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.

BM BCH GRADUATION CEREMONY, SATURDAY 15 JULY

Congratulations to all our newly qualified doctors. We wish you every success in your future careers and welcome you into the alumni fold. Stay in touch (and don’t forget to let us know your non-Oxford email address at: www.alumniweb.ox.ac.uk, or by emailing oma@medsci.ox.ac.uk). We will do our best to help.

CAREERS ADVICE FOR JUNIOR DOCTORS

Some of our young doctors are seeking inspiration and advice on their future careers. A group of over 100 consultants across the range of medical specialties have kindly offered to help. Dr Will Seligman has agreed to facilitate informal relationships around career advice. If you would like career advice or are interested in helping, please contact Dr Will Seligman (seligman@gmail.com).

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GRADUATION REUNIONS 2023


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.

MEETING MINDS OXFORD

22–24 SEPTEMBER 2023

Prof Sir Chris Whitty, Chief Medical Officer, will present the Osler Lecture on Saturday 23 September. To find out more about the range of medical specialities, have kindly offered to help. Dr Will Seligman has agreed to facilitate informal relationships around career advice. If you would like career advice or are interested in helping, please contact Dr Will Seligman (seligman@gmail.com).

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FUTURE CONTRIBUTIONS TO OXFORD MEDICINE

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

YOUR CONTACT DETAILS

Do we have the correct contact details for you? Let us know if you move house, change email address, or get a new phone number. Update your contact details and preferences on our website at: www.alumniweb.ox.ac.uk/oxford-medical-alumni or by emailing oma@medsci.ox.ac.uk.

We are indebted to Christine Fairchild, Director of University Alumni Relations, for helping OMA over many years, and we wish her a happy, healthy and fulfilled retirement.

Editor: Dr Lyn Williamson, OMA President

Editorial Board: Dr Chris Winears; Dr Tim Craske; Dr Neil Snowise; Dr Luke Williamson; Dr Sarah Ball; Mr David Williamson

Designers: Mr Joe Graham

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President’s Piece

Standing ovations are rare at medical meetings, but when SGLT2 inhibitor research was first presented to a delegation of diabetesologists, they jumped to their feet and applauded. Professor Richard Haynes deftly brings us all up to speed with these drugs that have become pillars of therapy for renal, diabetes, and heart failure patients.

The last 60 years has seen HLA/MHC transformed from a curiosity to the conductor of the immune orchestra. Sir Walter Bodmer was there from the beginning and shared with us his memories of the early days of HLA research.

Don’t try to lump or split this edition – it’s varied and unpredictable- reflecting the range of talents and interests of our alumni.

Contributors have chosen to probe difficult subjects – Is Surgery a Failure? Will A.I. take our jobs? Sexism at Osler House? Doctor Stereotypes? Why the junior doctor strikes aren’t going anywhere, yet.

The medical student pages bubble with energy and a hunger to drive the world better place.

I am grateful to them all, and especially grateful to our contributors.

At the time of going to print we received the sad news of the death of Professor John Ledingham, founding member of Oxford Medical Alumni. His influence was woven deep into the fabric of Oxford medicine and Oxford medical school. We will present a full tribute in our next edition.

R.I.P JGGL

President’s Piece

Dr Lyn Williamson

(St Anne’s College, 1974) OMA President

Imagery: Oxford Medical Alumni, OMA President
**SGLT2 Inhibitors: Another Benefit From Apple Trees**

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

Inhibitors of the sodium-glucose co-transporter 2 (SGLT2) protein feature heavily in modern medical school curricula and treatment guidelines, despite only becoming available commercially in the early 2010s. Although many readers will have left medical school in ignorance of this class of medication, all would have been taught about the concept of the kidney’s ‘renal glucose threshold’ (the concentration of glucose in blood above which glucose appears in the urine, and once exceeded, the urine glucose concentration is positively associated with the blood glucose concentration). It was the discovery of the mechanism underlying this phenomenon that led to the development of SGLT2 inhibitors, although their benefits probably far exceed the intentions of their creators.

Familial renal glycosuria is a genetic condition in which the renal glucose threshold is reduced such that glucose appears in the urine despite normal blood glucose concentrations. This condition was recapitulated pharmacologically in the 1930s by infusing glucose, an extract from apple tree bark. However, it wasn’t until the 1990s that the proteins involved were elucidated and their genes cloned. The sodium-glucose co-transporters were identified and localised to the kidney’s proximal convoluted tubule where they are responsible for reabsorbing filtered glucose (which would otherwise be lost in the urine and therefore waste calories). SGLT2 is a high-capacity, low-affinity transporter expressed in the early proximal tubule and is responsible for reabsorbing over 95% of filtered glucose in health. SGLT1 is a low-capacity, high-affinity transport expressed later in the proximal tubule which the remaining glucose is. It is also expressed in the gut where it absorbs dietary glucose. If SGLT2 function is blocked, SGLT1 can compensate, but only incompletely. Consequently, SGLT2 inhibitors were developed in the 1990s as a potential treatment for diabetes.

Dapagliflozin was the first SGLT2 inhibitor to be approved for the treatment of type 2 diabetes. Its effects on glycaemia are modest (reduction HbA1c by 0.5-1.0% on the absolute scale). Following the late discovery of adverse cardiovascular effects of another class of diabetes therapy (the ‘glitazones’), the US Food and Drug Administration mandated that any new diabetes treatment must be assessed for cardiovascular safety. This ruling has led to a plethora of large, randomized controlled trials of treatments for type 2 diabetes. The first of these trials to complete for an SGLT2 inhibitor was the EMPA-REG OUTCOME trial of empagliflozin. This trial was designed as a non-inferiority trial (i.e. to demonstrate that the new treatment was not worse than current best practice with respect to cardiovascular risk). However, the protocol also included a test for superiority (only to be done if the first hurdle of non-inferiority was passed). Many people’s surprise, empagliflozin was shown to not only be non-inferior, but also to be superior. The risk of cardiovascular death in particular was reduced by 38% (95% confidence interval 23 - 51%). In addition, there was evidence that empagliflozin slowed the rate of decline in kidney function. These two results generated a great deal of interest both in the cardiovascular (in particular, heart failure) and nephrology communities. Since the publication of the EMPA-REG OUTCOME trial in 2016, a further 12 large randomized controlled trials testing different SGLT2 inhibitors in three main populations have been published. Two large trials of other SGLT2 inhibitors among patients with type 2 diabetes at high-risk of cardiovascular disease have confirmed the results of EMPA-REG OUTCOME and provide support for guidelines recommending that SGLT2 inhibitors be used early in the management of patients with type 2 diabetes. One of these trials (canagliflozin) raised the hypothesis that SGLT2 inhibitors might increase the risk of lower limb amputation. However, this result is very different from the other trials and may just have been a chance finding and not a true hazard of this class of drugs.

Trials in heart failure populations have demonstrated substantial benefit, with SGLT2 inhibitors reducing the risk of cardiovascular morbidity and mortality in patients with heart failure with reduced ejection fraction (HFrEF) and in patients with heart failure with preserved ejection fraction (HFpEF). SGLT2 inhibitors are now considered first-line therapy for patients with HFrEF along with renin-angiotensin blockade, neprilysin inhibition and beta-blockers. The improvements in outcome in patients with HFpEF were particularly welcome as treatments for patients in this condition had not previously been identified. A key advance of these trials was the inclusion of people who did not have diabetes, who appeared to derive similar benefits as people with diabetes. This sheds some light on the mechanism of these drugs which does not appear to be dependent on the improvements in diabetes control they provide; it also increases the population who can benefit from SGLT2 inhibitors substantially.

The third major population in whom SGLT2 inhibitors have been assessed is patients with chronic kidney disease. The first such trial focussed on patients with diabetic kidney disease (CKD) and showed a substantial reduction in the risk of progression of CKD and hence of the need for dialysis or kidney transplantation. Two other trials have both confirmed this finding and extended it. The DAPA-CKD trial included some participants without diabetes who – as in the heart failure trials – appeared to benefit as much as participants with diabetes. The EMPA- KIDNEY trial (run by Oxford University’s Clinical Trial Service Unit) found similar results but extended the findings to a much broader population of people with CKD. The benefits were again unaffected by diabetes status but did appear to be modified by how much albuminuria (albumin leaking into the urine through damaged kidneys) participants had.

No drug is without side effects. The effect of these drugs on urinary tract infections is very modest (a relative risk of about 1.07 which means that for 15 people being treated with an SGLT2 inhibitor who develop a urinary infection, only one of those infections was caused by the SGLT2 inhibitor). They do cause a clear excess of genital candida infections, but this is easily treated and does not necessarily recur if the SGLT2 inhibitor is continued. The metabolic effects of SGLT2 inhibition do increase the risk of ketoacidosis; this causes a small excess in people with type 2 diabetes (about 1 case for every 1000 patients treated for 1 year), but a larger excess in people with type 1 diabetes. Trials show that SGLT2 inhibitors can improve glucose control in people with type 1 diabetes but the risk of ketoacidosis is considered by many to be too large to make this worthwhile.

SGLT2 inhibitors were thought to increase the risk of acute kidney injury, probably because of the expected dip in kidney function when they are started. This dip reflects a reduction in the pressure within the kidney glomerulus which is probably a good thing and contributes to the subsequent slow rate of decline. However, SGLT2 inhibitors actually reduce the risk of true acute kidney injury, possibly because SGLT2 is a major consumer of energy in the tubule and inhibiting it makes the tubule less susceptible to ischemic injury. This has led to SGLT2 inhibitors now being assessed in acutely unwell patients (including those with COVID-19 or receiving intensive care) where they might provide organ protection.

Overall, the trials of SGLT2 Inhibitors have shown very consistent benefits on important clinical outcomes in a broad range of patients, and demonstrate that we now have another effective treatment for conditions previously considered to have a poor prognosis. They are also being assessed in acute conditions and so may join a select group of medications with proven benefit in both acute and long-term care. It would appear that it is not just the fruit of the apple tree that keeps the doctor away.
Surgery is a failure - from operating theatre, to bench, to job centre?

A provocative title for a practising hand surgeon? Perhaps, but bear with me as I describe for you the philosophical drive that guides my work as a surgeon-scientist in Oxford. I hope that the physicians amongst you will recognise the key value of surgeons in research. I hope the surgeons will rest assured that we still have an important role to play in the future of medicine. And finally, I hope to challenge everyone to think more fundamentally about how medicine might be transformed in the coming decades.

Why is surgery a failure?

I was a clinical medical student in Oxford between 1996 and 1999 and had the pleasure to work with some giants of surgery. I was house officer for both the late Prof. Sir Peter Morris, and Prof. Neil Mortensen, both Presidents of the Royal College of Surgeons. I was also the on-call PRHO for the final shift of Mr Mike Kettlewell – Millennium Ever 1999, complete with champagne in recovery (a cup of tea only for me). No wonder I chose surgery.

However, it was in the Nuffield Orthopaedic Centre where I found my true inspiration, watching the elegant, technically accomplished hand surgery of Henk Giele and Peter Burge (Figure 1), two fantastic surgeons who I have since had the pleasure to call colleagues. Peter used to run a combined Hand Surgery – Rheumatology clinic every Friday, where I was house officer for both the late Prof. Sir Peter Morris, and Prof. Neil Mortensen, both Presidents of the Royal College of Surgeons. I was also the on-call PRHO for the final shift of Mr Mike Kettlewell – Millennium Ever 1999, complete with champagne in recovery (a cup of tea only for me). No wonder I chose surgery.

There are other examples of where surgery, once commonplace, may now be considered a failure of medical care: e.g., vagotomy for peptic ulcer disease, and coronary artery bypass grafting for ischaemic heart disease. The common thread that runs through these conditions is that to develop new revolutionary treatments, we first needed to understand the biology of the condition. Marshall and Warren won the Nobel Prize in 2005 for their discovery of H. Pylori and its role in peptic ulcer disease.

