Oxford Medicine
THE MAGAZINE OF THE OXFORD MEDICAL ALUMNI
Winter 2023

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Prof Sir
Adrian Hill

Sleep
Regulation
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And much
much more...

Cover image by Dr Kristoffer D. Fehér. “Orchestration of sleep” created with makeahuman 1.2.0 and adobe photoshop 25.2
The New School of Medicine and Biomedical Sciences: What, How and Why?

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David McCartney, Director of Graduate Entry Medicine
Robert Wilkins, Director of Preclinical Studies and Biomedical Sciences

This edition of Oxford Medicine provides an opportunity for us to update you on recent activity in the medical school. Historically, the official administrative home for the medical school was within the Medical Sciences Divisional Office but changes in culture, governance and compliance meant the School needed to become more operationally independent and break out on its own. On 1 August 2023, the preclinical, clinical, graduate entry and biomedical sciences courses were formally brought together as a completely new academic entity within the University, creating the School of Medicine and Biomedical Sciences. The formalisation of the combined School, and its union with Biomedical Sciences, represents a hugely significant and exciting step forward for medical/biomedical sciences education and all our students and staff, plus the opportunity to build on work already started. So why might we need to work more closely together? The good reasons range from improved student experience, both educationally and in a sense of ‘belonging’, to economy of shared endeavour and operational oversight (which sounds a bit dull but dry is becoming ever more important, not least to the GMC).

The most important drivers were our students. Those on the six-year A100 medical programme now stay in Oxford for the whole of their degree. In the past there was traffic principally between Oxford, Cambridge and London after preclinical, but this has now fallen away to leave opportunities for greater linkage and collaboration between the preclinical and clinical courses. In addition, students studying Biomedical Sciences (which replaced Physiological Sciences in 2010 and recently became a 4-year course) share many common lectures with the preclinical and clinical programmes to be able to share, collaborate and support each other creates a new and exciting sense of combined purpose and strategy for everyone across these incredible courses. It will also provide a bedrock for the looming expansion of medical student numbers (deep breath, and something for another edition!).

That said, the cultural baby that is Oxford Medical School is not being thrown out with the operational bathwater. Some things may have changed, but the new School will maintain and defend the core values and experiences that we hope that you will all remember from your time in Oxford: a strong emphasis on the academic and scientific basis of medicine, inspiring teaching from world-renowned scientists and academics, and a rich and supportive clinical experience. And somewhere that we had no idea existed. For example, when students had to report their positive covid tests to the University the form asked them to pick their academic department but there wasn’t one listed for the medics and BMS students. It sounds trivial but it was far from it; at a time when they felt most isolated and at distance they had no “home”. Above all things, that needed to change.

University education, with its demands and responsibilities, is changing at a dizzying rate (revolution more than evolution in many places) and consequently the academic delivery and administration of our courses has become more complex with higher stakes. For teams who work on elements of the four programmes to be able to share, collaborate and support each other creates a new and exciting sense of combined purpose and strategy for everyone across these incredible courses. It will also provide a bedrock for the looming expansion of medical student numbers (deep breath, and something for another edition!).

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The most important drivers were our students.
Malaria – Approaching the Endgame?

Professor Sir Adrian V. S. Hill KBE FRSE FMedSci FRCP (Magdalen College, 1978)
Director of the Jenner Institute, Lakshmi Metal and Family Professor of Vaccinology at the University of Oxford, honorary Consultant Physician in Infectious Diseases, and Fellow of Magdalen College, Oxford

At lunchtime on 2nd October this year about 20 people, including a television documentary crew, were packed into my one-person office at the Jenner Institute in Oxford – to listen to a press conference. This was led by the Director General of the World Health Organisation, Dr Tedros Ghebreyesus, who was announcing a decision on a malaria vaccine. This was the exciting R21//Matrix-M that has been worked on in Oxford and elsewhere for the last ten years. Made by my graduate student, Kath Collins, in 2011, no-one knew what the WHO had decided.

On a large screen, watching too, were the investigators from five trial sites in Africa who are still running follow-up in the key vaccine licensure trial that enrolled 4800 young children two years ago. And the Serum Institute of India, our amazing large-scale manufacturer and commercial partner in Pune, were on tenterhooks too. I had thought all these key announcements would have been shared with the company and trialists first – but not in this case.

Dr Tedros came right to the point. There was good news on malaria vaccine licensure. The R21 vaccine was to be recommended for widespread use in Africa with an expanded age range from 5-36 months based on the extensive R21 safety and efficacy data that the WHO policy advisory group had reviewed. Cue gasps, hugs, even tears, followed by cheers - online and across four continents. Yes, four, as our vaccine adjustant is from the US company Novavax.

Malaria control has needed a lift. Much progress was made from 2000 to 2017 with almost a halving of the million malaria deaths in 2000 over that period, but deaths are now higher again at 620,000 a year. And that has happened despite over $4 billion being spent annually deploying a range of interventions, from bed nets and insecticides to rapid early treatment and chemoprevention. Vaccines now offer a new intervention that, at least with R21/Matrix-M and its higher efficacy of about 75%, could well prove to be the most impactful tool yet.

But vaccine success has come slowly in malaria. The first studies were in 2001, the first human trial in 1940s. Since then, over 140 vaccine candidates reached clinical testing with only a handful looking at all promising. It’s a welcome change to explain success having spent years explaining why it has been so difficult. Our R21 vaccine induces unusually high antibody titres against a very conserved region of the coat protein of sporozoites. This is a repeat of just four amino acids, NANP over 20 times, so that in principle the parasite would have to mutate all twenty to escape the vaccine induced immune response. The big challenge has been both reaching the protective level of antibodies and then maintaining it. To do so we used a new nanoparticle that comprises hepatitis B antigen internally, to allow nanoparticle assembly, and a full coating of the malaria sporozoite antigen on the vaccine surface (Figure 1). With a saponin-based adjustant, the Matrix-M, we saw exceptional immunogenicity and efficacy in the first six months of pre-clinical testing.

The R21 vaccine was designed to be an improvement on the then-leading vaccine candidate in 2010, RTS,S/AS01 or “Mosquirix” from GSK. For R21 we increased the proportion of the malaria antigen and used less of the hepatitis B. GSK are now also planning their first large scale deployments next year in African children after their WHO approvals. But that vaccine, designed in the mid-1980s, has had a very bumpy road with modest efficacy and many pauses, notably for safety signals in the phase III licensure trial that required a million child vaccine “pilot implementation” program to confirm adequate safety and allow regulatory approvals. However, the scale of manufacturing of RTS,S is still very limited with only about 6 million doses available next year for over 40 million African children.

In contrast, the Serum Institute of India, who were by far the largest manufacturer of the “Oxford-AstraZeneca Covid-19 vaccine, expect to be able to provide well over a 100 million doses of R21//Matrix-M next year, and more as required. UNICEF have already made a huge order, perhaps encouraged by the much lower price of R21//Matrix-M ($4 per dose) than RTS,S. This should allow a widespread deployment of the R21 vaccine which has the significantly higher efficacy of 75%, first identified as an efficacy goal for malaria vaccine developers by WHO back in 2013. If R21 can be deployed as expected it should save hundreds of thousands of lives a year in Africa alone.

But there is still more to do in malaria vaccines and a lot is happening. Simon Draper’s group in the Biochemistry department has a blood-stage vaccine in African trials that could be combined with R21. Sumi Biswas, at the Jenner Institute, has two very promising transmission-blocking vaccines in clinical development. So, a multi-component multistage malaria vaccine is on the horizon and that could lead to an acceleration of the numbers of countries being declared malaria free, among eradication perhaps in the next 15 years.

However, that will require a vaccine against Plasmodium vivax as well as Plasmodium falciparum. P. vivax has been very neglected by vaccinologists but is now being targeted anew with vaccine approaches shown to work well for Plasmodium falciparum. And, of course, the excitement about mRNA vaccines for Covid has not been lost on the malaria field. But the realists appreciate that it will be much easier (and quicker!) to make Covid than malaria vaccines.

After 20 years of undertaking phase I and II early-stage vaccine trials, with far more disappointments than successes, being part of two successful phase 3 licensure trials in three years has been unexpected, exhilarating and – exhausting. Many have moaned, justifiably, that if all vaccines could only be developed at the pace seen in Covid-19 we would have many more useful vaccines much more quickly. That is undoubtedly true. But doing this in an academic setting – even with the extraordinary individuals and teams that come together for these major trials - is often overwhelming and persistently intense. I am beginning to understand why big pharma has thousands of staff deployed on such licensure trials, and a little of what they may all be doing.

References


Figure 1 Depiction of the R21 and RTS,S malaria vaccine immunogens. The surface of R21 (made in 2011) is coated with the circumsporozoite protein of Plasmodium falciparum which has a highly conserved central NANP repeat. This antigen is fused to the N-terminus of the hepatitis B surface antigen (HBsAg) to allow assembly of the nanoparticle which happens spontaneously in vivo and also in the yeast strain used for biomanufacturing. The surface of RTS,S, made in the late 1980s, is mainly HBsAg. It was not possible to express the fusion protein alone to generate a nanoparticle fully coated with malaria antigen at that time. The higher proportion of malaria antigen in R21 also allows a lower vaccine dose (5µg rather than 25µg) to be used, yielding greater yield of manufactured doses and reducing the cost per dose.

Figure 2. A child being immunised with R21//Matrix-M vaccine at Nanoro, Burkina Faso (courtesy Mehreen Datoo).
Sleep is a vital physiological process. Like eating or breathing, sleep is tightly controlled. Yet unlike nutrient or blood gas sensing, which ensure that essential metabolic parameters stay in balance, the principles governing the regulation of sleep have remained elusive until today.

The Viennese neurologist von Economo started the search for the brain regions that control sleep and wakefulness with his 1930 paper, “Sleep as a problem of localization” (1), identifying important brain structures, such as the hypothalamus or “interbrain” might cause insomnia or somnolence. Careful clinical observation led him to conclude that centres for sleep and wakefulness exist in the brain, antagonising contemporaries who believed that sleep was regulated by peripheral mechanisms such as asphyxiation caused by carbon dioxide, hypoventilation in the blood and cerebrospinal fluid, or vasoconstrictor mechanisms causing anaemia of the brain. His observations began the search for the circuitry underlying sleep-wake control, the foundation for the later conceptualisation of a ‘sleep switch’.

