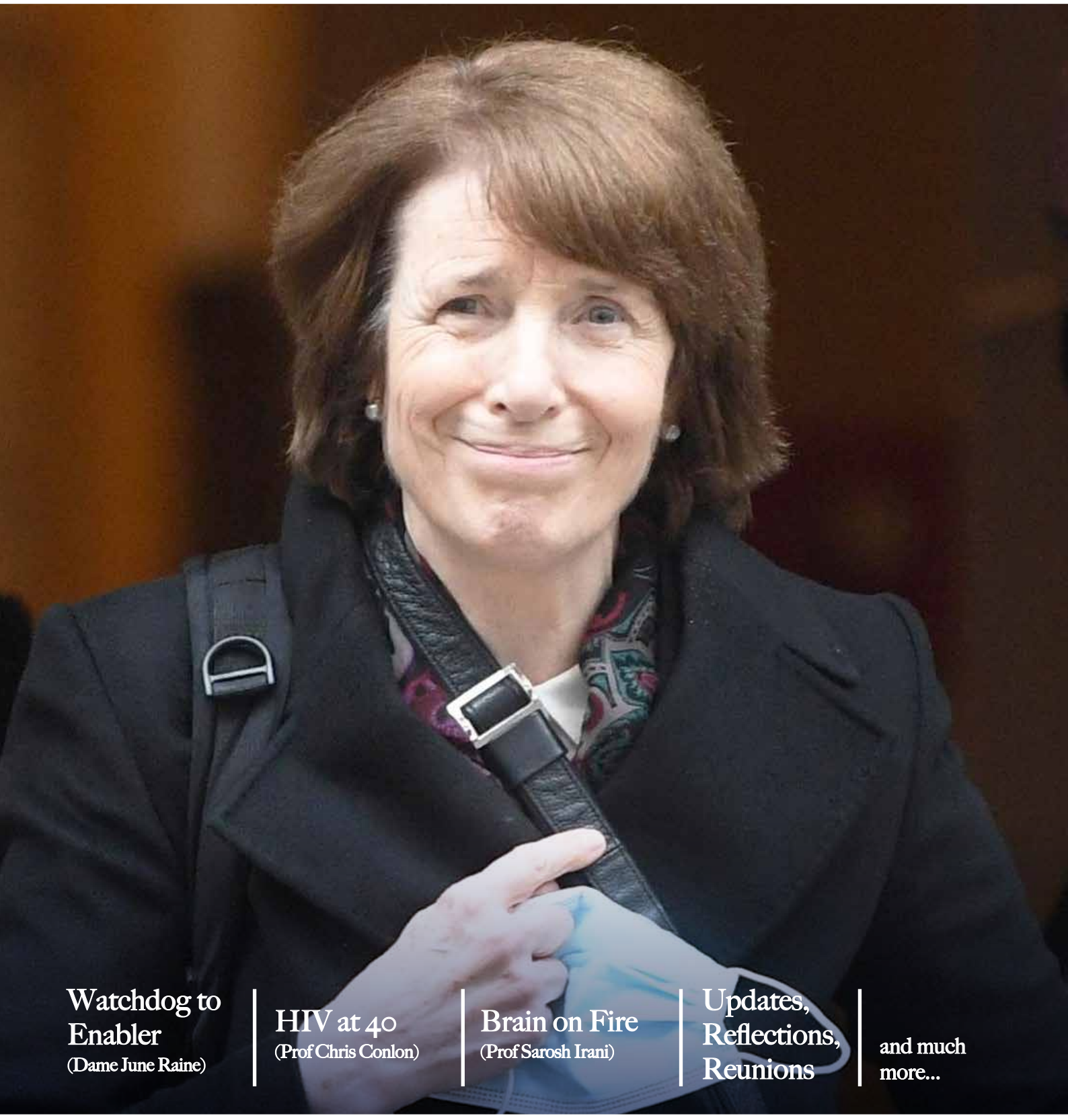
Oxford Medicine

THE MAGAZINE OF THE OXFORD MEDICAL ALUMNI

Oxford Medical Alumni

UNIVERSITY OF OXFORD

Winter 2022



Watchdog to Enabler
(Dame June Raine)

HIV at 40
(Prof Chris Conlon)

Brain on Fire
(Prof Sarosh Irani)

Updates, Reflections, Reunions

and much more...

Pictured: Dame June Raine announcing the approval of Covid vaccines outside number 10 Downing Street, December 2020

Oxford Medical Alumni Update

Oxford Medical Alumni (OMA) promotes good fellowship amongst graduates from the Oxford Medical School by offering regular meetings in Oxford and elsewhere for continued learning, exchange of ideas, networking, and socialising.

GRADUATION REUNIONS

The following schedule of Reunions has been confirmed for 2023. A full schedule is below or via the link: **https://www.medsci.ox.ac.uk/get-involved/alumni/events-and-reunions/oxford-medical-school-reunions.** If you are willing to serve as the 'Year Champion' for your year, please contact **oma@medsci.ox.ac.uk.**

CAREER ADVICE FOR JUNIOR DOCTORS – CAREER MENTORS NEEDED

Some of our young doctors are seeking inspiration and advice on their future careers. OMA is keen to facilitate informal relationships around career advice. If you feel you have something to offer (particularly if you qualified between 1990 and 2012 and are up to date with training programmes and consultant recruitment). Please contact Dr Will Seligman (**seligman@gmail.com**).

OXFORD MEDICAL LECTURE CLUB (OMLC)

The OMLC invites distinguished, entertaining, and interesting speakers to talk about their specialty and latest developments in clinical and scientific research. The meetings are currently held between 13.00 and 14.00 at St Hugh's College and via Zoom. For more information on the schedule of upcoming speakers and topics, please go to page 28 or via the link: **https://www.medsci.ox.ac.uk/get-involved/alumni/events-and-reunions/oxford-medical-lecture-club.**

MEETING MINDS OXFORD, 22-24 SEPTEMBER 2023

As part of this very popular programme of meetings, OMA will present the Osler Lecture featuring Prof Sir Chris Whitty, Chief Medical Officer, on Saturday 23rd September.

RECOLLECTING OXFORD MEDICINE

Dr Derek Hockaday and Dr Peggy Frith produced this is a unique oral history collection about medicine at Oxford from the 1940s onwards. Through a series of skilful face-to-face interviews we can listen to this special collection of memories: **https://podcasts.ox.ac.uk/series/recollecting-oxford-medicine-oral-histories.**

RECONNECTING WITH FRIENDS AND COLLEAGUES

If you have lost touch with old friends and colleagues and would like to reconnect, please email us at **oma@medsci.ox.ac.uk** and we will do our best to help.

OMA ADVISORY BOARD (OMAAB)

Dr Lyn Williamson (President), Dr Roger Bodley (Honorary Treasurer), Dr Zoi Alexopoulou, Professor Sir John Bell, Sir Michael Dixon, Ms Christine Fairchild, Dr Laurence Leaver, Dr Tim Littlewood, Dr David McCartney, Professor John Morris, Mr Gokul Parameswaran, Professor Gavin Screaton, Dr William Seligman, Professor John Stein, Ms Emily Stone (Alumni Relations Officer), Dr Catherine Swales, Dr Robert Wilkins, and Dr Kevin Windebank.

FUTURE CONTRIBUTIONS TO OXFORD MEDICINE

We welcome suggestions and contributions for future articles – clinical, scientific, timely, creative, reflective, artistic, humorous. Please contact **oma@medsci.ox.ac.uk.**

Editor: Dr Lyn Williamson, OMA President.
Thank you for your thoughtful and constructive comments to our recent feedback survey. We will bear them in mind for future editions, though perhaps not the horoscope!

Editorial Board: Dr Chris Winearls; Dr Tim Crossley; Dr Neil Snowise; Dr Luke Williamson.

Designer: Jess Aumonier

UPDATE YOUR CONTACT PREFERENCES

Contact **oma@medsci.ox.ac.uk** to let us know if your personal details have changed or go to the website at **www.medsci.ox.ac.uk.**

Grateful thanks to Christine Fairchild, Head of Alumni Relations, University of Oxford for her invaluable help with OMA.

CONTACTING OMA

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oma@medsci.ox.ac.uk | medsci.ox.ac.uk/oma

2023 GRADUATION REUNION DATES

Pre-clinical and Clinical Graduates are invited. Save the date and encourage your friends.

50th	1972/73	Thursday 20 April	Lunch	Worcester College
40th	1983	Saturday 3 June	Dinner	Balliol College
30th	1993	Saturday 10 June	Dinner	Balliol College
20th	2003	Saturday 8 July	Dinner	Balliol College
10th	2013	Saturday 10 June	Lunch	St Hilda's College
5th	2018	Date in Autumn TBC (contact OMA or Rebecca Oram rebeccacarmeloram@gmail.com)		

President's Piece

Dr Lyn Williamson
(St Anne's College, 1974)
OMA President

Is the smouldering pandemic that has claimed more than 40 million lives in the past 40 years on the cusp of disappearing? Chris Conlon who has been there since the beginning of HIV/AIDS, presents the twists and turns of this incredible success story of modern medicine. But we are not there yet.There are many hurdles to overcome. Beatrice Cockbain's quote from Angelina Namiba captures the essence of a recurrent theme in this issue. 'Unfortunately, even though we have come so far in terms of science, we haven't got a pill to deal with stigma'.

Talking of scaling mountains, June Raine's timely decision to approve the CV vaccines undoubtedly saved millions of lives, but the controversies around the approval played out in the public eye. Her 2022 Weatherall Lecture gave us a personal account of the science behind the headlines, insights into the approval processes and how they have (probably) changed forever.

The aggressively protruding tongue and zig-zag markings of the poisonous Brazilian viper, Bothrops Jaraca, whose venom lowered blood pressure in experimental animals, led to the synthesis of the first ACE inhibitor, Captopril – another medical success. Chris Winearls and Richard Haynes give us a 40-year perspective.

For me, this viper represents the rich and precious biodiversity of the planet, which needs more than a pill to protect it. However, unless we can influence the global forces behind the big climate decisions, we can but do our own personal best. In this issue we let the medical students lead the way.

Enjoy the science, updates, reflections and news - contributions from alumni of all generations. We look forward to your comments and your contributions in the future.

On behalf of the editorial team and OMA, I send you Season's Greetings and wish you happiness and good health.

FEATURE ARTICLES AND UPDATES

OPINION AND REFLECTION

OMA NEWS

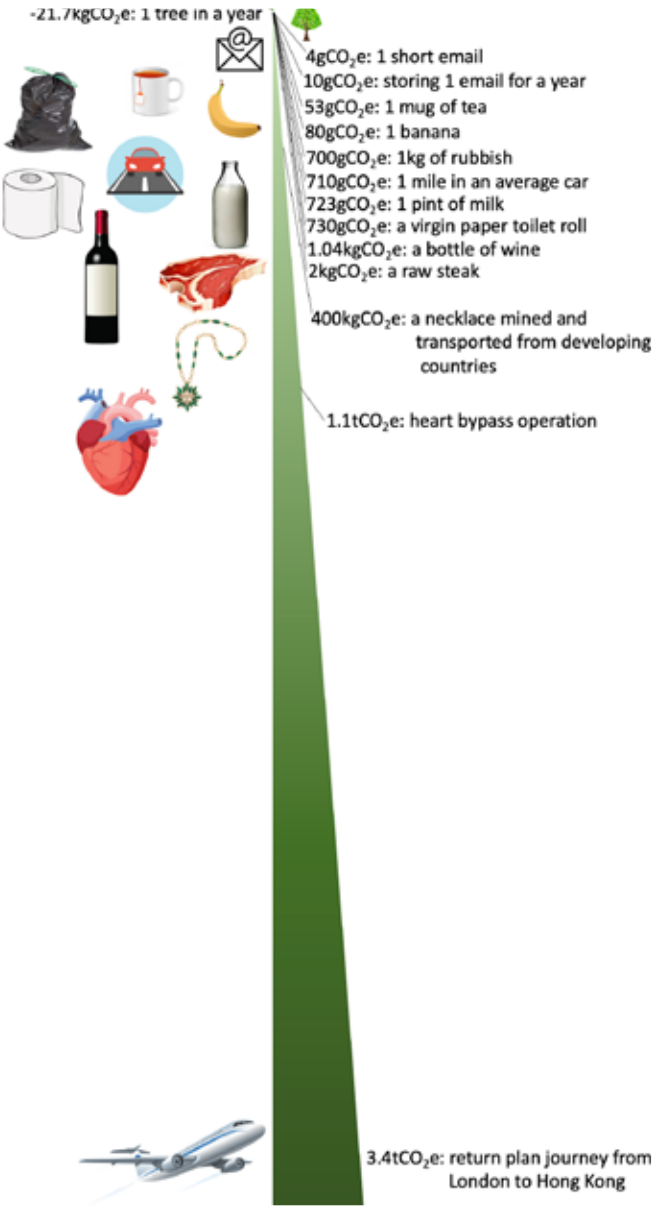
MEDICAL SCHOOL

OBITUARIES AND IN MEMORIAM

Planetary Medicine - Inconvenient Truths

Hannah Chase (Green Templeton College, 2018);
Sarah Peters (Somerville College, 2018);
Chloe Freeman (Somerville College 2020);
Roshan Karthikappalil (Green Templeton College 2018)

We begin with an unapologetic reprinting of material from our 'Sustainable Health' students recent articles.



Even though this scale is logarithmic, the carbon cost of this return long-haul flight would be 2 metres below the bottom of the table!

NHS REALITY CHECKS

✔ The NHS is responsible for five per cent of all UK emissions. It has the same global warming effect as the whole of Estonia.

✔ Air pollution kills 8.7 million people per year. In Oxford, higher pollution days are linked to six cardiac arrests outside hospital and eight strokes per year. Healthier travel protects climate, bodies, and minds.

✔ A third of all greenhouse gas emissions come from food production. Red meat has the biggest contribution. The average UK citizen eats 88kg meat/year. A diet to save our planet must include a maximum of 25kg/yr including only 5kg of red meat. Hospital catering needs to adopt the cheaper and healthier Planetary Health diet.

DIGITAL FOOTPRINT - THE CARBON COST OF EMAILS

Although small in the grand scheme of things, reviewing our overflowing inboxes full of untouched messages, is an easy rapid win for all of us now addicted to and inundated with digital communication. The culprits are greenhouse gases produced in running the computer, server and routers but also those emitted when the equipment was manufactured.

- One stored email is equivalent to 10g of CO2 per year.
- Sending and receiving emails have a larger carbon footprint, ranging from 0.3g CO2e up to 50g CO2e when there is a big attachment. Five such messages are like burning about 120 grammes (0.27 pounds) of coal. The carbon output of hitting "send" on 65 mails is on par with driving an average-sized car a kilometre (0.6 of a mile).
- Here is something to keep in mind the next time you type in a non-essential Google enquiry: A web search on an energy-efficient laptop leaves a footprint of 0.2 gCO2e. On an old desktop computer, it is 4.5 gCO2e
- Research suggests in the UK 64 million unnecessary emails are sent everyday contributing to 23,475 tonnes of carbon a year - equivalent of over 100,000 flights from London to Spain.
- With 1.5million people employed in the NHS, this is an example of small individual actions potentially making a significant collective difference.

https://phys.org/news/2015-11-carbon-footprint-email.html, https://eco-age.com/resources/how-reduce-carbon-footprint-your-emails

SHOULD I STAY OR SHOULD I GO - MEDICAL ELECTIVES ABROAD?

The debate about student electives abroad applies to us all. They conclude 'as a minimum, students should be asked to consider the environmental impact of elective placements'. **Inconvenient, but true.**

https://issuu.com/oxfordmedicalalumninewsletter/docs/oxford_medicine_summer_2022_final_print

HIV Forty Years On

Professor Chris Conlon
(New College 1974-77)
Professor of Infectious Diseases, Nuffield Department of Medicine. Returned to Oxford in 1989 as a consultant in Infections Diseases and General Medicine. Currently Professor of Infectious Diseases in the NDM and Chair of the Centre for Tropical Medicine and Global Health.

While we are in the closing phase of the COVID pandemic it is worth considering another pandemic that has flared and smouldered for decades and which has killed many more people. By the end of 2021, 84 million people had been infected since the pandemic started, and 40 million have died. It is estimated that there are 38 million people currently living with HIV. When I qualified in 1980 nobody had heard of AIDS. I was a bit surprised during my MRCP viva in early 1983 when Prof Sheila Sherlock asked me about AIDS, particularly as the acronym had only recently been coined. Luckily, I had done some reading, so she was equally surprised that I knew anything about it! I have subsequently spent most of my career involved in HIV work. This brief summary outlines the history of HIV and the extraordinary progress that turned this once universally fatal infection into a manageable condition with a good prognosis.

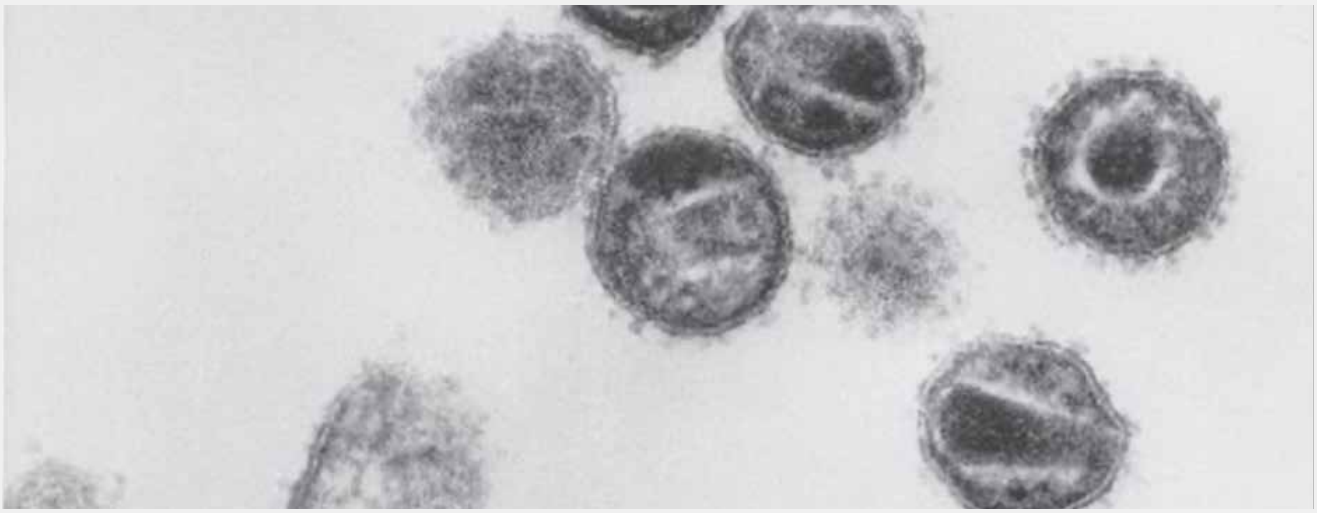
EARLY DAYS

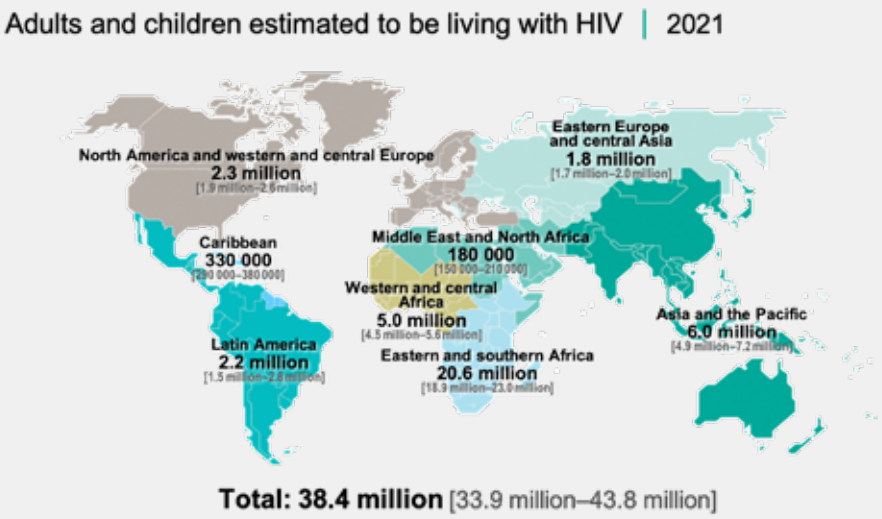
It was in early 1981 that reports appeared in the MMWR about weird infections and tumours occurring in previously health young gay men. These men were dying of conditions nobody had taught us about at medical school, and it soon became apparent that similar problems were being seen in those with haemophilia and in IV drug users. The unifying theme was that these diseases were those normally only seen in severely immunocompromised hosts. Although there was lots of speculation about the cause of this new syndrome (initially termed GRID: gay-related immune deficiency), including various recreational drugs, it soon became apparent that this was likely to be a bloodborne infectious agent.