With knowledge of this biology, vagotomy was consigned to the history books. Similarly, Mami and Feldman, amongst many others, defined the critical role of TNF in the biology of RA, and showed that anti-TNF antibodies generated a biochemical and clinical response in patients, paving the way for the multitude of biologics available today. A massive research effort has been expended on understanding the biological basis of atherosclerosis, and therapeutics that prevent the development of atherosclerotic complications is a major focus of medicine today.

Surgeons are critical in understanding the basic biology of disease.

My perspective on understanding the biological basis of disease is rooted in genetics, my very first passion as an undergraduate in Cambridge. Chronic diseases are “complex” diseases, whereby people have a genetic predisposition to a disease, and then several non-genetic factors push them over the threshold into what we would call a disease state. My research focuses on uncovering both the genetic and non-genetic factors that predispose to surgical disease.

Currently, the best way of looking at the genetic basis of these complex diseases is to use a study design called a Genome-Wide Association Study (GWAS). We don’t profess to have any knowledge of what is really behind the biology of a particular disease, we just know that there is a genetic predisposition, from twin or family studies, and so we look across the entire genome for signs of that genetic predisposition.

The markers we use are called Single Nucleotide Polymorphisms (SNPs). In our entire genome we have about three and a half billion base pairs, and out of those we all vary at around 10 million SNP sites — that’s what makes us different from each other. In a GWAS, we take thousands of cases and thousands of controls without a disease, often drawn from large population-based studies such as UK Biobank. We compare their genotypes at around a million of these SNPs spread evenly across the genome. We test to see whether any of those SNPs are more common in cases compared to controls. These SNPs then point the way to genes, molecules, and pathways that are critical in the development of disease.

In hand surgery, the three most common conditions I encounter in the elective clinic are carpal tunnel syndrome, Dupuytren’s disease, and hand osteoarthritis. Each of these diseases is typical of a complex disease, and my group and others have defined the common genetic basis of these diseases. As surgeons, we are key to defining the phenotypes in patients who we treat on a daily basis. For example, in many GWAS, researchers ignore surgical codes, often because they do not have surgeons as part of the research group. This ignores patients who often have a more severe phenotype (that required surgery), and therefore may have a greater genetic predisposition. My group has improved the genetic understanding of both varicose veins and abdominal hernias using our surgical knowledge to refine the definitions of cases.

Surgeons navigating the Valley of Death

The experimental medicine pipeline is illustrated in figure 2. There is a well-recognised “Valley of Death” for new discoveries, with most failing to translate to new treatments. This phase requires the in-depth study of molecules and pathways in the lab. Again, as surgeons we have a critical role here, and can help navigate this Valley of Death effectively. We have unparalleled access to patient tissues through the operations we perform, and these tissues can be used to create realistic in-vitro, ex-vivo, and even animal models of disease. This human-tissue-based experiments are more likely to lead to discoveries that translate into the clinic. The biological efficacy of new treatments can then be rapidly assessed in a small experimental medicine study where patients awaiting surgery are given a drug, and the effects are measured on pre-defined biochemical outcomes in tissue resected as a part of the operation.

I want to illustrate this concept using some of our work on carpal tunnel syndrome (Figure 3). CTS is a very common compression neuropathy of the median nerve at the wrist, and a typical complex disease. Our genetic work has shown that molecules involved in organisation of the extracellular matrix (not neuronal genes) are key to the pathology. We have therefore focussed...
The Story of HLA: from serology to physiology - a personal account of the Oxford contribution

Professor Sir Walter F Bodmer
Department of Oncology, First Oxford Professor of Genetics, former Head of ICRF and Principal of Hertford College, FRS and HLA pioneer.

Prologue

The story starts at Stanford University in the 1960s where I met Rose Payne who, with Jon Van Rood, had found that multiparous women who had not had blood transfusions had antibodies that reacted with the lymphocytes of the father and their offspring, as well as with unrelated subjects. This implied that the mothers had produced antibodies against lymphocyte surface determinants on their children inherited from their fathers. These reactions would be less complex than those from multiply transfused unrelated patients analysed by Jean Dausset[1], Rose Payne and others. They realised that such sera could be used to study a new antigenic system on lymphocytes.

Van Rood realised that sera reacting with the same determinant could be identified by the fact that, in spite of containing many different antibodies, they showed correlated reactions with random donors. His 1962 thesis showed how this could be used to define new antigens on lymphocytes, which he called 4a and 4b, now known as HLA-Bw4 and Bw6. Rose Payne asked me to help analyse the complex patterns of reactions she had found with her multiparous derived sera on a random panel of donors and handed me Van Rooy’s 1962 thesis. My statistical background working with the great statistician and geneticist, RA Fisher, led me to see that the problem could be solved by simple clustering of the serum reactions using 2x2 analysis. It was busy becoming a molecular biologist so I suggested to my wife Julia who was busy child rearing, that with her background in statistics, gained while studying PFE in Oxford, she could help with analysing these serum reactions.

She wrote the programme and did the analyses that discovered what are now called HLA-A*1 and A*2 and defined what is now the HLA-A locus by a series of alleles (1). Julia had learned virtually no biology, never did a PhD, but was eventually awarded an Oxford DSc. She became a renowned and fondly admired figure in the HLA field.


Setting up

Julia and I came to Oxford in 1970, where I had been appointed the first Professor of Genetics after meeting Jim (Sir James) Gowans when he was visiting San Francisco. By 1970, we had an HLA laboratory in Stanford which had contributed to the identification of the multi-allelic HLA-A and B loci. We had done field trips, with Luca Cavalli-Sforza, to Africa to study the distribution of HLA in pygmy and Bantu populations. We realised that such sera could be used to study a new antigenic system on lymphocytes.

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H-2 and specific immune responses made at the same time as Bernaceraff’s discovery of the genetic control of immune responses. Lilly had just discovered the associations between mouse virus induced leukemias and H-2, which led to a flurry of HLA and disease associations towards the late 1960s.

The first HLA association was with Hodgkin’s Disease, as defined by Arnell at the 1967 International HLA workshop. In 1972, I proposed that the basis for such an association may be variation at a closely linked locus in linkage disequilibrium, with the markers gene locus’s (3). This idea underlies the basis for Genome Wide Association Studies (GWAS) and marker imputation, which became a very active research area following the advent of DNA-based genotyping technologies (4,5). Investigation of HLA and disease associations continued with Hugh McDevitt (6) supporting the suggestion that the extensive HLA polymorphism was the result of frequency dependant selection where new HLA alleles were at an advantage for immune-based resistance to new infections, sometimes pandemics (7). This still provides a better explanation for HLA polymorphism than the classical balanced theory of polymorphism based simply on heterozygote advantage.

HLA Class II and international workshops.

The Mixed Lymphocyte Reaction (MLR) occurs when white blood cells from different individuals, cultured together, stimulate each other to divide. This did not occur when the individuals had the same HLA types as then defined, but these new types did not obviously correspond to the then known HLA types. This stimulated the search for sources of antibodies that could identify these new types. Van Rood discovered these first by using a complex assay. Our Oxford lab was amongst the first to detect specific HLA-linked antigens on B lymphocytes using a variety of less complex serological assays, for example, tests on the Burkitt lymphoma B cell line, Daudi, known not to express HLA-A,B,C on its surface because it lacked expression of β2 microglobulin (8,9). How then to resolve the mixture of similar but varying results from many different laboratories?

The answer was HLA International Workshops. These were started by Bernard Amos, an early H-2 and HLA pioneer, in 1964 just at the time we had defined HLA-A*1 and 2. The aim was to enable active working collaborations between different laboratories, initially by each testing a common set of cells with their own panel of antisera to see if the results matched up with each other. These workshops gradually grew in their scope of activities and the widening range of participating laboratories from all over the world. They also, through an associated nomenclature committee, ensured a common language to define the HLA system and its variants as the understanding of the huge system developed. This remarkable international collaboration has continued right up to the present - I have participated in all the workshops, except the first. Julia was very active in these workshops in particular the 5th, organised in 1972 by Jean Dausset with the aim of studying the worldwide distribution of HLA variant frequencies. Our studies on HLA distributions in Israeli Arab and Jewish populations, provided some of the first genetic evidence for a common element in diverse Jewish populations. Julia completed the editing of the final volume of workshop results whilst Jean Dausset went on holiday to recover!

The 7th international HLA workshop in 1977 in Oxford.

Julia and I organised the 7th HLA International Workshop in Oxford with the primary aim of sorting out what were then called the la types on B lymphocytes, following the H-2 nomenclature, and which became the Class II HLA types DR, DQ, and DP by the end of the workshop. This UK team included Richard Batchelor, Hilliard Festenstein, Andrew McMichael (just returned from McDevitt’s lab in Stanford) and Peter Morris who had already established himself in the HLA field.

For the workshop, the world was divided into 20 regions, each with its own regional officer. 150 laboratories participated, studying 360 antisera on a panel of a total of 3,000 lymphocytes from different individuals covering all of the world’s major ethnic groups. For analysis of all the submitted data, we relied on the rather meagre Oxford University computing facilities over weekends, run very effectively by our 19-year-old son! We used 200,000 punched cards and recorded the data on 1,500 microfiches, a huge body of data which would now easily fit on a small memory stick. There were agreed common protocols for the B cell serology, hidden duplicate cells and sera to provide quality control. The results were clear and enabled the definition of what are now called the DR, DQ and DP types, and the HLA Class II genes.

The workshop was a stimulus for coordinated HLA and disease studies. Julia did an interesting study with Allen and Hilary Hill at Stoke Mandeville Hospital, which showed that the strong association of B27 with Ankylosing Spondylitis (AS) was seen in women as well as men. The disease was however less severe in women and so B27 typing helped distinguish AS from other causes of lower back pain (10).

The workshop also promoted our involvement in a long-term study of the HLA association with Type 1 diabetes. This had already been shown to be strongly associated with DR3/DR4 heterozygotes, but our data suggested that this was probably an association with DQ because it was formed from polymorphic α and β chains and so could create distinctive heterozygote combinations while DR could not, because its β was effectively invariant (11). This was later confirmed by Todd, Bell, and McDevitt (1987 12), creating another HLA link with Oxford.

Somatic cell genetics and monoclonal antibodies (MAbs).

Our somatic cell genetics studies in Stanford created cell hybrids between fresh human lymphocytes and a mouse cell line. Weiss and Green had shown that such hybrids tend to lose their human chromosomes and so B cell hybrids could be mapped against human chromosomes by seeing which human chromosome, identified by its banding pattern, was consistently associated with the presence of a particular gene product. This mapped the human B2m gene to chromosome 15 and not to Chromosome 6 where the HLA genes are sited (13).

In the 1970s, Cesar Milstein and Georges Kohler (also Nobel Prize winners) used hybridoma technology to produce monoclonal antibodies which have become essential research and therapeutic agents. In our first work on monoclonal antibodies with Milstein in Cambridge and Alan Williams in Oxford we helped to characterise a MAb made against membrane from human tonsil lymphocytes. We showed it did not react with the HLA CI –ve Daudi cell line, but with virtually all other human tissues apart from red blood cells. The target mapped to chromosome 6 in our human mouse hybrids and was confirmed to be against a non-polymorphic segment common to the HLA-A, B and C gene products (14). This antibody, W6/32, has been extensively used in studies on the HLA Class I gene products.

The production of MAbs against various components of the HLA system, and their use for biochemical and tissue distribution studies, became an important part of our laboratory’s activities. One of our first MAbs against polymorphic HLA type, HLA-A*2, was made by

Peter Parham. Francis Brodyck’s DPhil thesis described MAbs against various HLA determinants including β2m, polymorphic HLA Class I and Class II determinants and a non-polymorphic antibody that reacts against all DR types (15). Some of these are still used.