The sleep switch

A flip-flop switch became a guiding principle of sleep research (2) following the demonstration of sleep-promoting properties of the prepro-hypothalamic region (3), wake-promoting properties of the ascending reticular activating system (4), and the delineation of their projections. This concept explains the rapid and complete transition between vigilance and sleep and the coordination of sleep and wake-associated functions. With the discovery of more nuclei that induce transition between sleep and wakefulness, and between rapid eye movement (REM) and non-REM (NREM) sleep, the concept was expanded and a new switch regulating transition between these two sleep states (5). However, while the sleep switch model helps describe the interaction between certain nuclei, it does not explain why and when the brain changes its state or what triggers the switch.

The circadian clock and the homeostatic hourglass

Timing, duration and intensity of sleep are regulated by two interacting mechanisms, a circadian and a homeostatic process (6). The circadian process describes the fluctuation of wake propensity and other physiological functions in a 24-hour rhythm. The molecular principle of this clock mechanism is well understood and the 2017 Nobel Prize in Physiology and Medicine was awarded for research in this field. The neuroanatomical ‘seat’ of this clock is also known. The suprachiasmatic nucleus of the hypothalamus appears to be the central pacemaker, driving biological clocks that exist in most cell types of the body (7). However, individuals can detach their sleep timing from the 24-hour rhythm, by getting up early or skipping one or more nights of sleep, and so to prevent damage to brain and body a homeostatic mechanism is needed. This hourglass process is a core mechanism, keeping track of accumulating sleep debt during wakefulness and adjusting subsequent sleep accordingly, but its molecular and anatomical correlates have been unknown.

Regulation of sleep homeostasis by the cerebral cortex

The canonical view was that the nuclei constituting the sleep switch in the brainstem and hypothalamus sense and integrate signals of the 24-hour rhythm, but conclusive evidence was lacking. In contrast, the cerebral cortex has never been considered as part of the sleep-wake regulatory circuitry despite properties that relate to the signalling of sleep debt. For example, the cortex generates ‘slow waves’ on EEG, the hallmark of sleep, and these slow waves are regulated in a local and invasive way. Cortical manipulations to improve sleep initiation in mice through two pathways that project to different elements of the sleep switch (12). An alternative approach to manipulate cortical activity is to use electrocorticography. Non-invasive brain stimulation exerts its effects on brain networks and behaviour by exciting or inhibiting cortical areas and has been used to influence sleep-wake patterns, sleep-related brain oscillations, and memory consolidation during sleep in healthy volunteers. However, attempts to facilitate sleep initiation and boost the amount or quality of sleep in insomnia patients have not been successful (13). Understanding the molecular, cellular and circuitry of cortical sleep regulation remains critical to successfully target the cortex to improve sleep.

The need for neuroscience-based sleep medicine

Sleep restriction is a key element of cognitive behavioural therapy for insomnia (CBT-I) but only about half of the patients receiving CBT-I achieve full remission (14). For long-term treatment of insomnia, the harms associated with prescribed substances outweigh the benefits (15). While some drugs help establish a stable circadian rhythm, none accelerate the homeostatic process that would initiate physiological sleep and its associated functions like memory consolidation; it remains essential to establish the neuronal mechanisms through which the cerebral cortex modulates sleep. Von Economo wrote that “the exact knowledge of the localization of the center for sleep regulation… would make it possible to treat insomnia and other sleep disturbances in a better and more active way than by drugs or by the roundabout way of hypnotherapy and psychotherapy” (1).

Acknowledgements

I extend my heartfelt thanks to Dr. Kristoffer Fehér for creating the captivating cover image and brain illustration. I would also like to express my gratitude to Jack Hamilton for proofreading and language editing this article. Special appreciation goes to my DPhil supervisors, Prof. Zoltán Molnár and Prof. Vladimir Vyazovskiy, as well as my academic great-grandfather, Prof. Alexander Borbély, for their insightful comments on the manuscript.

Bibliography

AI and the Future of Healthcare

Scarlett Harris (Magdalen, 2013) Recently graduated from Oxford, having squeezed a DPhil in the middle. Academic Foundation Trainee, St Mary’s Paddington

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Introduction

2023 was the year artificial intelligence (AI) rooted itself firmly at the forefront of the public consciousness. Defined as the ability of a machine to perform cognitive functions typically associated with human intelligence, the concept of AI was first documented by Alan Turing in his 1950 paper Computing Machinery and Intelligence. Five years later, the programme Logic Theorist was developed and capable of performing automated reasoning, seen by most as the first form of AI. Machine learning was pioneered in the 1980s, with computers learning from their mistakes to improve their functionality independent from computer scientist input. The AI industry has subsequently exploded, from generating driverless vehicles, to facilitating multi-omics biomedical research and assisting radiology reporting. Indeed, the AI-driven world imagined in countless sci-fi novels over the intervening decades may soon be upon us and it will be a major challenge of our time to adapt to this, just as we have done with the arrival of internet in the late-twentieth century. Healthcare is no exception and there are potentially great benefits, as well as significant harms, with the introduction of AI. In this article we discuss the possible impacts of AI on the doctor’s journey, from applying to medical school to a career as a consultant, highlighting key questions which we hope the medical community will be able to answer in the coming years.

First steps: Applying for medical school

Today’s children are likely to grow up in a world where AI is commonplace, with their education being no exception. One would hope for a world where AI technologies aid learning significantly: tailoring explanations to each student, analysing areas of weakness for development and making lessons more interactive. AI may even help guide their career choices. After all, who could know you better than the technology you carry on you every day, capable of analysing every tweet and google search? However, there is significant risk that those without access to the latest technology could lose out in the competition for medical school entry. The pandemic has taught us that the distribution of technology is far from equitable; this may prove particularly damaging in resource exploitative, expensive relationships with journal and software companies which would be particularly damaging in resource

The journey begins: AI at medical school

The impact of AI on education has been a topic of significant debate since the arrival of ChatGPT in late 2022. Capable of providing surprisingly eloquent answers to user-asked questions, this AI Chatbot has already demonstrated itself capable of passing law exams and possibly even the USMLE (United States Medical Licensing Exam), leading to concerns that it may be used by students to write essays or otherwise cheat at exams. On the other hand, some have argued that it can be used to make learning more interactive or as a writing aid to free up student time to focus on content and understanding rather than language construction. Currently, ChatGPT has several limitations which prevent it replacing student work completely; its information is often inaccurate, the references often entirely manufactured, the essays simplistic and its authorship relatively easily detected by examiners or software. However, these flaws may disappear as the model improves and thus there remains the need to determine how we will incorporate ChatGPT and other similar software into medical education.

Furthermore, there will be the need to determine how we incorporate training in the use of AI in medical settings and, perhaps more controversially, which areas of the current syllabus could be jettisoned with AI’s arrival. For example, will we see an increasing focus on skills and less on recall of facts as AI replaces the need for memory? Some medical knowledge remains hidden behind journal paywalls and a dependency on AI for up-to-date medical knowledge may inadvertently create exploitative, expensive relationships with journal and software companies which would be particularly damaging in resource poor settings.

Establishing oneself: postgraduate training

For many, the early days of doctoring are defined by the initial joy of finally graduating, only to be swiftly crushed by the burden of seemingly endless administrative tasks. These seem to take away from training and patient time but are nonetheless critical for continuity and good patient care. Here, AI may be transformative. For example, one company produces AI software capable of documenting physician-patient interactions in real time. Similarly, it has been suggested that AI may be capable of writing discharge summaries. By enabling AI into the medical record, we can also take full advantage of the information contained within, which is often far too great for a single person to process but can be easily synthesized by AI. Overall, the ideal effect would be to free up physician time for patient-centered tasks and training, and improve care by highlighting key information. However, there are still challenges raised, not least how we keep patient data secure and who is legally responsible for the AI-written medical record.

AI may also generate new training opportunities, particularly when it comes to simulation training. We have already seen advertised virtual reality training for surgeons, allowing for the development of precise surgical skills before operating on real patients. As AI develops further, it is easy to imagine this extending into all branches of medicine, with a range of AI-derived avatars on which to practice everything from our history-taking and communication skills to our emergency management. Conversely, there is the risk that a reliance on AI will lead to a generation of doctors without key skills. For example, companies are producing AI software to analyse radiological images, and their introduction into the clinic may mean future doctors never learn to interpret them. Day to day this is unlikely to be an issue and will allow more rapid care, but what if doctors are no longer skilled enough to confirm the AI result is a genuine error but remain legally liable in case of an AI-derived mistake.

Clinicians need to lead and shape the inevitable introduction of AI into their world.

Clinicians need to lead and shape the inevitable introduction of AI into their world. Working with our multidisciplinary teams, clinicians, industry and, most importantly, patients we can advocate for technologies which provide maximum benefit for patients and resist those that may be harmful. We propose the following five ‘rules for AI’ which we believe should guide the introduction of AI.

1. The doctor–patient relationship must remain at the heart of healthcare
2. Databases on which AI is trained must be representative of the entire population
3. Patients should decide the extent of AI involvement in their individual healthcare and healthcare systems
4. AI introduction into healthcare must align with the principles of evidence-based medicine
5. The physician remains the final arbiter
Another bed celebrates the contributions of two 17th century Oxford scholars. The first, Robert Burton (1577-1640), Student of Christ Church, is known for "The Anatomy of Melancholy", published in 1621, the year in which the garden was founded, and one of the most popular books of the 17th century. William Osler said it was "the greatest medical treatise written by a layman". Burton, who suffered from depression himself, recognised the positive impact of physical exercise on mental health. His writing still influences the study of mental illness. The bed includes borage (Borago officinalis) used for anxiety and melancholy. The second, William Cole (1626–1685), Fellow of New College, published The Art of Simpling (1656) in which he popularised the "Doctrine of Signatures" an ancient belief that plants were "signed by the Creator" so that the shape or colour of the flower, leaf or root, or the place in which the plant grew suggested what illness the plant might treat. Nonsense of course. For instance, the spotty leaves of lupwort (Pulmonaria officinalis) were said to evoke pulmonary miliary tuberculosis, so this plant was used for chest infections. The anthropomorphic root of mandrake (Mandragora officinarum) indicated an extraordinarily powerful plant, and mandrake was used for a variety of ailments, as an aphrodisiac and as a vital component of witches’ flying ointments (the antirheumatic trancpe alkaloids in this poisonous plant cause hallucinations, delusions – witches thought they flew– and eventually death). Both grow in this bed.