It wasn't until 1983 that Luc Montagner in Paris isolated a retrovirus from a lymph node of a person with AIDS that the cause was established. Robert Gallo's lab in the States then showed that this virus was in several others with AIDS. The virus was variably called LAV (lymph node associated virus) or HTLVIII (human T-lymphotrophic virus III) but was eventually called HIV. These findings soon led to the development of a test for antibodies to the virus – the so-called "AIDS test". Serological testing allowed screening of donated blood products from 1985 onwards and also helped clarify the epidemiology of the pandemic. What became clear was that this virus was not only transmitted by sex and by blood (via needles and via transfusions), but could also be passed from mother to child. This was of particular importance when it was realised that there was a large epidemic of HIV infection in sub-Saharan Africa driven largely by heterosexual transmission.

TREATMENT

While it could now be established who might be infected, there was no treatment available. In an early example of drugs being re-purposed, a drug called AZT (zidovudine), initially discovered in 1964 as a potential anti-cancer drug, was a nucleoside analogue known to inhibit reverse transcriptase, an essential enzyme for HIV replication. Following successful in vitro studies, AZT was used in a phase I trial in 1985 and showed significant improvement in those with AIDS. Further trials confirmed efficacy of the drug and it was soon licensed. Because of the early efficacy in those with AIDS it was logical to see if the drug could prevent AIDS in those who had HIV but were not yet symptomatic. An American study showed efficacy at one year but a subsequent Anglo-French study, the Concorde trial, showed that the efficacy fell off after the first year and by year 3 there was no effect. The reason for this was, unsurprisingly, drug resistance. By the end of the 1980's AIDS was the most common cause of death in men aged 18 to 44 in the States. There followed a decade of drug trials as new drugs active against reverse transcriptase (non-nuclease inhibitors) became available, with incremental improvements. A major breakthrough came when another enzyme in HIV, protease, was crystallised. This allowed a drug to be designed to inhibit the enzyme and relatively quickly protease inhibitors were tested and found to work. However, drug resistance remained a problem because of the high mutation rate in the virus, driven by drug pressure. Further trials using a combination of three drugs (a nucleoside reverse





transcriptase inhibitor, a non-nucleoside reverse transcriptase inhibitor and a protease inhibitor) showed remarkable efficacy and appeared to overcome some of the problems of drug resistance. This combination treatment was called Highly Active AntiRetroviral Therapy – HAART. Widespread use of HAART led to a dramatic fall in mortality from AIDS from 1997 onwards. Nevertheless, the initial HAART regimens had significant pill burdens and adverse effects. Over the years, better drugs became available, with better pharmacokinetics, so that once daily dosing has become the norm. Drug resistance can sometimes be a problem still, but viral sequencing can identify which mutations are present and usually helps to determine an appropriate salvage regimen. One of the early problems was that the cost of HAART made treatment unaffordable in Africa and other low-income areas. The licensing of companies in India and Brazil to allow the manufacture of generics dramatically reduced the cost of therapy. In addition, a major initiative by the George Bush government, the President's Emergency Plan For AIDS Relief (PEPFAR), provided heavily subsidised or free treatment for many countries in Africa.

With better, less toxic therapies the question remained as to the best time to start therapy. Initially treatment was only started when people were ill or when their CD4 lymphocyte counts declined to around 200/cm3. Further studies suggested starting at high CD4 counts but the landmark study in 2015, called START, established that early treatment was beneficial, reducing the risk of developing AIDS and improving survival. It is now established practice to start HAART – now known as Combination Antiretroviral Therapy (cART) – as soon as an individual is found to have HIV.

PREVENTION

Although treatment was the main focus of HIV research, there was considerable activity aimed at preventing infection. Early on there were examples of healthcare workers becoming infected via needlestick injuries. An early study suggested that AZT might prevent the acquisition of HIV if taken immediately after the accident. Although it was impossible to do a randomised trial, this Post-Exposure Prophylaxis (PEP) became established as the means of dealing with nosocomial risk. Following on from the concept of PEP, studies showed that treating pregnant women with antiretroviral drugs could reduce the risk of the child becoming infected. The success of this approach led to routine antenatal screening of women and undoubtedly saved many lives. At the same time, it was clear that HIV could be transmitted by breast milk, partly explaining the increased risk of mother to child transmission in Africa compared to Western countries. Avoiding breastfeeding was controversial in Africa but helped by the provision of free milk in many areas. Currently, with mothers remaining on cART, the risk of transmission via breast milk is extremely low and most mothers can breast feed safely. It was also logical to consider PEP if a person had been exposed to HIV by sex with an infected person. Trials again showed the efficacy of this and PEP for Sexual Exposure (PEPSE) became established.

With better and safer drugs that are easier to take, it became evident that people with HIV could achieve long-term control of the virus so that none was detectable circulating in the blood. Cohort studies showed that uninfected partners of people taking cART with undetectable viral loads did not get infected despite regular unprotected sex. Epidemiological studies also showed that as more people on cART became 'undetectable' in terms of viral load, new infections were declining. This led to the mantra: Undetectable = Untransmittable, or U=U, to encourage people to seek testing and treatment.

Despite the success of HIV treatments, some people still have high risk behaviours. Various studies have now shown that if an individual at risk takes antiretroviral drugs, either continuously, or just before or after sex, their risk of acquiring HIV is significantly reduced. This risk reduction by Pre-Exposure Prophylaxis (PrEP) has been demonstrated in men who have sex with men (MSM) and in heterosexual men and women. PrEP has been recommended for high risk groups since 2018 and has certainly reduced the rate of new infections.

Non-pharmacological means of preventing HIV transmission have also been studied. It has been shown that men who are circumcised are less likely to acquire HIV, and other studies have shown that microbiocidal vaginal gels can reduce infections in women. However, both of these interventions have been difficult to use at scale. Considerable work and money has gone into a search for a vaccine against HIV. There have been a variety of approaches using vaccines aimed at producing antibodies and others with a focus on eliciting T-cell responses. Although many of the candidate vaccines have produced encouraging laboratory responses, none have shown efficacy when used in the field. A large trial done in Thailand produced good neutralising antibodies in recipients but no protection. Nevertheless, vaccine work continues as, ultimately, a vaccine will be the most effective way to reduce the incidence of new infections.

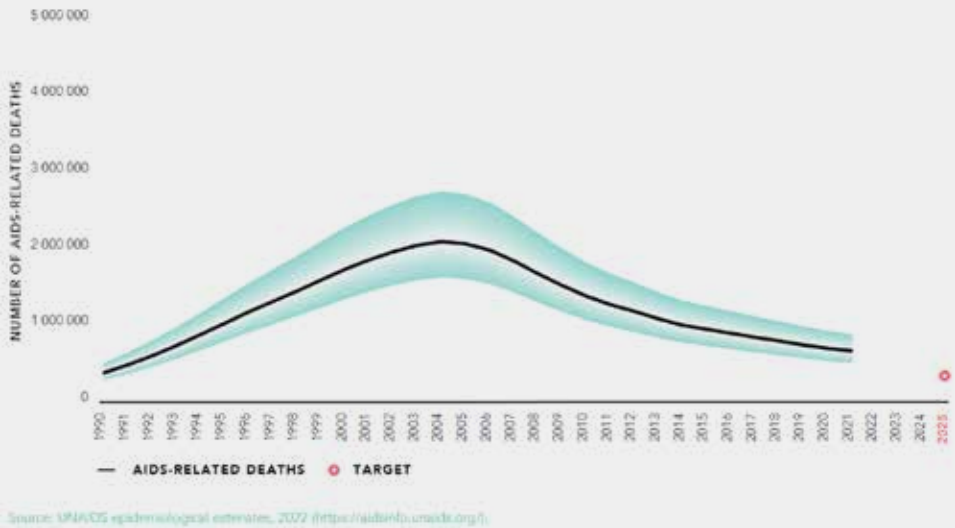
CURE?

There has always been hope that those individuals with HIV can, in some way, eliminate the virus and be cured. The main problem is that HIV can remain latent in cells so that drugs cannot affect the integrated virus and the immune system cannot recognise the infected cell. One approach has been to use a 'kick and kill' method using drugs to stimulate viral replication in latently infected T-cells, allied to therapeutic vaccines and antiretroviral drugs. So far this strategy has failed but research continues. There have only been two examples of real cure and both involved using bone marrow transplantation. A small number of individuals have a mutation of one of the cellular receptors that is critical for HIV binding to T cells, the so-called CCR5 mutation. Cells with this mutation are uninfectable. When a person with HIV in Berlin developed leukaemia, he was transplanted from a donor with the CCR5 mutation and, following successful engraftment and cART, his HIV was eliminated. There has been one similar patient in London. Clearly, however, this approach is not normally possible but it does provide some hope that cure is possible.

> *"Someone diagnosed with HIV today and started on cART will have a near normal lifespan*

What the history of HIV has shown is that in a relatively short time, concentrated scientific and clinical research has identified the pathogen, developed diagnostic tests and invented treatments that have completely changed the outlook for those infected. Current treatments are readily available in most of the world and are very efficacious. It is now the case that someone diagnosed with HIV today and started on cART will have a near-normal lifespan. Because treatment reduces infectivity it is likely that new infections will be all but eliminated in the not-too-distant future; in the UK the target for stopping new infections is 2030. The HIV pandemic also involved patient activists and advocates around the world that stimulated research and changed policies, making scientists, clinicians and politicians more accountable while stimulating public discussions. There are a lot of parallels to the current COVID pandemic although scientific advances and the internet have made the pace of discovery much faster. We still need to be vigilant and prepare better for the next pandemic.

FIG. 1.02a. Number of AIDS-related deaths, global, 1990–2021, and 2025 target



Source: UNAIDS epidemiological estimates, 2022 (https://aidsinfo.unaids.org/).

AIDS - remembering the beginning 40 years ago *(Eds)*

We, then young doctors, heard and read the anecdotes of a mystery illness in gay men in the USA and shrugged. Leave it to the Centre for Disease Control – after all, they sorted Legionnaires Disease. Then it arrived in Britain. It was a clinical diagnosis because the pathogen was unknown. We saw shrunken young gay men with devastated partners with infections we had hardly ever seen – CMV retinitis, toxoplasmosis, pneumocystis, systemic candidiasis, cryptosporidiosis, atypical TB and Kaposi sarcoma. We did not need to break "bad news" - they knew and died quite soon after. Public reaction to this "plague" was varied – horror, fear and "*serves them right*."

Then the diagnostic test came but we had to ask permission of the patient to do it. Once labelled, patients were sometimes shunned and isolated. Families recoiled, doctors and nurses were wary. Some in government were squeamish about the health campaigns on avoiding transmission. The gay community united and protested and supported one another. Infectious Disease, Respiratory and GUM doctors responded. Pharma sought and produced antivirals. They were scarce and expensive. Tropical medicine told us about what they saw in Africa – "slim disease" and obvious heterosexual transmission. People of African heritage developed a peculiar progressive renal disease called HIVAN – the glomeruli collapsed, and renal failure followed. HIV was in the blood product chain infecting haemophiliacs. Famous people succumbed – Arthur Ashe, Rock Hudson, Liberace to mention just three. However, scientific advances and the pharmaceutical industry have transformed a disease which was once a killer to a chronic disease for many.

Change HIV Inequality Today: The Ongoing Challenges

Dr Beatrice Cockbain
(Graduate-Entry Medicine, Magdalen College 2010-14) is an Academic Clinical Fellow and Specialist Registrar in Genitourinary Medicine and HIV at Chelsea and Westminster Hospital/Imperial College London.

The outlook for many people living with HIV today is thankfully unrecognisable to that of the 1980s. Testing, treatments and prevention have allowed many individuals to live long and healthy lives, including having condomless sex without fear. Indeed, screening for common conditions such as heart disease or diabetes within routine HIV clinics may mean individuals living with HIV have better health outcomes than those without.

In the UK, the mainstay of an HIV clinician's work is now common age-related comorbidities, and not the consequences of severe immunosuppression or side-effects of extremely toxic anti-retroviral drugs. Inpatient units have closed due to the drastic reductions in patient numbers and there are complications of HIV that my junior colleagues and I are unlikely to ever encounter. But the burden of HIV infection has been, and remains, shouldered by those most minoritised within society, with advancements in HIV care and reductions in HIV stigma not shared equally.

From MPs to actors, there are many examples of (predominantly openly gay male) celebrities living with HIV. For some, like the Welsh rugby player Gareth Jones, disclosure of their HIV status has been due to external pressures, as fear of exposure still can lead to blackmail and abuse. And for so many others, particularly women, and/or those from racially or otherwise minoritised communities, the stigma around HIV and its ongoing associations with other taboo subjects, inhibit engagement with both HIV prevention and HIV care. To this day, mistrust in government and structural racism may prohibit engagement in HIV care. The legacy of Thabo Mbeki's HIV denialism in South Africa is not only one of preventable infection and death, but also of ongoing distrust in HIV healthcare and science.

The recent coverage of the mpox outbreak has demonstrated how those with infections acquired through sex are still blamed and shamed. Healthcare professionals within the UK are also implicated in the persistence of HIV stigma, from the stereotyping found in questions on HIV in medical school and membership exams, to the assumptions so many still hold about what it means to have HIV. Even within sexual health services, women reporting condomless sex do not have HIV prevention medication (HIV pre-exposure prophylaxis, or PrEP) routinely discussed or offered. Viewing PrEP as a medication only for men who have sex with men gives an implicit message that HIV is not an infection for those outside that category, deterring people from testing for HIV or accessing PrEP. Even for those actively seeking PrEP, funding cuts to sexual health services create long waits for appointments, while an inability to offer PrEP outside of these services may prevent others from accessing it.

Outside the UK, the situation can be far more dangerous, with almost 50 countries restricting the travel rights of those living with HIV. In some, this may even extend to deportation or incarceration of those found to be living with HIV. Even in areas without such laws and with provision of HIV services, access to lifesaving antiretroviral therapy or prevention using PrEP may be prohibited by costs, or constantly interrupted due to economic or political instability affecting medication supply chains.

Of course, we should celebrate the remarkable advancements in HIV medicine over the last forty years, but in doing so we must not forget the ongoing inequities in HIV care, both within the UK and abroad.

> ***"Unfortunately, even though we have come so far in terms of science, we haven't got a pill to deal with stigma.***
>
> Angelina Namiba for the National AIDS Trust

Key facts from the Sophia Forum and Terrence Higgins Trust's report 'Invisible No Longer'

- **Women make up one third of people living with HIV in the UK, yet are left out of research, decision-making and service design and delivery.**
- **Almost half (45 per cent) of women living with HIV in the UK live below the poverty line.**
- **Nearly one third (31 per cent) have avoided or delayed attending healthcare in the past year due to fear of discrimination.**

Full summary:
https://sophiaforum.net/index.php/hiv-and-women-invisible-no-longer/

Weatherall Lecture 25th April 2022: From Watchdog to Enabler

Dame June Raine DBE FMedSci
(1971, Somerville College), Chief Executive of the Medicines and Healthcare products Regulatory Agency (MHRA) in the UK

It's a tremendous honour to give this Weatherall Lecture 2022, and a special privilege for me as a public health physician turned regulator. My purpose today is to tell you how the Covid pandemic has catalysed a transformation in the regulator, and to look ahead at what this might mean for the future for the life sciences industry and for public health. These are exciting times in the world of regulation and if you're not used to hearing the word 'exciting' in the same sentence as 'regulator', I hope I may be able to convince you otherwise today.

Professor Sir David Weatherall was a brilliant scientist but most of all an extraordinary clinician and teacher in clinic or at the bedside, often heard to repeat on the ward round his favourite phrase "for the sake of the students". David Weatherall's legacy is felt today far more widely than he would ever know, including in public health policy, and that's my link to the topics I'm going to be talking about.

This talk is about how that the regulatory learning during Covid is going to be embodied in the UK's Medicines and Healthcare products Regulatory Agency's transformation from a 'watchdog' to a progressive and enabling regulator. I'll consider new ways of working and new uses of data and new scientific methodologies to strengthen benefit risk decisions, all in the context of collaboration which is going to be essential to deliver a new era of patient benefit.

Many people have had reason to ask what the MHRA is, based as we are in offices in Canary Wharf and at laboratories at South Mimms, where the new oral polio vaccine was developed which is now used world-wide, and the home of the world's largest stem cell bank. The unique MHRA capability is to use basic science and real-world data as well as regulatory 'tools' to deliver public health outcomes in a complex healthcare environment.

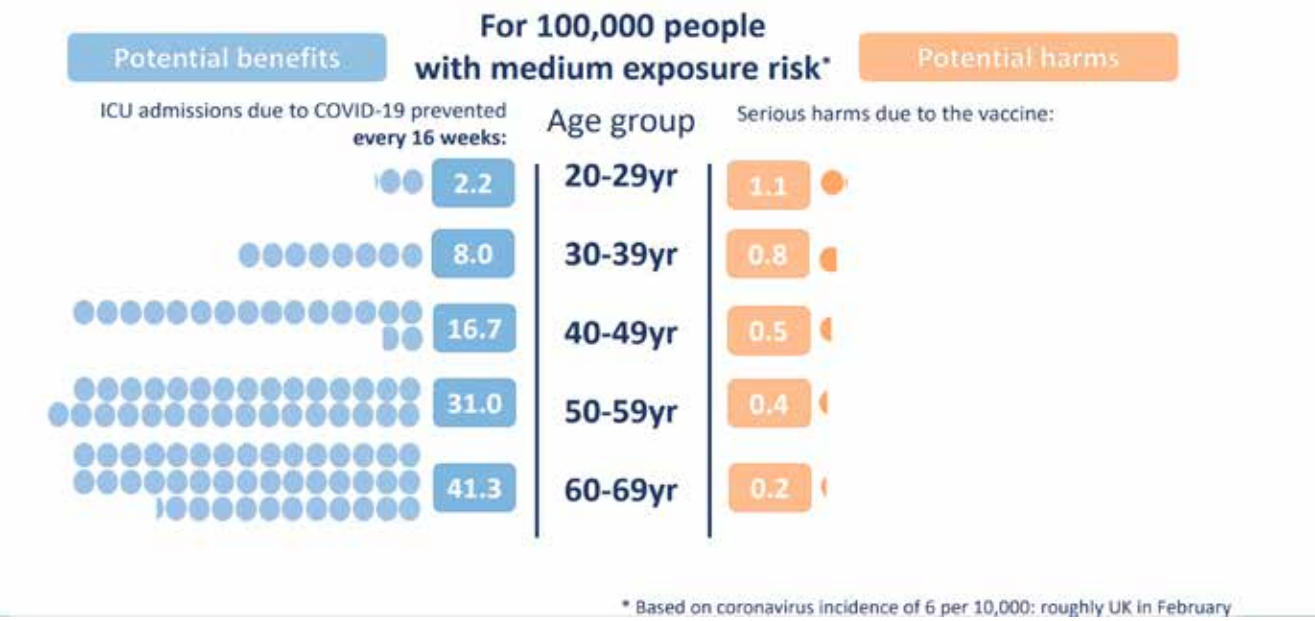
Here in Oxford the immense contribution to defeating the Covid pandemic made by Oxford clinicians and scientists comes immediately to mind. A century ago, Somerville College, University College and the Exam Schools were homes for recovering soldiers from the first world war, and also saw first-hand the impact of the Spanish flu pandemic. It's salutary to recall the fact that the death toll from that disease was of the order of a million lives.

Fast forward to 2020 and the growing concerns about the impact of the spread of COVID-19. At a meeting in Number 10 on accessing enough COVID-19 diagnostics the need for a regulatory view came into the discussion and the PM remarked that 'the MHRA will stop us killing people'. I had to respond that, no, the MHRA will help you keep people alive. This moment represented for me the turning point from watchdog to enabler.

On 5th March 2020 I received an email from Professor Andy Pollard seeking my availability for a brief discussion on work on a vaccine going on in Oxford. Our inspectors promptly set out to support the establishment of vaccine manufacturing sites in the event that the benefit risk of one of those vaccines selected by the Vaccines Task Force proved positive, that could be in clinical use, manufactured at scale preferably in the UK, recognizing absolutely that this might all end in failure.

How were effective and safe Covid vaccines delivered in about 300 days when it was thought that the development process

Weighing up the Potential Benefits and Harms of the Asta-Zeneca COVID-19 Vaccine



would take at least a decade? Our part of the story was the introduction of a wholescale change in the regulatory approach. All the pieces of regulatory evaluation that are normally done sequentially were done in parallel – a 'rolling review'. We created an innovative approach to vigilance, using artificial intelligence tools as well as rapid cycle analysis of signals. We introduced a new level of transparency, with regular press briefings on how regulatory decisions are made, helping to build public trust and confidence.