An early result from the use of the monoclonal antibodies on cell lines was the observation that a colorectal cancer derived cell line, Lovo, like Daudi, did not express HLA Class I determinants on its surface. This led to the suggestion that this lack of HLA Class I expression was due to selection for resistance against T cell immune attack, since T cell recognition of cellular targets depended on the presence of HLA Class I on the cell surface.

Another similar observation was the lack of HLA Class I on syncytial trophoblasts, which could explain how the maternal immune system avoids attacking the earliest stages of differentiation (16).

The chemistry of HLA

Immunochrometry was a forte of the Oxford Biochemistry department, headed by Rodney Porter who received a Nobel Prize in 1972 for work on the structure of immunoglobulins. Knowledge of the structure of HLA determinants was needed to elucidate their function. Porter advised me to talk to Michael Crumpton who had worked with him at St Mary’s Hospital on antibody binding sites and our collaboration continued for many years. Early results were the first amino acid sequences of a part of HLA-A and B proteins (17) and the structure of the HLA Class II proteins (18).

This put Major Histocompatibility type at the centre of immunological function.
Oxford from 1990 - present
Julia and I moved to the Imperial Cancer Research Fund (ICRF) in 1979. Our research on HLA continued there and included the first DNA cloning of an HLA Class II gene, DNA encoding the nonpolymorphic HLA-DQα chain. When, however, the ICRF supported the setting up of a new Medical Oncology unit in Oxford towards the end of the 1980s, Julia and I decided to have a Cancer Immunology laboratory in the new unit. This provided a link between the ICRF HQ London and its new Oxford outpost.

The 1980s were a period in Oxford of major expansion and discovery in work on the H-2 system in the mouse, which was very relevant to future similar work on HLA. This included the pioneering research of Alain Townsend and colleagues showing the genetically determined structures on the cell surface that regulate immunological reactions.

In this personal account I have not done justice to many other details of peptide processing and peptide to HLA binding affinity, Sue Fuggle’s work on transplant immunology (she started her HLA career as a research assistant with Julia), and many HLA and disease studies.

This is an abridged version of the full article with the references available via the OMA office.

Our HLA work in the Oxford laboratory included novel developments of DNA/ PCR-based HLA typing (19) and further studies of loss of HLA expression in cancers, particularly if they are mismatch repair defective, primarily due to mutations causing loss of β2m expression (20). This was further evidence of strong selection to evade T cell immune attack particularly in tumours with a high load of mutations, and is now the basis for successful treatment of mismatch repair defective cancers using immune checkpoint inhibitors.

Epilogue
In this personal account I have not done justice to many other aspects of HLA work in Oxford. These include Peter Morris’ studies related to transplantation. Tim Elliott’s work on the details of peptide processing and peptide to HLA binding affinity, Sue Fuggle’s work on transplant immunology (she started her HLA career as a research assistant with Julia), and many HLA and disease studies.

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1) Tissot shared the 1975 Nobel Prize for Physiology or Medicine with Benacerraf and Snell for their “discoveries concerning genetically determined structures on the cell surface that regulate immunological reactions.”

There is much discussion about the role of AI in clinical medicine. Without doubt the tools provided will allow us to replace many functions currently performed by doctors.

Analysis of images, both radiology and pathology will soon be accessible by this approach and wherever there are large, structured datasets progress will be rapid. Regulatory obstacles will be greater in medicine than in other areas but that should improve with time. Ethical concerns are likely to create further impediments, but these issues are solvable. Simple clinical functions such as routine appointments in primary care are also likely to be enabled or replaced.

What is more difficult is providing the human functions necessary for patient interactions. Often diagnostic or decision-making cues emerge from face to face consultations where human emotions and empathy are crucial elements. Not only are these critical for patients but they provide essential signals to the physician. It is also going to be some time if ever that complicated diagnostic problems can be interpreted correctly by AI. Like many aspects of medicine, getting a learning set that reflects the range of complexity seen in that setting will be hard. Using patient records will certainly not work given how noisy these are and the use of AI assumes there is an answer, when often there is not as we have a long way to go to understand disease itself.

Surgery provides another opportunity for AI but again the learning set needs to be large and regulatory hurdles will slow progress. Human input at some level will be needed for a while yet. Overall AI will help reduce the burden on doctors and health systems but it is hard to see how doctors will be replaced any time soon.

Will A.I. Replace Doctors?

With AI here to stay, we asked Regius Professor Sir John Bell and ChatGPT (in the style of Regius Professor Sir William Osler) whether they thought we would all be out of a job within the next 20 years. ChatGPT only narrowly beat Professor Bell in speed of response. Unlike Professor Bell, ChatGPT went over the word count, repeated concepts, and needed editing. This piece is a conflation of 3 ChatGPT attempts. It will be interesting to follow whether the publication of this article influences future AI. contributions. LDW

The winds of change are blowing fiercely through the hallowed halls of medicine, and the topic that lingers in the minds of many is the potential replacement of medical doctors by the ever-advancing artificial intelligence (AI). While the advances in artificial intelligence are undeniably impressive, it is with caution that we consider its potential to replace medical doctors. Medicine, my dear friends, is a tapestry woven with both scientific precision and the art of human interaction. It is an amalgamation of analytical reasoning and empathetic understanding, a delicate balance that forms the foundation of our calling.

The practice of medicine transcends mere data analysis and algorithmic decision-making. It requires the cultivation of a profound connection between physician and patient, rooted in trust, compassion, and a deep appreciation for the human experience. Furthermore, medicine demands the exercise of clinical judgment, the interpretation of subtle nuances, and the ability to navigate the intricate webs of disease and patient context. While AI may possess immense computational power, it cannot replicate the discerning wisdom that comes from years of study, practice, and exposure to the intricate complexities of the human condition.

In conclusion, my dear colleagues, it is unlikely that AI will replace medical doctors within the next 20 years. Our calling is built upon a foundation of human connection, empathy, and the wisdom acquired through years of experience. Let us embrace technology as a tool to enhance our practice, but never forget that the true essence of medicine lies in the timeless qualities that reside within our human souls.

There is much discussion about the role of AI in clinical medicine. Without doubt the tools provided will allow us to replace many functions currently performed by doctors.

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Monkeypox - the Twilight of Smallpox

Dr Philip Mortimer (New College 1960-63) Modern History, qualified St Thomas’ 1969. Former director PHLS Virus Reference Laboratory, Colindale.

Abstract

During 2022 monkeypox (mpox) was imported into the economically privileged world. It has since spread rapidly among sexually active gay men. A comparison with outbreaks of smallpox before and during its global eradication phase is instructive in devising an effective public health response to this unusual new epidemic, one which has the potential to become pandemic. If it is to be prevented from doing so, it will be mainly due to the availability and use of Jenner’s famous vaccine in its modern attenuated form.

Introduction

In Europe and beyond, smallpox was a frequently mortal disease during much of the last millennium, and wherever European invaders took it, for instance to the Americas, it acted as a devastating new disease. Thus, during the sixteenth and seventeenth centuries, smallpox seems almost to have wiped out some indigenous populations. It was not as infectious as measles, but it was more deadly and once introduced, it remained epidemic at intervals of several or more years. Worldwide, both children and adults were vulnerable to it until the Turkish practice of engraftment and then Jenner’s vaccine became available to protect them. Thanks to Jenner, smallpox was, from the start of the twentieth century, no longer very prevalent in the First World. In the UK the last smallpox outbreaks of any size occurred during the 1870s and in 1902, and subsequent outbreaks were small and due to single importations. These were quickly contained with the exception of an outbreak in South Wales in 1962 that lead to nineteen deaths. In response to it (and in hindsight perhaps unjustifiably) an estimated 900,000 people nationwide were quarantined, and further spread interrupted by ring vaccination under the skin, using a hand-held needle with bifurcated tines. Wherever outbreaks of smallpox were known or suspected, local political support was engaged, cases were isolated and quarantined, and further spread interrupted by ring vaccination around cases, however they became known. In Nigeria, for instance, Feige learnt of suspected smallpox from Lutheran village missionaries. Feiner et al’s excellent account of the entire process has since been conveniently summarised by the Drs Glyn.1 The number of smallpox outbreaks gradually declined and the last known community-acquired case occurred in Somalia in 1977. WHO declared the world free from smallpox in 1980, but it then spent several years searching for missed cases. The suspected few were found out to be due to the closely related orthopox virus, monkeypox.

The WHO eradication programme

This programme was based on Jenner’s vaccine, mostly distributed in a freeze-dried form and usually given into and not under the skin, using a hand-held needle with bifurcated tines. Wherever outbreaks of smallpox were known or suspected, local political support was engaged, cases were isolated and quarantined, and further spread interrupted by ring vaccination around cases, however they became known. In Nigeria, for instance, Feige learnt of suspected smallpox from Lutheran village missionaries. Feiner et al’s excellent account of the entire process has since been conveniently summarised by the Drs Glyn.1 The number of smallpox outbreaks gradually declined and the last known community-acquired case occurred in Somalia in 1977. WHO declared the world free from smallpox in 1980, but it then spent several years searching for missed cases. The suspected few were found out to be due to the closely related orthopox virus, monkeypox.

But people continued to ask whether smallpox had really been eradicated…

The world population under 40 is unvaccinated against smallpox.

The mpox epidemic highlights the need to develop vaccine technologies to meet future unexpected epidemic threats.

Monkeypox takes centre stage.

During the search for residual smallpox cases that followed the WHO eradication programme attention was drawn to several other orthopox viruses variously referred to as monkeypox, cowpox and camelpox. Single cases and small outbreaks of human monkeypox have long been recognised in Central and West Africa, but few secondary cases have followed. It is doubtful whether any monkey species is the natural host of the virus. Recognising that the attribution is uncertain and potentially stigmatising, WHO now calls monkeypox mpox. Until 2021 the public health importance of mpox was confined to sub-Saharan Africa, but since May 2022 it has fast become an international pathogen. By August 2022 WHO was describing it as a global emergency, and by the end of the year 80,000 laboratory-confirmed human cases were being spoken of from a hundred countries. By March 2023 the Centers for Disease Control and Prevention, Atlanta, had received over 80,000 reports of mpox from within the USA, at least a third of them with known coincidental HIV infection.

Until recently almost all these mpox cases have been in men who have sex with men (MSMs). But the infection has been spreading to other groups and is presenting in various clinical forms.3-5 This poses questions about the means of transmission of the current wave of cases. How much further might mpox spread before control can be established, and how long will that take? How wide is the range of clinical expression of the mpox virus in humans, and how accurate will clinical diagnoses alone be?

Smallpox used to spread through close aerial transmission and the virus was also shed from lesions on the skin. Mpox may be spreading by both these routes, but it is also by sexual contact. Though in the West this has been almost entirely in MSMs, in May 2023 there came a report from Kenya of a heterosexual transmitted outbreak of mpox with numbers of secondary cases.2 There is often fever and lymphadenopathy, and the orogenital lesions can be painful. Deaths have been very infrequent, however, and following African vaccination they are rare. There is a significant report of sexual spread of mpox in another risk group, and with the same clinical pattern, and mpox is also being seen in some sex workers and other female contacts in other countries. There have been a few cases in newborns and children, and unless care is taken mpox may spread further, by injection, tattooing and even blood transfusion.1

Accessing laboratory diagnosis and treatment

The years since the eradication of smallpox have seen a revolution in the laboratory diagnosis of mpox as of other viruses, and the polymerase chain reaction (PCR) for mpox infection is now widely available to sexually transmitted diseases clinics. The modern attenuated form of Jenner’s vaccine prevents mpox as it once did smallpox, and widespread vaccination of MSMs may have forestalled a lasting pandemic. Even after exposure, immediate vaccination may mitigate illness, and antiviral treatments like tecovirimat and cidofovir are also being trialled.4-6

In the high-income countries where mpox has now become prevalent, the disease is well recognised, and the stigma once associated with diseases predominately seen in MSMs is hopefully being avoided. Those at risk are being offered vaccination, ideally twice within one to two months. Elsewhere though, the attenuated smallpox vaccine is less readily available, and where homosexuality is unlawful and/or unacceptable, public health interventions against the spread of mpox may be impaired or absent.