A midwifery bed features herbs used to help women in labour (or as abortifacients) including mugwort (Artemisia vulgaris) "the mother herb", motherwort (Leonurus cardiaca), birchwort (Aristolochia clematitis) and lady’s mantle (Alchemilla mollis). Common barley (Hordeum vulgare) is host to the parasitic fungus Claviceps purpurea, a source of ergot alkaloids. Bread made from contaminated grain causes blood vessel constriction with gangrene and John Chassar Mor (1900–77), Oxford’s first Nuffield Professor of Obstetrics and Gynaecology (1937–67), started investigating the potential of ergot to prevent post-partum haemorrhage in the early 1930s while still working in London. Ergonovine saved the lives of countless women. The Lancet reported in Chassar Mor’s obituary it was one of the great medical advances of the 20th century. "

Treatments such as beladonna, opium, foxglove leaf and colchicine were advocated by Sir William Osler (1849–1919), the 21st Regius Professor of Medicine, in his classic textbook “The Principles and Practice of Medicine” first published in 1892. A modern medicines bed features these plants and others. The discovery of salicylic acid also has an Oxford connection. Edward Stone (1702–1768), Fellow of Wadham College, published the use of willow bark powder for “curing agues and intermitting disorders”. Willow (Salix alba) and meadowsweet (Filipendula ulmaria) are sources of salicin from which acetylsalicylic acid (aspirin) is derived and both grow in this bed. Tobacco plants (Nicotiana tabacum) reflect the work of another Oxford Regius Professor of Medicine, Sir Richard Doll (1912–2005) who showed how cigarette smoking led to lung cancer and many other diseases. Genetically modified tobacco plants (Nicotiana benthamiana) are being used to produce a wide range of pharmaceuticals including next-generation antibiotics.

Malaria kills more than half a million people every year. In the 1960s Mao Zedong in China ordered a search for new malaria treatments. Tu Youyou, a Chinese chemist with expertise in both modern science and Traditional Chinese Medicine (TCM), found that in 340CE a physician, Ge Hong, had reported that Artemisia annua (Sweet wormwood or qinghao) controlled intermittent fevers. Her team showed that extracts of this plant had antimalarial activity and determined the structure of the active chemical, artemisin. Tu Youyou received a Nobel Prize in 2015. This story also has an Oxford link. Prof Sir Nicholas White (born 1951) is a Professor of Tropical Medicine in Oxford and Professor at Mahidol University in Thailand. White’s Thailand team pioneered the use of artemisinin combination therapy, now the first-line treatment for malaria worldwide. By 2006 the WHO was recommending artemisinin-based treatments for malaria. Artemisia annua celebrates both their contributions.

70 - 95% of people in developing countries depend on traditional medicines. Global health beds will contain plants used in practices such as ayurvedic medicine, TCM and South African ‘muthi’. Examples include Glycyrrhiza glabra (liquorice) used in ayurveda. Agapantus africanus used in muthi, Ephedra sinica used in TCM for thousands of years to control coughs (ephedrine, the active chemical in an effective bronchodilator) and Yarrow, whose leaves contain caffeine, used by Native Americans in cleansing rituals (tea prepared from the leaves was drunk in sufficient quantities to induce vomiting – hence the name Ilex vomitoria). Madagascar periwinkle (Catharanthus roseus) was used in many parts of the world to treat diabetes but investigation showed that extracts of the leaves do not alter blood glucose. Instead, the extract caused a profound drop in the white blood cell count. The resulting vinca alkaloids revolutionised the treatment of childhood acute lymphoblastic leukaemia. Many traditional remedies may merely be placebos but as the stories of vinca alkaloids, artemisin and ephedrine show, some may warrant further investigation. 45% of our flowering plants are threatened with extinction. We cannot afford to lose them. “

Oxapoppo poppy

Longworth laurel

Madagascar periwinkle

Oxford Botanic Garden is the oldest in the UK and recently celebrated its 400th anniversary. It was Oxford’s 6th Regius Professor of Physick Thomas Clayton (1575 -1647) who played a key role in its founding. Clayton studied languages, music and natural philosophy at Balliol College, receiving a master’s degree in 1598. After spending several years as Professor of Music at Gresham College in London, he returned to Oxford to complete his medical studies. He became Regius Professor of Physick in 1612, a position he took over from his father-in-law. Clayton wanted to provide facilities for the study of medicinal plants, but money was needed to establish a physic garden to facilitate this. Henry Darvies, Earl of Danby (1573-1643/4), a distinguished soldier who had retired to live near Oxford came to the rescue. A contemporary account describes that Danvers was “minded to become a benefactor to the University, determined to begin and finish a place whereby learning, especially the faculty of medicine, might be improved”. It is also recorded that Darvies “suffered much ill health” in retirement. It seems likely that Darvies would have consulted the eminent physician, Thomas Clayton. Clayton’s image on the Oxford Botanic Gardens and the Medicinal Garden at the Royal College of Physicians.
Suicide in Doctors

Reports of doctors' suicides understandably cause considerable disquiet, not just for family and friends, but also for other members of the profession. They also raise questions, such as: Why did they do it? Surely, they could have got help? And, most pertinently, was there something that could have been done to prevent this sad event? Here are some facts about this issue of suicide in doctors, some thoughts about what can be done to try to help colleagues in distress who may be at risk, sources of help for troubled doctors, and how those affected by the death by suicide of doctors can get support.

Until some years ago, suicide rates in doctors of both sexes in the United Kingdom were elevated above those of comparable groups in the general population. This is in keeping with the pattern in several other countries. However, the rate in male doctors in England has since declined such that the risk has become relatively low. Suicide rates in female doctors in England also appear to have declined to being comparable to those of other women. In terms of numbers of doctors’ deaths recorded as suicides in England by the Office for National Statistics, between 2011 and 2021 there were 178 in total - 120 in men and 58 in females, so averaging approximately 11 deaths per year in men and 5 per year in women. This reduction in levels of suicide in doctors is clearly encouraging, but the questions of why they did this, and in particular what can colleagues do in this regard? It is impossible. But a more general approach to helping colleagues who appear to be going through difficult times may be effective. This can include simply reaching out to clearly troubled colleagues, acknowledging that they don’t seem to be their usual self, or, if there is clearly a crisis for an individual, offering the opportunity for a friendly confidential chat.

Introducing this possibility with statements such as, ‘you seem to be having a difficult time just now, I wonder if you might you find it helpful to have a chat’ may encourage a troubled doctor to begin to share their problems. The potential value of someone expressing concern and wishing to help in such circumstances should not be underestimated (some of the most powerful factors that may prevent suicides are human connection, expression of concern, and showing empathy). Where it becomes clear that a doctor needs help related to mental health or substance misuse problems, in addition to the usual potential avenues for seeking help (e.g., general practice, occupational health, local psychiatric services). NHS Practitioner Health can be a particularly valuable source of help (weblink below).

When a doctor dies by suicide, colleagues may well feel in need of help to cope with the loss. One easily accessible source of information is Help at Hand, which is available as a pdf and as a free hard copy (link below). Informal discussion with colleagues also affected by the loss may be helpful. In addition, there are several bereavement support organisations in the UK which provide specific help for people bereaved by suicide. Finally, NHS England has recently developed a toolkit for help with the aftermath of suicide by any health professional (link below).

What do we know about factors that contribute to doctors’ suicides?

To some extent these are similar to influences on suicide in other individuals, including, for example, mental disorders, alcohol and drug misuse, major physical illnesses, disruption of key relationships, and financial problems. But there are other factors somewhat more specific to being a medical practitioner, such as serious adverse outcomes of patient care, difficulties in relationships with clinical colleagues and management organisations, and medicolegal issues, especially those that lead to disciplinary actions. Additional factors that may contribute to risk are knowledge of, and access to, means used for suicidal acts, especially poisoning.

What can be done to prevent suicides of doctors, and in particular what can colleagues do in this regard? It is important, first, to recognise that we have learned that the prediction of who is likely to die by suicide, whether a doctor or anyone else (including people with mental disorders) is virtually impossible. But a more general approach to helping colleagues who appear to be going through difficult times may be effective. This can include simply reaching out to clearly troubled colleagues, acknowledging that they don’t seem to be their usual self, or, if there is clearly a crisis for an individual, offering the opportunity for a friendly confidential chat.

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When a doctor dies by suicide, colleagues may well feel in need of help to cope with the loss. One easily accessible source of information is Help at Hand, which is available as a pdf and as a free hard copy (link below). Informal discussion with colleagues also affected by the loss may be helpful. In addition, there are several bereavement support organisations in the UK which provide specific help for people bereaved by suicide. Finally, NHS England has recently developed a toolkit for help with the aftermath of suicide by any health professional (link below).

Many of my English colleagues with whom I trained are now retired. So why I am still working? And enjoying it?

My field of Obstetrics and Gynaecology imaging has advanced massively thanks to new high-resolution ultrasound machines, the advent of foetal MRI, advances in genome analysis, all backed up by high quality neonatal intensive care. In addition, thanks to new software platforms I can now teach across the globe (Radiology across Borders https://ogimagingupdate.wordpress.com). This week I delivered a teaching session to 600 doctors from 72 different countries, helping doctors in the developing world improve their ultrasound interpretations and hence their patients.

But for me it’s human interactions, not technical skills, that are key.

A GP friend observed the death of caring senior clinicians in the medical workforce. She meant a lack of kind, caring role models for trainees, not disdain for patients, and I agreed.

In Australia it is competitive at every level of medicine. Junior doctors have to work harder, publish more and achieve more to get on. Many find the pressure of constant exams, the relentless expectations, and their fear of failure overwhelming. There is a high rate of burnout (43% for G&G trainees in one UK study (1)) and doctors’ suicide remains of great concern. (2). So, we need kinder, more supportive senior clinicians.

As I reflect, many examples come to mind where simple acts of kindness - a well-wishing text to an ill trainee, a listening ear, a bunch of flowers, a card, a prayer - have made important differences both to the recipients, and maybe those observing them.

It’s caught, not taught.

Dr. Babu Janardhanan (weblink below)

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It’s caught, not taught.
The discussion of artificial intelligence (AI) applications in day-to-day life and work looms large in the media and professional landscape. Medicine is no exception to this repetitive news-cycle-driven affliction, but are we putting the cart before the horse?

There is a comical and irritating contradiction between the struggle for hospitals to fully digitise and the omnipresent explosion of artificial intelligence (AI), an omnipresent buzzword which implies a high-level of digitisation.

However, a recent survey showed that three-quarters of NHS trusts in England, continue to rely on paper. Even in hospitals that have digitised, the government reports describe substantial variation between organisations and legacy systems which in some cases simply do not work. Frustrated healthcare professionals circumnavigate or completely avoid certain features, while medical journals espouse the potential for AI in diagnosis and management of patients.

Pushing boundaries in research advances healthcare but focusing on AI advances, while medical journals espouse the potential for AI in diagnosis and management of patients.