What other regulatory flexibilities did we introduce? Our clinical trials team was particularly agile in evaluating new protocols. The world's largest Covid trial, the RECOVERY trial, went from first protocol approval to first patient in 9 days. Many trials failed to recruit enough patients - as many here will know, RECOVERY has enrolled over 40,000. It has been estimated that about five percent of Covid trials had actionable results – RECOVERY found that dexamethasone could reduce mortality in severely ill patients by up to a third. It is estimated that RECOVERY has saved around a million lives, proof of principle that robust data can be rapidly generated, analysed and lead to action and public health outcomes.

And let's not overlook that ongoing today in Oxford is a quite different community-based study of the first antiviral, molnupiravir, where people participate from their own homes with online diary cards and follow up phone calls. It will help to confirm whether the efficacy of molnupiravir in the initial studies is demonstrated in real world use.

We also took some new approaches with Covid tests. The work of Professor Derek Crook gave us an excellent scientific basis for further regulatory developments. We emulated the WHO concept of publishing target product profiles, which might sound a very simple thing to do, but it's the kind of innovation that makes a difference. Other countries could adopt these and did. Our inspectors supported the Nightingale hospitals to allow local manufacture of much-needed medicines and intravenous products on site, publishing guidance for all the Nightingale hospitals could do this.

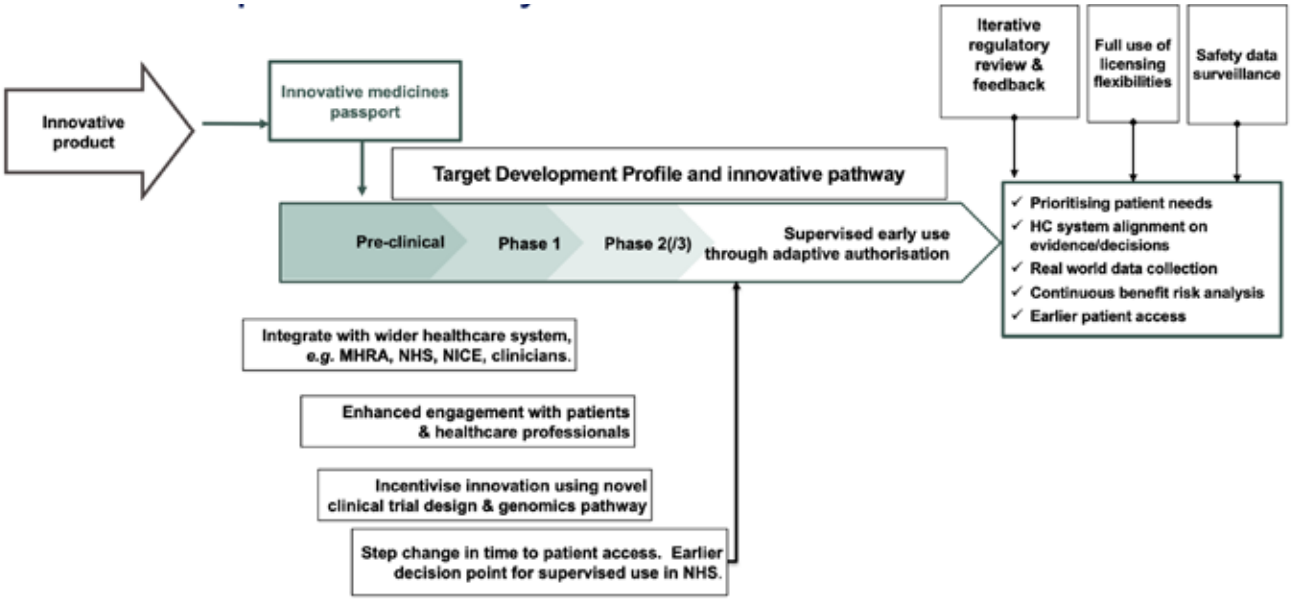
Finally, we implemented an innovative approach to vaccine safety monitoring, having anticipated that we would receive a large volume of reports of suspected adverse reaction reports, both via our Yellow Card website and via the Yellow Card app. Using artificial intelligence to detect signals meant close to real-time vigilance and the capability to publish the latest reporting data and trends, such as the signal of vaccine-induced thrombosis with thrombocytopenia, identified after three reports of cerebral venous sinus thrombosis. Here again, Oxford clinicians came to the fore in risk assessment and management, with Dr Sue Pavord's landmark paper in the New England Journal of Medicine.

So where are we now? Today's regulator faces a number of challenges - growing patient expectations for access to medical breakthroughs without delay; changing demographics and disease patterns bringing new aspects to benefit risk evaluation; the digital world that we wish to embrace; and unlocking the potential of transformative medicines and the genome. Our learnings during the Covid pandemic have reinforced the need for a regulator that is nimble, that listens and acts on patient perspectives, that works with the research community not only with the life sciences industry and that makes the UK the go-to place to develop and deploy innovative products.

Are we going to be able to make these regulatory changes permanent? I do not think we can go back to 'normal' now. But it's going to take a culture change to fully identify as an enabler rather than a controller, to be a patient champion rather focussing on population health, and to be a full system partner rather than what has been called a 'black box'. It will also take new ways of working and even legislative reforms. I'm pleased to say that new ways of working and proposals for regulatory reforms have already been initiated.

Our new Innovative Licensing and Access Pathway is an important step forward, based on integrated working with

New Development Pathway for Innovative Products



heath technology and healthcare partners. The 'ILAP' pathway enables the award of an 'innovation passport' to products of promise, to signal to the health care system to get ready for change. Each of these innovation passport drugs has its own target development profile and the health technology appraisal bodies including NICE are on standby to evaluate data as soon as it is available. The first innovation passport was granted for belzutifan, a medicine for von Hippel-Lindau disease, and others have soon followed, such as sacituzumab for metastatic breast cancer, all of which are medicines where we mustn't keep patients waiting.

In a particularly exciting development, we are developing proposals to use our Yellow Card database of adverse reactions for genomic studies. Locked in our millions of reports could be the clues to preventing side effects which limit the usefulness of many medicines. The ultimate aim is to make available simple screening tests that will reduce the burden of adverse reactions. The recent report on personalized prescribing by the Royal College of Physicians and the British Pharmacological Society sets out the vision for the future, that by using pharmacogenomic testing, prescribing can be optimised both for efficacy and safety.

Thanks to scientific and technological advances, more and more treatments will be manufactured at the point of care. A new medicine may have a half-life of only minutes and need to be safely manufactured at the patient's bedside. This will require a new legal basis which we're currently preparing.

We are also planning the reform of our clinical trials legislation, to streamline and remove obstacles, to drive greater representativeness, to 'take the trial to the patient' and to make sure we build international interoperability so that the UK is a preferred site for multinational trials. This is exactly what was envisaged in the Clinical Trials Charter adopted by the G7 countries at last summer's meeting here in Oxford. The G7 Hundred Days Mission is our challenge not just for vaccines but for diagnostics and therapeutics, by embedding best practice and making the exceptional the everyday.

In conclusion, our regulatory learnings from Covid have catalysed new ways of working and a new, enabling approach. We want to be able to bring innovation safely through to patients by embedding these new ways of working. We want to maximize the opportunities of new scientific tools and methodologies such as genomics and observational data and to collaborate with other regulators globally.

It seems that Charles Dickens captured the essence of the times we have lived though in his 'Tale of Two Cities'. "It was the best of times, and it was the worst of times. It was the age of wisdom and it was the age of foolishness, it was the epoch of belief, it was the epoch of incredulity, it was the spring of hope, it was the winter of despair, we had everything before us, we had nothing before us - in short the period was so far like the present that some of its noisiest authorities insisted on it being received for good or for evil in the superlative".

I'm sure many here will agree that we as a country, our scientists, our NHS and our people, have been 'in the superlative'. Those that worked tirelessly in research and in patient care, who came forward in thousands to participate in trials, volunteered at vaccination centres, even those that simply took food to the housebound. I'm very grateful to everyone for listening to this talk, including those online, but I'm especially grateful to this great man, the superlative and the unique Professor Sir David Weatherall.

Acknowledgment Dr Tim Crossley for his help in transcribing this lecture.

Brain on Fire - Extinguishing the Concept of Immune Privilege

Dr Sarosh Irani
(Corpus Christi College 1997, Somerville D Phil 2004) Professor of Autoimmune Neurology; Head, Oxford Autoimmune Neurology Group; MRC Senior Clinical Fellow; Senior BRC Fellow; Honorary Consultant Neurologist; University of Oxford and Oxford University Hospitals

A sanctum. A privileged site. Ever since Nobel prize winner Peter Medawar showed that skin transplanted into the mouse brain was not rejected, the central nervous system (CNS) has been considered largely invisible to the immune system. However, particularly in the last 20 years, this dogma has been re-evaluated with a series of clinically-inspired and basic findings that now indelibly make the CNS one of the most intriguing anatomical sites of immune attack and human autoimmunity.

Of course, for many decades now, multiple sclerosis (MS) has been recognised as an autoimmune disease of the CNS. The MS brain shows an abundance of monocytes, T cells and B cells within discrete lesions, multiple genetic associations which relate directly to immune system and, particularly in the last decade, a wide variety of immunologically-active agents have been identified which can suppress MS attacks. However, MS still lacks a clear pathophysiological model, putative autoantigens remain elusive and few medications work to prevent or significantly slow the disability-generating progressive phase of the disease.

By contrast, an annually-expanding range of autoantibody mediated diseases of the CNS are defined by their CNS-expressed autoantigen, and are potentially highly treatable. In around the last 15 years, over 20 neuroglial targets of the human autoantibody attack have been identified to include key CNS proteins such as the NMDA and GABA receptors and the astrocyte water channel aquaporin 4. Importantly, these autoantibodies are directed against the extracellular domains of their antigens, meaning they can - and do - modulate their target in humans. Hence, their pathogenic functions which have been increasingly well characterised both *in vitro* and *in vivo*.

A key feature of these conditions is their frequent response to immunotherapies. Corticosteroids and plasma exchange, sometimes with rituximab or cyclophosphamide in addition, markedly improve patient outcomes in several observational studies, and it has consistently been shown that earlier administration of these immunotherapies lead to the best patient outcomes. However, despite these, patients have almost universal residual deficits, some have frequent relapses and many side-effects of immunotherapies can significantly impair quality of life. Hence, there remains lots to learn.

> *"...over 20 neuroglial targets of the human autoantibody attack have been identified..."*

Excitingly, with identification of each new antigenic target, a clinically distinctive syndrome has been defined. Taken together, these patients can present with multiple features including memory loss, personality change, psychosis, depression, seizures, spinal cord dysfunction, movement disorders and florid dysautonomia. Yet, very rarely do any one of these features present in isolation. In fact, it is almost the

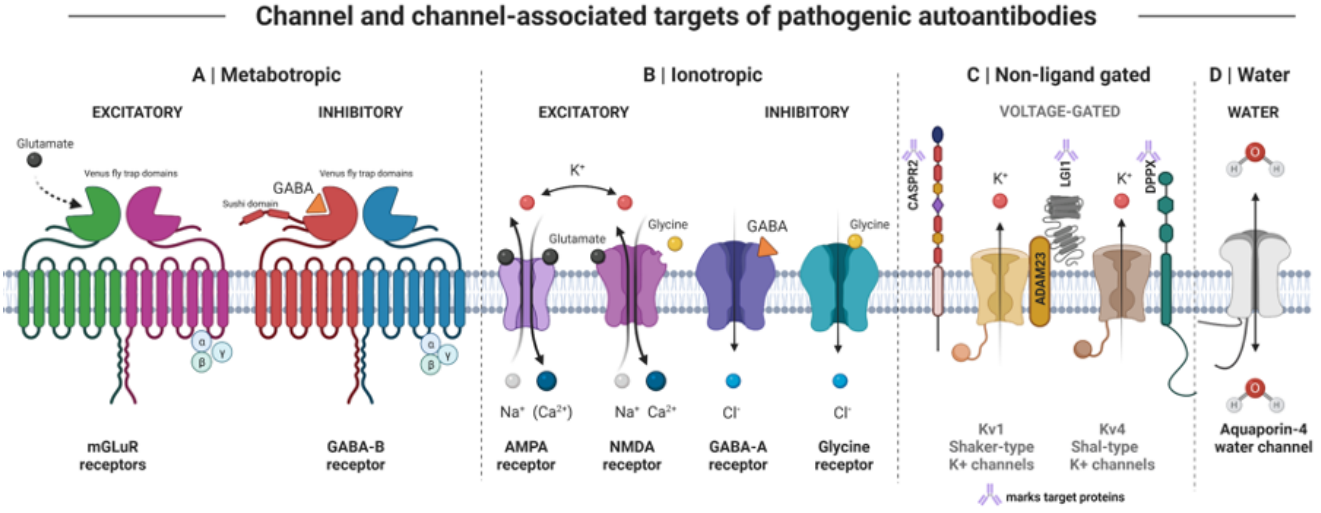


Fig 1. A selection of pathogenic antibodies targeting channels and channel related proteins. Figure courtesy of Dr Sophie Binks, Oxford.

> *Excitingly, with identification of each new antigenic target, a clinically distinctive syndrome has been defined.*

rule that the precise mixture and nature of these features is the clinically characteristic aspect of the syndrome, and highly predictive of the underlying autoantibody reactivity. For example, patients with autoantibodies to the NMDA receptor typically first present to mental health services with a mixed set of psychiatric features, including prominent affective and psychotic components. Often just a few days later they develop memory problems, disorientation, other cognitive difficulties, seizures and movement disorders. It is this combination of features which defines the abrupt onset of NMDA receptor antibody encephalitis, a disease which reached the popular media as New York Times journalist Susanna Cahalan accounting her personal experiences in a book entitled 'Brain on Fire'. She described a long period where her disease was attributed to a primary psychiatric illness and to hysteria, misdiagnoses many of our patients continue to encounter. Historical accounts of very similar clinical descriptions were attributed to encephalitis lethargica and other post viral forms of encephalitis, suggesting this entity has now filled some important gaps in neurological history. The autoantibodies cause internalisation of the NMDA receptors at neuronal synapses, and hypofunction of this

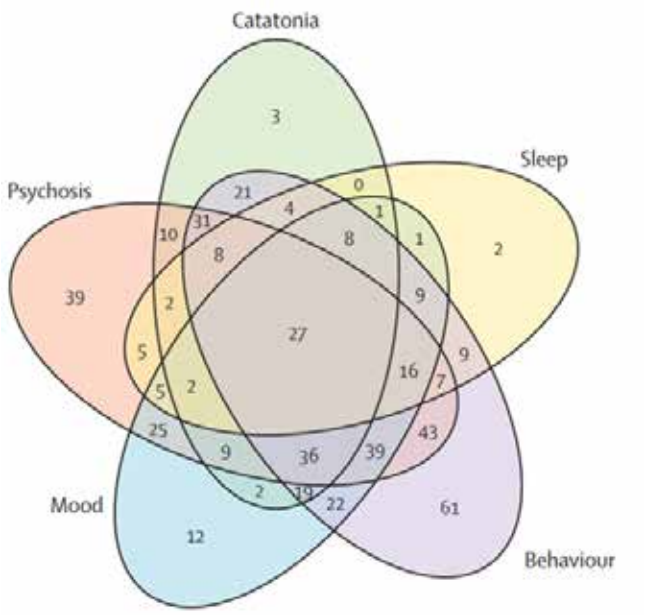


Fig 2. The mixed psychopathology of patients with NMDAR-antibody encephalitis.
From Al-Diwani, A. et al. The psychopathology of NMDAR-antibody encephalitis in adults: a systematic review and phenotypic analysis of individual patient data. The Lancet Psychiatry 6, 235–246 (2019).

autoantigen is proposed as sufficient to explain the patient's symptoms. These findings can be mimicked upon patient immunoglobulin infusion into experimental animals, and resolve after the infusion is paused.

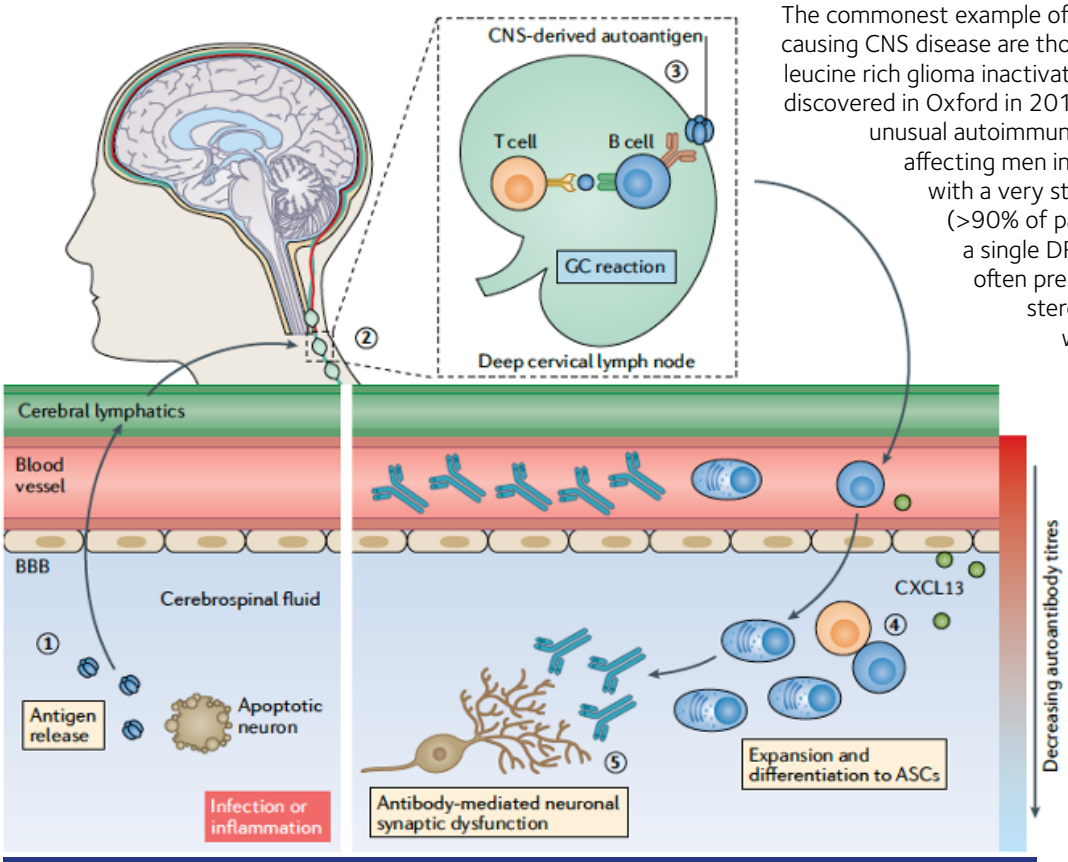


Fig 3. The immunobiology dynamics underlying autoantibody-mediated forms of CNS diseases.
From Sun, B., Ramberger, M., O'Connor, K. C., Bashford-Rogers, R. J. M. & Irani, S. R. The B cell immunobiology that underlies CNS autoantibody-mediated diseases. Nat Rev Neurol 16, 481–492 (2020).

The commonest example of autoantibodies causing CNS disease are those directed against leucine rich glioma inactivated one (LGI1), discovered in Oxford in 2010. This is a very unusual autoimmune disease, typically affecting men in their 60s and 70s with a very strong HLA association (>90% of patients carrying a single DR allele). Patients often present with highly stereotyped focal seizures which typically affect the face and the arm (which we termed Faciobrachial dystonic seizures'), sometimes occurring several hundred times per day, in addition to other focal seizure semiologies. Subsequently, often after a few weeks of seizures, patients develop memory impairment. Several studies have shown that immunotherapy is far more effective

> *"...response to treatments makes these "not to miss" diagnoses.*

than antiseizure medications (such as carbamazepine) in treating the seizures. Further, and perhaps more intriguingly, the early administration of effective immunotherapy appears to prevent the development of otherwise incipient cognitive impairment. Hence, in this disease, simple interventions such as corticosteroids and plasma exchange can dramatically alter the natural history of the illness. Recent immunological studies have shown that there are abundant B cells in the patient's cerebrospinal fluid, suggesting a key pathway to pathogenicity is the generation of high local concentrations of the rogue autoantibodies in the CNS: a paradigm which may well apply to all these illnesses.

Another landmark in the field was the discovery of aquaporin 4 antibodies in patients with Neuromyelitis optica.The detection of these antibodies in a subset of patients previously erroneously thought to have multiple sclerosis has dramatically altered their prognosis, treatment and care and now defines a disease which is far commoner than MS in many equatorial countries. Largely thanks to the discovery of this biomarker, NMO is now a clinically recognisable and distinctive illness, very different from multiple sclerosis. It has also been established that several drugs given for MS often worsen neuromyelitis optica and, unlike MS, patients with NMO require lifelong immunotherapy. To this end, three FDA-approved drugs are now part of the neurologist's armamentarium to combat NMO, each with distinctive immunological mechanisms of action. Hence the discovery of this water channel directed antibody has directly improved tailored patient care across the globe.
Other autoantibodies continue to be discovered, on an annual basis. To date, these include autoantibodies to the glycine receptor, GABA receptors and AMPA receptors, all critical molecules at neurological synapses. In addition, the discovery of some antibodies, for example those against iglon5, opens up a whole new field stimulating research into a protein whose function was unknown prior to the discovery of the autoantibody.