Conclusion

In mid-2023 the pandemic risk from mpox may be receding, but it is still prevalent. Unlike the ongoing pandemics of HIV and Covid19, both of which have also been ascribed to genetic adaptation from zoonotic origins, mpox is a double-stranded DNA virus and until now shows the adaptability and propensity of these RNA viruses. Nonetheless, clinical awareness of mpox needs to improve especially if the clinical range of those at risk widens. Public health decisions yet to be taken this year may be crucial. Other than sexually, mpox is not very infectious, but unless vaccine is widely deployed among the man risk group, including in countries where MSMs form a hidden minority, mpox will persist beyond its African origins.

It is set to remain as a sexually transmitted disease, and emphasises the need to develop vaccine technologies over a broad range to meet unexpected epidemic threats.

References from OMA
William Morris, Lord Nuffield
Benefactor of Oxford Medical School

It started with an appendix. Not Nuffield Maths O level, nor a Saturday cleaning job at my local Nuffield hospital, nor an attachment to the Nuffield Department of Medicine for my first medical student firm, but it was when there was an exhibition at Oxford about Lord Nuffield that he really entered my consciousness, and only because his preserved appendix was on display.

Eight years ago I visited Nuffield Place, his home from 1933 until his death in 1963, now a National Trust property, off the road to Henley on Thames. There was the appendix (Fig 1) amongst a miscellany of tools in his bedroom cupboard (he liked to mend clocks at night). His bedroom carpet was made of scraps sewn from the left-overs from the cars Nuffield Motors manufactured. The house is extraordinary; it feels much as it must have been like when he died. His books are still on their shelves; there is a mechanical horse in the billiards room (for riding practice); and an iron lung (Fig 2). He would make one at no charge in the car factory in Cowley for any hospital in the Commonwealth that wanted one and made 1700 in all. There was a portable anaesthetic machine, the Oxford Vaporisor (Fig 3) that he had been party to the development of, and was still being used by the British Forces during the Falklands War. Having visited the house, I wanted to read a biography about him but Oxford City Library did not have one, and the one I tracked down at the Union Library has not been read by anyone else since the first time I borrowed it.

Five years ago, David Cranston and Peter Morris produced a beautifully illustrated, concise biography ‘Lord Nuffield and His Double Legacy’ which has hopefully made his life more accessible to a wider readership.

So, why should we be interested in William Morris, Lord Nuffield? The answer is because he did so much for the foundation of Oxford’s clinical medical school, and for the Oxford hospital services.

Born in 1877 in Worcester, he moved to Oxford at the age of 4 when his father became bailiff on the farm in Headington Quarry, rented by William’s maternal grandparents at Magdalen College. William was educated at the Church School, Cowley, leaving at 15 to work in a bicycle repair shop, being himself a keen cyclist. He earned five shillings a week, and by exhorting and encouraging himself, he built the biggest bicycle workshop in the city of Oxford, winning prizes for his designs, and later buying the finished bikes in his front window. An early customer was the 6 ft 3-inch-tall Rev Francis Pilcher of St Clements, who requested that William make him a large framed bicycle. William apparently had to borrow the £4 required to buy the parts from a neighbour. He serviced the bicycle for many years, and later bought it at a jumble sale and kept it next to his office in Cowley. He bought most of his parts in Birmingham, and on occasions would cycle the 120 miles there and back to collect them and then might then work through the night to effect a prompt repair. At 17 he took up competitive cycling, making the lightweight bicycles to ride on. He was repeatedly champion of races, but not the year that he had all his teeth out, an experience unpleasant enough to make him champion the field of anaesthetics later in life. In 1896 he rented a bicycle shop at 48 High Street and then workshops in what is now called Longwall St (where there is a window display). In 1904 he went into partnership with a student from Christ Church who was supposed to be a sleeping partner, but he squandered money entertaining potential customers and the business failed, leaving William Morris with his £50 share of the debt. His newly wedded wife sold all her jewellery, apart from her wedding ring, to help him and it was said that he had to stand in the rain to buy back his tools, some of which he had made himself. Having had the proceeds of his previous 13 years’ work wiped out he made two resolutions: to put all his money into production, not promotion; and never again to work in partnership with anyone else. William Morris had a good reputation, and so was able to borrow money from suppliers, which, in addition to a small bank loan, enabled him to rebuild his business.

In 1906 William first set up a car hire service. He made his first car in 1912, “The Bullnose Morris”. By 1914 he had made 1,000 cars, having bought a disused military training college in Cowley as his production facility. During World War 1 the factory changed production to mine sinks, manufacturing over 50,000, for which he was awarded an O.B.E. By 1923 he was selling 20,000 cars a year and had factories in Oxford, Abingdon, Birmingham and Swindon. In 1927 he sold 60,000 cars and by 1935 he was selling 100,000 a year, a third of all Britain’s car production. In 1928, that the year his appendix was removed, Henry Ford visited the Cowley Plant and in 1939 Morris’ millionth car was made (it was auctioned by the Guy’s Hospital Ladies fund at their garden fête in aid of their Appeal Fund). William was a keen golfer (as was his wife) and he bought Huntercombe golf course, near to the village of Nuffield, when it fell on hard times. At first he and his wife lived in the club house, but later they bought a house nearby (now Nuffield Place). When he was raised to the peerage in 1934 he took the title Lord Nuffield. William Morris played golf with many doctors, especially from Guy’s Hospital and he was a great benefactor of Guy’s Hospital where a statue of him stands, and also to St Thomas’s. When he attended the coronation of George VI he stayed with Sir Herbert Eason, the Superintendent of Guy’s.

Durin his lifetime William Morris gave away £30 million to charity (equivalent to £1.4 billion in 2018). In 1926 he gave £10,000 to help parents of boys in Borstal visit their sons (ironically, a prisoner of war camp next to his house in Huntercombe was later converted to a Borstal and is now a prison). That year he also gave £100,000 to Oxford University to establish the King Alphonsus XIII Chair of Spanish Studies as he felt that Britain had limited facilities for learning Spanish. In 1927 he gave substantial dolllar equipment. His endowments were legion, but Oxford University was greatly blessed to have received such generosity from a man who was local, modest, and incredibly hard working.

During his lifetime William Morris gave away £30 million to charity (equivalent to £1.4 billion in 2018)
It takes 10 years to get a new fact into the literature and the rest of time to get it out.

Dr Judith M. Taylor (nee Mundlak) (Somererville College, 1952) After graduation she emigrated to the United States and did postgraduate training in New York, as a board certified neurologist. She has always been interested in the history of medicine and wrote a series of short pieces for various journals. In 1994 she and her husband, Irvin Taylor, moved to California. There she began writing the first of her seven books on the history of horticulture. She has two sons and six grandchildren www.horthistoria.com

The Radcliffe Infirmary, that beautiful Georgian building established in 1770, was by the mid-twentieth century quite the modern institution. Following de-commissioning, the building became Oxford University’s English Department where I had spent many instructive months as a medical student.

In World War II the hospital had served the military as did Somerville, my alma mater and indeed Vera Brittain was one of the college’s alumnae. In World War II the hospital was again pressed into service but by 1942 the Churchill Hospital had been built in Headington and certain specialties were moved there, adjacent to the Nuffield Orthopaedic Centre (renamed from the Wingfield-Morris Hospital in 1950). Joseph Trueta created an outstanding department of orthopaedics. Trueta, a Catalan, had assisted the Republicans in the Spanish Civil War and derived immensely valuable surgical insight from treating bomb-victims including the value of emergency blood transfusions. Dame Janet Vaughan, the haematologist, principal of Somerville from 1949, had learned from him and had established the nascent UK National Blood Service in 1939.

In World War I the hospital had served the military as did the college’s alumnae. In World War II the hospital was again pressed into service but by 1942 the Churchill Hospital had been built in Headington and certain specialties were moved there, adjacent to the Nuffield Orthopaedic Centre (renamed from the Wingfield-Morris Hospital in 1950). Joseph Trueta created an outstanding department of orthopaedics. Trueta, a Catalan, had assisted the Republicans in the Spanish Civil War and derived immensely valuable surgical insight from treating bomb-victims including the value of emergency blood transfusions. Dame Janet Vaughan, the haematologist, principal of Somerville from 1949, had learned from him and had established the nascent UK National Blood Service in 1939.

The six months of patient contact we had on each major service, gave us much more confidence than students gained elsewhere, especially the Continent; useful when starting house jobs. One of the rites of passage was having to swallow a G tube. There was a mad dash to pair off with the best students for this, but the lesson was to understand the awfulness of medical procedures. And students were drafted as subjects of an experiment on polio vaccines. Gustav Bohr, the son of the great medical procedures. And students were drafted as subjects of an experiment on polio vaccines. Gustav Bohr, the son of the great physicist Niels Bohr, was one of the researchers - the first time I had ever had blood drawn.

The community midwife having received the patient’s call would ring the medical school summoning the student on call who would set off by bicycle, possibly a few miles up and down the hills around Oxford. Home deliveries involved newspapers protectively spread across the carpet, sometimes piled up so you could barely get through the front door. Once the midwife sighed “I am so glad you are a girl. Novel! Can go and have a rest.” Possibly the first and only time in my life when being a woman in medicine was an advantage.

A dreadful case of a PPH causing a maternal death at home led the bluff New Zealander John Stallworthy to establish the “flying squad”, an elite team in a specially equipped car with everything they might need. The midwives were given strict criteria to make sure they called for help early enough while there was still time to save the patient. This squad performed admirably. Stallworthy succeeded Mor, and was in due course knighted. Mr Embrey, who later invented the tocograph, was another powerful department figure – but all we knew was that he did internal examinations without gloves, startlingly.

Maybe naively, I did not perceive discrimination. We did everything the men did. What I did not know then was that all the really important stuff took place in the male enclave of the pub – nice girls did not go to pubs.

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Abridged by TC – Full version on request from OMA.

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Oxford University Medicine School in the 1950s: Was it all larger-than-life consultants and scary nurses?
Fairy Bleep - Sexism at Osler House

Dr Jennifer Barraclough formerly Jenne Collins (Somerville College 1967), Consultant in Psychological Medicine Churchill Hospital 1991-2000

In response to an appeal for Tyngewycke memorabilia (Oxford Medicine Winter 2022) sent in the programme from 1969, when I played the part of “Fairy Bleep.” It was the first year that female medical students – Hilary Pickles, Hennie Brown, and me - had appeared on stage. It was all good fun at the time, but some of the material would seem crudely sexist today. The pantomime was called Prowlapse, contained lines like “No nurse mends being stared at, it gives her confidence”, and a proposal for buying “pink elephant” bras and pants for female players was made at the next AGM. The magazine editors remarked on the comment and invited me to write an article about my experiences at Osler House with special reference to this topic.

Sexism is defined in the Oxford Dictionary of Philosophy as “the inability or refusal to recognize the rights, needs, dignity, or value of people of one sex or gender”, and is usually assumed to be directed at women. In the second part of this article I will review the subject in relation to different women and medical students, giving examples from personal experience. First, some general recollections about my career.

Student days and after

In my time the medical students’ club, Osler House, was located in an 18th century building next to the old Radcliffe Infirmary on the Woodstock Road. I was one of only three women in my intake of 20-odd clinical students in autumn 1967. Medical and surgical wards were at the Radcliffe, some specialist services based at the Churchill. With only a few of us attached to each firm we had ample opportunity for clerking patients and doing practical procedures: venesection, drips, ECGs, lumbar punctures, catheters, assisting in theatre. Nights on take were busy and sometimes fraught, but the atmosphere was mostly friendly and relaxed, with far less regulation than I imagine there is today. The consultants got to know us individually, and often gave us lifts between hospitals. A highlight of our surgery attachment was visiting the cottage hospital at Moreton-in-Marsh with Mr Ted Maloney. We saw a few patients there and had a splendid afternoon tea.