My concern is that ignoring this contradiction will lead to greater health inequalities, through digital variation and a hospital postcode lottery. This is contrary to the NHS’s purported utilitarian ethics, if the use of QALYs by NICE is not entirely accurate) answers to queries.

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Putting the cart before the horse?

The government plans to meet core digitisation standards, including for 95% of trusts to have electronic records by March 2025, with £2 billion invested in secondary care technologies to that end. At the same time the intersection between computer science and statistics, in the form of AI and data science, has evolved to deliver products like ChatGPT which use natural language processing to produce staggeringly fast and comprehensive (albeit not always entirely accurate) answers to queries.

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F1 Survival Page

Painting
Dr Elizabeth Hatton
(St Catherine’s College, 2017) F1 Great Western Hospital, Swindon

F1 is daunting. It’s what you’ve been working towards for years – every essay, every placement, every exam building up to the day that you can finally call yourself ‘doctor’. Of course, there are great things about the job. You’re now a key member of the team and are possibly the face patients see the most. They grow to trust you, and that is truly a privilege. Nonetheless, learning how to separate work from home is essential.

I have always enjoyed art and remember desperately trying to weave this hobby into my personal statement. I talked about my dexterity and my eye for detail, skills I thought were essential for a doctor. However, the escape it provides has ended up being far more important. I rediscovered my love for art during lockdown and have continued through my first months of F1. It helps me switch off at the end of a long day. I particularly enjoy painting portraits and when focussing on the brushstrokes, I leave whatever happened that day behind me.

Climbing
Dr Jack Wilson
(Queen’s College, 2017) F1 Gloucester Royal Infirmary

I started climbing towards the end of medical school, going to the climbing wall in Brookes because some of my friends went. I really enjoyed the combination of physical challenge and different techniques, so I started going regularly. As well as being a physical endeavour, the mental part is what makes it so great for switching off from work and other stresses. You can’t be thinking about much else when holding on and moving to the next position is stopping you taking a fall! It’s a sociable and welcoming sport and helped me make some great friends when moving to a new city to start my foundation training.

I’ve always loved the outdoors, so a hobby where I spend the day in cool locations in the countryside is a great contrast to my working life, even if I’m only climbing a couple of routes, a day being outside always seems to reset my mental state in such a good way. The other great thing is that there are no fixed training sessions, so it fits around the varying schedule of working in medicine without impacting the level of enjoyment I take from it.

Crocheting
Dr Leasha John
(Oriel College, 2017) F1 Great Western Hospital, Swindon

In my spare time I find myself gravitating towards creative outlets. I was a very active sports person but, following an ACL reconstruction this year, my energy is now poured into making clothes by sewing and crocheting. I became enamoured by both during lockdown (very clichéd) but throughout childhood my mum would always be sewing and so it was always at my fingertips.

I can vouch for it as a stress relieving activity; how can you be thinking if you prescribed the correct PPI when you’re obsessively counting crochet stitches or trying so carefully to not pierce your fingers with a sewing machine? My magnum opus thus far was my Magdalen Ball 2023 creation: a full four-piece ensemble with a top, skirt, corset belt and crocheted shawl to match. I cannot emphasise enough how important it is to have a comfort hobby to wrap yourself in when you just need to reset, like a warm handmade blanket on a rainy day.
Denis Noble was born in 1936 in London to working-class tailors and there is an early photograph of him in 1945 outside their garden in Balham in London, looking so thin after the war as there was so little to eat. He was the oldest of four boys and went to Emanuel School in London and it was here in 1947 that he encountered four brilliant science teachers of whom Harry Hirst in chemistry was the most inspirational.

He secured a place at University College London to do medicine, passed the 1st MB, but then went straight on to a BSc and PhD. So, he never trained clinically but does now have an Honorary FRCP!

Otto Hutter was his PhD supervisor and a mentor throughout his career until his death in 2020. Otto was working on the cardiovascular physiology at the University of Oxford from 1984 to 2004. He is one of the pioneers of systems biology and developed the first viable mathematical model of the working heart in 1960. He is an Emeritus Fellow of Balliol College Oxford.

As a teenager, he was trained as a Magician by a stage performer, Tommy Dee. He plays classical guitar and sings Occitan troubadour and folk songs (Oxford Trobadors). In addition to English, he has lectured in French and Italian, Occitan troubadour... be bold!...be bold!

His days began at 5am to collect hearts from the slaughterhouse, arriving back at the lab to put them into Tyrode solution. During the day he would dissect out the Purkinje fibres and experiment till 10 o’clock at night. At 11pm he would have a cup of coffee and at 2am went to the computer for two hours. It was a 24-hour rhythm that would go on for three or four days and then he would crash out. A few months later he found the answer and would never forget seeing the first data coming out with the rhythmic up-and-down wave form. The results were written up for a paper in Nature. Denis was 24.

In 1963 he was approached by William Paton, Professor of pharmacology in Oxford, to apply for a fellowship in physiology at Balliol. By this time he had married Susan, a student at Somerville College, who, with Hilary Brown, Dario Difrancesco and Denis, found that other mechanisms, particularly the HCN channel, were important.

Denis was asked to give an annual review lecture to The Physiological Society based on this work, only to have the subsequent paper rejected by the Journal of Physiology! However, it was accepted by The Philosophical Transactions of the Royal Society and in 2015, when the society was celebrating 350 years, they chose that paper alongside an extraordinarily distinguished set of previous papers that began with that of Sir Isaac Newton.

It was at this stage in the interview that Denis pointed to his bookcase with 30 facsimile scrolls and 36 volumes of Japanese translation of Chinese medicine kept by the Imperial Family in Japan for over 1000 years. He had been the moral tutor to the Empress of Japan when she was a student in Oxford, and this gave him access to this extraordinary archive kept private for over 1000 years. It was a compilation by Tamba Yasuyori in the 10th century of all he had learned of Chinese medicine, filtered by his own Buddhist credentials, excluding toxic metals, and animal products. Japan had turned out to be the guardian of a unique compendium of herbal Chinese medicine.

In 1984 Denis Noble was appointed as the Burdon Sanderson Professor of Cardiovascular Physiology. Burdon Sanderson was the Regius Professor of Medicine in Oxford before William Osler, and was the first person to do a long-lasting nature of the heart action potential showing that the T-wave was the repolarisation wave.

In the 1980’s Denis was the founder of ‘Save British Science’ which resulted from Margaret Thatcher’s cut in funding and he remembers Professor Jim Gowans coming in to address the MRC committee he was chairing at that time, explaining a 20% cut to the MRC budget. As much of the funding had already been committed for five years, it meant that awards were cut from seven or eight projects to one.

After retiring in 2004 he worked on The Music of Life which was published in 2006. It was a direct challenge to Richard Dawkins, whom he knew well, having examined his thesis in 1966. They met again at a famous debate at The Institute of Art and Ideas festival at Hay-on-Wye which remains available on Youtube and on Denisnoble.com.

In the last chapter of Dance to the Tune of Life published in 2016, he explores the idea that our knowledge is relative to what we already know, and we ought to recognise what we don’t know. He illustrates that with reference to the model of the universe which is exceedingly fragile. He reaction to the Big Bang model (he is a modeller himself and was in discussion with some of the key proponents of this) is that it can’t be true and would not predict what we are seeing as some of the earliest structures that are now being accessed by the James Webb telescope.

“There’s something missing here, so my feeling about our knowledge of the things that exist, that’s the universe, how did they come to exist, the big ‘Why’ question why do they exist, the best answer is we don’t really know, so I think that atheism is not a bad description of an agnostic view which I hold.”

Asking what he hoped the government would do for science he said: “I would love to be able to do what I did in 1996, roughly 10 years after Save British Science was formed. I was able to speak with Tony Blair and said: “We have now had 10 years of not being prioritised. Can you look forward to a ten-year period in which you can slowly rebuild that?”

He appreciated that and eventually he appointed David Sainsbury of the Sainsbury family as the Science Minister, who did just that. Hence, we changed the name to The Campaign for Science and Engineering.

When asked if Brexit had damaged science he replied: “Yes, we have damaged ourselves. French colleagues have felt we have thrown away the best science in the European Union, but there is a way back if we only remove this extreme insistence on sovereignty above everything, we could restore some of the damage.”

And asking what advice he would give a young scientist today he replied: “First I would say you will get nowhere unless you get some funding, make a brilliance for whatever you can do that will raise funding for yourself, but then try to do what I did for many years. Keep 5% - 10% for those barny ideas which you may not even yourself believe in. You know one of those might be your savour you never know - be bold!”

1Hyperpolarization-Activated Cyclic Nucleotide-Gated Ion Channels and Cardiac Function. In the heart, HCN channels control the spontaneous depolarization of the sinoatrial node and, therefore, commands the heart rate.
The story of the clinical medical school at Oxford begins in 1939 (there had been one that opened in 1780, but it closed in 1833). Over the years the Directors of Clinical Studies (DCSs), have been responsible for the evolution of the medical training as well as the pastoral care of the students.

In the first decades of the twentieth century almost all students doing their preclinical degree at Oxford went to London hospitals to continue their studies. In the 1930s, Sir Hugh Cairns suggested establishing an academic clinical school solely to train doctors to go on to academic posts in the new Nuffield Departments but it did not materialise.

The idea of a clinical school re-emerged when WW2 began. The resultant clinical school was largely due to the work of Dr Alexander Cooke, a physician both erudite and enthusiastic. London medical schools were dispersing students and patients outside London because of fear of bombing in the capital. Dr Cooke felt it was sensible for Oxford students to stay and do their clinical training in Oxford. The school opened within days with sixty students. Dr Cooke was the first DCS, holding the post from 1939-1949 (he was actually called sub-dean, which is the term other medical schools used).

In 1944 the Goodenough Committee on Medical Schools recommended that Oxford should become a small experimental undergraduate clinical school, radically new and ground-breaking. Whilst this caused great excitement, it came to nothing and only five students joined in 1945.

In 1949 Dr Sidney Truelove took over as DCS. He was a gastroenterologist and was famed as an outstanding teacher. If students failed to come up to scratch on a ward round, they were dispatched to the library and told to give a presentation the following week.

The student numbers were still low, and Truelove published a memorandum recommending, among other things, better communication between the hospital and the medical school. In addition, he felt there should be more beds under the control of the professors for the teaching of students.

The problem was addressed by Sir George Pickering who became Regius Professor of Medicine in 1956. He had a lifelong passion for teaching and medical education and, working with his DCSs, was largely responsible for the success of the modern clinical school. Dr John Badenoch became DCS in 1955. He and Pickering travelled round the country, especially to Cambridge (which did not have a clinical school), espousing the virtues of the Oxford clinical school. Subsequent DCSs carried on the good work.