Overall, these autoantibody-mediated diseases have captured the imagination of neurologists with their highly distinct and fascinating clinical features. Their consistent, albeit partial, response to treatments makes these "not to miss" diagnoses. And their ongoing discovery and expansion continues to challenge just how many currently idiopathic neuropsychiatric diseases may be attributable to autoantibody-mediated pathogeneses. From a biological perspective, the autoantibodies are both key diagnostic tools and the pathogenic entities which permit simultaneous studies of the immunobiology and neurobiology underlying these diseases.

So, today, the immune system is no longer considered blind to the CNS. However, many challenges and questions await us in terms of how it may access and then modulate this key organ across a variety of diseases.

Names Have Changed

Dr Tim Crossley
(St Edmund Hall 1974)
Retired Wolverhampton GP

The next patient I called in I knew a little from a single previous time. A benign slightly loud chap from the hostel down the road. "*Hello Kevin*" I began.

"*Good morning, Tim*" he said, as he took charge of the consultation.

It made me smile. Practicing amongst a largely inner-city population but with a scattering of professionals, and some academics, the patients who quickly felt comfortable, even entitled, to call me by my forename from the off were middle class. Social equals to the doctor. With this group I would avoid using their first name at all until the relationship was firmly established and defaulted to formality; I wouldn't beckon the local solicitor from the waiting room with "*Come in, Janet*" or similar. Initially it was Mr This or Ms That. And the bulk of my patients would just call me '*Doctor*'.

At Oxford I observed some doctors addressing patients as '*Sir*' or '*Madam*' in a display of respect. But to me it was unconvincing. Not my style, I resolved.

Kevin however had a mild learning difficulty, not great social skills, and a considerable history of homelessness. He was a bit rough looking but clean and immediately likeable. And I had patronised him by using his first name in an attempt to assert a parental authority only to be outmanoeuvred with his admirable confidence.

The wise doctor recognises that a gift from a patient is not without strings. It means something in the little power game of the relationship. Similarly, the little dance around names has meaning and is about more than social comfort. Kevin called me Tim for twenty more years. We were both okay with that, as I had learned a lesson.

The Sound of One Hand Clapping

Graz Luzzi DM FRCP
(Christ Church, 1978). Consultant in Sexual Health & HIV (retired), and former Medical Director, Buckinghamshire Hospitals

Before coming to the Oxford clinical school I was at Trinity College, Cambridge, having taken the Cambridge entrance examination. When looking through earlier exam papers, a particular question (statement for discussion), struck me: 'The sound of one hand clapping'.

I didn't know, in 1974, that the phrase originated from an 18th century Japanese Zen monk, Hakuin Ekaku, as a kōan – a riddle in Zen Buddhism, designed to provoke thought and facilitate meditation, intended to have no logical solution. He asked: "Two hands clap and there is sound. What is the sound of one hand?"

I wondered how I might have tackled that question then, at 17, and now, at 65. Two approaches come to mind: to address the challenge as a scientific one, as might a physicist; or alternatively, as a philosophical one, as perhaps might a metaphysicist.

Isaac Newton famously used clapping to calculate the speed of sound by overlapping the echoes returning from a wall in Nevile's Court at Trinity Cambridge in 1686. Being sound, it was amenable to scientific study, and these days can be recorded and analysed phonographically, its elements subjected to comparison. The shape of the hands can change the sound (for instance, cupping hands produces a different sound from flat hands).

Consequently, an experiment might involve recording two flat hands clapping, then two cupped hands, then one cupped hand against a flat hand. Compare the sounds phonographically, and it might be possible to attribute the 'cupped hand' and 'flat hand' elements to the respective hands. But the sound made is always made by both hands, so I expect that no elements can be attributed to one hand alone.

Young Graz contemplating one hand clapping 1974

Which led me to the metaphysical approach. When I looked into metaphysics, I could just about grasp the equivalent of a Ladybird book, and even that was a challenge. But I did pick up that unlike physics, metaphysics is a purely cognitive discipline, which does not concern itself with questions that can be answered using empirical approaches. Scientific approaches do not help with metaphysical questions because the challenges are not tangible. Metaphysical questions are addressed with logic and reasoning (or ratiocination, but I mustn't get carried away).

Apollo Belvedere copy from the one in the Vatican Museum

So, the approach might be as follows. One hand can't make a clapping sound. Two hands can. The sound made by clapping hands can exist with certainty, and that is not in dispute. So, in the context of two hands clapping, each hand is making sound. Hence, there is such a thing as the sound of one hand clapping.

> *"Two hands clap and there is sound. What is the sound of one hand?*

But what next? I would venture as follows. The interdependence between the two hands in creating a clapping sound is absolute. The sound generated can therefore also be regarded as absolute, and – at the risk of seeming fanciful – if you think of that absoluteness as you might, for instance, think of infinity (infinity divided by two = infinity); then I think we can construct an answer to the challenge. By which I mean, the sound of one hand clapping, in the context of two hands clapping, is identical with the sound of two hands clapping.

I feel curiously satisfied by this conclusion; even though I'm not at all sure that it arises from a metaphysical argument. (But then, I came away from my very limited exploration of metaphysics with the strong impression that it's all about not being sure about anything).

I imagine there are many who will be in a position to challenge everything I've written from a more informed perspective. **Wouldn't it be interesting to hear from them?**

Reflections on 50 Years on the Medical Register

Andrew Molyneux
(Emmanuel College Cambridge 1965; Exeter College and Osler House 1968 – 1971)
Consultant Neuroradiologist, Oxford, Retired (more or less)

Arriving in Oxford from Cambridge in September 1968 there were only about 15 of us starting the clinical Course, the larger Oxford intake started in December. It was the start of what have been many exciting and rewarding years. I met Judy, when she X-rayed my chest as a medical student, and we married a few months before finals! As clinical students we benefited from a superb clinical training: Michael Dunhill was our Director of Clinical studies, Jim Holt, Medical Tutor, and Teddy Buzzard, the senior physician on my medical firm who was sadly suffering from Parkinson's disease.
Time flew by and after house jobs on the Buzzard, Sleight and Lane firm and a surgical job at Stoke Mandeville. I was fully registered in August 1972. It had always been my intention to travel and work overseas in a developing country and I set about equipping myself with the basic skills. This included an A & E job, an Obstetric job which was arranged by going to see Douglas Ellis, the Obs. & Gynae Consultant in charge of the rosters, who would put you down on his list for a SHO Obstetric job! – you can start in December!

So, after 6 months Obstetrics at the newly opened JR1 (designed in the 60's and known as the "Headington Hilton") when the main JR 2 was still a hole in the ground, after 2 weeks anaesthetics we set off for Papua New Guinea, then an Australia Trust Territory to work as a General Duties Medical Officer. We were posted to Kundiawa, Chimbu district in the Highlands in a 3 doctor District Hospital, serving 200,000 people.

My colleagues were Anne another British doctor about our age, who had done quite a bit of paediatrics and Daryl an Australian who had more surgical experience. My obstetric experience was invaluable, and we did everything from Caesarean sections, ruptured ectopic pregnancies to autopsies. At weekends it was dealing with axe and arrow wounds from inter-tribal fighting and the usual common tropical diseases of malaria and syphilis.

Memorable cases included needing to amputate an arm for gas gangrene following an arrow wound and doing a Caesarean section for placenta previa under the epidural anaesthetic that I had just done. After a year in the highlands, we had 3 months posting on the spectacular north coast of New Guinea near the Irian Jaya (Indonesian) border (following Stephen Frankel, another Oxford graduate) My stay in PNG was cut short by family illness at home and the death of my Father with lung cancer.

District Hospital Kundiawa Chimbu 1973

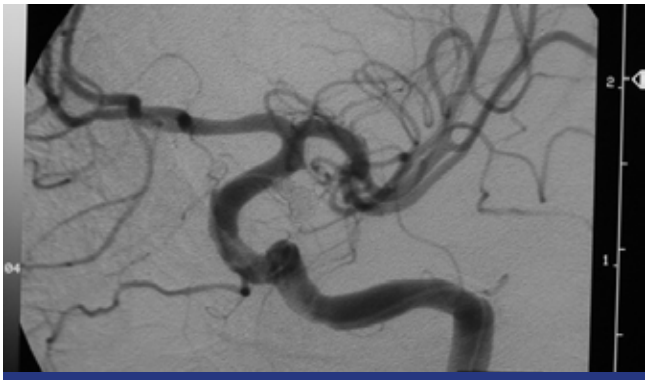
My plan to pursue a career in Tropical medicine changed by the need to stay in the UK. My brother David, later to become Dean of School of Tropical Medicine in Liverpool, was heading to Bukino-Faso for 2 years to start a WHO project to eliminate river blindness. So, I made the switch to a Radiology training in Oxford and gravitated to the practicalities of Neuroradiology. My early training was in the pre -CT era and thus the need to do many direct puncture carotid angiograms and even Air Encephalograms for Neurological diagnosis. The first head CT (EMI scanner) arrived in the Radcliffe Infirmary in 1977 and the imaging revolution started.

Parallel with the imaging revolution was the development of the endovascular techniques for treatment of vascular lesions in the brain and rest of the body. In the early days these were detachable latex balloons which we tied on to a catheter to treat carotid cavernous fistulas with my trainer and mentor Philip Sheldon. The balloons were successful in that indication and for occlusion of the carotid arteries in awake patients for large carotid aneurysms.

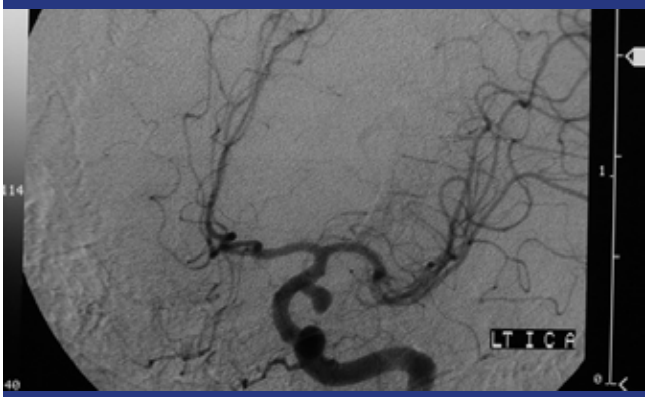
During the late 1980s and early 1990s there was rapid development of these endovascular techniques and nationally the Radcliffe Infirmary led the way in the development of endovascular treatment of CNS vascular lesions. I was strongly supported in the developments by Chris Adams my Neurosurgical Colleague.

In 1992 we started using a detachable platinum coil device which could be placed in a cerebral aneurysm under X ray control which was detached by electrolysis of the junction when the correct position of the coil had been reached. This was known as the Gugliemi Detachable Coil (GDC) after the Italian Neurosurgeon who was the inventor and developed in California by Target therapeutics on the West Coast and University of California Los Angeles.

Initially we treated difficult or impossible to clip surgical aneurysms both ruptured and unruptured often at the tip of the basilar artery, a location which carried extremely high surgical risks.



Internal Carotid aneurysm post coiling



Internal Carotid aneurysm pre coiling

It was clear that the technique was relatively safe and we were getting good clinical results and in discussion with my friend and colleague Muir Gray then Regional Director of Public Health at the time suggested "*you need to do a randomised trial"* in his characteristic Scottish brogue.
So, in early 1994 we started planning such a study with the help of colleagues across the car park at the Radcliffe, Mike Clarke and Rory Collins from the Clinical Trials Services Unit which was then situated in the Harkness building.
We obtained regional research funding for a pilot study with my co-Principal investigator Richard Kerr, my Neurosurgical colleague and developed a protocol for a superiority trial comparing Neurosurgical clipping with Endovascular Coiling. The primary outcome was relative reduction of death and dependency of 25% at one year. The International Subarachnoid Aneurysm Trial (ISAT) was borne.

We enrolled the first patient in September 1994, 2 years after our first use of the device to treat aneurysms and applied for MRC funding.

Our initial recruitment target was 1000 – 1500 patients but bearing in mind that a large Neurosurgical centre only saw about 120 patients a year with acutely ruptured aneurysms, this was a major challenge. The MRC at that time were not in the habit of funding major pragmatic trials of established surgical procedures such as aneurysm clipping.

Eventually in 1996 we got MRC funding, but they wanted a 90% power with 1% significance level so set a recruitment target of 2500 patients because they reasoned that if this trial is positive, it would result in a paradigm shift.
Over the next 7 years we managed to expand to 43 centres, which included most UK Neurosurgical centres as well as many French and German centres, a couple in Canada and one in Australia but only one in the USA who enrolled only a single patient.

In May 2002 when recruitment reached 2143 patients Data Monitoring advised we stop recruitment because the 2-month improvement in clinical outcomes had passed their stopping rules of 3 standard deviations! (P=0.01).
This presented a major challenge, we had to tell the investigators that the trial recruitment had been stopped and why. Namely that coil treatment had shown better clinical outcomes, but of course we could not immediately publish the results. There were a frantic few months for Richard Kerr and I, especially as we both had effectively full time NHS contracts!

The first interim results paper was published in the Lancet in October 2002 and the reaction from some in the Neurosurgical community particularly in the USA was immediate and critical. It was mainly focussed on the fact that we had not recruited all the patients in the centres with SAH (no trial does!!) and the lack of expertise of the UK Neurosurgeons, not being "*specialist neurovascular surgeons*". Ignoring the fact that when a patient collapses with an acute SAH they are treated in the nearest Neurosurgical unit; patients do not have a choice to go the "best" surgeon who ever that maybe!

In UK and much of Europe there was an immediate shift to coil treatment with between 60 and 80 % patients with ruptured aneurysms being treated by coiling within the next year.
This meant that alongside very busy clinical jobs with an increasing workload Richard & I had many demands for speaking at national and international meetings to disseminate the results of the study. We continued to follow the UK patients for a minimum of 10 years and published these in the Lancet in 2014.

In 2008 it was time to put down the catheters and coils after 30 years of vascular work and I retired from my main NHS job. Of course, in diagnostic Radiology continuing to report MRI & CT scans is possible and I also continued with my academic attachment to the NDS which had supported our later research grants.

Along the way and in the more recent years of my career I have been doing expert witness work, mainly clinical negligence cases for both Defence and Claimant. Doing expert witness work has taught me a lot. The importance of proper note writing, consent and not least "words matter" especially when writing reports.
It has provided a fascinating insight into the legal profession, and the extraordinary skill of Barristers. I was able to observe this at first hand in a case which went to trial at the High Court (very rare!). The QC for the Claimant was James Badenoch, whose father John had been senior Physician at the Radcliffe when I was a medical student. It was James who a few years later, in his last case, represented Mrs Montgomery at the Supreme Court against the Lanark Health Board. This case was responsible for the long overdue re-writing of the law on Consent.

My revalidation is due next year, and I will relinquish my licence to practice after just over 50 years on the register. I think I have done enough!

Oxford's First Patient to Receive an ACE Inhibitor

Christopher Winearls D.Phil, FRCP
(Keble College, 1972)
Consultant Nephrologist in the Oxford Kidney Unit 1988-2016

It was the summer of 1978 and I was the renal ward SHO. The registrar told me that he had accepted a patient from the Intensive Care Unit (then in the Radcliffe Infirmary) who had acute renal failure as a consequence of accelerated phase hypertension. She was 31 and had had high blood pressure since the age of 24 but no cause had been found. She had been admitted to the ICU with a blood pressure measured on an arterial line of 300/160 mmHg, papilloedema and retinal haemorrhages, and hypoxia from pulmonary oedema. She had been difficult to ventilate. Pink froth had come up the endotracheal tube. The creatinine had risen to 800 µmols/L but she had not been dialysed. She came to the ward on a medley (more accurately a muddley) of drugs and was unable to stand up because of syncope. However, without the cocktail of methyldopa, minoxidil, hydrallazine, furosemide and atenolol, her lying blood pressure was very high.

Dr John Ledingham, who had a special interest in hypertension, came to see her and I could tell that he had no immediate suggestions as to what we might do to get out of this bind. The patient remained in limbo on the ward and became exasperated, especially when the minoxidil started to cause hirsuitism and she became even more depressed on the methyldopa. She felt ghastly so my twice daily ward rounds caused me shame at my/our failure to resolve the problem. J Led as we called him, came back the next week for his Friday ward round and I presented the intractable problem to him again. Suddenly his eyes lit up and he said "What she needs is the new Squibb drug." I had no idea what he was talking about. He announced confidently, "I am going to get some from one of my colleagues in London." He phoned an eminent professor of clinical pharmacology who told him that under no circumstances could any of this new drug, which was still at the most preliminary stage of testing in patients be released. So, unabashed he phoned the MRC High Blood Pressure unit in Glasgow and they gave him the same answer, "The drug is just not available for compassionate or named patient use." However, they suggested that we could refer the patient to their unit but we would have to arrange the transfer to Glasgow.

John turned to me and said, "Could you get the patient on the London Heathrow to Glasgow shuttle? I have agreed with colleagues there that they will take her tomorrow morning and", he said, "be a good chap and write a really first rate summary and transfer letter. I don't want us to look amateur." This was about 4.45pm on a Friday. I asked him whether he would mind phoning the House Governor to authorise the purchase of the air ticket and the ambulance to take her to Heathrow Airport. He did so. I made my way to the secretaries' office to find that it was deserted, apart from the Home Dialysis Organiser. I begged her to type my summary. These were the days before word processors. She said she did not really take dictation but if I just spoke clearly and slowly she would type directly onto her IBM typewriter. Corrections would be difficult and Tippex would look messy. So my summary was prepared and the patient left for Glasgow the next morning. She returned about 3 weeks later with her blood pressure immaculately controlled on SQ14225 (captopril), later to be called CapotenR. I asked her to tell me what had happened in Glasgow. After she arrived she had heard (in Glasgow) doctors saying that the Oxford Unit just did not know how to manage difficult blood pressure. So they had stopped all the drugs that we had prescribed, which caused a sharp increase in her blood pressure. They started re-introducing them in various combinations but achieved no better control than we had. They admitted to her that they, too, were defeated and offered her a trial of SQ14225. The effect had been miraculous. The BP was < 130/80. She was left with significant chronic kidney injury but it was 10 years before she eventually reached end-stage renal failure and required dialysis. She was fortunate that continuous ambulatory peritoneal dialysis was by then an established treatment and within 6 months she had had a kidney transplant. In 1988 10 years after her first presentation I returned to Oxford as a consultant, and took over her long term follow up.

She would kindly let me tell recount her medical history to any medical students who happened to be in the clinic or chat to them herself. She had a marvellous story to tell, of keeping one step ahead of her illnesses and relying on clinical pharmacology to provide the solutions. She was rescued by the ACE inhibitor in 1978 and was fortunate to have 10 years without the need for renal replacement treatment before she progressed to requiring CAPD. She had her kidney transplant later that year, three years after cyclosporin was licensed, and this has kept her transplant functioning free of rejection for 25 years. She stayed on captopril 25 mg tds until 2014 when she was advised to switch to take a "more modern ACEI".

Having met ACE inhibitors in so dramatic a way, I followed their development and application I learnt how the clue came from the venom of the Brazilian snake, Bathrops jararaca. This had been brought to Professor John Vane's laboratory by Sergio Ferreira in the 1970s. It was actually a bradykinin potentiator and was called "BPF" but they discovered that it also inhibited the ACE. It was in the Squibb laboratories that the "unlikely feat" of producing an oral form of the drug was achieved. Many experts felt that the effect of inhibiting the converting enzyme would be catastrophic. Indeed, only two of the twelve clinicians offered the drug for testing were interested. Prescription of ACEI was at first limited to patients with resistant hypertension. Indeed, this woman was the first case in a series of patients with resistant hypertension successfully treated with captopril. The paper was published in 1980 in the Lancet but you do not get to be an author for doing emergency discharge summaries or arranging air shuttle transfers! Not only have ACEI have

become the first line and successful treatment for young patients with essential hypertension but they have transformed the management of progressive chronic renal failure by delaying progression of proteinuric nephropathies, especially in diabetics. They have become the rescue treatment for scleroderma crises and they are now a mainstay in the management of heart failure. They are a billion dollar pharmaceutical product.

We were, of course, perplexed by the cough suffered by 20% of patients. It was ironic that Sir John Vane himself had to give up taking the drug he helped to invent because of cough. His personal experience is also recorded in the Lancet. He was switched to an Angiotensin Receptor Blocker, conceding that his "ACE" had been "trumped".

