. If you want to solo on a stranger, though, you may well be the one who gets pinched. Still, the most they will probably charge you with is simple assault, unless, of course, you do it on

Sunday in one of our stricter communities.

Pinching can be practiced any time, but like quail shooting or haha snodding, it has its best seasons. For outdoor work, spring is far and away the cream of the seasons. Then are the girls prettier, their step lighter, their eyes friendlier, their wiggles wigglier. He would be an unhandy man indeed who could brush shoulders with such nubile provocation without at least vague twitchings of thumb and forefinger. Many inveter pinchers, in fact, maintain that spring is the only time for worthwhile outdoor pinching, for then there is a challenge, an element of chance that adds a delightful fillip to the game. The veteran knows that, in the first really warm days after winter, a girl may be wearing a great deal more — or less — than is visible to the naked eye.

Contrary to general belief, pinching should rarely be attempted while the subject is bending over. Bending tends to stretch the epidermis, making it resilient and unyielding. The result is that even a well-executed pinch, amount of wristy follow-through, is topped with what would normally be just the right miserably and the pinch nets little more than a wisp of dry goods. Even that may be one of those slippery, unpleasant new synthetic fabrics which are so frustrating to the pincher. Old hands are agreed that the bending subject calls for a different approach.

One of the most difficult problems of the pincher is to know just how to follow through. There are purists who insist that the pinch itself is everything; that to follow it up in any way at all is to lose caste as a triple-distilled, blown-in-the-bottle **aficionado.** Others, less straight-laced, maintain that there is nothing wrong with meeting the subject's eye briefly and raising the hat a trifle. This should be accompanied by a short, modest inclination of the head, downward and somewhat to one side (a slight, appreciative smile is entirely optional). There is a touch of restrained elegance in this gesture which is reminiscent of the delightful Regency custom, often practiced by the Prince himself, of turning gracefully as a fair lady passed by and glancing at her ankles, lightly and appraisingly, through a single eyeglass. Occasionally, if the damsel warranted it, or the day was fine, this little accolade was accompanied by a raised eyebrow and a murmured, "Gad; monstrous pretty!"

A wink, even when accompanied by the tipping of the head-piece, is passé and somewhat plebeian, but it does not begin to approach the utter vulgarity of the whistle. No one with the dash and verve to aspire to pinchdom would stoop to whistling.

Essentially, the whistler (or "wolf-caller") is a one-sense creature. He approaches the object of his admiration through the auditory sense alone, a pathetically feeble form of tribute. Even a patter has more gallantry — risk from propinquity. But the whistler? at least he makes contact and runs some trifling Like as not he is even afraid to emit his childish cheeping alone, but must needs take cover among a bunch of low fellows like himself. Then, as the subject turns a withering glance, he affects an innocence that does his courage little credit, turning his eyes upward and studying the Ex-Lax sign overhead.

Pinching should be a gentleman's sport or avocation, full of finesse and graceful nuances. It deserves the clear eye and the steady hand and should never be furtive or sheepish. What could be more discreditable than the would-be pincher who, taken to task for his clumsiness, flushes to the roots of his messy hair and stammers a gauche apology about mistaken identity. Far better to emulate the clear-headed sang-froid of George Frazer of Charleston, S.C. Rebuked by a young lady after a single, well-aimed pinch, he bowed, doffed his homburg and murmured, "Excuse my speaking to you, miss, but I believe I have already introduced myself."

Onward, as the motto goes, and upward to the stars!

WHO'S WHO IN MEDICINE

1) **Hodgkin's disease.**

Thomas Hodgkin (1798-1866) was not appreciated in his day and generation. In fact he may be described as a failure. In 1832 while Curator of the museum at Guy's Hospital, he read a paper with the title "On Some Morbid Appearances of the Absorbent Glands and Spleen." It attracted little attention. Eventually he abandoned medicine altogether.

2) **The Graafian follicle.**

Regnier de Graaf (1641-1673) was born in the Netherlands. One of his fellow students was Niels Stensen (of Stensen's duct fame). It was de Graaf who discovered the Graafian follicles of the ovaries. He dissected rabbits and discovered the corpus luteum and he traced the passage of ova down the oviducts to the uterus. He died of plague when 32.

3) **Cheyne-Stokes Respiration.**

Stokes recorded an account of this type of respiration 15 years after Cheyne's original description. Why their names are linked is anybody's guess. John Cheyne (1777-1836). He studied hard and eventually became the first Professor of Medicine at the Royal College of Surgeons in Ireland.