Dr Michael Dunnill, a notable pathologist, who was DCS from 1966 to 1972, remembers telephoning Cambridge tutors and visiting to speak to undergraduates there. Dr Dunnill, as a member of the clinical sub-faculty, produced a memorandum in 1969 proposing changes to the course. These included shortening the clinical course from three to two years. An introductory course was brought in and continuous assessment replaced some of the more formal examinations. Finally a revision course was added in the final three months. This was controversial as it was feared students might be tempted to cruise through the clinical course doing little work but pass finals due to what they learned in the revision course.

Dr Jim Holt took over as DCS in 1972. He worked in the Nuffield Department of Medicine, as a consultant general physician. He was quite junior when he became DCS. He increased the length of the clinical course back to three years and tutored students in the “bridge course” which was set up by Professor Paul Beeson to link the preclinical courses of Oxford, Cambridge or London with the clinical course at Oxford.

Professor John Ledingham served two terms as DCS, from 1977 to 1981 and 1991 to 1995. Well known to us all (and an important founder of the OMA), he was loved by his students and immersed himself in student life. He was always ready to fight the students’ battles and he spoke up for them when they feared losing Osler House, their club and home at the Radcliffe Infirmary, when Green College opened.

He was followed as DCS by consultant radiologist, Sir Christopher Paine in 1982. He sent a questionnaire to all the clinical students to learn their views on the course and worked with John Ledingham to improve the curriculum. At this stage the intake was a hundred students. If the number dropped below this, it was financially detrimental to the university.

Surgeon Mr Julian Britton took over in 1985. The reputation of the clinical course by now was such that over three hundred potential students applied for the one hundred and fifty places available. However, he worked with the Nuffield Professors Sir David Weatherall and Sir Peter Morris to interview all the teaching staff to get their views on the course and how it could be improved further. It resulted in the important development whereby general practice became a significant part of the course, with dedicated teaching time.

The baton was passed to radiologist Dr Basil Shepstone in 1988. He hailed from South Africa and is fondly remembered as a warm and humorous teacher. One saying was: “Everyone here is clever but you also need to be kind.”

Following John Ledingham’s second term of office, Professor John Sear became DCS in 1995. He continued his work as anaesthetist and played an important role in the development of Green College and also the Graduate Entry Scheme which enabled graduates with an arts or other degree to enter the clinical school. John Sear selected and taught these students, making sure they learned the necessary basic sciences.

Dermatologist Dr Susan Burge, DCS from 1999-2002 was the first woman in the role. She faced the challenge of two imminent rigorous inspections of the medical school; one by the GMC and one by the Quality Assurance Agency (a body that exists to maintain the standard of higher education in the medical profession as well as to oversee the training of doctors). She navigated these inspections and the next, the GMC inspection, with aplomb.

The result of the work of these fourteen DCSs is a medical school that is highly regarded both nationally and internationally. The medical school lacks a written curriculum (students are encouraged to explore topics widely as they still are) and final examinations tended to reflect the interests of the clinical examiners, rather than being blueprinted to the curriculum. The clinical teachers collaborated and agreed a curriculum. Examiner training was formalised and examinations were restructured. The medical school passed with flying colours.

The next appointment was Professor Tim Lancaster who was DCS for a long tenure (2002 -2017), the first time the DCS was a GP. He was interested in the academic side of primary care but continued his clinical commitments throughout his time as DCS. He enjoyed hands on teaching and the pastoral care of the students. He is an outstanding teacher and was very much involved in the care of the students. He responded to a request from final year students for guidance regarding their study for finals by developing small group teaching sessions with patients and experts, which evolved into a webinar series. After stepping down as DCS, he spent four years as Dean of Medical Education at King’s College London, and is now back in Oxford in clinical practice.

Dr Tim Littlewood took over as interim DCS for a year in 2017. He is a haematologist, with a love of teaching and was nominated as a role model by his junior staff in the BMJ in 2017. The present DCS, appointed in 2018, is rheumatologist Dr Catherine Swales. She stresses the importance of team work in the department, from medics to administrative staff. Like previous holders of the post, she relishes the variety of the job, ranging from the pastoral care of individual students, to making major decisions for the future of the medical school.
Poirot, Clues and Psychology

‘To begin with’ Poirot says to his friend, Hastings, ‘we apply our psychology. We find three points at which Monsieur Renauld displays a distinct change of view and action – three psychological points therefore.’

This quotation is from the second Poirot novel, _The Murder on the Links_, first published in 1923. Poirot’s use of the word psychology here marks the most significant development in Agatha Christie’s evolution as a writer of whodunits.

We first meet Poirot in _The Mysterious Affair at Styles_ (1920). In this novel Poirot is essentially a Belgian Sherlock Holmes. With metaphorical magnifying glass in hand, Poirot inspects the scene of murder in great detail, smelling an almost invisible stain on the carpet, and using a fine pair of forces to extract a fragment of green cloth. This behaviour demonstrates the brilliance of Poirot but is of little help to the reader in solving the puzzle. In explaining his methods Poirot emphasises the importance of details, and of putting one fact at a time together to form a chain in order to seek a missing link. He makes no mention of psychology.

In this first published novel Christie, unlike Conan Doyle, was attempting to write a genuine whodunnit. It is partially successful. There are clues that can help the reader but by her later standards these are desultory, and the plot depends on some rather arcane pharmacology (that we didn’t know despite having been taught by Professor Grahame-Smith).

In _The Murder on the Links_ Poirot (and Christie) undergo a transformation. He is no longer the caterpillar he was in the first novel, but not yet the butterfly he will become. What Christie is beginning to understand is that the physical clues, what might be called sleuth clues, are of little help to readers in solving the puzzle. The ‘distinct change of view and action’ that Monsieur Renauld displays, however, can indeed enable the alert reader to solve one of the puzzles in the book.

The term psychology marks Christie’s realisation that she must go beyond ‘sleuth clues’ if she is to set readers difficult puzzles that can be solved. From her very next Poirot novel, _The Murder of Roger Ackroyd_ (1926), Christie developed new types of clue and Poirot never again makes use of a pair of forces.

Poirot does not elaborate at this stage on what he means by psychology; it includes odd remarks and inconsistencies in what people say, and changes in people’s behaviour. But it seems to encompass for both Poirot, and for Christie herself, almost any type of clue other than Holmesian sleuth clues. Poirot does however hint, in _The Murder on the Links_, at a more profound sense of the importance of psychology in solving a crime.

... when you have two crimes precisely similar in design and execution, you find the same brain behind them both. I am looking for that brain, M. Giraud—and I shall find it. Here we have a true clue—a psychological clue. You may know all about cigarettes and match ends, M. Giraud, but I, Hercule Poirot, know the mind of man!"

That hint, knowing the mind of man, remains dormant. In the ten years from 1926 to 1936 Christie wrote several of her greatest whodunits, developing her particularly sophisticated approach to plots and clues. Many of those clues involve how people behave or what they say, but they are not ‘psychological’ in that more profound sense of revealing the mind of man.

And then in 1936 Christie published _Cards on the Table_, the first novel in which we meet that fictional crime writer, Mrs Ariadne Oliver. _Cards on the Table_ was a bold experiment that didn’t quite come off. Christie was attempting a new approach to clueing, a new kind of whodunit. Her experiment is so interesting, the set-up so good, and the character of Mrs Ariadne Oliver such fun, that we will see very few novels better than that have a more satisfying solution.

The setting of _Cards on the Table_ was outlined in _The ABC Murders_ published earlier the same year. Christie knew that she was trying something original and was worried that readers would not appreciate it. She took the unusual step of providing a foreword. She wrote: ‘The deduction must, therefore, be entirely psychological, but it is none the less interesting for that, because when all is said and done it is the mind of the murderer that is of supreme interest’.

At the centre of the novel is the asexe Mr Shaitana. He is a collector of fine things, like Chinese furniture, Persian rugs, Japanese prints, and murderers: ‘A murderer can be an artist… Surely my dear M. Poirot to do a thing supremely well is a justification.’ The caught murderer, he argues, ‘is necessarily one of the failures. No! I look on the matter from the artistic point of view. I collect only the best – the ones who have got away with it.’ He invites to dinner, and to a game of bridge, four people whom he thinks have got away with murder.

What Christie was attempting was to set the reader the task of identifying the murderer by matching the nature of the murder to the mind of one, and only one, of the suspects. Poirot puts the point clearly: ‘We know the kind of murder that has been committed, the way it was committed. If we have a person who from the psychological point of view could not have committed that particular type of murder, then we can dismiss that person from our calculations.’ Hence Christie’s decision to make it crystal clear who are the suspects, and to limit their number to four.

Christie provides three sources of information to help the reader build up the psychological profiles of the four suspects. First, how they played bridge. Second, their past, and in particular the details around the deaths which may in each case have been murder. Third, the answers they give Poirot when he asks them to describe the contents of the room in which they played bridge.

Christie was in effect writing a novel about criminal psychological profiling, over 50 years before it became popular in fiction, in books, films and TV dramas (such as _The Silence of the Lambs_ and _Criminal Minds_), and over 30 years before the first unit devoted to such an approach was set up in the FBI in 1972. Perhaps Christie knew about the attempt to use such an approach in the Jack the Ripper case in London in the 1880s. Perhaps it was simply the outcome of her developing the idea of ‘psychological clues’ in a whodunit.

This experiment in psychological profiling failed as a whodunit. No reader can be confident in identifying the murderer on the basis of matching the suspects’ psychologies to the nature of the murder. More definitive clues are needed. But Christie did not give up on exploring the nature of psychological clues. Her creative mind kept thinking about the possibilities.

In _Appointment with Death_ (1938) Christie explored the idea that the crime can be solved through an understanding of the psychology of the victim, rather than of the murderer. At the beginning of the denouement, which makes up almost 20% of the novel, Poirot says: ‘My arguments are mainly psychological’. Carbury, the non-nonsense military Englishman, responds with a sigh: ‘I was afraid they might be.’ ‘But they will convince you’ Poirot reassures him.

Despite Poirot’s rhetoric, however, it is the ‘actual’ clues that are the key to solving the murder. Psychological profiling once again failed to provide the basis for a convincing whodunit. Christie gave up on the idea. Then, in 1949, she published _Crooked House_. This highly original whodunit comes wrapped in a romantic cover. The nature of the solution posed narrative problems and as a by-product of solving these, Christie wrote the most successful of her novels that involve ‘knowing the mind of man’.