Our perceptions of the different specialties, and even future career choices, were strongly influenced by the quality of teaching in the relevant departments and whether medical students were made welcome there.

Experience on most attachments was positive. For instance, despite having fewer serious interest in bones, I enjoyed the course at the Nuffield Orthopaedic Centre thanks to the enthusiasm of Professor Robert Duthie and Mr Campbell Simple. One day, in recognition of Lord Nuffield’s endowment of the service, we visited the Morris car factory. Also excellent was the week I spent in rural general practice, staying in the home of Drs Frank and Jean Hame at Blockley. In contrast, the course at the Littlemore Hospital was poor, leading me to put aside my intention to specialise in psychiatry until several years later.

I don’t recall any formal teaching about sexual discrimination and other gender-related issues, nor other “soft” subjects like doctor-patient communication, medical ethics, the psychosocial correlates of health and disease, complementary medicine, or stress management for ourselves. I did write down a comment from Dr Hookaday: “an emotional crisis can make the hypochondrius go all twirly”, and many years later I experienced this myself.

My years at Osler House were happy ones. Social life involved parties, receptions and dinners at various colleges, friends’ houses, and The Lamb and Flag near Longworth (Dirty Dudley’s), large quantities of food, and an alcohol intake far in excess of current guidelines. I sang in the hospital choir. Richard Redman and David Lawrence had built a punt while at Cambridge, and over Easter 1968 I joined the crew bringing it to Oxford along 160 miles of waterway with many locks, camping on the canal banks overnight.

After qualification I had a series of jobs in radiotherapy, general practice, clinical and academic psychiatry. These diverse experiences all proved relevant when I found my niche as consultant in psychological medicine at the Churchill. I worked mainly in Sobell House and the oncology unit and set up a psycho-oncology service. Since returning to Auckland with my New Zealand husband, interests have included exploring natural therapies, editing medical books and a wartime memoir, writing novels (self-published), animal welfare, choral singing and piano. I visit Oxford sometimes and it still feels like home, even though it was a shock to find the Radcliffe Infirmary demolished; a symbol of how much has changed since my student days. One big change has been the increased proportion of women in the medical profession.

Sexism: then and now

About half the doctors in the UK are now female. This has probably encouraged a kinder “macho” culture with better work-life balance but sexism is still apparently rife, even if less overt than it used to be. In a large recent survey of women doctors over 91% of the 82% who responded felt that because of their sex they had been discouraged from certain specialties, had their clinical ability undervalued, received unwanted comments or physical contact. I wonder whether the non-responders had perceived an equally high frequency of abuse. This year, the BMA has launched a 10-point plan to “stamp out sexism” towards female healthcare staff.

Sexism can also lead to the differential care of male and female patients, but that is a separate topic not covered here.

Sexism can be divided into “benevolent” and “hostile” types. Benevolent sexism involves the well-meant but sometimes patronising assumption that because women are more empathic but less robust than men they are better suited for some specialties (such as general practice, paediatrics or psychiatry) than for others (such as cardiac surgery, orthopaedics or intensive care), need to be protected from the more arduous aspects of medicine, and will inevitably want to marry and have children. Even in these days of gender fluidity these assumptions may still be valid in many cases, but unthinking application of stereotypes can limit women’s self-confidence and career opportunities. It could also give them unfair advantages if male consultants charmed by pretty young women, or female ones keen to support their own sex, favour women candidates over more able men.

As an example of hostile sexism, I remember a case presentation when a female student was reduced to tears by aggressive questioning from a visiting male surgeon. Nobody challenged him. I never experienced hostility from men myself, but there were a few older nursing sisters who openly objected to female medical students. I was humiliated when one such nurse, who didn’t look like the back of a bus” were embarrassing. I was sexually harassed when the houseman on my medical firm took a fancy to me. What began with comments on my dress or hairstyle progressed to inappropriate suggestions and physical touching in the ward office, and twice he followed me home at night. I rejected his advances and he eventually gave up. On two occasions later in my career – not in Oxford - I was groped in taxis by male consultants. These incidents were unpleasant, though I don’t believe they caused me any lasting psychological trauma. It never occurred to me to report them to anyone in authority. The results of the BMA survey suggest that, despite the modern influence of the #MeToo movement and widespread opportunities for lodging complaints and requesting support, such harassment still goes on and women are still hesitant to report it. They may not know how to say “no” to senior males, fear not being believed, or be wary of prejudicing their career prospects.

Is there a risk that the current awareness and sensitivity regarding sexism could lead to it being over-diagnosed?

Men and women do tend to have contrasting qualities, whether due to inborn characteristics or social conditioning, which may indeed make them fitted for different specialties. Light flirtation and banter between the sexes, like the moderate use of black humour, can ease the tensions of medical practice. While damaging variants of sexism are clearly unacceptable, it would be sad if every remark with a vaguely sexual flavour was labelled as abuse, and if efforts to prevent discrimination against women worked to the detriment of men.

I write these comments from an outsider’s perspective, having left Oxford Medicine some years ago to live on the other side of the world.

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I started to see the benefits of more disruptive ideas, pushing myself out of my comfort zone, but also enabling others who felt they needed permission to act.

Hearing you dare to act.

I came across NHS Change Day (now NHS England) and the idea of a Littotomy Challenge. Obstetricians and midwives try out lithotomy to understand what it feels like for the women. I did it for an hour feeling vulnerable and exposed despite wearing clothes with people gaping and talking across me. Maternity staff elsewhere followed suit. I wrote a blog about my experience and got the bug for writing. When we won funding for a national maternity experience project titled ‘Nobody’s Patient’, focusing on women falling between gaps in services, I found my creative side writing the required monthly project reports as Stella’s stories, newsletters, and videos.

Inspired by the ice bucket challenge, I hit upon the idea of a Littotomy Challenge. Obstetricians and midwives try out lithotomy to understand what it feels like for the women. I did it for an hour feeling vulnerable and exposed despite wearing clothes with people gawping and feeling vulnerable and exposed despite wearing clothes with people gawping. The strap line for the Maternity Transformation Programme is ‘Safe and personalised care with an emphasis on choice’. Co-production and genuine involvement of people using services from the beginning, co-designing and creating is the direction of travel of the NHS but the reality is this can be messy and uncomfortable for those in power. What people think is a priority can be totally different to what staff see as the problem. We need to be open-minded and flexible when things do not align. This can be difficult in the constraints of a tight budget and limited staffing or when we are required to account for a particular project to hospital management.

In maternity, we are fortunate as we have Maternity Voice Partnerships (MVP) who bring women, families, and staff together at local level to work through improvements together. These are formally part of the wave of maternity scandals, however tensions remain. Can we be brave enough as NHS leaders to let go? We co-produced a #MatExp musical on the Expo NHS main stage, with over 30 people from maternity services up and down the country coming together singing about the progress being made. We thought it would be celebrated, a true demonstration of co-production, but our initiative was frowned upon by the powers that be. My personal creative journey is ever evolving. In 2019 I heard a talk about podcasting providing health information in a more accessible way. I was inspired. Researching, I found midwifery podcasts but not an obstetric one, so I started a podcast: TheObsPod. I take clinical topics and my experiences and try and make sense of them for staff, students, and families. I signpost to relevant guidance. I am trying to demystify the role of the obstetrician and provide useful information. I have had positive feedback that it has helped women ask questions and have discussions with their own obstetricians. Students and midwives contact me and tell me how useful it is to hear the obstetric view.

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I started to see the benefits of more disruptive ideas, pushing myself out of my comfort zone, but also enabling others who felt they needed permission to act.

Having fun has been key. If people remember an enjoyable workshop charting over tea and cake or playing a board game, they are more likely to follow through, maintain relationships and improve things. Over the years, we have rewarded action with small tokens. It’s amazing what people will do for a badge or miniature croc. At one workshop on International Women’s Day a challenge to dance led to one of the fathers leading fifty or so delegates, babies and all in a brief dance resulting in giggling, clapping and a sense of what we can achieve together.

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Doctor stereotypes 2023: Attributes and Personality Traits of Doctors

Much has been written about the personality of aspiring doctors, and we may all have occasionally wondered if we were suited to the particular profession, which we choose to follow. A recent Opinion Piece in JAMA, in March 2023, describes some of the many qualities which make a good physician. These include passion, curiosity, commitment to lifelong learning, scientific aptitude, empathy, resilience and integrity, among others. It’s not just the professional media which discusses attributes of doctors. The Times, in April 2023 (in a piece about the junior doctor strikes) provides their view of the virtues of a good doctor - empathy, compassion, altruism and integrity.

Such serious views appear in stark contrast to the daily barter between medical colleagues, where light-hearted, humorous, tongue-in-cheek exchanges are often the norm. Prejudice and stereotypes in medicine have become exaggerated for the purpose of workplace amusement.

We chase grumpy radiologists, growling at anyone who dares disturb their dark sanctuary, and dithering psychiatrists. Patients, while the carefully cultivated image of the busy GP is not universally bought into by colleagues. And so the list goes on.

Are there differences between physicians and surgeons? The late Richard Asher, eminent endocrinologist at the Central Middlesex Hospital, once wrote of “The mind of the Physican, and that structure which corresponds to the mind in the Surgeon…”

Several studies have attempted to measure doctors’ personality traits, usually using the Five Factor Model, which assesses agreeableness, conscientiousness, openness to experience, neuroticism, and extraversion. Between specialties, moderate differences exist. Surgeons showed higher conscientiousness but lower agreeableness and neuroticism than other specialists. In one study, paediatricians were the most extravert whereas psychiatrists scored high in openness but low as extraverts. Various theories abound to explain the many and varied findings.

For example, the challenging and risk-taking aspects and the meticulous nature of surgical specialisation may attract those who do not have a tendency to experience negative emotions in response to stressful duties and situations. Of course, we all know colleagues whom we can pigeon-hole into whatever category we choose! Perhaps some degree of personality testing might help younger colleagues choose their specialty (Figure 1).

Reasoningly, one study showed that healthcare professionals (HCPs) had lower levels of dark triad personality traits (Machiavellianism, narcissism and psychopathy) compared with the general population. But should we be concerned that between specialities, HCPs scored higher in neuroticism, and lower agreeableness and neuroticism than other specialists? This probably won’t worry the general population. But should we be concerned that between medical colleagues, where light-hearted, humorous, tongue-in-cheek exchanges are often the norm, prejudice and stereotypes in medicine have become exaggerated for the purpose of workplace amusement?

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Wages across most professions have recently deteriorated. The BMA has done a fantastic job of communicating the message with clarity – a real terms pay cut saw 2008/2009 of a staggering 26.1%. These figures are shocking, and hard to argue with.

Secondly, in the intervening seven years, pay has further deteriorated. The initial deal was felt to be inadequate by many. Even getting to free hospital accommodation for newly qualified doctors was abruptly frozen at just the wrong moment. Near the end of the day, a nurse calmly approached me at the desk and asked if I was free. I was, and I assumed from her manner that this would be a menial task. Saying nothing else she led me into a side room, and pulled the crash buzzer. The team arrived and rapidly assessed the situation by calmly fetching the most junior doctor on the scene. That's not to say it becomes easy. It is simply that with further experience, a greater proportion of the thinking can be offloaded to our intuitive, automatic System 1. Cognitive appraisal is, "how severe are the stressors眼前的 current spike in inflation, the government's own target for inflation (10%) has proved intolerable. It's worth noting that even without the current spike in inflation, the government's own target for inflation is 2%, and the Bank of England's monetary policy reflects this. The contract was never due to be a pay rise but would keep pay static in real terms.

In September 2016, the BMA called for a 5-day strike at relatively short notice. It was focused on the social contract, the social covenant, the social responsibility of employers. For this cohort of doctors, the government's ‘race to the bottom’ logic simply does not work. It's not to say that we wouldn't work hard, but in the face of severe pay erosion (both in absolute terms and in comparison, to other professions) we are increasingly compelled to act. Junior doctors are more acutely aware of several ‘social contracts’ that have been broken.