To have been a trainee physician when a drug that has had such an impact on clinical practice was being tested in a patient one was looking after was an unforgettable experience. It was such an elegant example of physiology, pharmacology and clinical effect. I loved to watch the faces of the medical students as this memorable patient told her story. For those who look a bit sceptical, I print out the paper from the journal website right in the consulting room. I could not have done that in 1978 either.

When I retired in 2016 I had known her for 38 years. She was 68 and I was 67. At the last consultation I stood up to shake her hand. Instead she embraced me and neither of us could find any words.

A young Chris Winearls

ACE Inhibitors: From Snake Venom to Modern Medicine

Prof. Richard Haynes DM FRCP
(Magdalen College, 1997)
Professor of Renal Medicine and Clinical Trials, Nuffield Department of Population Health, University of Oxford

FROM SNAKE VENOM TO PRACTICABLE THERAPY

The renin-angiotensin system (RAS) is beloved by medical students for its linear simplicity and direct application to physiology and pharmacology. Needless to say, this is an over-simplification and instead the RAS is just one part of an intricate web of vasoactive peptides which mediate multiple homeostatic mechanisms and pathophysiological pathways. The first enzyme in the RAS (renin) was identified in 1898[1], as the rest of the RAS was dissected over the next 60 years or so the potential of its inhibition for therapeutic benefit in hypertension and heart failure was clear.

In his accompanying case study Chris Winearls describes the challenge of translating the venom of a South American pit viper into an oral medication. The first point in the RAS to be targeted was angiotensin converting enzyme (ACE), and the first commercially available ACE inhibitor (ACEi) was captopril. Many studies have shown the blood pressure lowering efficacy of ACEi; in large, long-term randomised trials allocation to ACEi reduces average blood pressure by 5.4/2.3 mmHg.[2] Such reductions are much smaller than seen in rare individuals with malignant phase hypertension (as in the accompanying case study), but nevertheless translate into significant clinical benefits.

BLOOD PRESSURE REDUCTION AND CARDIOVASCULAR DISEASE

Probably the most well-known of the placebo-controlled trials of an ACEi was the HOPE study which compared ramipril with placebo in 9297 participants at high cardiovascular risk.[3] Although blood pressure was 'only' 3/2 mmHg lower in the ramipril group at 2 years, the risk of myocardial infarction, stroke or death from cardiovascular causes was reduced by 22% (relative risk 0.78; 95% confidence interval 0.70-0.86). Results like this suggested the benefits of ACEi were more than would be expected from blood pressure reduction alone. The totality of the evidence suggests not, with two exceptions.[4]

SPECIAL BENEFITS OF ACEI

The potential of ACEi in heart failure was confirmed by the SOLVD trial of enalapril which showed a 16% (RR 0.84, 0.74-0.95) reduction in the risk of all-cause mortality among 2569 people with heart failure.[5] Inhibiting the RAS has remained one of the foundations of managing patients with heart failure with reduced

In the early 1980s, hypertension conferences were routinely enlivened by the poisonous Brazilian viper, Bothrops jararaca. With its striking zig-zag markings and aggressively protruding tongue, images of the snake were a welcome break from graphs and tables in presentations about captopril — the first of the angiotensin-converting enzyme inhibitors, whose effects on blood pressure mechanisms mimicked those of the snake's venom. When the cardiovascular juggernaut alighted in Sao Paulo, Brazil, for a major congress in 1984, there was even an opportunity for delegates to visit a snake farm and see the beast in all its glory. NGS

Brazilian Jararaca (Bothrops jararaca). The discovery that its venom lowered blood pressure in experimental animals, by inhibiting angiotensin-1 conversion to angiotensin-2 and potentiating bradykinin, led to the synthesis of captopril, the first ACEI- drug. (© David Warrell)

ejection fraction ever since. ACEi have also been shown to retard the progression of proteinuric kidney diseases, most notably diabetic kidney disease.[6,7] Their efficacy in a broad range of kidney diseases is one piece of evidence of a "final common pathway" of progression of chronic kidney disease which is driven by intraglomerular hypertension. As angiotensin II causes efferent arteriolar vasoconstriction, ACEi (or ARB) reduce intraglomerular pressure which paradoxically immediately reduces the glomerular filtration rate (a marker of kidney function) but delays the need for kidney replacement therapy like dialysis or transplantation (as demonstrated in the case study).

While ARBs avoid the irritating dry cough experienced by some patients taking ACEi (again related to their "bradykinin potentiating" effects), they are no more effective. Enthusiasts for inhibiting the RAS tried "dual blockade" (i.e. combining ACEi and ARB), but appropriately-sized trials have not found this to have superior efficacy to monotherapy and there are some clear harms.[8,9] One mediator of the harms of an activated RAS is aldosterone (produced by the adrenal cortex in response to angiotensin II); inhibiting its receptor does improve outcomes in both heart failure and proteinuric diabetic kidney disease.[10,11]

The elucidation and manipulation of the RAS has been one of modern medicine's major achievements, improving the lives of millions of people around the world. Although ACEi are no longer new treatments, they form one of the pillars of management of some very common conditions and provide a context in which any new treatment needs to prove additional benefit. It may not be the last time a treatment is derived from snake venom, but it may remain one of the extreme examples of the aphorism that whatever doesn't kill you makes you stronger.

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An Unexpected Journey from Aotearoa, New Zealand

Mr Thomas Swinburn
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The full version of this essay was one of three winners of the Ascona Prize offered by the International Balint Federation. For the full version contact: ***tswi135@aucklanduni.ac.nz***

When I found out that I would begin my first-ever clinical placement in oncology, I couldn't have imagined that the patients I would meet on this unexpected allocation would so fundamentally challenge my perception of clinical medicine. This is the story of one of these patients, an Indigenous Māori man named Ereuti*.

Ereuti was a gaunt, pale man with sunken eyes, sprouting various lines leading to various whirring devices. Listening to him on the ward round, I wondered whether he just wanted a bit of normalcy, as he asked simply whether he could go home. The consultant was sympathetic but didn't mince his words: Ereuti could go home but, without his constant intravenous infusion, he'd be making the choice to go home to die. Ereuti looked into his hands and said nothing.

Later that day, I took Ereuti's history. We're taught to ask about ideas, concerns and expectations, and previously I'd perceived these as nothing more than perfunctory, tokenistic questions. However, intuition spurred me to ask Ereuti what mattered most to him now. Without skipping a beat, he replied, "*Money and career don't matter now. What matters is relationships. Deep relationships. Relationships like the one we're building.*"

Our conversation allowed me to realise that, despite the professional context, the student-patient relationship is just that – *a relationship* – and relationships are healthiest when both parties feel comfortable revealing their true selves, communicating openly, and sometimes being vulnerable. Standards necessarily exist to define the boundaries and maintain safety but these need not and should not impede establishing the connection that is so fundamental to the art of medicine. By becoming too tied up in the showmanship of the formalities and formulas, we diminish our ability to relate as people. The Māori concept of whakawhanaungatanga is often defined as the process of establishing relationships, but its literal translation is more akin to 'the act of making family'. Taking time to engage in kōrero (conversation) is fundamental in identifying the shared connections that bind us. The student-patient relationship is no exception to this ancient wisdom.

Ereuti continued to receive inpatient treatment after my placement in oncology had ended. You can imagine my surprise when I later came across him, waiting to be discharged with a big smile on his face. As we parted for what I thought would be the last time, Ereuti joked that I could find him catching 'kingi' off the wharf in Kawhia. As the months passed, I found myself smiling at the thought he was fulfilling those wishes he had shared in our very first conversation.

That was until I passed the palliative care doctor unexpectedly in the corridor. "*Ereuti's back. You might want to visit him, because this will probably be his last time in hospital.*" I realise now that the gravity of those words hadn't quite sunk in as I made for Ereuti's room. Ereuti had returned, but he was gaunt with sunken eyes once more. A wave of shock then indignance then finally profound sadness washed over me. "*It's good to see you again. I'm at peace with dying,*" Ereuti managed between laboured breaths. Whilst I longed to sit with him again, to hear any final existential musings the 'master' might have for his 'apprentice', the space we once knew and shared had changed. I sensed that he just wanted some time alone. Ereuti had embarked on the final chapter of his unexpected journey. Holding back tears, I said goodbye and we exchanged warm smiles for the final time.

> "*...asking and listening are among the most essential tools in our medicine cabinet*

I feel privileged to have learnt so early in my career that the practice of medicine lies as much in sharing our common humanity as it does in prescribing and intervening. Sitting alongside penicillin and morphine, asking and listening are among the most essential tools in our medicine cabinets. Sometimes, a simple smile is top-shelf medicine. Whilst I have no doubt that the plethora of lines and devices contributed to Ereuti walking out of hospital, at least for a time, so too did simple gestures of kindness.

When I set out on the very first day of our very first clinical year, I thought medicine was about diagnosing and treating disease. Walking alongside Ereuti, however fleetingly, I am privileged to know now that it is about much more. As I embark on my own unexpected journey, whilst there are many technical skills to learn, Ereuti showed me that sometimes it is the human qualities we all possess that are the most powerful medicine.

*name changed

watermark photograph: Milford Sound by T.S.

Not all Who Wander are Lost...Ebola

Professor Chris Bulstrode
(University College, 1968)
Chris Bulstrode was a clinical Reader in Trauma and Orthopaedics at the NOC and JR2. He took early retirement to do Humanitarian work in Haiti, Nepal, Afghanistan and Sierra Leone for Doctors of the World and then went on to become a Ships doctor in Antarctica and on expedition ships until smitten with Parkinsons and Lewi body dementia. He is now official litter collector for Stanton St. John verges

I had written a rather rude article about the Royal College of Surgeons and was duly summoned by the President to discuss this rather 'disloyal' piece. It was a bit like being summoned to the headmaster's study. I was sat down and told how disappointed he was, not so much by my opinion, but by the damage the article might do to the reputation of the college.

I protested that all of what I had said was true. To my surprise he agreed but pointed out that he would never have become the President if he had said the things that I had. I realised that his ambition, like many others, was not to improve the system, but to advance his own career. I was angry because I was guilty of this too, but I was bored with it. I was on the GMC and the Council of the College but my ambitions to bring about some radical changes were being blocked by the usual gang of committee apparatchiks, whose sole ambition was not to rock the boat, in the hope that they might be promoted to chair some valueless committee.

At 60 I received a letter from the University inviting me to consider early retirement. I promptly binned the letter, reminded by Roy Jenkins' comment "I am not the retiring type." My partner Vicky retrieved the letter and asked rather brutally, I thought, "What are you going to do in the next five years that you hadn't already done?"

I had been grumbling for some time that I was bored, so she gave me a sheet of A4 paper divided into four boxes labelled:
1. What am I good at?
2. What am I not good at?
3. What do I like doing?
4. What do I not like doing?

I was then given a glass of wine and invited to fill in the boxes.

I duly did my home-work, and handed in what I thought was a jumble of ideas. She looked them over and said that she could see a clear picture. 'I wanted to work in the third world again but I did not want to be killed.' I had worked in a refugee camp in Sudan as a young doctor and come as close to being killed as you can be. I was not keen to repeat that experience.

We made a plan. I joined the Territorial Army and received a rapid but fierce training at Sandhurst and was then sent to Afghanistan for 7 months. I returned, a fairly hardened and experienced aid worker in 3rd world countries where the work was very dangerous. But it was what I wanted to do.

I had been doing some work for Doctors of the World (Medecins du Monde), and when the Ebola epidemic broke they needed doctors. Paradoxically I had spent ten years at the Nuffield Orthopaedic Centre doing joint replacements under Robert Duthie. He insisted that they should be performed in complete space suits with hoods and external breathing systems, so I was well used to gowning up and the claustrophobia of working in full PPE. They knew that working with Ebola would require full protection so asked me if I would lead the team which was funded by the British Government but which would be run by their Spanish branch.

Before I left for Sierra Leone, I went to a grand round on Ebola at the John Radcliffe. It was eerie. At no stage was there any mention of patient care. It was all about antibodies and laboratory techniques. This was the Western scientific world's view of Ebola. It was becoming clear to me that this initiative was nothing to do with helping local residents with Ebola. This was about protecting white people from a disease which was threatening to escape from darkest Africa. I left the Grand Round deeply unimpressed by the value constructs of Western doctors. That impression was going to be reinforced over the next weeks.

Posted to Sierra Leone with me was John Wright, a Professor of Public Health from Bradford, who was a dose of sanity. He had common sense and a great sense of humour, and in the end he saved the project. The clinical team were highly experienced ITU nurses from Scandinavia. They had never worked in the third world but knew how to manage infectious diseases. The administrative team were Spanish.

The old Ebola Hospital at Moyamba

The staff of the 'old' Moyamba Ebola hospital. Flip-flops, not always masks or gloves.

Dressing up to enter the infected area

Aerial view of the new 100 bed Ebola hospital

The inside of one of the new wards

John and I arrived in Sierra Leone and went straight to an Ebola hospital in Bo which was already working. We put on protective gear and went into the wards to learn how to manage patients. I use the word 'manage' deliberately. We were not treating. There was no treatment. We were working at over 35C. The suits we had been given had no breathing system and so overheated and filled with condensation in minutes. This meant that we could spend, at most 15 minutes in the ward before we got hyperthermia. It was difficult and dangerous to put up or run drips as you could not see because of the condensation on the face masks. A finger prick could be fatal, and anyway there was no way to monitor the drips, once they were running. While we were learning how to put on and remove protective gear (a very time-consuming procedure) the Royal Engineers were building our 100-bed hospital in Moyamba.

It was interesting that when we arrived in Moyamba there was already an Ebola hospital run by the local nurses.

They had flip-flop shoes, no gloves, no face masks and worked in a corrugated iron shed. Yet none of them got Ebola. They were not given jobs in the new hospital because they refused to put on the full protective gear. They said it was impossible to work in the heat. They were right!

Finally, the hospital was ready, but there seemed to be innumerable reasons why it could not be opened. There were Sierra Leonians lying dead in the street, but still the hospital stayed closed for one reason after another.

In our area the Army had taken over the management of the Ebola crisis as all the doctors had fled. But the local population were terrified of the Army after what had happened in the recent civil war. Even so, as soon as there was word of an Ebola outbreak in one of the outlying villages, the Army went out and rounded up as many people as they could catch (most fled into the bush) and brought them back packed into the back of a Land Rover. Confirmed cases were mixed in side by side with those who had no symptoms - not an ideal situation.

After many delays, we were at an impasse. John had an inspired idea, pretended to take a mobile-phone call, announced the Army were bringing a load of Ebola cases to us - in 10 minutes. The result was electric. Talk was replaced by actions, but we were too late. The hospital opened just at the end of the epidemic, which was dying out of its own accord, and we only handled about twenty cases.

The lesson I learnt was that the huge amount of money and resources spent to train staff and to build a hospital was nothing to do with helping the people of Sierra Leone. We were staffing a prison designed to prevent Ebola spreading to the developed world. If it hadn't been for a few Westerners catching Ebola and then coming to Europe and the USA, Ebola would have been allowed to spread through Africa and then die out as it has done many times before, because it was only Africans who were dying. The isolation hospital and the special protection suits were all about protecting white people from getting Ebola. If a single nurse had got Ebola I would have been for the high jump. If there were Sierra Leonians lying dead in the street, then that was Kismet. Perhaps next time we provide aid, we should question who the help is for, and whether it is genuinely helping. In this case we spent over £200 million treating around 20 patients, but we and the other four hospitals may have prevented Ebola from spreading to white people in the first world, so perhaps it was worth all the money spent.

Shreeves and Worster

Dr Brian Murray MA
(Trinity College, 1986) MRCPsych is a consultant psychiatrist working for Oxford Health NHSFT on an older adult inpatient unit in Aylesbury.

Affiliation: Trinity and Green, Matriculated 1986, Graduated 1992

It was nearly lunchtime as I eased my Audi TT through the chicane of traffic-infuriating measures installed at Fugglestone General Hospital.

I dropped the old jalopy in my usual space. I say 'usual space': of course, the NHS does not tolerate spaces reserved for consultants thanks to some woke nonsense, but my resourceful registrar Dr Shreeves managed to negotiate a modest monthly bribe to the otherwise all-too attentive parking attendant Mr McSavage, a man known to clamp a car faster than most cardiothoracic surgeons can clamp a mid-op aorta.

I managed to swerve past the outpatient matron and was met by the faithful Dr Shreeves. Shreeves was a tall chap with thinning hair that belied his youth. He was always immaculately dressed with a clean-shaven face and a Roman nose that probably looked better on the original Roman.

'What ho, Shreeves!' I cried, my jollity designed to mask my lateness.

But from behind I heard the dreaded sound of matron, a woman with a face as ruddy as her calves, whose charge towards me reminded me of a painful weekend in Pamplona.

'Dr Worster!'

'Matron, would you mind sparing us a few minutes? Dr Worster and I are discussing a patient,' asked Shreeves with glacial politeness, and we turned away.

'You *are* free to see a patient or two?' he politely enquired.

'Why don't you see them first, and then we can discuss them?' says I, always willing to look for an opportunity to educate my ...SHO? Core Trainee? Specialty Registrar? The-artist-formally-known-as-junior-doctor?

The problem was that I needed to be on the golf course by 3. Now, you may think the idea of a consultant on the golf course on a Friday afternoon is some lazy cliché spewed out by some hack writer purely for comedic purposes, but I can assure you it is all above board. In fact, it was our Clinical Director himself who suggested I have more time to myself, which I thought was jolly decent, as we had just spent three hours discussing my latest Serious Untoward Incident.

Shreeves was back five minutes later and ushered me into the clinic room where a patient was lying in the foetal position, facing the wall, his trousers around his ankles, which made shaking hands a rather time-consuming exercise.

Shreeves went on to introduce a Mr Peverel, and droned on about a weakened urinary stream, 5 bar gates and nocturia. To be honest, I was already mentally preparing for my golf with Dr 'Binkie' Murderstone (Binkie's a psychiatrist so let's face it, no one's going to miss him).

'What would you recommend, Sir?'

I was jerked out of my reverie. Mr Peverel's face jutted up from the couch expectantly.

'Sounds like prostate to me. Have you done a PSA?'

'Of course, although as I am sure you are about to inform me, a PSA alone is considered somewhat unreliable. Perhaps a... rectal examination?'

I looked blankly at Shreeves, then at Mr Peverel's posterior, then back at Shreeves. Slowly the penny dropped. Now, one does not get into medicine by being squeamish, but I was not having that.

'Very good, Shreeves,' I said, staring him out in what I thought was the fair but firm manner of a supportive clinical supervisor. 'I'll leave you to it. Call me if you get stuck.' Mr Peverel's upper end registered some alarm.

'- I mean, metaphorically, of course,' I added hastily. I started to beat a retreat but my escape was cut off by an angry couple swinging into the outpatient lounge in a manner that did not suggest they were patients, nor, for that matter, were they lounging. They both wore fake tans and the man had a chain around his neck so large that I thought he was trying to fence off his chest. The woman had an odd swinging gait. At first, I thought Trendelenburg, but then I recognised her.

'Hide me, Shreeves.'

'Sir?'

'It's Mrs Grudthumper and her husband. I did a breast reduction on her in the Nuffield and it went wrong'. Hence her listing to Starboard.

'But you're not qualified to perform surgery.'

'Dammit, I know that now!'

'The Nuffield *can* be somewhat eclectic in its taste of consultants,' he sniffed.

'There's no point being clever after the event.' If I don't do private work, the rest of the consultant's mess will think I'm a Communist!'

Shreeves swept out. He was gone about 11 and a half minutes, leaving me to stare at the back of Mr Peverel's head for what I can only say was about 11 and a half minutes too long. I was just about to attempt a shadow puppet when Shreeves stole back in. That's unfair: a doctor such as Shreeves does not 'steal' around the place. If his movements were likened to a crime I think high band tax evasion would fit the bill.

Cartoon by John North

'The deed is done, sir.'

'Shreeves, you're a marvel, how did you do it?'

'Simple, sir, I just told them you were on the golf course'.

'What?' I cried. I practically had the chap by the lapels. 'But I *am* going to the golf course!'

'The excuse had to be convincing. Mr Grudthumper - if I may omit some of the more exotic phraseology - said he found it only too plausible that you would be on the golf course at this time in the afternoon.'

'But dash it all, Shreeves, How does this help?'

'I gave very detailed instructions.'

''Eh? But... but -'

'- Dr Worster, your secretary never answers her 'phone, so he must have gone to your office to find out that you were in out-patients. That's a 20-minute walk from the car park. It's then another 15 minutes to outpatients and 15 minutes back to the car park. These are, of course, minimum times, assuming he does not get lost.'
'I don't care about his perambulations!'

'Your mind working so much faster than mine will already have grasped that the 50 minutes Mr Grudthumper has spent looking for you, plus the 11.5-minute time with me, means he will be well past the statutory 1 hour minimum on his car parking ticket.'