In the key scene the narrator, Charles Hayward, a man in his thirties, is talking to his father who is Assistant Commissioner of Scotland Yard. ‘Dad’, Charles says, ‘what are murderers like?’ In the course of his long and thoughtful answer, Charles’ father says that the brute that operates with instinct ‘in order to prevent us from killing doesn’t operate with murderers. He goes on:

A child, you know, translates desire into action without compulsion. A child is angry with its kitten, says ‘I’ll kill you’, and hits it on the head with a hammer – and then breaks its heart because the kitten doesn’t come alive again! Lots of kids try to take a baby out of its pram and drown it; because it upsets attention – or interferes with their pleasures.

He goes on to adumbrate his views on the development of moral sensitivity: first children learn that things are wrong in the sense that they will be punished if they do them. Later they develop a true moral sense and ‘feel’ that certain things are wrong. Murderers, Charles’ father is arguing, are often morally immature. In this scene Christie does most of the groundwork of enabling the reader to form a psychological profile of the as yet unknown murderer. In this novel, as in so many of her whodunits, we see Christie combining the three principal elements of her art to form a satisfying whole: clever plots, complex clues and cunning misdirections.

Sally and Tony Hope’s book _Agatha Christie: Poirot, Clues and Misdirections_ was published in September 2023 by The Book Guild Ltd.
It is the pantomime season (‘oh no, it’s not’ if this is the summer issue) and a pink elephant called Rita will again grace and disgrace the Tingewick stage. But why a pink elephant and why Rita?

A wave of Basil Shepton’s magic wand, Figure 1 and a magic spell (‘a sprinkling of stars, a hey and a ho, it’s into the archive we must go’ let us escape 2023 and its trumpey-Thump, and go back to the even darker days of 1939.

The first 25 years of Tingewick are documented in the archive by GE Moloney, presumably the Moloney that was Professor of Surgery in Riyadh; the author of ‘A Doctor in Saudi Arabia’ and described by Terence Ryan thus: ‘Ted Moloney (‘operating as quickly as he eats’) in a Bentley swinging speedily into the car park’. Yes, young readers, doctors did once drive Bentleys. In 1939 the London hospitals were evacuated (neuroscience & surgery went to a field in Sussex) and Oxford students had to stay in Oxford for their clinical training where they were joined by London emigres accustomed to an Xmas concert. The war heightened the need for escapism and in 1940 a pantomime, ‘Dick Whittington and his Dog’, Figure 2 was staged. On the last night the instigator, the same Charles Fletcher as ‘Dick Whittington and his Dog’, Figure 2 was staged. On the last night as Dr Who, albeit with cheaper actors and lesser special effects, Rita regenerates at regular intervals but the archive has photos of only some of the Ritas. The 70s Rita had tusks and very big eyes. In 1983 the beast was, in my un-elephantine memory, fragile and smelly yet still working in 1985 Figure 5.

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In 1990 (A Christmas Carbuncle) she was spotted as a very elegant elephant hybrid, Figure 8 whilst the the latest, and biggest, Rita, Figures 9,10,11 seems to attend lectures, play drums and maintain a social media presence. https://www.facebook.com/rita.tingewick In other years she has been present in head only. Figure 12, 13.

Rita has featured in every fund-raising programme, and Tingenwick memorabilia is still available, as ties, bow-ties and more. Figure 14. One former serenity might have roused on what pink elephant garment can be issued to lady members in lieu of the society tie?” but please don’t send suggestions. Traveling the archives, the casual unquestioned sexism of the past stands out. “Opinion at meetings has been strongly in favour of keeping the cast all male”. There were officially no female members of the society until 1969 (by a vote of 7 to 5 with many abstentions). Dr Smail, the serenity who campaigned for the admission of women, recalled in 2007 that “the 1969 production marked the emancipation of women within the Tingenwick society – hard to believe that it took until then to give women equality in the Tingenwick society when women were first admitted to medical degrees in the UK in 1876!!” With comments like “as for the female talent in Osler House, it has to be admitted that the quantity is very limited”, it is remarkable that any woman student ever wanted to take part. “What an irony that, in meeting after meeting, the honorable gentlemen of the Tingewick society failed to notice the presence or gender of the very female Rita, the . . . er . . elephant in the room. Fortunately, like trunk calls on a telephone, those days are long gone.

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One peculiar aspect of the whole charade is that actual hallucination of a pink elephant seems rare indeed in the medical literature, despite how often we hear it associated with excess alcohol or delirium tremens. A search of case reports located a single report of the hallucination of an elephant, but not a pink one and, in this case, a patient suffering from schizophrenia. Is it too commonplace to report, or is it a myth? In the neurology world one might imagine a pink elephant appearing in Charles Bonnet syndrome or as an epileptic aura but if so, it isn’t reported. Parkinson’s and Levy Body dementia patients frequently report visual hallucination but, at least in my experience, nobody ever ever sees a pink elephant. One might imagine them appearing in the phenomenology of LSD or MDMA but no, not here either. Wikipedia (no effort has been
Life after Medicine: Antiques

Eleanor Feldman DM (St Hilda’s College, 1975) Consultant Liaison Psychiatrist/Hon Senior Clinical Lecturer, Barnes Unit, John Radcliffe Hospital, Oxford, Consultant in Eating Disorders, Warneford Hospital, Oxford (Retired)

Pluripotent in your youth, with scope for varied interests as students, once qualified, with much less leisure time, work can become all consuming. If we’re not careful, our role defines us, being a doctor becomes our identity, making it hard to contemplate letting go as retirement approaches. Fear not, life after Medicine offers us a golden opportunity to dedifferentiate.

Many of us will have had hobbies and interests that were just pursuits to amuse and relax us during time off, sometimes these hobbies become passions. In my case it was antiques, especially glass. So, when planning my retirement, it was time to set up a small antiques business.

Many antique dealers start as collectors, the pleasure of treasure hunting becomes addictive, we accumulate so much that our homes become cluttered, but engaging the hunt, we just can’t stop buying. The solution is to sell, hence the hobby morphs into a small business. Keep it small, no need to take on overheads like leasing premises or employing staff, tax affairs are simple for a sole trader with profits below the VAT threshold. You’re only doing it for fun, not income... and nobody dies. You discover that a lot of the skills and attributes you used in your medical career come in handy in your new business. What are they then?

People skills

Useful in every walk of life: building rapport with customers, no hard sell, just a friendly chat much like talking to patients. This helps you discover what they want and why, so you’re not totally in the dark about what to bring for sale. If renting space in a centre that employs staff, make friends with them; they will be selling your items. When negotiating a purchase be friendly to facilitate negotiating the best deal; dealers at antique fairs often have a pretty boring time and enjoy intelligent conversation so even if you don’t buy but do like their items, compliment their stock, you may learn something useful from them and it may help you get a better deal in the future. When buying, asking what’s the best for cash?’ will get you at least 10 percent off unless the ticket says NT (no trade), or the item is already very cheap. Another tactic can be to allow silence to do the work; you don’t know how keen the dealer is to sell or what they paid. Tolerating silence to encourage a response is a learned clinical interview skill.

Knowledge is power

Some dealers are very expert in just one or two areas but have little knowledge or interest in the rest of what they offer. This is where study skills come into play. Prior decades of collecting and handling items, visiting museum collections (including abroad), reading, and ‘Googling’, albeit with a critical eye, means you accumulate vast knowledge and experience giving you an edge when buying. Add a good visual memory and you can make great spot diagnoses.

Business skills

If you’ve worked exclusively or mainly in the NHS, these will be something to acquire. However when it comes to tax affairs, the NHS travel claim form proves a useful template for business travel and subsistence. Stock needs to have a wide appeal, which means keeping abreast of fashions in antiques and collectibles.

Understand the particular ecosystem of your market: what do competing dealers in the same space sell?, who are your customers?, what do they want?

And finally, academic skills in research, writing, and lecturing watch this YouTube video to find out more about how I have applied these! https://www.youtube.com/watch?v=hPBWwqfBX_U

‘Fear not, life after Medicine offers us a golden opportunity to dedifferentiate.'
I was wrong. My prediction that very soon all articles will be prefaced with reference to the climate crisis did not happen. Call me impatient, but I could not let this edition slip through without considering our role in helping prevent the impending cataclysm. Global problems undoubtedly need global strategies. Negotiating economic interests and entrenched behaviours requires skills and influence.

The medical community is a powerful, trusted societal group, and we are therefore well placed to advocate for change. Although ‘no one snowflake believes they are responsible for the avalanche’, we as individuals can be part of the solution. We can influence our own prescribing and treatment options. Although ‘no one snowflake believes they are responsible for the avalanche’, we as individuals can be part of the solution. We can influence our own prescribing and treatment options. Although ‘no one snowflake believes they are responsible for the avalanche’, we as individuals can be part of the solution. We can influence our own prescribing and treatment options.

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I confess to a quiet glow of pride when I see the cycle park buzzing with children on bikes and hear parents who have travelled after many hoops and hurdles, we built a ‘miniature village’ cycle training park; trained volunteers to teach cycling; run a cycle shop to restore, repair and sell pre-loved bikes, and have established local cycle charity. (Farcycles).

And finally . . . a good news story, first to make you smile, and then to make you think. Last year David and I received a Queen’s Award for voluntary services (the equivalent of an MBE for a charity). It wasn’t expected, but the recognition encourages us to share the story.

Sometime in 2018, this Youtube clip Frozen Parkinson’s Patient Cycling Skillfully woke me up to the importance of learning to cycle in childhood, as an important life-skill. And life means life.

Two of my passions ignited (encouraging people to exercise and reducing carbon emissions), I decided to help every child in our town to learn to cycle, by chipping away at the obstacles and excuses: nowhere to learn; no teachers; no bikes; broken bikes; parental fear and apathy. Two years later, after many hoops and hurdles, we built a ‘miniature village cycle training park, trained volunteers to teach cycling, run a cycle shop to restore, repair and sell pre-loved bikes, and have established local cycle charity. (Farcycles).

Every time I see an adult on a bicycle I no longer despair for the future of human race.

HG Wells
Oxford Medical Alumni Update

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

Graduation Reunions
In 2023, OMA hosted successful reunions for 1973, 1983, 1993, 2003, 2013 and 2018 graduates this year. If you are interested in helping organise 2024 reunions, please contact lyn.williamson@medsci.ox.ac.uk

BM BCh Graduation
In July the new graduates were conferred their degrees and celebrated with representatives from the medical school, OMA and their families and the Sheldonian and the at the Examination Schools. We welcome them to the OMA fold and wish them well in their future careers.