William Stokes (1804-1878) was one of the greatest teachers of clinical medicine who has ever lived. He wrote the first English classic on the use of the stethoscope while still a student. His great colleague was Robert Graves (of Graves' disease fame).

* * *

A maid in the land of Aloha
Got caught in the coils of a Boa
  Like arms the snake squeezed
  And the maid, not displeased,
Cried, "Go on and do it Samoa."

ULYSSES AND ANATOMY VIVAMSHIP

OH so we've got him have we? I knew I should have worn a sailing club tie. Looks as if he's got some bones in his pocket; I'd feel much better if we took this thing tomorrow.

"Good morning, Sir." Offer him the small stool to sit on. No, he wants the tall one — they never fall for that one anyway. Good he's asked John the first question; smile and nod that's it. Now it's Bob. He knows his stuff, good man. My turn next; hope I get an easy one.

"That, Sir, is the right, um left, yes the left coronary artery. It is developed from the vasa varosum as the heart begins as a blood vessel." Fine; nothing like a little embryology for wool pulling.

Hello, he's asking if the others agree. Nod violently at the others. They all agree, of course. What's he doing now? "Yes, sir, it is the right coronary as you say."

Bob's turn next judging by the way he's looking. Oh no! What's the skeleton of the heart? Careful, this is a trick one.

"The heart, Sir, has no skeleton, the elephant, however has an os cordis." That will fix him. Why does he always ask the others if they agree when I've answered? Nod violently again. Good they all agree — sink or swim together. He disagrees, in fact, he's sure there is one — sink.

"Yes, Sir, we'll learn it thoroughly by tomorrow." I know we shouldn't have taken it today.

* * *

A lobbyist who was opposing any large appropriation for a state college approached a legislator who boasted of his self education.

"Do you realize," asked the portly lobbyist gravely, that up at the state college men and women students have to use the same curriculum?"

The legislator looked startled.

"And that boys and girls often matriculate together?"

"No!" exclaimed the lawmaker.

The lobbyist came closer and whispered, "And a young lady student can be forced at any time to show a male professor her thesis?"

The legislator shrank back in horror.

"I won't vote 'em a damn cent.

* * *

Mother was reciting Mother Goose rhymes to little Bobbie.

"The Queen of Hearts, she made some tarts,' she canted.

"And what was the King of Hearts doing?" questioned Bobbie.

"I wouldn't be a bit surprised, dear," said mother, a suspicious smile lurking at the corners of her mouth, "if the King was doing the same thing."

ONE MINUTE DIAGNOSIS

1) Young patient, acutely ill.
- **a) Temperature 104 F.**
- **b) Pulse 140.**
- **c) White Blood count 25,000.**
- **d) Flitting pains in lower limb.**
- **e) Positive blood culture (s. aureus).**

2) Adult female complaining of:
- **a) Intermittent, swollen painful mass, just beneath chin.**
- **b) Pain is aggravated by eating.**

3) Mentally deficient young child presents with:
- **a) Bony changes.**
- **b) Hepatosplenomegaly.**
- **c) Corneal opacities.**

4) Adult male complaining of:
- **a) Progressively increasing dysphagia.**
- **b) Regurgitation of previously swallowed material into the pharynx.**
- **c) Gurgling noises during deglutition of fluids.**

5) Young sheep farmer presents with:
- **a) Sudden onset of rigor, fever and hearache.**
- **b) Dyspnoea and cough.**
- **c) Pain in the chest.**
- **d) Delirium and unconsciousness.**

6) Elderly male presents with:
- **a) Developing jaundice.**
- **b) Ascites.**
- **c) Fever.**
- **d) Confusion.**

7) Housewife presents with:
- **a) Polydypsia.**
- **b) Polyuria.**
- **c) Periodic episodes of muscular weakness.**
- **d) Tetany has been observed.**
- **e) Developing hypertension.**

8) Young child recently vaccinated.
- **a) Headache.**
- **b) Vomiting.**
- **c) Pyrexia.**
- **d) Drowsiness and photophobia.**
- **e) Irritability, delirium, trismus and stabismus.**
- **f) Incontinence of urine.**

9) Elderly male.
- **a) Aching pain and oedema of arm.**
- **b) Tender cyanotic area noted.**
- **c) Prominent superficial veins.**
- **d) Venous pulsation can felt.**
- **e) Shallow ulcers developing on hand.**

10) Middle-aged polycythaemic female presents with:
- **a) Sudden vomiting.**
- **b) Liver enlargement.**
- **c) Ascites.**
- **d) Mild icterus.**