At medical school, the general perception was that if you work hard in medicine, you might not be rich, but you'll be comfortable. It is becoming clear that this is no longer the case. On a junior doctor's salary, the idea of owning a home in London without significant family support is a pipe dream for most. The consultants I have encountered have set an inspiring example of what can be achieved with appropriate work-life balance.

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An Extract from Chapter 1

A well-known principle in cognitive psychology is the ‘stress-performance’ curve, which suggests that the relationship between one’s stress levels and their performance takes the form of a bell-shaped curve. Too little stress and we are inadequately stimulated to perform at our best. Too much and we become overloaded, paralysed, and unable to usefully deploy our skills. It seems that there is a Goldilocks zone where our stress levels can just be right. Another name for this phenomenon is the ‘Yerkes–Dodson’ curve, named after the scientists who developed the theory by adjusting the stress (in the form of electric shocks) applied to mice completing a maze task.

In his book Peak Performance under Pressure: Lessons from a Helicopter Rescue Doctor, emergency medicine consultant Stephen Hearn’s stresses the importance of understanding the ‘Yerkes–Dodson’ curve, our physiological stress response, information overload and, cognitive appraisal.

Cognitive appraisal is, "how we perceive the magnitude of the situation, the risks involved and our personal ability to overcome them'… If we perceive that attempting to address a problem will be extremely risky for either the patient or for ourselves, and that problem-solving resources are likely to be overwhelmed, we are pushed to the right of the stress-performance curve. Early in my Intensive Care job onboard the University SpaceShuttle, I experienced a mixture of all three ‘hearns’ elements, leading me to freeze at just the wrong moment. Near the end of the day, a nurse calmly approached me at the desk and asked if I was free. I was, and I assumed from her manner that this would be a menial task. Saying nothing else she led me into a side room to the patient. Still saying nothing, she jabbed her finger in the air towards the patient’s monitoring screen, which was angled towards the other side of the room. I craned my head around – and stopped. The patient’s systolic blood pressure was only 40 mmHg.

I froze. The way the nurse had responded to this pen-arrest situation by calmly fetching the most junior doctor on the entire ICU was so bizarre, so out of kilter with what the scenario demanded, that I was mentally thrown. Despite having completed the year since graduating, I was truly back to square one when it came to assessing this intubated, critically unwell patient. I was returned for such a situation, and the sudden and unexpected change of cognitive pace created such a massive physiological stress response that I entered the state of freezing, rather than fight (beginning resuscitation) or flight (rapidly fetching help). In my head I wanted to ask for the patient to be shifted to a Tandem blaster position right away, to increase the venous return to the heart, but my lips wouldn’t say the words. Luckily, before I had time to snap out of it, a Senior Sister assumed control and pulled the crash buzzer. The team arrived and rapidly diagnosed the problem, which turned out to be a kink in the line supplying noradrenaline to the patient. Once uninked, the blood pressure was soon corrected.
Alumni Books

Scholarship Boy to Engineer, Plastic Surgeon and Sportsman
by Prof Anthony Roberts OBE (Clinical Medicine 1969 - 1972)
From his early life as a tuberculous child of a poor divorced mother, treated with a new antibiotic, via a career in engineering to clinical medicine at Oxford, he became a Plastic Surgeon at Stoké Mandeville and six disasters and his next autobiographical book 'Plastic Surgery in Wars, Disasters and Civilian Life' is to be published in February 2024.

All proceeds from Anthony Roberts's book donated to Restore - Burn and Wound Research.

Brain Fever: How Vaccines Prevent Meningitis and other Killer Diseases
by Richard Moxon FRS
“This is a wonderful book that recounts the story of one of the great figures in virology, Richard Moxon. A pioneer in the field whose work led directly to several of the most important vaccines for meningitis, Moxon tells the story of how this field developed over his career, utilising a range of tools such as genomics to better discover powerful immunogens. His contributions to the field are reflected in the story bridges continents and many areas of science, from basic to translational. His contributions to the field are reflected in the book, as it has a role in the program produced one of the major Covid vaccines. It’s an engaging story about a leading scientist and his contribution to this most important field.”
Sir John Bell Regius Professor of Medicine

Royalties shared between: Meningitis Research Foundation and Meningitis Now

Talent is Everywhere, Opportunity is Not
Growing up in a council house estate and coming from a family with no healthcare professionals, I appreciate how talent is everywhere, but opportunity is not. From a low-income household to the dreamy spires of Oxford University, I am incredibly grateful to be able to study here at Oxford Medical School and it has been my mission since 2018 to level the playing field and to tackle the information, inspiration and skill gap that still permeates the medicine application process.

A week before freshers’ week in 2018, I founded The Aspiring Medics, a social enterprise helping students to get into medicine. It started off with £200 I had as pocket money from the summer of Year 13. Through the years, it has grown from an idea with a small group of friends to a thriving social enterprise with over 50 medical students and doctors in our community. Working with a team of 10 medical students across the UK we have created an Online Work Experience Course which is, and will always remain, completely free. So far the project has given over a thousand state school students free access to our online work experience and interview courses.

It is difficult for 15-17-year-olds to organise hospital work experience, especially those with no school mentors or medical connections. I vividly remember emailing more than 500 doctors individually from a directory of London hospital doctors to try to organise work experience. Only 5 replied and offered me work experience. I vividly remember emailing more than 500 doctors individually from a directory of London hospital doctors to try to organise work experience. Only 5 replied and offered me work experience, but that was plenty! Nowadays with more red tape, it’s even harder for students to access hospital work experience. Medical School Admissions Departments are aware of this and accept work experience in many forms such as volunteering at a phone line service, care home or pharmacy. Post-COVID, there has been a massive shift towards Online Work Experience. Although this may be seen by many medicine applicants as inferior to in-person hospital work experience, I believe that Online Work Experience is here to stay. Advantages include more time, plus videos to explain a disease from first principles, so students can understand symptoms and treatments. This is exactly the how the idea for The Aspiring Medics Online Work Experience Course came about during the start of the pandemic.

We recently launched a FREE Online Work Experience Course containing over 15 specialists with each specialty containing videos of anonymous patient case studies to enable students to find out if medicine is the career for them, understand NHS values and understand of the responsibilities of a doctor. No matter your connections or your network, you will be able to shadow a consultant cardiologist online or gain an insight to heart surgery. In the next lesson, you can learn about neurosurgery and then what a GP clinic is like. This will also help to inspire the next generation of doctors and ensure that their motivations to go into medicine are well thought out and that they are making an informed decision.

It has certainly been challenging to grow a social enterprise whilst at medical school but through delegating, creating automated emails and learning from mistakes, we’ve been able to continuously grow. The majority of our access work comes from our website containing guides on every step of the application process and our Youtube channel of nearly 5,000 subscribers, in which we create weekly videos for aspiring medics on the NHS, current medical issues, work experience, entry exams as well as medical school interviews. From using our phone as cameras, after receiving an Innovation Grant from the UK Government, we’ve been able to expand to film and edit videos using professional camera, microphone and lighting.

Our Youtube videos are popular especially with colourful infographics to help break down complex topics. By having medical students from across the UK, we’ve been able to showcase a range of perspectives and personalities. It’s been a pleasure to work with such an amazing team of medical students that are also passionate about widening participation!

The project is still in its infancy, and we are always looking for more medical students and doctors of all seniorities and specialties, clinicians and academics, to record more lectures.

If you share our vision of widening participation and would like to get involved in recording an online talk / lecture on a topic of your choice, please do get in touch and have a look at the below brochure link for further information - https://drive.google.com/file/d/1ES_Req5AV58YKb7VjQXk7Wv1FClEzdpSj/view?usp=sharing

CONGRATULATIONS
At the time of going to press we received news of a special alumnus distinction.
Professor Sir John Irving Bell is appointed Companion of Honour (CH) in the King’s Birthday Honours List for his transformation of the University’s research and innovation ecosystem, enabling billions of pounds of investment in research programmes, equipment and infrastructure. The development of the Oxford AZ COVID-19 vaccine would not have been possible without his vision to build vaccines research in Oxford over the past 30 years.
‘A King’s Honour; for the work I have done in medicine and life sciences, reflects the efforts of the very large number of people across the sector who have made this one of the UK’s strongest disciplines.’

Oxford University on Mont Blanc: The Life of the Chalet des Anglais
by Stephen Golding (University College 1972) Emeritus Fellow of University College, Chairman of The Chalet des Anglais Trust
The ‘Chalet des Anglais’ on Mont Blanc, home to the longest-running university reading party, is a unique survivor from Victorian and Edwardian-Oxford, established in 1891 and continuing today. The story of this remarkable institution has never previously been reported. The chalet is a unique lens through which to understand what is meant by a collegiate university and also to illustrate the implications of close student-tutor relationships over the last century.

Ultra-Processed People Why Do We All Eat the Stuff That Isn’t Food – and Why Can’t We Stop?
by Chris Van Tulleken
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Dr Sarah Bell
How is it already summer? Punt season is here, Pimm’s has been cracked open and students are starting to consume copious amounts of coffee as exams loom. Over the last 6 months, Osler House has been buzzing with activity from glamorous black-tie soirees to the not-so-elegant Bops. We finished for the New Year with the Osler House Christmas party, overflowing with mulled wine, mince pies and more Christmas decor than anyone asked for! In February, we celebrated the finalists finishing their exams with the first Osler Bop to sell-out in history, with nearly 150 attendees. To calm things down we then had our annual Halfway Hall Dinner at Corpus Christi, marking 5th years reaching the midpoint of the clinical course. And, finally, to top things off we had a couple more of the classic Osler Bops!

Beyond the big events, this year has also seen the rise of a bigger and bolder Osler spirit. In February, we introduced Ozzy the Octopus - Osler's very own mascot. Ozzy arrived in Oxford at the Finalists’ Bop and has since made appearances at numerous sporting events, parties and some say even the wards. Our Osler spirit rose even further with the re-introduction of staff in the form of hoodies, sweatshirts and much, much more. This surge in Osler spirit culminated in our women’s football team winning the coveted Cuppers trophy dramatically on penalties, in a fashion that puts even the Lionesses to shame. In other news, the societies under Osler House are flourishing like never before, arranging countless events - be it socials, conferences or lectures. To name just a few, the Obs and Gyne society put on their inaugural conference featuring prominent speakers and practical workshops, the Pediatrics society has created an excellent 6-part revision series on all things children and the Clinical Research Society has even organized a symposium that gives students a platform to present research they have undertaken.

With the year almost up, I can finally say Osler House has fully recovered from the pandemic! The student body is brimming with new and exciting ideas to bring the Osler community even closer together and I am excited to see what next year’s committee has in store for us. I would also like to give my sincerest thanks to the current Osler committee for their hard work over the course of the last year!

### Torpids

The men got their first bump in recent memory, a fantastic achievement given our difficulties in putting together a squad. Meanwhile, our incredible W1 continued their ascent up the bumps charts, ending the week +1 overall. For lots of our rowers in W1 and M1 it was their first-time racing in bumps. We’re really proud that we have managed to teach them so quickly and put out such competitive crews with fewer resources and training time than most college crews.

### Novice Regatta

This was the first year that Osler House has entered a novice regatta since our revival. The crew won their first race and unfortunately poor weather conditions prevented any further races, but it’s an exciting milestone for the club as it continues to grow!

### University Level Rowing

We have significant medical student representation at University level this year. Osler rower Rosie Lynch competed for OUWLRC in the lightweight boat race this year, and three clinical medical students Alison Carrington, Phoebe Mountain, and Maria Nielsen-Scott competed for OUWBC in the Varsity boat race. At

### Alumni Thanks and Boat Renaming

I also wanted to give a massive thank you to all our alumni who have supported us financially this year. The cost of entering races and maintaining the boats has risen significantly this year and without your help we wouldn’t have a boat club. Excitingly, we have also bought two concept2 blades so that W1 have a full set of women’s blades and don’t have to use the men’s ones anymore! We’ve also re-vinylled our boats so that they all have OSG boat codes, and we plan to rename our new men’s shell soon. If anyone has any suggestions for the name of our new boat (or any other queries) please get in touch with me at iwan.raza@worc.ox.ac.uk.