The light started to dawn, but I let Shreeves continue as he likes to sound clever.

'I believe Mr Grudthumper will find that, by the time he has fully absorbed my instructions, his car will have been clamped. The parking enforcement team, as you yourself have averred, can be most assiduous.'

As I rolled out the old Audi TT, I reflected on what a stroke of luck it is to have a man likes Shreeves on the firm. My reflections were only temporarily interrupted by the sight of a deepening shade of Mr Grudthumper, now furiously engaged with Mr McSavage. Ah, Shreeves! What a pity my report for his ARCP is going to be a bit of a stinker. He might need to repeat a year, but of course, he'll be welcome to repeat it with me.

What can I say? We make such a good team.

Retirement

Dr Lesley Starr
(St Annes College, 1977-9) General Practitioner (retired) Bath

After decades of working until you expire
You cope as you know you're about to retire.
Soon you'll have time to pursue all your hobbies
No longer concerned with diseases of bodies.

Then we'll go out for lunch, and watch daytime tv,
Read cheap, trashy novels, have lie-ins, guilt-free.
Meet friends at the theatre, go to the pub,
Try yoga, do crosswords, and join a book club.

Perhaps we'll learn bridge and then take up Pilates.
I'm sure we can cope just as soon as we've started.
Now that we've left all that knowledge behind,
We'll have to do more to stretch body and mind.

But amazingly soon we forget all we knew.
Its so hard to admit that you haven't a clue.
Our friends still all think we're a source of advice
On bunions and skin tags, sore elbows and lice.

I know what I'll do-I can keep up to date-
Read the journals each week-it isn't too late.
Perhaps I can start with this week's BMJ...
But I'll check the obituaries first, if I may.

Retirement at last brings us all we could wish
But still there are things which we find that we miss-
Our colleagues, the challenges, curing the ill,
The status, and friendships-a void hard to fill.

L M Starr, Oct 2022

Lesley Starr and husband Kevin Gruffydd-Jones with their four grandchildren.

Some of Lesley's recent art - whilst enjoying her retirement...

Critics Corner: OMLC Lecture Series

Dr Sarah Ball
(Somerville College, 1974) Conservation Geneticist and retired Consultant Paediatric Haematologist

For individual links to the videos of the lectures, please visit: **https://www.medsci.ox.ac.uk/get-involved/alumni/events-and-reunions/oxford-medical-lecture-club** and click onto each lecture title for access to the video.

Dr Andrew Molyneux:
OH DEAR, GRANNY'S HAD A STROKE, SHALL WE CALL THE DOCTOR? WHAT HAS CHANGED IN 50 YEARS?
27 June 2022

I remember, back in the day, it was only possible to get a CT brain scan for a patient in the JR A&E by pleading with the neurosurgeons at the Radcliffe Infirmary. Now everybody knows to act FAST, that Time Is Brain. This talk provided a striking illustration of how interventional neuroradiology has embraced technology, and that what once seemed impossible is now standard practice. Carrying on in this vein (sorry), I would love to have heard more about the very first uses of ingenious devices to retrieve clots, being reminded of Fantastic Voyage (1966), in which a miniaturised submarine conveyed its crew through blood vessels to remove a clot in the brain of a scientist. Once again in this series of medical lectures, we were also reminded of the power of national and international collaboration in achieving advances that would have been science fiction 50 years ago. But, returning to the question of poor Granny, the logistics of accessing timely intervention have unfortunately not kept pace with what can and should be achievable. Plus ça change...

Dr Lukas Krone:
THE CORTICAL REGULATION OF SLEEP
31 October 2022

Another impressive speaker in this series of talks, which must definitively put paid to the still propagated myth that medical doctors are not proper scientists. This was real proper science, and how, an articulate and elegant trip through the investigation of different pathways of control of sleep, largely based on Dr Krone's own research. I cannot do it justice by trying to summarise it here; if you were unable to get to the talk (and even if you were there), I strongly recommend watching the recording. As ever in this lecture series, there were interesting and clever questions from the interesting (and interested) and clever audience, including on the evolutionary role of sleep. Who knew that fruit flies would be useful in sleep research.

> *"...interventional neuroradiology has embraced technology; what once seemed impossible is now standard practice.*

Paul Bowness:
THE OPERATION DRAWINGS OF BARBARA HEPWORTH
28 November 2022

This was another wonderful talk, by another erudite Oxford-based clinician scientist, but in other respects this was not typical of the talks in this lecture series. The speaker, who happens to be the grandson of Barbara Hepworth, gave a fascinating account of a less well-known aspect of his grandmother's art. In her Operation Drawings of 1947-1949 we get a glimpse of her drawings and paintings rather than the more familiar abstract sculptures, with an incredible delicacy and finesse of hands and eyes, in a composition illustrating the coordinated focus and skill of a theatre team. These had been stimulated by the illness of her daughter with osteomyelitis. The question-and-answer session was also fascinating, often more personal than scientific given the nature of the talk, and with revelations from audience members about their own connections with the artist and her family. Inevitably perhaps, the discussion turned to the management of osteomyelitis in the very early days of mass-production of penicillin, and especially the Oxford links in supplying it to the artist's daughter.

Serendipitously, a new exhibition on the Art and Life of Barbara Hepworth has just opened at Tate St Ives (26 November 2022 to 1 May 2023).

> *"...incredible delicacy and finesse of hand and eyes illustrating the coordinated focus and skill of the theatre team.*

Professor Sir Adrian Hill:
A VACCINE FOR MALARIA AT LAST?
2022 Osler Lecture

Sir Adrian Hill KBE FRCP FRS delivered the 2022 Osler Lecture at the 15th Anniversary of Oxford Alumni- Meeting Minds- on 17th September 2022 in the Andrew Wiles Building of the Mathematical Institute in the Radcliffe Observatory Quarter. He is Director of the Jenner Institute and Lakshmi Mittal and Family, Professor of Vaccinology at the University of Oxford.

Vaccines have done more for human health than any other medical intervention and have recently been centre stage. Prof Hill reminded us of the persisting huge burden of malaria and its high mortality, in low income countries in Africa and elsewhere. Attempts to produce an effective and safe vaccine have hitherto been disappointing. He shared the data from the trials conducted in Burkina Faso, testing booster doses of the R21 vaccine, with low or high doses of adjuvant in children. The controls received a rabies vaccine. The vaccine contains a number of target antigens which should reduce the risk of escape by parasite mutation. The vaccines were administered before the peak of the malaria season and proved 70% and 80% effective in the low and high adjuvant groups respectively. No serious adverse events related to vaccine were observed. Results from a larger Phase III trial are expected later this year. This achievement is the culmination of many years of sometimes dispiriting work.

It was fitting that attendees walked past the entrance to the old Radcliffe Infirmary where there is a plaque marking the first administration of penicillin on 12th February 1941.

By Chris Winearls

OMLC LECTURE PROGRAMME 2023

Monday 30th January 2023:
Professor David Cranston: William Osler and China

Monday 27 February 2023:
Mr James Badenoch KC: Consent after Montgomery

Monday 27 March 2023:
Professor Sarosh Irani on Brain on Fire:
Immune Privilege or Not?

Monday 24 April 2023: Dr Catherine Swales

Monday 29 May 2023:
Professor Frances Hall: A Connective Cornucopia

Monday, 26 June 2023:
Professor Chris Conlon on HIV at 40 Years

2023 Osler Lecture
Saturday 23rd September 2023
Professor Sir Chris Whitty:
THE ROLE OF THE STATE, THE MEDICAL PROFESSION, AND THE PUBLIC IN PREVENTING ILL HEALTH

OMA has been approached by two local medical history projects that may interest you:

EXPLORING HISTORIES OF HEALTH AND MEDICINE IN OXFORD

A new project from the History Faculty at the University of Oxford, investigating historical practices of medicine and healthcare in and around the city. The project will result in a publicly-accessible website where visitors can explore research, listen to oral histories, and discover, via maps and other resources, the rich history of medicine in Oxford and its surrounding area. The website will be of interest to the local community, highlighting the experiences of people who have contributed to healthcare in Oxfordshire, and the work of local historians, medical and healthcare professionals, and academics.

The project team is keen to hear from people who work, or have worked, in healthcare in Oxfordshire, and from local historians with an interest in the topic.
Sally Frampton: **sally.frampton@humanities.oc.ac.uk.vcf**

COLLECTING COVID

A collaborative project between the History of Science Museum and Bodleian Libraries (funded by the E P A Cephalosporin Fund) which aims to preserve and share the story behind the University s response to COVID-19. We are inviting individuals and teams across all divisions to donate objects, records, and memories to be permanently preserved, forming part of the established collections of both institutions. Highlights of these long-standing collections include the papers of Nobel Prize-winning chemist Dorothy Hodgkin and a blackboard used by Albert Einstein during a 1931 lecture in Oxford.

We are keen to hear from individuals to discuss any material they would be willing to donate, or to hear any suggestions that may benefit the project. Enquiries can be sent to Michaela Garland (Project Archivist) and Tina Eyre (Project Curator) at **collectingcovid@glam.ox.ac.uk**

NEWS & CONGRATULATIONS

PROFESSOR MARTIN BURTON (Clinical Medicine, St Edmund Hall, 1980) Professor of Otolaryngology, Director of Cochrane UK and Research Fellow in Clinical Medicine, and Vice-Master (Executive) at Balliol, has been elected as the next Master of Sidney Sussex College, Cambridge

PROFESSOR CHRISTOPHER FAIRBURN OBE (Clinical Medicine, Worcester College 1969) has been awarded the 2022 American Psychological Association (APA) Award for Distinguished Scientific Applications of Psychology in recognition of his ground-breaking conceptualization of eating disorders and the development and implementation of their most effective psychological treatment.

PROFESSOR DAMIAN R. GRIFFIN (Clinical Medicine, Green Templeton 1986), Professor of Trauma and Orthopaedic surgery at the University of Warwick, has been awarded Officer of the Order of the British Empire (OBE) in the Military Division for his work with the Army Medical Services. Professor Griffin is the founder and lead doctor of the Hip Arthroscopy Clinic and is a Colonel in the Army Reserve.

PROFESSOR KAMILA HAWTHORNE MBE (Clinical Medicine, Somerville 1978) has become the next Chair of the Royal College of GPs. She is the first South Asian woman, and first Wales-based working GP, to hold the position. As Chair, Professor Hawthorne will be responsible for setting the colleges policy direction, and will lead the RCGP decision making body.

PROFESSOR PAUL A. MOSS (Clinical Medicine, Lincoln College 1983) is Professor of Haematology within the Institute of Immunology and Immunotherapy at the University of Birmingham and Deputy Head of the College of Medical and Dental Sciences. He has received Officer of the Order of the British Empire (OBE) for services to immunotherapy and COVID-19 research.

PROFESSOR RICHARD MOXON, Emeritus Professor of Paediatrics and a Professorial Fellow of Jesus College received the Royal Society's Buchanan Medal, for helping pioneer the field of molecular microbiology, discovering 'contingency loci' in bacteria (repetitive DNA regions that can enable rapid adaptive evolution), and making key contributions to the development of meningitis vaccines.

PROFESSOR ELIZABETH R. PLUMMER (Clinical Medicine, New College 1989) received Member of the Order of the British Empire (MBE) for services to medicine. Professor Plummer is Professor of Experimental Cancer Medicine at Newcastle University and an oncologist specialising in treating patients with melanoma.

SIR ANDREW POLLARD, Professor of Paediatric Infection and Immunity at the University of Oxford, Honorary Consultant Paediatrician at Oxford Children's Hospital and Vice Master of St Cross College, Oxford, has been awarded the James Spence Medal in recognition of his work on the advancement of knowledge and understanding in paediatrics and child health.

PROFESSOR STEPHEN H. POWIS (Clinical Medicine, St John's 1982) has been awarded a Knight Bachelor in recognition of his services to the NHS and his role leading the response to the COVID-19 pandemic. Professor Powis is NHS national medical director and interim chief executive officer of NHS Improvement. He is also a professor of renal medicine at University College London.

MR PRASANNA PUWANARAJAH (Clinical Medicine, New College 1999) has become the newest Dummet Fellow at New College. After excelling as an undergraduate and 4 years of clinical medicine, he became an actor, writer and director (recently playing Martin Bashir in the Crown).

PROFESSOR PARVEEN YAQOOB (Physiological Sciences, St Hilda's College 1987) has been awarded Officer of the Order of the British Empire (OBE) for services to higher education. Professor Yaqoob is Deputy Vice-Chancellor and joint Pro-Vice-Chancellor for Research and Innovation at the University of Reading.

Please contact the OMA Team (oma@medsci.ox.ac.uk) regarding any news you would like to be considered for entry in the next edition of Oxford Medicine.

Reunions

2022 GRADUATION

Our graduation was an incredibly special moment to celebrate the completion of our medical degree, having done so while navigating through a global pandemic.
Our shared and treasured experiences – including experimenting on each other s physiology in the labs, attending chaotic bops and producing a highly successful pantomime – had resulted in a very close-knit cohort, composed of friends for life. Packed tightly in the Sheldonian theatre, I felt excited for our next chapters and grateful to all those that had made our journey such a special experience. Thank you all!

Dr Lily Watson *(Jesus College, 2016)*

10TH REUNION, ST HILDA'S COLLEGE, AUGUST 2022

On a sunny Saturday in August, the 10-year reunion of the 'Class of 2012' was held in the beautiful grounds of St. Hilda s college. Over 60 alumni attended, along with their families, for a lovely afternoon of celebrations, lawn games and a delicious BBQ. Many thanks to Christina, Emily and Bella from the Oxford Medical Alumni association for their organisation, and to the staff at St. Hilda s for hosting. Everyone who attended had a wonderful time and can't wait for the 20-year reunion (if we can't fit something in before that!)

Dr Emma Forman *(Hertford, Matric 2006)*

20TH REUNION, MAGDALEN COLLEGE, SEPTEMBER 2022

30TH REUNION, ST PETER'S COLLEGE, SEPTEMBER 2022

Medics from the graduating year of 1992/matriculating year of 1986 came together for their 30-year reunion on September 3 at St Peter s College, with guests welcomed by Oxford University s Director of Alumni Relations, Christine Fairchild. It was particularly good to catch up with old friends who had moved away from Oxford for their clinical courses. We were treated to excellent-after dinner talks by Paul Wordsworth and OMA President, Lyn Williamson, and, in a moving after-dinner interview-style conversation, Adam Towler told, with remarkable calmness and compassion for his attacker, how he survived a knife attack in 2019. Reminded of how precious life is, we look forward to meeting again in another five years.

Professor Calman McLennan *(Keble 1986)*

40TH REUNION, BALLIOL COLLEGE, NOVEMBER 2022

It was great fun to be back in contact with colleagues, many of whom had not met since qualification. A huge diversity of career paths were represented, both in and out of clinical medicine. Oxford Medical Alumni had worked hard to track down as many people as possible and raided the archive for some early pictures of the cohort. Julian Britton kindly drove down from Carlisle to be with us for the evening, representing those who had taught us. A yearbook is available from OMA containing pen portraits of many of the year.

Mr Bruce James *(New College 1976)*

For the 2023 Graduation Reunion dates, please see page 2 or click here:
https://www.medsci.ox.ac.uk/get-involved/alumni/events-and-reunions/oxford-medical-school-reunions

"A WORD FROM THE MEDALLISTS" 15th Anniversary Reunion Dinner of Meakins-McClaran Medallists:

Dr Jacqueline McClaran

The Meakins McClaran medal is awarded to the final year Oxford medical student who has scored the overall highest marks in all assessments throughout the whole clinical medical training.

To mark the 15th Anniversary of the Meakins-McClaran Medal, Professor Jonathan Meakins and Dr Jacqueline McClaran, hosted a reunion dinner and seminar for all the medallists at Balliol College in September 2022. In seminar, the medallists highlighted the positive aspects of their Oxford education and its impact on career development.

Professor Meakins opened the meeting, noting that prior to 2001, only students who excelled in the clinical viva section of the final examination in medicine and surgery competed in the prize vivas. A rethinking of the student assessment process across all clinical rotations by Director of Clinical Studies (DCS) Dr Tim Lancaster and his team was felt to provide a reliable system to determine the overall best students. It was trusted by the students and was useful in applying for Foundation Programs. With this assessment system in place, the Meakins-McClaran Medal was created and endowed.

The Medallists reflected on aspects of their own Oxford medical education which had helped them in their careers.

Pre-clinical: small group tutorials; essay writing; working from first principles; tutorials as role models; and the near-peer model of learning.

Clinical: thinking from first principles; the firm, and role modelling; interaction and support from the DCS; the small ratio of students to tutors.

Paradoxically, tutorials and essays seemed to prepare students for OSCEs more effectively than problem-based learning alone.

Strong leadership, guidance and caring from the DSC was a great source of comfort and inspiration, enhancing individual student performance at every level. A capacity and desire to know and recognise every single student even after class expansion, was highly motivating and of value to students.

The ability both to teach and to design and develop new curriculum and guidance in clinical and research settings. This competency had surprised their peers and senior physicians.

Reasoning from first principles where the patient and/or the system was unusual and where no appropriate guidelines existed, then innovative action was required. This skill was particularly useful during Covid with several Oxford Medallists emerged as leaders in Covid guidelines and Public Health during this period.

These tried and tested systems of learning in Oxford and elsewhere are under threat because of pressures to teach and train much larger cohorts of medical students and junior doctors leading to shorter rotations, decreased clinical exposure and less time for students to know role models. Large classroom teaching risks depersonalising medical education. The group discussed ways to mitigate these effects including near peer-teaching (improving the teacher-student ratio), the use of simulation, and just in time learning in the clinical setting. Peer teaching facilitates an ongoing learning environment, such that continuing education becomes a lifelong activity.

> ***"..be ready to change, to recognise opportunity, to take the fork in the road, and not discount the alternative pathway.***

Career Choice and Development was constantly discussed throughout the seminar. Professor Meakins shared some strategies he had found helpful:

1. Formulate a plan - Where are you heading? Whose job do you want? How will you get there?

2. Be ready to change, to recognise opportunity, to take the fork in the road, and not to discount the alternative pathway. An Oxford education encourages adaptability, as illustrated by the experience of three medallists whose education was impacted by Covid - the transition to virtual teaching and use of Zoom platforms was quickly adopted by Oxford and the DCS, and was well received by students, despite some limitations underlined in learning physical examination skills!

This was a joyful, reflective, and inspiring evening. The Medallists felt that their Oxford education had equipped them to teach, to create innovative clinical and research pathways, and to step into leadership positions in health care systems and research teams. The group plan to meet annually to welcome each new Medal Winners, and we look forward to hearing from them.

Professor Jonathan Meakins and Dr Jaqueline McClaran with ten of their 'family' of medal winners
Left to right, top row: Jaqueline McClaran; Lily Watson; Lyn Williamson (OMA President); Nisha Hare; Mary-Ellen Lynall; Oliver Skan; Nicholas Black; Catherine Swales (DCS)
Bottom row: Emily Groves; Catherine Taylor; Michael Shea; Tim Littlewood (former DCS); Ned Naylor; Jonathan Meakins

List of Meakins-McClaran Medallists

CHERRY A. ALVIANI	2008	MICHAEL SHEA	2015
EDMUND B. NAYLOR	2009	NICHOLAS BLACK	2016
DANIEL J. STUBBS	2010	HARRIET FELDMAN	2017
JONATHAN P. WORDSWORTH	2010	EMILY S. GROVES	2018
KATHRYN J. MACALLISTER	2011	MATTHEW J. SLINEY	2019
CATHERINE J. TAYLOR	2012	OLIVER W. SKAN	2020
MARY-ELLEN LYNALL	2013	NISHA G. HARE	2021
EMILY L. BROWN	2014	LILY L. WATSON	2022

Radcliffe Orchestra Concert on the 12th November in Memory of Dr Donald Lane (1935-2022)

Professor John Stradling
Emeritus Professor of Respiratory Medicine, University of Oxford

An obituary for Dr Donald Lane appeared in the previous Oxford Medicine. Donald had been a respiratory physician at the Churchill Hospital, but he always wanted to be remembered for having set up the Radcliffe Orchestra in 1978, for health care workers, family and friends to come together and make music.

This was initially a small concert annually, to raise money for the Jill Broadis fund, but it grew and grew to become a full symphony orchestra performing three times a year. Donald ran the orchestra for over 26 years, until 2005, raising money for medically related charities. These concerts inspired a loyal following of both musicians and audiences, largely due to Donald's kindness and enthusiasm. Many musical health care workers in Oxford are grateful that Donald kept their musical interests going during a very busy time in their lives, through the medium of the orchestra and its friendly rehearsals. The 100th concert was in 2016, and the orchestra is still performing three concerts a year, some 44 years later, and carrying on the tradition of raising money for medically related charities.