Career Advice for Junior Doctors – Career Mentors Needed
For young doctors seeking inspiration and advice on their future careers. OMA is keen to facilitate informal relationships around career advice. If you feel you have something to offer (we are particularly looking for consultants, GPs and senior trainees who qualified between 1992 and 2014 and are up to date with training programmes and consultant recruitment), please contact Dr Wil Seligman (seligman@gmail.com).

Future OMLC Lectures St Hugh’s College
This popular lecture series takes place at St Hugh’s College on the last Monday of each month, 12.30-2pm, in person or via Zoom. For more information contact Professor John Morris: john.morris@dpag.ox.ac.uk

OMA Annual General Meeting and OMAAB Meeting
Thursday JANUARY 25th 2004 4-5 pm
The linking of OMA with the new School of Medicine and Biomedical Sciences brings us the opportunity to completely review the structure and functions of OMA. If you are interested in the future of OMA and feel you can contribute, please attend, either in person or online.

OMA Annual General Meeting and OMAAB Meeting
Date: Thursday January 25 2024
Time: 4-5 pm
Venue: Medical Science Teaching Centre, South Parks Road, Oxford. OX1 3PL Seminar Room UGa/b

Attend in person or via zoom: Meeting ID: 962 898 9943 Passcode: 954342

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Recollections Oxford Medicine
This unique oral history collection about medicine at Oxford from the 1940s onwards, inspired by Dr Peggy Frith (former President of OMA). Through a series of skilful face-to-face interviews by Dr Derek Hockaday you can listen to this special collection of memories. Please contact Lyn Williamson if you are interested in helping with taking this project forward.

lynn.williamson@medsci.ox.ac.uk

RECOLLECTING OXFORD MEDICINE PODCAST SERIES

Future Contributions to Oxford Medicine
We welcome your suggestions and contributions for future articles – clinical, scientific, timely, creative, reflective, artistic, humorous. Please contact me if you would like to join the editorial team.

Editor: Dr Lyn Williamson, OMA President

Editorial Board: Dr Tim Crosseley, Dr Neil Snowise, Mr David Williamson, Dr Sarah Ball, Dr Alison Rickard, Luke Williamson and Dr Paul Morrish

Update your Contact Preferences and Personal Details
https://www.medsci.ox.ac.uk/about-us/alumni/about-us.

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Future OMLC Lectures St Hugh’s College
December 19 Henry Marsh: The Self–Deception of Surgeons**

January 19 Hedw de Wit: The Gut Brain Connection: recent advances & future perspectives

February 26 Peter Rothwell: The untimely death of Clinical Pharmacology: missed benefits and untold harms

March 25 Anthony Bradlow: How the Boer War 1899-1902 made the Royal Army Medical Corps fit for purpose

April 29 Rachel Clarke: The Power of the Narrative in Medicine

CLICK HERE FOR OMLC LECTURES WEBINAR LINK
Webinar ID: 993 5688 8975 Passcode: 886561
Listen here to RECORDINGS OF PAST OMLC LECTURES, including the 2023 Osler Lecture by Sir Chris Whitty and Weatherall Lecture by Professor Trish Greenhalgh.

I loved seeing old friends who I’d fallen out of touch with and hearing about what they’ve been up to, it was a wonderful night.

Planetary Health: Law, Finance and Economic Perspectives from 5pm-6.45pm

February 8th

Planetary Health and global financial stability: Jo Paisley, Richard Barker

February 15th

Planetary Health beyond growth: Catherine Howarth, Kate Raworth

February 22nd

Planetary Health and legal ramifications: Jojo Mehta, Thom Wetz

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Planetary Health and legal ramifications: Jojo Mehta, Thom Wetz

Planetary Health and legal ramifications: Jojo Mehta, Thom Wetz
HIV at 40 Years

Monday 26 June 2023

Professor Chris Conlon

The talk was preceded by an engaging and thought-provoking tribute to the great Professor John Ledingham, a very hard act to follow. But this month’s speaker, the Professor of Infectious Diseases and Head of NDM Experimental Medicine, gave an entertaining, informative and fascinating account of the HIV pandemic, centre-stage in the 1980s. What began as a classic detective story, finding the common links in a set of far from common presentations, led to an effective international multidisciplinary cooperative effort involving molecular biology, immunology, infectious diseases, pharmacology, affected communities, epidemiology, midwifery, paediatrics… While HIV can now be controlled, it has not gone away; the global cost of lifetime management of infected individuals is not always offset by access to generic drugs. HIV at 40 years is a success story, but remains a cautionary tale.

Plants, Medicine and Magic

Monday 30 October 2023

Dr Sue Burge

The speaker, a former Director of Clinical Studies at Oxford University and Honorary Consultant Dermatologist, treated us to a fascinating historical account of the medicinal uses of plants. The finding of camomile and yarrow DNA in Neanderthal dental plaque suggests that self-medication with plants goes back a long way. Modern medicine was founded by the development of pharmacopeias over the centuries, dating at least to the 7th century BCE. Do not discount folklore! The direct extraction of pharmacologically active components of plants may be prohibitively time consuming and expensive but has been the springboard for the development of many of the drugs widely used today. Time for a visit to the medicinal plant display in the Oxford Botanic Gardens.

2023 Weatherall Lecture: Doctors on Social Media: Virtue and Vices in the Digital Space

Monday 27 November 2023

Professor Trish Greenhalgh

We were treated to a fast-moving talk by another impressive speaker, Professor of General Practice and Health Sciences, member of independent SAGE for the Covid pandemic, and leader of a healthy large research team. The talk invited us to look at scientific truth and post-truth, doctors as conspiracy entrepreneurs, and the perils of medical orthodoxy. We were reminded that even scientists operate with “shared mental models which may serve to perpetuate flawed thinking”, and that data visualisation and extended reach on social media can be used to promote false partisan narratives. Best sit back and hope for another paradigm shift, though will we ever again be able to believe what we are told?

The infamous Osler House Garden Party marked the beginning of the academic year, as hundreds of students flocked to Osler House for possibly the largest and most anticipated event of the medical calendar. Our theme was ‘Medics in Wonderland’ and included Queen of Heart tarts, a surfboard simulator, wood-fired pizza, live classical and jazz music, and a themed photoshoot. It was splendid to have students from across every year and entry pathway unite to celebrate a fresh start. The momentum continued into Freshers Week as the incoming students were cordially welcomed into the clinical segment of the Osler Family who support the transition. The excitement was contagious and only flourished following the Osler Freshers Fair, an exhibition with over 27 societies representing both sporting and academic disciplines.

The new academic year also ushered in a dedicated committee, which I am proud to say is particularly notable for our commitment to fostering inclusivity and awareness within the student body. We have had original posters showcased for Black History Month, a Diwali sparklers night, LGBTQ+ welcome drinks, and sober-friendly socials such as the new Osler House Book swap. I couldn’t be more grateful for their support and ideas so far. Our William Osler House building is certainly not missing out on the action, with the Osler House Committee brainstorming practical improvements for the computer suite, mail system, coffee provisions and more! The student community have been enjoying the new interior paint decorating and gym inductions, and both the Paediatrics Society, and Obstetrics & Gynaecology Society, have already had their annual conferences in the building.

Whilst empowering those societies registered under Osler House, Osler Football Club and Tingewick, we have accepted a host of new registrations including the Oxford Medical Humanities Society and Osler House Orchestra. The Orchestra have been preparing for their debut concert this December, featuring The Nutcracker Suite. Somewhere in My Memory and singalong carols. This complements other Osler festivities as the Osler Choir prepares a spectacular repertoire for the Oxford University Hospital’s Carol Service. It has been an eventful beginning to the new academic year, and what a wonderful start it has been! "

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

**Miss Toluwani Duckworth-Essilfe (Keble College, 2019) Tingewick Producer 2023-24 and 5th Year Medical Student**

In recent years, Tingewick has become a huge effort to raise money for charity, with events throughout the year, culminating with the annual pantomime. In the few months since I last wrote about Tingewick we have been busy!

The current Tingewick Firm has successfully established itself and raised lots of money for Oxford Hospitals Charity and Yellow Submarine. The achievement of a group of 29 medical students is incredible.

In May we took on the 3 Peaks Challenge and, despite rain, students is incredible.

Yellow Submarine. The achievement of a group of 29 medical students in May we took on the 3 Peaks Challenge and, despite rain, reaching the summit in just under 24 hours. The team raised over £3,000 for charity and enjoyed the views of the surrounding mountains.

In recent years, Tingewick has become a huge effort to encourage the year below us to audition for their own show. In the past, Tingewick has produced a pantomime and an annual production based on the Disney classic, The Lion King. This year, Tingewick produced a pantomime based on the life of Charlie in the Chocolate Factory, which was a huge success and raised over £5,000 for charity.

July saw the rowers add to our charity total by rowing the 170km from Oxford to London over 3 days, an amazing effort.

Missing the spotlight halfway through the year, we began rehearsals in July and August for a September mini-production. Far from mini in the end, this production ended up a full-scale show, Charlie in the Chocolate Factory: Every Dream Starts with a DRE saw a group of still-optimistic medical students get lost in a world of imagination, lethal CT scanners and a septic tank pipeline. Our craving for drama created enough hype to encourage the year below us to audition for their own Tingewick show.

A collective 183.4 miles was run by the Tingewick Firm in the Oxford Half Marathon in October, another incredible effort. Multiple personal bests were achieved, with our director getting a shoutout on BBC Radio Oxford for completing the race in a cardboard yellow submarine!

November is a month filled with tradition for us. The Tingewick annual production will also take place. Over 300 people will be attending the opening night of Tingewick Show 2023, which will be held at the University Theatre. The show will be based on the life of Charlie in the Chocolate Factory, with a special focus on the role of the Willy Wonka character. The show will feature a cast of over 50 students and is expected to be a huge success.

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The approach of the pantomime signals that our time on Tingewick is coming to an end but is just the beginning for our successors.