### Alumni Rowing Invitation

If you handled an oar during your time in Oxford, for your college or Osler House, and would like to re-live the experience, we’re planning to have VIIIs outings for medical alumni over the Meeting Minds event, during the afternoons of Friday 22 – Sunday 24 September. Don’t worry if you feel a bit rusty – you’ll have the opportunity to re-familiarise yourself before we go on the water, and one or two of the present OHBC members will join the boat to make sure it goes in the right direction. The cost will be £50 per person, to raise funds for OHBC, and will include tea and cake afterwards for survivors.

If you are interested, please get in touch before the end of August, by email to david.sprigings@ouh.nhs.uk.

### Access GEM Spring News

Magdalen grounds and gardens are beautiful in May, and provided the perfect backdrop to the first annual AccessGEM Spring Party. It was a great evening of jazz music, conversation, wine, and nibbles. The evening raised funds for the new need-based bursary for future graduate entry medical students. The event was a great success, auctioning off a Formula One Race Weekend Experience at the Williams F1 Team factory for £450 amongst other donations! In total we’ve now raised more than £46,500 out of our £125,000 goal. The party will be held again next year, so do keep it on your radar.

We’re so grateful to everyone who has supported us so far, and can’t wait to see how much progress we make over the next academic year!
Tingewick

Tingewick has always felt like something of a rite of passage. As pre-clinical students, all that we knew were the shows. For us, it was ‘The Goutfather’ as Freshers and ‘Doctor Ria’ as Third Years with the gap in the middle due to the pandemic. Although all the clinical japes would go above our heads, being introduced to Rita at such an early stage has meant that so many of us were keen to take part in Tingewick in some way. Being able to experience the pantomimes as a part of the audience was one thing, but being a part of the cast is another. This year, we finally had our turn (and the jokes finally started making sense)! Our contribution to Tingewick’s legacy was a take on the Hollywood classic ‘Legally Blonde’ but with a clinical twist.

This year Tingewick came home and returned to Tingewick Hall. The show, a culmination of the efforts of the previous Tingewick Firm, was incredibly well-received. It was clear that all those late nights spent rehearsing in Osler House were worth it in the end. The money raised from the show, plus other fundraising events across their year was over £30,000. The show, for them, was better, and bolder than ever before.

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Tingewick is back! Bigger, better, and bolder than ever before.
Catherine Swales, 2023

The next Tingewick Pantomime takes place 29th November to 2nd December 2023 in Tingewick Hall. Tickets will be on sale later in the year.

What does ‘excellent’ look like?
Directions for the future

• There are established roles for patients with clinical signs, who agree to be examined at OSCE stations. We want to expand the role of patients in OSCEs, developing content that is designed by patients, and with patient assessors. We will also explore how patients can work as observers and examiners and how metrics of importance to patients – such as listening and interpersonal skills – might be assessed and incorporated into the marking system.

• The Patient and Doctor Course in years 1 – 3 provides opportunities for people to meet patients in general practice, but we would like to see more normalisation of collaborative partnerships, perhaps with longitudinal projects that buddy up students and groups of patients across the duration of the degree.

• We are also exploring ways in which patient experience might be used to augment the preclinical science teaching, harnessing the power of patient stories to illustrate the clinical significance of the science and help make the content resonate.

• We would like to develop roles for patients in the selection process and consider how patients might influence assessment and admission to medical school, challenging aspiring medical students in ways that are not included at present.

• In the fullness of time, we would like to see the medical school have an established faculty of experienced patient tutors and contributors – people who are using their experience of illness to guide curriculum content, develop new content and contribute to teaching and assessment, as well as training other patients and acting as a valuable resource for students and teaching colleagues across the 6 years.

Strengths and assets

This is a challenging brief, but there is huge enthusiasm and support for these initiatives. We benefit from well-established examples of excellent practice, such as the Expert Patient Tutor programmes in Year 5 Women’s Health and Neurology, and many inspirational examples of patient involvement in courses and clinics across the student experience. Much of our task is to pull this together, share best practice and capture the impact on student experience. The Medical School at Oxford is also unusual in appointing people with designated responsibility for patient involvement. This critical first step is a visible expression of a commitment to ensuring patients’ voices help to shape doctors of the future.

Dr Noemi Roy
noemi.roy@medsci.ox.ac.uk

Dr Catriona Gilmour Hamilton
catriona.gilmourhamilton@medsci.ox.ac.uk

Co-Leads for Patient Involvement in Medical Education, School of Medicine and Biomedical Sciences since 2022.
Graduation Reunions 2023

50th/51st Reunion - April 20th
On a beautiful spring day in an otherwise dull, cold and sometimes wet April, the 50th and 51st reunions of Oxford Medical School took place in Worcester College. We were not a uniform cohort. The clinical course was shortened, and the two terms of the old ‘path and bac’ course subsumed, while we were there. Consequently, some of us had matriculated in 1965, some in 1966, and some in 1967. Others were in the clinical intakes from Cambridge, and a few had transferred from other universities. Some had done pre-clinical research and moved years. This, plus the attendance of some partners and swapping of seats between courses, allowed much widening of conversation beyond simple reminiscence. John Morris reminded us of what things were like and told us of how things have changed: the biochemistry building with its paternoster is no more! We are all grateful to Emily Stone and Lyn Williamson for arranging such an enjoyable day.

Neville Goodman, Magdalen 1966

I felt that Time had Stood Still and Flown Backwards as so many old memories came flooding back. Tyngewicke scenes, dinners in different colleges, formal, old flames punting, Eights Week bumps, pre-tutorial anguish, fiddling smoked drum tracings, ceremony and colour - but above all friendship and camaraderie based around the colleges and Osler house.

A Toast to old friends and colleagues. Many Happy Memories.
Roger Bodley, Worcester 1966

10th Reunion – June 10th
The 2013 clinical graduates gathered at Osler House on Saturday 10th June to celebrate their 10 year reunion. It was fantastic to meet on such a beautiful day and reminisce in the place where we made so many of our core medical school memories. The adults were well catered for with a delicious spread put on by What’s Cooking Thame, whilst the toddlers were entertained by the soft play, ball pit and games in the garden. Thank you so much to the Osler House committee for generously providing the venue, and to OMA for their support in coordinating such a wonderful event.

Abigail Moore, St Hilda’s 2007

30th Graduations Reunion - June 10th
30 years after qualifying, nearly 50 members of the graduating class of 1993 and their guests met for dinner at Balliol for a reunion organised by OMA. For many, it was the first time we had seen each other since that summer day in the Sheldonian, so an evening of reminiscing and revisiting old haunts was enjoyed by all. Many thanks to John Morris for presiding and updating us with the changes Oxford Medicine has seen since we were last here, and especially to Emily Stone and the OMA team for all the hard work that goes into organising these events.

Simon Yarrow, Magdalen 1990

50th/51st Reunion Lunch
Worcester College did us proud in catering for the alumni crowd. Fine dining clearly was the rule - no penny-pinching, insipid gruel. We met old friends and talked a lot. Though appearances may have changed somewhat, conversation was all extremely prudent. We even included Cambridge students.

The speeches brought us up to date on changes in the building state: Some for better, some for worse. But all with good intent - of course!

Medical teaching’s not altered much. The students still get the tutorial crutch to support them in their failing learning and to try in vain to get passion burning.

We had apologies from those who couldn’t attend. Hopefully not because unwilling to spend. They sent regrets at missing the fun and play. Though not for behaviour back in the day. But everyone seemed to have done OK. At least that’s what I heard them say.

So thanks to the organisers and, being candid, I hope you benefited as much as we did.

Harvey Sagar, Brasenose 1966

I felt that Time had stood still and flown backwards as so many old memories came flooding back.

40th Reunion – June 3rd
The 40th anniversary of those who studied medicine circa 1977 to 1983 was held last night at Balliol College. Around 30 of us (plus guests) attended, plus our special guest (and my former clinical tutor and boss, Derek Jewell). From the fact that we had to be politely but firmly escorted from the venue by the college staff at a time later than advertised, I’d say the evening was a great success. Friends reunited! None of us had materially changed either physically or in character over the preceding 40 years. My thanks to Lyn Williamson and Emily Stone at OMA for organising a wonderful reunion. We’ll meet again before long I hope so that some who couldn’t come this time can attend.

Neil Bryson, Christ Church 1975

2023 reunions to come:
20th Reunion (2003 Graduates)
8th July, Balliol College

(New) 5th Reunion (2018 Graduates) 30th Sept, Somerville College

"I felt that Time had stood still and flown backwards as so many old memories came flooding back."
Dr Michael Kenworthy-Brown (1936–2023)

Michael and I were partners at Jenico HC and friends for over 40 yrs. He was an exceptionally kind, caring professional who was justly proud of obtaining his MRCP by examination while young and working full time with triplets and a young son at home, and his FRCEP by election having been an early College member, this spoke of his knowledge and love of medicine and GP.

He was continuously innovative, he was a founder member and active participant of the Oxford College Drs, a group which met regularly for fruitful exchanges. He much enjoyed his involvement professionally and socially with his own college, Oriel, while we increasingly looked after other colleges medically, now numbering eight. This student involvement developed into medical inductions and seeing all Freshers in October annually and welfare groups and regular meetings in each college, plus the introduction of invaluable college nurses.

In the 1970s, he took a session out of his extremely busy GP week to work hard with Dr Rosemary Rue in the ground breaking initiatives of encouraging Drs to get back into medicine (often female Drs having families) by setting up part time working and continuing medical education.

At the Jenico HC he introduced the first Yellow Fever travel service in Oxford. Dr Kenworthy left from his close and long-standing involvement with Oxfam, for whom we did pre-, mid- and post tours medical on all their staff who they sent to work abroad. This created a GP association with travel medicine flourishing and we diagnosed Malaria, Dengue, Leishmaniasis, Schistosomiasis among others, and held regular meetings with Oxfam and Prof Chris Conlon for invaluable expert advice. We were one of the first Oxford practice to have a practice manager at Michael’s suggestion and this was hugely beneficial.

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Dr Judy Bogdanor

Mr Ian MacKenzie (1942–2023)

Ian Mackenzie trained in medicine at Bristol Medical school. He began his career in Oxford as a Senior Registrar in the mid-1970s and was appointed to a consultant post and readership a few years later. He later became a Professorial Fellow of St. Hugh’s College, Oxford. He began his research career following a clinical research fellowship with the late Mostyn Embrey.

He led research into use of prostaglandins in O&G for more than two decades. This resulted in the use of these agents to induce labour and termination of pregnancy which revolutionised clinical practice worldwide. He expanded his research interests to include uterine angiogenesis and tamoxifen-induced genes. Throughout his career he also produced many other novel and ground-breaking insights into clinical practice. For example, his work was largely responsible for D&C being abandoned as a routine gynaecological procedure.

He continued publishing many years after his retirement in 2009 in both obstetrics and gynecology. Wanting to contribute more to research, he became a member of Oxford South Central Ethics Committee B in 2010 and was still working for the committee right up to his death.

It is, however, the profound support he provided to colleagues and medical students that he will be most remembered for. He was devoted to teaching and his ward rounds were universally popular and much enjoyed. His wisdom and considerable clinical experience also meant that he was the automatic choice for hundreds of medical and nursing staff who sought his care during their pregnancy. The love and respect felt for him by his colleagues and mentees clearly shines through whenever Ian is mentioned.

Ian Mackenzie was my mentor for many years as a young doctor. He always struck me as immensely all-knowing and personable. The love and respect felt for him by his colleagues and mentees clearly shines through whenever Ian is mentioned.