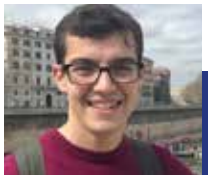
On Saturday the 12th November, the Radcliffe Orchestra dedicated their Autumn concert to Donald. Our soloist for Schumann's piano concerto was Dr Ivan Tang, appropriately a respiratory trainee who has worked in the department Donald ran. Ivan gave a superb and sensitive performance that was enthusiastically received by the audience. The money raised is to fund respiratory nursing education, something Donald championed throughout his career. In addition to the piano concerto, the orchestra played Mendelssohn's Hebrides overture and Beethoven's third symphony (the Eroica), under the baton of one of the orchestra's regular conductors, Andrew Gray. The performance was in St Andrew's Church, Linton Road, and the audience was greatly swelled by many people who came because it was in honour of Donald. He would have been pleased to see the orchestra in fine form and the concert was a fitting tribute to his enthusiasm. The next Radcliffe Orchestra Concert is on Saturday 11 March.

Dr Ivan Tang plays Schumann's Piano Concerto

Dr Donald Lane at his piano

Osler Boat Club News 2022

5th Year OHBC rowers beating rivals Addenbrookes at the inaugural medics boat race



Mr Iwan Raza
(Worcester College 2018)

Since the success of the Boat Club in Summer VIIIs, we have continued to progress from strength to strength. Here is a selection of what we've been up to, in an attempt to restore OHBC to our former glory. But before that, a brief introduction. My name is Iwan (5th year at Worcester College) and I'm the Boat Club's alumni officer. If you have any queries, or would like to be added to our mailing list, please do get in touch via email (iwan.raza@worc.ox.ac.uk).

NEW RECRUITS

With the start of a new academic year come new clinical medical students – and new people to recruit into rowing! We held a recruitment barbeque and taster rowing sessions for the first time this year, with four taster boats full of new novices getting out on the water.

ROW TO LONDON

In 2021 OHBC rowed from Oxford to London in order to raise money for the boat club and for our fantastic Tingewick charities. This year, we wanted to repeat the feat, with 33 medics signed up and ready to row and cox 185km along the Thames to Putney.

Unfortunately, a combination of thunderstorms and the tragic passing of Her Majesty Queen Elizabeth II meant that we didn't feel it was safe or appropriate to embark on our row. Nevertheless, we have raised £1250.00 so far, which will be divided between the Tingewick charities, Helen and Douglas House and Oxford Hospitals Charity, and the boat club.

We are hoping to embark on a similar challenge later in the year to make sure we well and truly earn the money, so keep your eyes peeled for updates on our exploits on the GoFundMe page! **https://gofund.me/f2041a18**

VARSITY MEDICS BOAT RACE

On Saturday 24th of September, we welcomed our fierce rivals from Addenbrooke's Boat Club, Cambridge to the Isis for the inaugural Oxford-Cambridge Medics' Boat Race.

In the first race, our incoming 4th years put in a huge shift but came up just short against the more experienced Cambridge crew. The pressure was on for the 5th years to bring home the glitzy trophy, and due to an unfortunate brush with some trees from Cambridge, succeeded in winning our first race by a mile.

With the competition tied up at 1-1, the 5th years once again rowed for victory and, despite the opponents successfully navigating the Isis this time, Osler House roared home to seal a 2-1 victory. This was a particularly special moment for me, with my first and second victories in a rowing race coming in my 5th year of rowing!
The competition and the following dinner were a huge success, and it was a lovely opportunity to get to know our counterparts form the Other Place. We have already planned a return leg in February 2023.

THE YEAR AHEAD...

Racing – Osler House will be once again trying for blades in Oxford bumps racing this year. In addition, we will be aiming to compete in United Hospitals London events against other medical schools, and to go head-to-head once again with Cambridge in February.

Alumni Events – we hugely appreciate all of the support we receive from our alumni and want to give back to you. We plan to host events for alumni in the new year. Make sure to also watch out for information about our club dinner at the end of Michaelmas term.

We would love to see you all at each of these events - join our mailing list to keep up to date!

OHBC W1 crew taking the Isis by storm in Summer VIIIs

Osler House News

OSLER HOUSE

Gokul Parameswaran
Osler House President 2022-23
Design by Leoni Loughlin, Osler LGBTQ+ rep 2022-23

Pictured (T-B): Medical students at the Osler garden party, LGBTQ+ drinks, freshers' fair, and freshers' formal.

What a start to the year! From fancy dinners to pumpkin carving, this year Osler House has it all. We kickstarted the year at the end of August with a Midsummer Night Dream themed Garden Party, which after 2 years, is finally back in Osler House. This was an amazing night for everyone to enjoy as Osler House overflowed with great music, not so great dancing but most of all, off-the-charts energy! We then celebrated the arrival of the 4th years to clinical school with lots of action packed events from the annual Fresher's Dinner at St. Edmund's Hall, a 'meet your Osler Parents' evening and the BopTogaFest (Festival/Toga themed Bop) to top things off.

Apart from our events, the biggest priority this year has been welfare. As a committee, we wanted to ensure every medic feels supported and welcome in Osler House. To do this our welfare team has organized a diverse set of events appealing to different types of medics, irrespective of background. We arranged a fantastic LGBTQ+ drinks evening at Jolly Farmers (attended by nearly 50 students), a fabulous BAME Bollywood movie night with Indian snacks and pizza as well as regular drop-in welfare events such as Halloween pumpkin carving.

In other news, Osler House is encouraging medic societies and sports clubs like never before. Apart from the ever-enthusiastic rowers, this term we have seen lots of other societies, clubs and charities step-up! They have organised everything from casual sport practices to specialty-focussed career evenings and even schemes helping refugees better navigate the healthcare system in the UK. To celebrate this expanding roster of active clubs and societies we organised the inaugural Osler House Freshers Fair this year which was a smashing success with over 100 attendees. We hope these numerous societies bring students together and help them pursue any area that interests them like never before. Despite all this exciting news, the year has only just begun and Osler House is only getting started!

Recent Work from *AccessGEM*, the Graduate Entry Medicine

Ms Morganne Wilbourne
(Magdalen College, 2020)

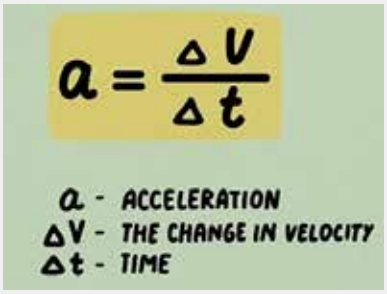
We are a group of current graduate entry medical students working to raise money to create a need-based bursary for future students on our course. Over the summer, we first wrote about our ambitions and why we have embarked on this project. In brief, graduate entry medicine is an expensive course and the loans and bursaries currently available may not be sufficient for students carrying previous student debt or who do not have familial support. Our fundraising goal is £125,000, which will endow a bursary for one Graduate Entry Medical student at a value of £5,000/year. This gift will hopefully help to open the Graduate Entry Medicine course at Oxford to a wider population of academically excellent students who may not have the financial resources to take up medical studies with the current funding system in place.

We now have some exciting updates. Thanks to the generous support of our first donor, we have raised £30,000 so far toward our goal. In addition, we hosted our first fundraising event, a golf tournament, on 12/10/2022. These successes have enabled the Medical Sciences Division Development Office to support us in our efforts to raise the remaining £95,000. In the spring, we will be hosting the official kick-off event for our campaign, a cocktail party at Magdalen College. Tickets will go on sale early in 2023.

If you would like to donate to our cause, please go to **www.development.ox.ac.uk/GEMS22** and scan the QR code above to join our mailing list.

Graduate Entry Medicine Update

David McCartney
(St Edmund Hall, 2003) Director of Graduate Entry Medicine in the Medical Sciences Division, Fellow by Special Election at St Edmund Hall and works clinically as a GP in Oxford.



Regular readers will know that each issue normally contains an update from the Clinical School and the Director of Clinical Studies. However, for this edition, the column has been given over to an update from the Graduate Entry Medicine Course, in the year in which we mark 21 years of Graduate Entry Medicine in Oxford.

Many of you won't be familiar with the course given (in the context of Oxford Medicine!) it's a relatively recent inception, in 2001. For those of you who aren't familiar (but forgive me if you are), the course is an accelerated four-year programme for postgraduate students with a previous science degree. In the first 18 months, there is a rapid whistle stop tour of basic and pre-clinical science combined with an introduction to clinical medicine, before integration with the standard course students, to complete clinical training.

Back in 2001 under the leadership of Dr Paul Dennis, the course welcomed its first cohort of just ten students who were admitted to four (!) select colleges (Green, St Peter's, Somerville and Worcester). We're now over three times the size, and each year admit approximately 36 students across ten different colleges. Despite the increase in size, the course very much retains its small feel and one of the delights of the course is the way graduates of the programme (many of whom are now well into successful careers as Consultants, GPs and Clinician Scientists) keep in touch.

With students coming to the course from diverse educational backgrounds, it's an academically intense programme. For many Graduate Entry Medicine students there are also significant financial challenges, with considerably less financial support available than for those studying undergraduate medicine. Indeed, the financial challenges are so great, Graduate Entry Medicine at Oxford is simply unaffordable for some.

In partnership with current students, we've committed to a programme of activities intended to widen access to Graduate Entry Medicine in Oxford, ensuring that that the very best students are admitted – in the context of which I'm absolutely delighted that this piece sits alongside an AccessGEM update from Morganne Wilbourne (Graduate-Entry Year 2 Student), launching the university supported, student-led fundraising campaign for a Graduate Entry Medicine Bursary. The initial target of £125,000 will be enough to endow a £5,000 Bursary for one Graduate Entry Student per year. This fundraising campaign would not have got off the ground without the tenacity, determination and hard-work of Morganne and her colleagues; a real tribute to the character and fortitude of our Graduate Entry Medicine students. Please do support the campaign if you can, and I hope that my next update about the Graduate Entry Medicine Course won't be in another 21 year's time!

Obituaries

DR ALISTAIR H LAING (1931 - 2022)

Alistair Laing was appointed Consultant in Radiotherapy and Oncology to the United Oxford Hospitals, based at the Churchill, in 1965. He also had a contract for some sessions with the Oxford RHA, because this Regional Specialty provided a service to several district hospitals in the Region, and to Swindon. He retired in 1991.

He was a very skilled and caring physician, and a wonderful teacher, who had a special interest in thyroid disease – benign and malignant – and in the use of radiotherapy with chemotherapy, which at that time was confined to about half a dozen cytotoxic drugs such as cyclophosphamide, vinca alkaloids and doxorubicin and their derivatives, often combined with corticosteroids, but were beginning to have useful effects for some patients. His special interest was in ovarian cancer and lymphoma.

Alistair was keen to use the new radiation modalities that came along during his time, as conventional deep x-ray therapy was replaced by higher energy equipment: Cobalt-60 beam therapy and then linear accelerators. These had the advantage of more accurate radiation dosage, and sparing of skin so saving a patient the severe skin reactions of the earlier equipment. And he, like all of us, valued enormously the huge developments in diagnostic imaging and scanning that we have had in recent decades: the first CT scanner in Oxford was at the Churchill, paid for by an appeal led by Dr Fred Wright and the Oxford Star. It was invaluable to us in Radiotherapy, where it was vital to know the extent of a tumour that it was desired to irradiate accurately.

Veterinary radiotherapy in Cheshire, April 1979: Alistair Laing, Chris Paine, the horse [name illegible] and Murphy the vet

Coffee break, Radiotherapy, 1969 - (L to R): Alistair Laing, Prof Ray Oliver (Physicist), Dr Keith Durrant, Dr Jill Brock, Dr Chris Paine.

Dinner for Alistair Laing, May, 2015 (L to R) - Dr Elaine Sugden, Mrs Ann Lemmon, Dr Chris Alcock, Mrs Kate Laing, Dr David Cole, Dr Alistair Laing, Dr Bernadette Lavery Sir Chris Paine.

Alistair went to medical school in Glasgow and decided early on to make radiotherapy and oncology his career. He took the MRCPEd, then continued in specialist training in Glasgow until he moved to the Royal Marsden Hospital as Senior Registrar. Here he was mainly based at Sutton and worked with well respected teachers and specialists: Dr Julian Bloom, Dr Joan Baker and Sir David Smithers. The Marsden then had all the latest equipment, and the skills he learned there were most useful at Oxford. Here too he developed an interest in lymphomas – the treatment of which (especially in Hodgkin's Disease) began to lead to the real prospect of cure in early cases.

When he arrived in Oxford, Alistair took on our largest outside regional clinic, at Swindon, which produced about a quarter of all our new patients, as well as seeing many Oxford patients. He delivered a wonderful service in both places.

His personality was particularly valuable in a specialty where there is often extreme worry and emotion. He was always helpful and approachable to patients, and to the 70 or so staff we had in our department – radiographers, physicists and biologists, and also to our trainees and his consultant colleagues: his door was always open. From the start of his time with us, we had regular pathology and radiology meetings on current patients which foreshadowed the multi-disciplinary team discussions we have today.

When Alistair and our colleague George Wiernik first arrived at Oxford (on the same day), they and others felt strongly that we needed to establish improved palliative care in the hospitals, as modelled by Dame Cicely Saunders at St Christopher's Hospice in London. Alistair was a prime mover in this, and out of it came our Oxford hospice, Sir Michael Sobell House, based at the Churchill, near our department. He oversaw the early moves to set it up, and very importantly saw that it required specialist staff to run it, and helped to attract Dr Robert Twycross to come to Oxford to do this. During this introductory period he was its acting Medical Director. Under Robert and his successors, Sobell house has been developed to give wonderful service to our patients ever since.

He did his stint of five years in administrative charge of our department, where he settled matters of concern with calm sensitivity, including on one occasion fisticuffs among some staff, and on another the discovery of a hoard of stolen silver hidden among our radium sources. Human Resources would now perhaps deal such situations, but Alistair was trusted by all for his fairness and I doubt whether outsiders would have been as good.

Alistair had severe type 1 diabetes since he was 27. He dealt with this carefully, and never complained despite serious complications as he grew older. Staff got to know when he needed a bit of help.

On one occasion we were asked by a don to treat her horse with a skin malignancy on its cheek. Off we went with some Gold-198 grains and a device to implant them, to a field in Beckley, where the vet, Mr Hastie, anaesthetized the horse and Alistair and I implanted it. There was a scuffle at one point as the horse began to come round, but we sat on its head (despite the radioactivity) and more anaesthetic was given. Its tumour had responded well at follow-up.

Alastair was married to Kate (whom he met when they were both medical students in Glasgow) for 65 years, and had a wonderful family life with his children, grandchildren and, now, three great grandchildren. Kate could read his diabetes like a book, and saved his life on many occasions by her prompt action.. For his last few years, they lived near their daughter Carol in Solihull, where he died peacefully at home as he wished.

We who worked in the Radiotherapy department through his time there were privileged indeed to have him with us. He was a shining example of a really caring doctor, and a delightful and loyal colleague. May he rest in peace.

By Christopher Paine

GODFREY FOWLER OBE, FRCP, FRCGP, FFPH (1931–2022)

Godfrey Fowler was born in 1931, in the rural Worcestershire village of Wolverley, the eldest of six. His parents, Donald, a businessman, and Dorothy (nee Bealey), a homemaker, had both left school at 14. His parents were not well off, but he won a scholarship to Sebright, a local minor public school, where he showed his strength of character by refusing to join the school's Army Cadets on conscientious grounds. The Headmaster was cross, and told him that whenever the Cadets were exercising, he was to work on something demanding in the School Library. He chose Gibbon's Rise and Fall of the Roman Empire.

There was no Oxbridge tradition at Sebright, but the chemistry master urged him to aim high and enter the Oxford Scholarship Exam, despite the Headmaster's discouragement. He was surprised to be awarded an Exhibition by University College Oxford to study medicine, but he must have stood out because he had contrived to demonstrate thorough knowledge of Gibbon in a General Paper essay.

Later as a conscientious objector he had to face an unpleasant military tribunal which did not go in his favour but at appeal the chairman, William Costin, was more sympathetic and supported his decision. In later life Godfrey found that (Sir) William Costin had been appointed as president of St John's and Godfrey became his doctor and was able to remind him of how helpful he had been in the appeal.

When he arrived in Oxford in 1950 he felt out of place because he thought his contemporaries were from "posh schools", which was true, and were cleverer than him, which was not. However he soon entered into the swing of things, which in his case involved joining the Alpine Club and Oxford roof-climbing at night which included scaling the Radcliffe Camera. For many years he was a regular visitor to Snowdonia staying at the famous Pen-y-Gwryd Hotel at the foot of Snowdon, made famous as the home of British Mountaineering and the training base for the successful 1953 assault on Everest.

He graduated in 1954 and was present when his friend Roger Bannister broke the 4-minute mile record on

Godfrey and Sissel

6th May that year at the Iffley track. Later that year Godfrey moved to work at University College Hospital, London (1954-59). Here he specialised in obstetrics, gynaecology and paediatrics, and there was an expectation that he would continue in paediatrics but his interest in general practice was strong, and after leaving London, he joined Dr Alan Richards in his Oxford practice, now located at 19 Beaumont Street, first as an assistant, but he remained associated with the practice, for the rest of his life as Partner, Senior Partner, Honorary Partner and finally as a patient.

One of his patients in his new practice was Sissel Vidnes, a Norweigan, who had come over to act as an au pair to a family in Rawlinson Road. Godfrey was doctor to the family and saw her as a patient for sinusitis and then a few months later Sissel came to the surgery for a smallpox injection. Asking the date of her birthday he was surprised to find it was the same day as his although she was 10 years his junior. She left the surgery and a few minutes later Godfrey drove up in his car and offered her a lift. Apparently Godfrey had told the receptionist he had an emergency and left a waiting room full of patients! They were engaged in May and married in Oslo in September 1962. Subsequently Norway became very much part of Godfrey's life, and together they often used a skiing hut near Oslo which Sissel's parents owned. Two sons Jeremy and Adrian were born to them, although in 1995 they had the desperate sadness of losing Adrian following an accident at Oxford railway station.

Lord Florey, the Provost of The Queens College, was a practice patient, and happened to need treatment when the senior partner was away and so by chance Florey became Godfrey's responsibility. Florey took to him and appointed him College Doctor to Queens in early 1966 – a very controversial appointment, because in the sixties College Doctors were usually elderly Senior Partners in local practices. In an uncharacteristically cynical moment Godfrey said in 2014 that in those days most College Doctors were more interested in having dining rights in the colleges than looking after students. In 1968 when Florey had his myocardial infarct, from which he subsequently died, he was perfectly happy with Godfrey's management but Godfrey persuaded him to ask Sir George Pickering, the Regius Professor of Medicine for a second opinion. Florey reluctantly agreed, but Pickering did not change Godfrey's management. CS Lewis and his wife Joy Davidman were also Godfrey's patients, and Godfrey remembers driving up to the Kilns in Headington in his Morris Minor in the early hours of the morning to drain Joy Davidman's ascites when she was dying from metastatic breast cancer.

Godfrey was also effectively Balliol's College Doctor from the mid-sixties, although the appointment was not made official until Alan Richards retired in 1974. Over the years he became College Doctor to many other Colleges, including St John's and University, his undergraduate college, for which he had life-long affection.
In the 1960's student health provision in Oxford was organised by the Colleges and was patchy and inadequate. Along with what he called a "gang of students," Godfrey campaigned for the creation of a central medical centre and gathered supporting information by visiting several major universities, including Harvard, to study their arrangements. Lord Bullock, the Vice Chancellor, called him in to discuss the proposal, and became a strong ally, but it came to nothing, because it was resisted by the Colleges. It did however stimulate them to do better by improving arrangements for College Nurses.

It was agreed that there was a need for central provision for student mental health, because of concern at the number of student suicides and he played a significant role in establishing the University Student Counselling Service which was set up in 1972. It is now an important central support system with a dozen full time professional counsellors and used by around 3000 students every year.

During this time he continued to work as a traditional GP doing home visits, looking after families, delivering babies and developing close relationships with the patients on his list. Looking back in 2014 he said that he had found this the most satisfying part of his life's work.

By the early seventies he was well-known as a leading GP. Sir Richard Doll, the Regius Professor of Medicine at the time, asked him to help make a case for a University appointment in General Practice, and gave him the daunting task of presenting the case in person to the Clinical Medicine Board. Although one Board member questioned the academic credentials of general practice, the University created a half time post of Clinical Reader, leaving the incumbent the credibility of being in practice for the other half. Initially Godfrey was not going to apply but Doll persuaded him to do so and he was appointed to the post in 1978. There was no automatic College attachment, but Balliol moved swiftly to secure him. His department became what is now the large and successful Nuffield Department of Primary Care Sciences. His first challenges were to devise new general practice teaching and convince Oxfordshire GPs to provide up to 70 placements a year – a target he met successfully.