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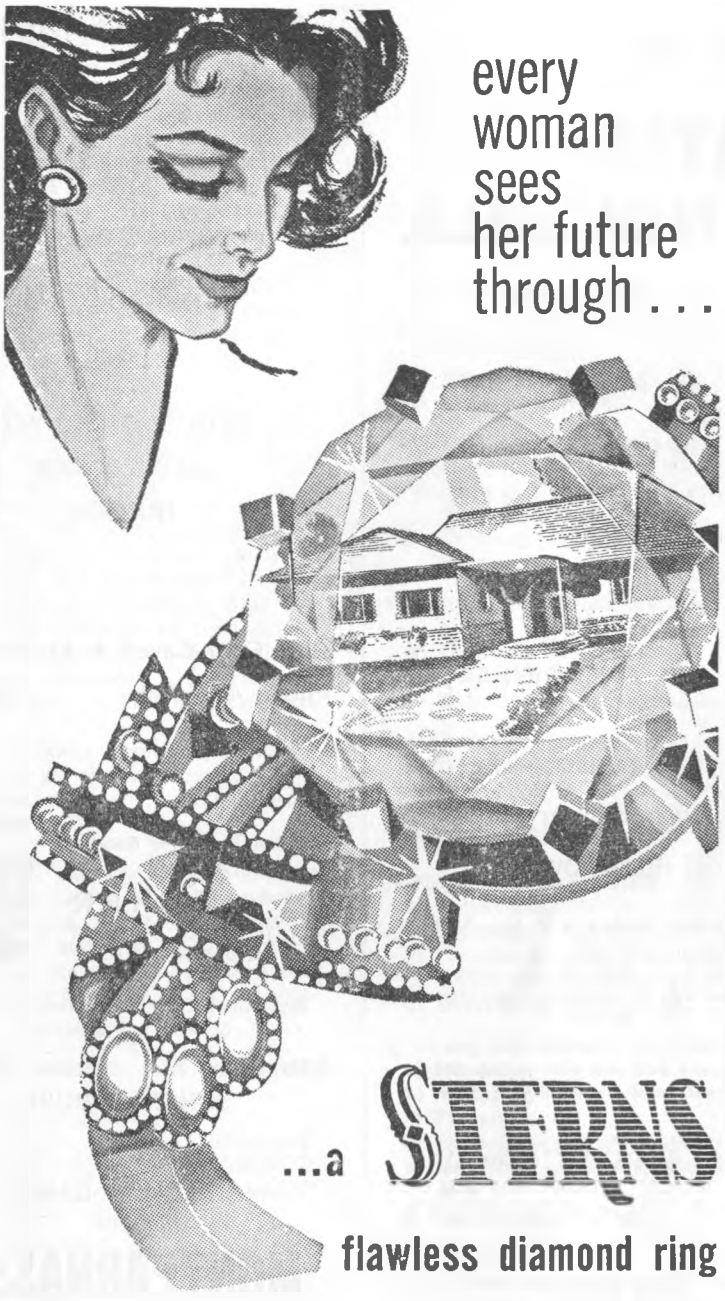

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CELEBRATED CASE HISTORIES
WALT WITMAN

WALT WHITMAN the "poet of democracy" was born in Long Island, America in 1819 and grew to be (as he himself wrote) "an American bard at last! One of the roughs. large, proud, affectionate, eating, drinking and breeding, his costume manly and free, his face sunburnt and bearded, his postures strong and erect, his voice bringing hope and prophecy to the generous races of young and old. . . ." Although he was the prophet of the perfect body, the last 30 years of his life were dogged by ill health.

As a young man he was a publisher and editor of numerous newspapers in which he wrote essays, stories and poems. Probably his best work is a book of poems called "Leaves of Grass" which appeared in 1855.

His "usual good health" continued until about 1858 when he was 39 years old. He suffered then from "sunstroke" this being probably the first of a subsequent series of strokes. He recovered and except for numerous colds accompanied by slight deafness he remained well until 1863. While assisting in the amputation of a gangrenous limb of a soldier, he cut his right hand, which subsequently became inflamed and swollen and red streaks ran up to his shoulder. He recovered but the infection left him very weak. Now he began to complain of "aching and fulness on the head" and "spells of deathly faintness". These annoying symptoms increased both in frequency and severity until in 1864 he was "prostrated" undoubtedly by a small cerebral haemorrhage. Now he began to have the appearance of a man not entirely well, and in 1873 at the age of 54 he awoke one night to find his left leg and arm partially paralyzed. He again recovered but only very slowly and in 1885 he had another stroke of such severity that a year later he was still "scarcely able to get up and down stairs". It was at this time that Dr. William Osler was called to see Whitman. After a careful examination Osler told him that "the machine was in fairly good condition considering the length of time it has been on the road."