Pat MacKenzie had the honour of working as his registrar and SHO and again on research projects as a gynaec onc SSt. I learnt so much from him in terms of communication, integrity and his mentorship cannot be underestimated. He took time and interest in people, working with his junior trainees on research and audit projects, rather than expecting them to produce stuff for him that he then attached his name to. I learned a lot about how to be a consultant from watching him, both in terms of attitude, temperament and surgical ability.

He thought before he spoke, based advice upon evidence and if he didn’t know the answer, and the evidence did not exist to answer a clinical question, sought to find out for himself by audit and research.

Miss Jo Morrison, Gynae oncological consultant Taunton and Somerset NHS Trust

She was a superb surgeon and obstetrician and an excellent supportive colleague. She spearheaded teaching of medical students in Oxford and trained many clinicians. He will be greatly missed worldwide.”

Prof Margaret Rees, Reader Emeritus in Reproductive Medicine, and Supernumerary Fellow, St Hilda’s College

Ian died peacefully at home in his sleep. He will be greatly missed worldwide. Our thoughts go to his wife Valerie and the family.

Professor Sally Collins

Dr Patricia Markus (1929–2023)

To put it simply, Pat Markus was a very special person and exceptional family doctor although she would not have been pleased with me for saying so publicly.

Pat was born in London in 1929 and spent her early childhood in Blackheath. From the age of 7 she attended a Catholic Boarding School in Hertfordshire where the philosophy focused on kindness, community and learning – themes that best describe the attributes of a good Primary Care Doctor. The same three words sum up the person I fondly remember from our GP Partnership in Thame.

She came up to Oxford in 1948 to study Medicine at St Anne’s College. Academically gifted she still found time for sporting exploits. Represented the University in fencing both in the UK and abroad. There was also a hint of rebelliousness in that she, the all-female College had a 10.00pm curfew. Pat found she could break this by using the College coal delivery shute. It was at Oxford that she met Andrew who was also studying Medicine.

They both moved to London to complete their clinical training. Pat at Bart’s, Andrew at UCH. Whilst there, they were married at St Ethelreda’s.

As was the norm after the war, Andrew was expected to complete his National Service which he did at the RAF Hospital in Wimorton, Wiltshire. On completion Andrew applied for GP Partnerships and in 1960 moved to Thame, back in Oxford.

Pat described this phase of her life as being “just the doctor’s wife”. The role was far from quiet. She was expected to answer the phone, make appointments, sterilise the instruments, place anxious patients and act as PA to Andrew as well as care for her growing family of children.

When Andrew’s partners went on holiday, Pat would often step in and offer to help with the clinic lists. Soon, by popular demand from patients, Pat was offered a partnership in her own right and developed a loyal following with particular interests in child health, women’s health and psychological problems. Those of us at Thame Health Centre who knew her well, remember her for her kindness, gentleness, calmness under pressure and a wonderful store of wise words. She always seemed to know what to say and, more importantly, when to say it. Pat nurtured many of us with her cooking, being a kind and generous host. She carefully nurtured my career and I still find myself quoting on her wise words to the current cohort of Oxford Medical Students.

When Pat retired, Thame patients mourned the fact they had lost the best GP anyone could wish for and I felt I had lost my role model. She never sought the limelight, always happier to serve than to lead. But she was an influencer long before social media had invented the word. She would quietly plant wise thoughts in the right ear and things would happen in the fullness of time! Such an amazing skill.

After retirement Pat and Andrew explored the world and enjoyed their five children and fourteen grandchildren. As you would expect, Pat continued to give her energy back to her community becoming Parish School Chair and later Chair. She supported the Friends of Thame Community Hospital. Perhaps her more taxing role was to become a visitor for Bullingdon Category A Prison. This position tested many of her skills but as you would expect, Pat rose to the challenge and subsequently became Chair of the Prison Visitors’ Association.

Pat, thank you for your life, well-lived and well-loved.

Dr Ken Burch

In Memoriam

Mr Joseph D. Abrams. (University College, 1945) Notified in March 2023

Professor Roger J. Buckley. (Exeter College, 1963) Died October 2022

Dr Richard J. Cook. (St John’s College, 1966) Notified in March 2023

Mrs Elizabeth N. Davies. (Lady Margaret Hall, 1943) Died January 2023

Professor Robert A. Dickson. (Hullffield College) Died March 2023

Dr Geoffrey A. Douglas. (Oriel College, 1964) Died February 2023

Mrs Rosamond A. Gallant. (St Anne’s College, 1965) Died January 2023

Dr James M. Gumpel. (Trinity College, 1954) Notified in January 2023

Professor Henry M. Hodgkinson. (Brasenose College, 1949) Notified in December 2022

Dr Roderick B. Macauley. (Lincoln College, 1946) Notified in February 2023

Professor Geoffrey A. Machin. (Magdalen College, 1959) Notified in September 2022

Dr Clare H. Matthews. (New College, 1984) Notified in December 2022

Dr Brian N. McQuade. (Trinity College, 1943) Notified in January 2023

Dr David C. Mills. (St Peter’s College, 1967) Died March 2023

Dr Robert V. Ogilvie. (Jesus College, 1962) Died October 2022

Professor David G. Penington. (Magdalen College, 1950) Notified in February 2023

Dr Stanley R. Richardson. (Merton College, 1949) Notified in February 2023

Dr Alan M. Smith. (Trinity College, 1947) Died February 2023

Oxbridge Fellows
Critic’s Corner: OMLC Lecture Series

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

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

This was a talk of two halves. The first was a fascinating biographical resume of William Osler, one of the great founder fathers of medicine, interspersed with interesting facts (did you know that Mrs William Osler’s great-grandfather was Paul Revere?), and with interesting quotes from Osler. The second half was an even more interesting presentation of high-intensity focused ultrasound (HIFU) as a precision surgical tool, developing from a collaboration with the National Engineering Research Centre for Ultrasound Medicine in Chongqing, China. Where there just happened to be a portrait of William Osler, and one of his inspirational quotes, forming the link between the two halves. As always, questions at the end of the talk provoked animated discussion – about the cost, the general availability of the technology (Oxford currently has the only machine in the UK), linking HIFU with MRI for targeted precision, validation and training. Watch this space.

Consent after Montgomery
Dr Ian Baxter
Monday 27th February 2023
James Badenoch KC

This month’s talk was very different from the usual talks in the series, being given by an eminent lawyer who had been instrumental in the landmark Case of Montgomery v Lanarkshire Health Board 2015, hailed by many as “the most important UK judgment on informed consent for 30 years”, by others as the law catching up with GMC guidance at the time. Our learned friend treated us to an entertaining and informative speech, without notes, blowing Babcock’s principle out of the water, exposing the evils of medical paternalism, and explaining how the landmark case of Montgomery made it more difficult for the medical profession to try to defend the indefensible (absolutely nothing to do with the lawyers). This was debated hotly in the discussion session by members of the audience who might perhaps have been anticipating the lawyers). This was debated hotly in the discussion session by members of the audience who might perhaps have been anticipating the lawyers). This was debated hotly in the discussion session by members of the audience who might perhaps have been anticipating the lawyers). This was debated hotly in the discussion session by members of the audience who might perhaps have been anticipating the lawyers). This was debated hotly in the discussion session by members of the audience who might perhaps have been anticipating the lawyers). This was debated hotly in the discussion session by members of the audience who might perhaps have been anticipating the lawyers).

A Connective Cornucopia
Dr Frances Hall
Monday 27th March 2023

Another fascinating rheumatology talk by an inquisitive speaker, starting with a useful summary of the difference between innate and adaptive immunity for those of us who might be feeling a bit rusty (in immunology as well as lines), followed by a selection of weird and wonderful case histories illustrating different clinical syndromes. This was not just about catching the afflicted with clever science, but also how to establish management pathways, including access to targeted therapy for patients with rare autoimmune presentations. The speaker expertly baited away a question on inflammatory, but embraced the gut microbiome as a potential player. Once again, a reminder from this series of lectures that intelligent, science-led medicine is still very much alive and kicking.

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

Radcliffe Infirmary-History Hidden in Plain Sight

Mr Ian Baxter MA+PGDip CQSW
(Keele College, 1976) Social Worker; Radcliffe Infirmary and John Radcliffe Hospital 1984-1989, and later Chiltern Railways and rail industry director. Setting up ‘Friends of the Radcliffe Observatory Quarter’ in 2023

The University’s Schwarzman Centre for the Humanities is rising at the heart of the former Radcliffe Infirmary site to complete what is now the ‘Radcliffe Observatory Quarter’. Some elements of 2 centuries of Oxford health care, research and art (1770-2007) remain hidden in plain sight.

In the manner of the collages of Infirmary images on the walls of the corridor between the John Radcliffe Hospital II and the West Wing, Oxford Medicine’s Summer 2023 cover illustrates these reminders of ‘the Radcliffe’ which a proposed ‘Friends of the Radcliffe Observatory Quarter’ hope to celebrate.

TOP ROW – NUFFIELD MATERNITY HOME
The Duchess of York, later H.M. Queen Elizabeth, the Queen Mother, opened the Nuffield Maternity Home at the Infirmary in October 1931, accompanied by Lord Nuffield who funded it. Its gate pillars to Walton Street remain today. The Friends would like to see the fine, elegant gates restored, as the Infirmary site’s regeneration is completed, opening up visibility between the Quarter and Walton Street and Jenicho.

SECOND ROW – ST. LUKE’S CHAPEL
A patient receives care in Henry Holiday’s (1839-1927) stained glass in St. Luke’s Chapel at the Infirmary. 2 figures sculpted by Laurence Bradshaw (1899-1978 and the sculptor of Karl Marx’s bust in Highgate Cemetery), originally decorating the 1932 Nurses’ Home, now grace the north wall of the chapel. Bradshaw’s ‘Mother and Child’ was relocated from Nuffield’s Maternity Hospital when it was demolished in 2008 to today’s Nuffield Department of Primary Care Health Sciences on the modern extension to the former Out-Patients Department at the Infirmary. Hospital commissioned art work highlighting.

CENTRE COLUMN 3rd photograph and BELOW – RI BENCHES
Original RI Out-patients and ‘Piccadilly’ benches in the JRII-West Wing corridor today, with an illustration of these at the RI OPD in 1959. Replica of such benches could add both history and aesthetics to Radcliffe Observatory Quarter buildings of today.

THIRD ROW (left/middle) – POST-2nd WORLD WAR INFIRARY
The Harkeish Medical and Nursing Teaching Building (1970) and Gibson Pathology Laboratories (1964) at adjacent to the Radcliffe Infirmary. The side remaining post-war Infirmary buildings, they remain in use by Primary Care Health Sciences and Philosophy and Theology faculties. As a PGDip Theology student in 2016 I was brought to a rather stunned stand as I entered the Gibson Building for the first time since working in the RI in 1989, as it still very distinctly held the smell (in positive nostalgic terms) of the hospital.

THIRD ROW (right) – THE ORIGINAL TRITON FOUNTAIN
The University installed a superb replica of the Triton fountain in the Infirmary courtyard in 2012. The fragile Grade II-listed 1857 original, sculpted by John Bell (1812-1895), was splendidly repaired in parallel but is conserved in rather lonely isolation at Castle Mill Graduate Accommodation west of Oxford. The Friends wish to work with the University to find a space to best-display and interpret the first Triton within the Quarter.

For information please contact me on: 07799864250
ian.baxter@icloud.com

If you would like to support this or receive further information (please contact me on: ian.baxter@icloud.com
See: Remembering the Radcliffe Infirmary at https://www.youtube.com/watch?v=ZTwUIcY9g
Bitterns are wonderfully camouflaged and blend into the reed beds, making them hard to spot, even if you know they are there. The bird in this photograph knew I was just a few yards away, but decided to rely on its ability to hide, rather than take flight. Extinct a hundred years ago, there are now several hundred in the UK and 3 females raised young last year on Otmoor, just 4 miles from the John Radcliffe.