Godfrey's research at the university focused on preventive medicine and improving primary care, especially in the transfer of chronic disease from hospitals to the community, exploring the effect and cost-effectiveness of such changes. He sought better ways of helping smokers to stop and to help people adopt healthy eating habits. He also investigated the effects of GP-conducted health checks and advice on cardiovascular disease and cancer risk; another study examined "shared care" records in patients newly diagnosed with cancer.

He soon established a small research group which grew, and during the next twenty years he published widely on general practice and preventative medicine including his work on helping smokers to stop with nicotine replacements. He also served on many influential national health committees and in 1989 was awarded the OBE for services to medicine. Godfrey became a professorial fellow at Balliol College and a fellow of the Royal College of General Practitioners in 1978 and a fellow of the Royal College of Physicians in 1996. He became honorary director of the Imperial Cancer Research Fund's GP research group in 1987.

His books for Oxford University Press included two on preventive medicine (1987 and 1993) and Prevention of Cardiovascular Disease (1996); he also edited a series on general practice for OUP.

He retired in 1997 and remained active visiting Norway several times a year and enjoying a monthly walking group which Roger Bannister and he founded in 2004. He also completing the Annapurna Circuit and the Tour de Mont Blanc. He died earlier this year after a short illness.

Not all his patients were straightforward. On one occasion shortly after joining the Oxford practice, one of the stall holders from the St Giles' Fair brought in a pet monkey with a cough asking for penicillin. Uncertain as to what to do he asked the advice of the senior partner, Dr Richards who said "*I would just give him some, he had the same problem last year when I treated him*".

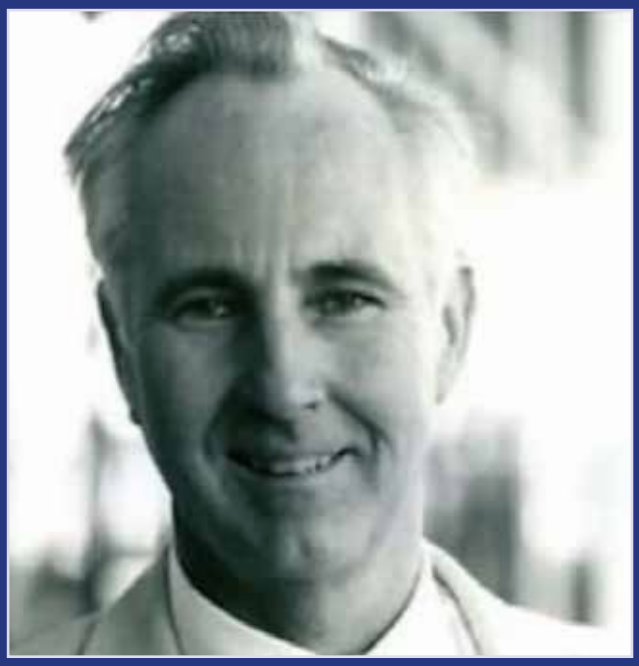
While some of this is from my personal communication with Godfrey before he died, I must thank Professor John Jones who gave me access to the oration he gave at Godfrey's service at Balliol earlier this year, and Sissel Fowler for checking the text.

By Professor David Cranston

PROFESSOR SIR PETER MORRIS FRS (1934-2022)

Peter died peacefully of metastatic colon cancer on Saturday 29th October at home in Witney. He was born in Horsham in the state of Victoria Australia in 1934. His father Stanley Morris was a civil engineer, his mother, Mary (nee Hennessy), was a pharmacist. His father died suddenly at the age of 49 from a heart attack, when Peter was 14.

At Melbourne University Peter switched from engineering to medicine. and was first introduced to immunology by Sir McFarlane Burnett. He excelled at sport, representing Australia in University baseball and cricket. He graduated in 1957, and started his surgical training in Melbourne, then came to the UK to take the FRCS examination. He worked in Southampton and at the Hammersmith Hospital. In 1964 he moved to a surgical resident post at the Massachusetts General Hospital in Boston. Later as a research fellow he continued his surgical training under the direction of the renowned Professor Claude Welch, a superb technical surgeon and always calm and polite in theatre. Peter vowed to emulate him. In 1967 he received a phone call to say that his post in Melbourne had been frozen. On hearing this, David Hume, the Head of Surgery at The Medical College of Virginia, invited him to set up a tissue typing laboratory in what was then the biggest transplant unit in the world. He accepted and set about testing the pre and post-transplant serum samples for lymphocytotoxic antibodies with Paul Terasaki. They discovered that, contrary to popular opinion, antibodies did appear after transplantation and their presence predicted a high risk of hyper-acute rejection.



He returned to Melbourne in 1968 to a transplant surgeon post and to set up and direct the tissue transplantation laboratories, working with Professor Priscilla Kincaid-Smith, a nephrologist and renal pathologist, and a surgeon, Dr Vernon Marshall who had started the transplant unit. Typing and cross matching, organ retrieval and implantation took up to 15 hours. He and Jocelyn now had five children, who remember waiting in a very hot car outside the Royal Melbourne Hospital, for the ward round to finish before a visit to the beach.

He was appointed as First Assistant in the Department of Surgery. From data of transplant outcomes he showed that blood transfusion before transplantation, which could 'sensitise' patients, was paradoxically associated with improved survival of kidney transplants. This conundrum has never been satisfactorily explained. In 1973 he was on the point of accepting the Chair of Surgery in Adelaide when he had a phone call from Sir Richard Doll, Regius Professor of Medicine asking him if he would be interested in the Nuffield Chair of Surgery. He travelled immediately and after discussion with several of Oxfords senior scientists he applied. The electoral board confirmed his appointment but Peter himself only learned of the decision when he received a congratulatory telegram from a London friend who had seen the announcement in The Times.

He arrived in Oxford in 1974 where the Department was in the doldrums following the death in office of his predecessor Phillip Allison. His first day in the office was August 4th when he found an invitation from Sir Hans Krebs, whose lab was nearby, inviting him for coffee. Morris admitted that he had no idea he was still alive and working!

He established the transplantation programme with the backing of Rosemary Rue, who was Chief Medical Officer of the Oxford Regional Health Authority at the time, and Dr Desmond Oliver, a New Zealander and former All Black, who was running one of the biggest home haemodialysis units in Europe at the Churchill Hospital. To that date the UK survival figures for renal transplantation were poor with only a 40% one year graft survival. The first two patients were transplanted on 29th and 30th January 1975 before and after midnight. Both kidney transplants were successful and the patients lived for many years. Despite the early scepticism of many patients, who were aware of the poor outcomes after transplantation, there were soon more than a hundred patients on the waiting list. For the first few years he did most of the transplants himself but gradually he trained up a team of surgeons. He insisted on doing the living donor transplants himself as the consequences of technical failure involved both donor and recipient..

He was also a vascular surgeon and set up an academic department of vascular surgery that provided an excellent service to the Region. Soon after arriving he was called in to see a patient whose infected aortic graft was bleeding into his duodenum. The terrified house physician who had called him in, later became his first Oxford D.Phil student. For a time he was the only surgeon to perform carotid endarterectomies – a risky procedure to prevent strokes.

First Australian OMA meeting Tasmania 2012

He developed an internationally renowned research programme in transplant immunology. He made important contributions in tissue typing and cross matching which led to longer kidney graft survival and more organs being suitable for transplantation. He also started the Oxford Pancreatic Islet Research Programme for the treatment of diabetes.

He retired from the Nuffield Chair in 2001, with a three day festschrift delivered by leading surgeons and scientists from around the globe and ending with a cricket match and banquet at Blenheim Palace.
He was elected President of the Royal College of Surgeons of England serving from 2001 until 2004. He was extremely energetic in this role. He visited five to six hospitals each month, to see how surgical services and training were being delivered. He would meet the CEO's medical directors, consultants, and trainees, separately. He would listen to the clinicians suggested improvements and follow up on the actions taken. Despite his workload he enjoyed life with a fondness for fine wines, food and sport. Sky Sports was put into the Presidential Office so he would occasionally be late for meetings but provided the latest test match score. He was a keen golfer so was overjoyed one day to be playing golf in Australia one hole ahead of Sir Donald Bradman
As Chairman of the RCS Research Board he drove the implementation of the Research Fellowship Scheme, which has led to the appointment of more than 900 research fellows. He established and chaired a working party on Transplantation in the UK which led to the rationalisation and improvements in the way organ transplant services were run. While President he realised that there were 19th century human remains that had been taken from Aboriginal graves in Australasia and some of this material had ended up in the museums of the Royal College of Surgeons. Understanding their spiritual belief that the body should be intact and be returned to their native land, these exhibits were repatriated.

After demitting he established the Centre for Evidence in Transplantation at the Royal College of Surgeons and the London School of Hygiene and Tropical Medicine to evaluate the quality of evidence in the field of organ transplantation. He was responsible for the development of an electronic library of all randomised controlled trials in organ transplantation.

He later served as Chairman of the British Heart Foundation and President of the Medical Protection Society which provides medical indemnity for some 250,000 physicians worldwide.

On one occasion when he was due to fly to New York he was asked to collect a donation for transplantation research at Heathrow from British Airways staff one of whom was a patient. To his delight he was upgraded to Concorde and invited to the flight deck as the plane came in to land during a storm.

He was editor of the Journal 'Transplantation' and author of ~800 papers. 'Kidney Transplantation' is a classic textbook, now in its 7th edition. He was the founding editor of the Oxford Textbook of Surgery.

He was elected a Fellow of the Royal Society in 1994 and a Foundation Fellow of the Academy of Medical Sciences in 1998. In 1997 he was awarded the Lister Prize for his contributions to surgical science and the Medawar Prize in 2006 for his contributions to transplantation. He was knighted for services to medicine in 1996 and he was made a Companion of the Order of Australia for services to medical sciences in 2004.
In 2002 he was a castaway on Desert Island Discs.
https://www.bbc.co.uk/programmes/p009487n

Despite his huge workload he was a loyal family man, and he and Jocelyn opened their home to welcome new arrivals to the NDS with coffee mornings, family suppers and quality Australian wine.

A memorial is planned for 2023.

By Professor David Cranston
and Professor Christopher Winearls

Peter Morris was the foundation on which the success of the OMA Meetings in Australia were based. He attended and "hosted" the first meeting in Cradle Mountain, Tasmania, in 2012, which was a great success because he persuaded so many of his former colleagues from both Australia and Oxford to come for a reunion which turned into a long weekend party.

Ill health prevented him attending the meeting a few years later in Adelaide but he sent an upbeat video message and was always very interested to hear of the adventures that his former colleagues had had since Tasmania.

By Dr Roger Bodley

Peter Morris's 'Recollecting Oxford Medicine' interview will soon be available so you can listen to him tell his own story:
https://podcasts.ox.ac.uk/series/recollecting-oxford-medicine-oral-histories

STUART MUCKLOW (1968 - 2022)

Stuart Mucklow was a Consultant Haematologist at the Royal Berkshire Hospital in Reading from 2005 until his death on 12th October 2022. The eldest of four children of Lynn and Ted Mucklow, who were both paediatricians, Stuart was born in 1968 and grew up on the Isle of Wight.

He was educated at Ryde School, where he quietly excelled at most things, gaining an entrance scholarship to Exeter College, Oxford to study Medicine in 1987. The Island nurtured a deep interest in the natural world that was to last all his life, overlapping with his love of outdoor travel and adventure. He continued a high academic trajectory gaining one of the top Firsts in his year and embarking on an intercalated PhD in Oxford with Siamon Gordon in Paris with Paul Crocker, which culminated in the sequencing of Sialoadhesin (CD169) the first member of the Siglec family of cell surface proteins. Time in the lab was lightened by meeting his future wife Lisa Walker and stretched a little thin at times by University Rowing where he achieved a place in the Blue Boat Trial Eights, narrowly missing out on a place in Isis. He graduated BA DPhil BM BCh in 1997.

With such an important insight into leukocyte physiology under his belt, it was natural to gravitate towards haematology and Stuart moved to the North London Deanery, enjoying the London concert scene with Lisa, a budding Clinical Geneticist and talented musician. They were married in 2006 and have a son, Alastair.

Stuart was rarely angry, except with himself, although he became increasingly frustrated as the modern consultant life of red-tape, form-filling and lack of independence interfered with his ability to ensure the best course for a patient, based on decades of education and experience. He eschewed the higher academic echelons and settled for a beautiful spot to live with Lisa and Al, taking great pride in their achievements; the model of a supportive husband and father. However, something would not be at peace within him and after wrestling for several years with a darkness that few suspected, he ended his own life.

Stuart was a magnet of kindness. Young and old alike were attracted by his quiet reflective manner, his interest in others and appreciation of beauty in the world. At his memorial service, family members, old school buddies, college friends, his rowing crew, and half of Dorchester-on-Thames found that he had touched them all with the same unforgettable gentleness and generosity. For a man who had radiated such humanity of spirit to so many, it is a great sadness that he could not find contentment in his own unique nature.

By Professor Matthew Collin

DR OLIVER ORMEROD (1954 – 2022)

Oliver Ormerod (1972 St Peter's College) devoted his career to the care of patients with heart disease in Oxford. Oliver boarded at Marlborough College as his parents were overseas (his father working as a diplomat in India, New Zealand and then France). His early life was tinged with sadness; his younger sister Robin was born with congenital heart disease and was frequently unwell, at one point needing to be airlifted to hospital while the family were transiting the Panama canal. She tragically died aged 23.

He went up to Oxford in 1972, meeting his future wife Penny only a few weeks into the first term. He completed clinical training in the old Radcliffe Infirmary. After junior doctor posts in Oxford, Gloucester and Stoke-on-Trent, he completed his DM thesis while working as a clinical lecturer in Cambridge. He was appointed as a clinical lecturer in Oxford in 1986, working for Professor Peter Sleight, and was appointed consultant cardiologist in 1992. His career mirrored the development of cardiology as a specialty, spanning imaging (he was an early adopter of transthoracic echocardiography and helped set up the nuclear cardiology service in Oxford), interventional procedures (from PCI and pacing earlier in his career to structural intervention later) and subspecialist patient care (particularly in congenital heart disease and maternity cardiology). I (JO) was privileged to watch him at work, first during work experience age 16, and again when I joined the department as a registrar. He usually wasn't one for unsolicited advice, but when he did offer it was always valuable. His advice when I graduated medical school: "always be a good colleague", was particularly memorable. It was a statement he lived by.

Oliver was a humble man and tried to avoid being the centre of attention. There was a hint of quiet relief when a global pandemic intervened to prevent him having to give a speech at his planned retirement party. Even so, he was happy to laugh at himself, with his Tingewick performance as "Double-O Chicken" being a particular highlight. With family and friends, Oliver would just smile amid the hubbub, offering his pithy one-liners, relaxing in the fraying JR Coronary Care Unit sweatshirt that he habitually wore at home. In early student days, I (GR) was often his sparring partner when he honed his sharp instrument skills at the Cricketers Pub dartboard in St Clements. Over the following decades, he was a great friend, support through untimely bereavements, shared updates of progress on our various allotments, and impromptu lunches in the conservatory leading to his garden haven. When he became unwell and was no longer able to work, he endured a series of operations for prostate cancer and bowel disease with staggering fortitude, only to be felled, ultimately, by pancreatic cancer.

The July 2022 Memorial for Oliver at St Annes was an extraordinary event, a celebration of a remarkable life and career. More than 300 of us sat in the manner of a Quaker meeting and experienced a breathtaking range of emotion and sentiments expressed by those whose lives Oliver had touched: family, friends, neighbours, senior academics, clinicians, patients, students - all admirers. Many young Olivias and Olivers are out there in the environs of Oxford, named by mothers with heart disease who survived their hazardous pregnancies through Oliver's selfless care and innovative attention. Oxford Cardiologists spoke of their gratitude for skills they learned from Oliver. He was a great teacher, even though some techniques came so easily and quickly to him he struggled to slow down enough to demonstrate them. A famous cardiac surgeon spoke of their work together, with visible emotion. Nurses spoke of his respect that defied any consideration of hierarchy. He was simply cut from a different cloth.

We enjoyed a final lunch together at the Old Bookbinders in Jericho in May of this year and this proved to be his last trip from home. In typical fashion, he made it there by bicycle. He loved to cycle: around Oxford and the south of France, up Mont Ventoux. He cycled to the Churchill for radiotherapy and chemotherapy, even after he needed to walk the last few metres up Morrell Avenue. But that was Oliver. He challenged convention, was utterly unique, and was loved and respected by so many. He leaves his lifelong love and soulmate, Penny, three children and eight grandchildren.

By Dr Julian Ormerod and Professor Graeme Rocker

In Memoriam

Professor Dame Valerie Beral
(Director of the Cancer Epidemiology Unit at Nuffield Department of Population Health) Died August 2022

Professor Sir Colin Blakemore FRS
(Emeritus Professor at Department of Physiology Anatomy and Genetics)
Died June 2022

Dr Alan Jeremy Stuart 'Budgie' Burge
(1957, Pembroke College)
Died August 2022

Dr Peter Fan
(1954, St John's College)
Died June 2022

Dr Hugh Neville Hardy
(1946, Trinity College)
Notified in October 2022 of his death

Professor Nicholas Trevenen Jaco
(1938, Merton College)
Died September 2022

Dr Robert Allan Oxlade MRCPsych FRCPC
(1959, St John's College)
Died May 2022

Dr Colin Smith FRCPC
(1951, Trinity College)
Notified in October 2022 of his death

Please contact the OMA team **(oma@medsci.ox.ac.uk)** regarding any obituaries of friends or colleagues you would like to be considered for entry into the next edition of *Oxford Medicine*.

Rita Needs You

Dr Lyn Williamson
Serenity 1978 (St Anne's College, 1974)
OMA President

Tingewickian? Archivist? Gifted at facial recognition? Curious? Read on...

Rita is now over 80 years old and needs a little help gathering together her long and happy history. Her pachydermoid memory remains clear, but some of her scripts, programmes, recordings, and photos are lost.

MISSING PROGRAMMES YEARS:

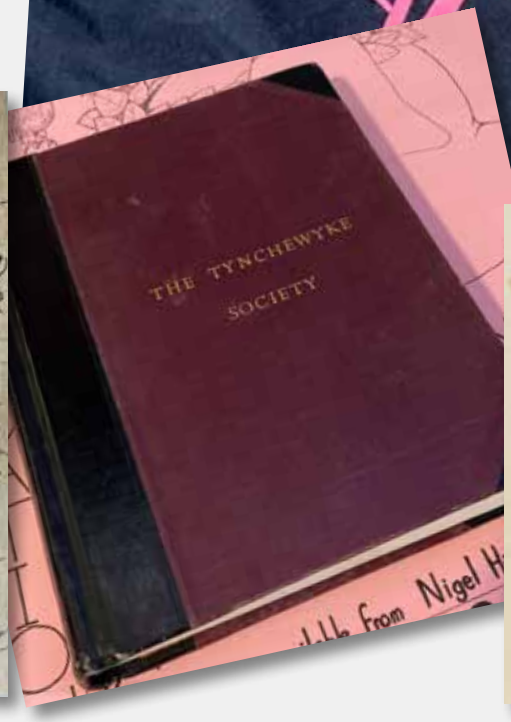
1940s: 1948, 1949.
1950s: 1955, 1956, 1957, 1958, 1959
1960s: 1963, 1964,1965, 1966, 1976, 1969
1970s: 1970, 1971,1972,1975,1977
1980s: 1980,1981, 1983, 1985, 1988, 1989
2019 onwards

If you or you family or friends have programmes from these years, please contact us. We have a few spares for swaps, plus many copies of the compromising 'topless' calendar, appropriately from the mid - 'noughties'.

Serenities, Tyngewickians, Friends, the Sacred Minutes of the Tingewycke Society Books are still well preserved and full of delicious anachronisms and ripe for 'History of Rita' and 'History of Tingewickian Women' reviews.

Can anyone give us background to either of these two intriguing photos?

If you have Tingewick memorabilia you are happy to donate to the archive, or would like to get involved, please contact **OMA@medsci.ox.ac.uk**




Who, when, where, whither?
RITA NEEDS YOU
"HIS MASTER'S VOICE" RECORD
GREATEST ARTISTS FINEST RECORDING

Every autumn as summer migrant birds are leaving the country for warmer climates, huge numbers of winter migrant birds start arriving from the Arctic, Iceland, and Scandinavia. Winter thrushes like this redwing descend on garden berry bushes when it freezes and they can't feed in the fields. We have lived in Tackley for 35 years and last winter was so mild that our cotoneasters were left untouched for the first time, and so far this year they remain heavy with berries.

Redwing, Tackley **© Dr John Reynolds** *(St Catherines College, 1975), Associate Head of Medical Sciences Division (Clinical Affairs) and Consultant Physician and Clinical Pharmacologist, John Radcliffe Hospital, Oxford . (Retiring 31st December 2022)*