In 1888 he had another severe stroke and again Osler saw the patient. They found him bedfast, mentally confused, and his speech "blurred and indistinct". Again he improved, but by 1891 the light of his life had begun to fade. He looked older than his seventy years, he was barely able to get about even with a cane, his memory for recent events was poor, and he complained of indigestion, constipation and "bladder trouble".

On the afternoon of a December day in 1891 he had a severe chill and became pyrexial. He coughed up mucus ringed with pus. Physical examination indicated areas of consolidation in both lungs. It was believed that he had "a widely diffused broncho-pneumonia". At the end of the first week it was noted that the lung involvement had spread, his respiration was laboured, and the pulse was rapid and weak. Then he recovered.

Two months later still confined to bed, it was observed that if he turned on his right side, there was an immediate outburst of coughing with profuse expectoration. The doctors reasoned that bronchiectatic cavitation must have occurred. Dusk began to settle in. He lost weight, hiccoughed persistently and towards the end had occasional urinary and faecal incontinence.

On March 26th, 1892, his dyspnoea increased, his pulse became irregular. Night had fallen.

Autopsy: The following was found: Right lung—far advanced pulmonary tuberculosis. Left lung—atelctasis, tuberculous empyema and a bronchopleural fistula; disseminated abdominal tuberculosis, tuberculous abscesses of the sternum, fifth rib and left foot; cyst of the left adrenal; chronic cholecystitis and cholelithiasis; cerebral atrophy with meningitic adhesions; cerebral arteriosclerosis, benign prostatic hypertrophy; pulmonary emphysema and cloudy swelling of the kidneys.

"Praised be the fathomless universe for life and joy, and for objects and knowledge curious.

And for love, sweet love—but praise! praise! praise!

For the sure en-winding arms of cool-enfolding death."

A professor of botany was lecturing to a girl's class. "This twig you will notice," said he. "is composed of bark, hardwood and pith. Of course you know what pith is."

The class stared at him blankly. "Don't you know what pith is?" the professor repeated. "You Miss Brown, you now what pith is, do you not?"

"Yeth, thir," said Miss Brown.

* * *

Conversation between a Greek tailor and a customer:

"Euripides?"

"Eumenides."

LAST LAUGHS

The gallant old gentleman took pity on the pretty girl swaying on the strap in the crowded street car. He offered her a seat on his lap assuring her that it was all right as he was an old man. She hesitated a moment and then esconced herself on his lap. The car had bounced along only a few blocks, when the old gentleman spoke up. "Miss," he said, "I think one of us will have to get up. I am not as old as I thought I was."

* * *

Mal: "It says here that in California last year they grew about 2,449,000 tons of grapes." Hal: "Drink up man, they are gaining on us."

* * *

Everyone expected the war to develop a certain amount of power-shortage but nothing like the scene encountered by a certain motorist who came upon a car stuck in the mud of the road. Getting out to help he discovered the car's driver in the act of harnessing a pair of kittens to the front axle.

"Good God, you're not going to try to pull the car out with those kittens are you?" he gasped.

"Why not?" demanded the marooned driver. "I got a whip, ain't I?"

* * *

One of the most popular of the many Lincoln stories is concerned with the visit of the Emancipator of a man named Bates, who brought his family.

"Permit me, Mr. President," he began, "to introduce my wife, Mrs. Bates, and my daughter, Miss Bates, and my young son, Master Bates."

"Indeed," said Lincoln, "But why boast about it?"

* * *

Two army officers met on the street one day and one of the chaps had a row of medals across his chest.

The other remarked, "Where did you get all of those?"

"Gunnery."

"The hell you say. Why, I had it three years ago but I never got decorated."

ANSWERS TO ONE MINUTE DIAGNOSIS

1) Acute osteomyelitis.
2) Submaxillary salivary calculi.
3) Gargoylism.
4) Oesophageal diverticulum.
5) Pulmonary anthrax.
6) Hepatic failure.
7) Hyperaldosteronism.
8) Post-vaccinal encephalitis.
9) Arterio-venous fistula.
10) Budd-Chiari Syndrome.

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In the third act of a melodrama that had met thus far with nothing but derision from its audience, a troop of cavalry was supposed to gallop across the stage in pursuit of the villain. As the horses came on one of them dropped a load of turd.

"A bit of a critic,eh?" observed a man in an aisle seat.

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