**“Our craving for drama.”**

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**In Memoriam**

The following deaths have been notified to the Alumni Office, since the previous Edition of Oxford Medicine

**Dr. Ian H. Borton** (Magdalen College, 1955)
Died May 2023

Dr. Peter G. Johnson** (Merton College, 1951)
Died May 2023

Dr. Margaret S. Barrett** (Somerville College, 1946)
Died June 2023

Dr. Kenneth Hughes** (Jesus College, 1958)
Died June 2023

Dr. Frederick P. Greenwell** (Magdalen College, 1949)
Died September 2023

Dr. Henry M. Steady** (St Peter's College, 1966)
Died September 2023

Dr. Elizabeth K. McLean** (Somerville College, 1950)
Died August 2023

Dr. Ruth Lister** (Somerville College, 1944)
Died August 2023

Dr. Maggie C. Eisner** (Somerville College, 1965)
Died May 2023

Dr. Maggie C. Eisner, who has died aged 75, was a GP in Yorkshire, who gave her utmost to her patients, her practice and to her young colleagues. Within her practice in Shipley she established a service for home births in Bradford and led the GP training scheme, under which many cohorts of trainees benefited from her teaching. Full obituary in The Guardian https://www.theguardian.com/society/2023/mar/16/maggie-eisner-obituary

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**Obituaries**

**Professor Richard J. Phillips**
(Dickenson College, 1975)
Died August 2023

Professor Phillips worked within the Faculty of Life Sciences & Medicine, King's College, London for more than 25 years, first as a Senior Lecturer and subsequently as Deputy Dean, a role he held since 2010. He contributed significantly to the Faculty’s success, helped to launch the careers of thousands of medical students and he was also a valued mentor to many educators within the GKT Medical School. https://www.kcl.ac.uk/news/a-tribute-to-professor-richard-phillips

Dr. Tim Lancaster** (Corpus Christi College, 1974)

writes: ‘I met Richard when I moved from Oxford to King’s, as Dean of Medical Education, in 2017. We worked in adjacent offices and he often dropped by to offer advice, share his deep institutional memory, and encourage at difficult moments. He was a wonderfully kind and insightful man, generously committed to supporting students and fellow faculty.’

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**Dr. Geoffreym. Durbin**
(Keble College, 1963)
Died May 2023

Dr. Geoffrey M. Durbin, who has died aged 78, was a consultant neonatologist whose early research was one of the crucial steps in improving the treatment of babies with breathing difficulties. He was the first full-time neonatologist at the Birmingham maternity hospital. He set about developing the unit, offering, for the first time, life-sustaining support for premature babies.

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**Dr. Magatte L. Bishop**
(St Edmund Hall, 1983)
Died August 2023

Dr. Bishop completed his medical training at Glasgow University, before becoming a General Practitioner. As a GP he worked in Striling and on Benbecula in the Outer Hebrides in the late 1980s, he joined the regular British army, training as an officer at Sandhurst. He subsequently...
Dr Martin Moncrieff (1933-2023)

Martin Moncrieff was educated at Marborough College, Oriel College and, for clinical training, the Middlesex Hospital. As the son of a distinguished paediatrician (Professor Sir Alan Moncrieff, first Chief of the Nuffield Professor of Child Health at the Institute of Child Health and Great Ormond Street Hospital), he expressed no concern for the potential advantages of the University. He joined this hospital and, after National Service, he began a career in paediatrics.

As a Senior Registrar at Birmingham Children's Hospital with Richard White, he was involved with the early development of paediatric nephrology and was one of the eight founding members of the British Association of Paediatric Nephrology, the so-called ‘Dublin Eight’ because of their inaugural gathering at a European conference in Dublin in 1972. His first consultant post was at Derby Children’s Hospital where he was busy and happy but, in 1976, he was persuaded to move to Oxford, where paediatric services were still based both at the Churchill Hospital and theRadcliffeInfirmary.

Paediatricians of the 1970s were few, had no on-call commitments, and had to be skilled in the care of the newborn as well as older children although the development of the neonatal service under Professor Peter Tizard at the new John Radcliffe Hospital provided him with the opportunity to develop his skills in neonatology. He was appointed Director of the Oxford Paediatric Nephrology Unit in 1976. He became the first consultant in paediatric nephrology in Britain that year. He was a visiting consultant at the Children’s Hospital in Boston and at the Royal Children’s Hospital in Melbourne where he had the opportunity to work with one of the greatest paediatric nephrologists in the world, Dr. J. Michael Kaplan.

Martin Moncrieff was a dedicated clinician. He was an outstanding teacher and was a major influence on many of the paediatricians who trained with him. He was a kind-hearted man with a gentle manner and a great sense of humour. He was a wise and compassionate clinician who always put the welfare of his patients first. He was a true gentleman and a great friend to many of his colleagues.

As an undergraduate Martin had been a very good squash player; he continued playing to a high standard far longer than most. But his happiest times were in mountains, in France and at his home near Oxford. He had climbed the Matterhorn as a young man and was skilled on alpine glaciers, slies and mountain trails. In retirement he undertook a full-time undergraduate degree in French and enjoyed his many visits to France. With his wife Ann, he shared a wonderful family house and garden with their four children, and the later generation of grandchildren, of whom he was quietly proud yet modest about their achievements. After experiencing declining health in his last few years, Martin died at home with his family by his side.

Dr Nick Leigh-Hunt (1972-2023)

A tribute from his wife, Dr. Sabrina Leigh-Hunt, Consultant in Old Age Psychiatry, November 2023

Nick was diagnosed with Multiple Myeloma in 2003. He carried his illness with great dignity and privacy. Originally, he intended to be a paediatrician and Nick obtained his MRCPCH and Masters in Child Health in 2008, at Leeds University. He later embarked on a career in Public Health and undertook a Masters in Public Health in 2011. Nick worked as a Consultant in Public Health at Rotherham Metropolitan Borough Council, where he led on all things Healthcare Public Health, developing strong relationships with Rotherham CCG and the local NHS providers. His systematic review on the public health consequences of social isolation and loneliness became one of the top cited and most read articles in the Public Health Journal. Towards the end of his career, he played a vital role in Rotherham’s response to the Covid 19 pandemic, providing clinical guidance for health and care settings, supporting schools and workplaces to manage risks. During what was a difficult time for Public Health and for Nick personally due to his vulnerability to infection he delivered this role with his usual academic rigour, compassion and diligence. He retired in 2022, due to a recurrence of his myeloma.

Nick travelled extensively around the world. He loved learning from people and getting to know different cultures. He spent time in Africa during his gap year and Sudan during his elective. He had a passion for walking, especially in Yorkshire, Scotland, Wales and the Lake District. Nick was an excellent gardener and an avid reader. He passed these passions on to his daughter Sophia. He was very modest, kind and thoughtful to those around him.

A devoted family man with great professional integrity, and loyalty to friends, Nick was widely admired and will be greatly missed.

Obituaries

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Dear John,

Many of us were lucky enough to benefit from your care, cartilage, research, and author. You have also been a genuine, unfussy Washington Post, Dr. W. But what I know best is how to ask the right questions. Stimulated us to think and learn for ourselves. You will never know how many careers you have inspired, and how many lives you have touched.

Mary Ryan and Lynn Williamson

John Ledingham was a commanding presence in Oxford medicine for nearly three decades. He was the archetypal general physician not tied to the routines of a medical specialty. This suited his eclecticism, his tendency to fill his in-tray with too many tasks for a day, and his gregarious nature. He could joust with the medical specialists, the surgeons, and the scientists too. He loved Oxford, with its clubby social mix, for him on New College where he was a fellow. In 1974 he was appointed to the May Readership in Medicine. He was the ideal wingman for Sir David Weatherall the newly appointed Nuffield Professor of Medicine, a haematologist. This post provided Ledingham with a platform for his broad range of skills and energy allowing him to contribute locally and nationally to the NHS, the Oxford Clinical School, research, and education. The University awarded him a Personal Chair in Medicine in 1989. He was so content in Oxford that he politely declined a number of approaches to move elsewhere. This was just as well for he was not temperamentally suited to the stress and time-consuming nature of a Medical Department. He was too kind.

EJR Burnough describes him as ‘A Percy Blakemore’ of the world of medicine. He was the synthesis of the bedside doctor and the scientist, both sometimes fighting simultaneously for his way of practicing medicine and equal natural common touch did not have to fight; they were joined and presented a united front. He had that rare capacity to be caught up in his own predilections professionally to stand aside: civilly to support him in his life and personally to mourn him at his death. He too had a kindly, scandalous repertoire about events and people which showed a fine and often hilarious perspective.”

He was born on the 19th October 1929 in London, son of John and Una (Garvin) Ledingham. His father was a general practitioner and his mother a general practitioner. His maternal grandfather was J. Garvin, the editor of the Observer which may be why John was said to have described his grandson as ‘an inattentive student’. He, with Mark Pottle, edited his uncle Gerard Garvin’s 1914-1916 correspondence from the trenches in France with his parents. The book “We hope to get word tomorrow – the Garvin family narrative” was published in 2009. Gerard Garvin was killed the day he completed his 2 contrasting interviews and you can listen to him in the Recollecting Oxford Medicine Interviews. He gave his tribute in the June 2020 edition of Oxford Medicine Obituaries. We honoured Professor Ledingham with a birthday tribute in the June 2020 edition of Oxford Medicine Obituaries: https://www.medsci.ox.ac.uk/about-us/alumni/

Obituaries

President of the British Society for Rheumatology), Catherine Marsh (a farmer and wife, Claire Bowron, a fiction editor at Penguin and Sarah (Coupe), a physiotherapist. Retirement in 1995 allowed him to pursue his passion for music, history, golf and fly-fishing. To his annoyance a succession of hisselectors over the years. He had four daughters who helped shape his attitude to women. He championed women at work and at home, nurturing any interest they had and supporting them both practically and with words of humanity and wisdom through their various trials. Joanna Ledingham became a consultant rheumatologist (and later President of the British Society for Rheumatology), Catherine Marsh (his wife and daughter) and Claire Bowron (a fiction editor at Penguin). 2016. We hope to get word tomorrow – the Garvin family narrative: https://www.medsci.ox.ac.uk/about-us/alumni/

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His name is also well known, he is a retired member of the Royal College of Physicians of Great Britain and Ireland, and President of the British Hypertension Society. He served on the Executive of the National Kidney Research Fund (now Kidney Research UK). He much enjoyed being a Trustee of the Best Trust advising on scholarships and infrastructure awards. In 2010 he published a book, Controversies in the renin-angiotensin system was rewarded with the opportunity to be appointed to a consultant post at the Middlesex he was invited to apply for one of two new posts in general medicine, endocrinology, diabetes, his speciality medicine and nephrology in the United Hospitals. He and Dr Derek Hockaday were appointed, John became part of the Lee, Ledingham, Juel-Ledingham-02 in his own voice:

Obituaries

Part II examiner for eighteen years. His reputation for common sense ensured invitations to serve on various boards dealing with animal experimentation, the bioethics of xenotransplantation and coronary disease prevention.

In 1961 he met Elaine Malphant, ‘a Cardiff girl’, also from a medical family (her father was an obstetrician). She was herself a doctor working at the Middlesex, specialising in Obstetrics and Gynaecology when they met. They became engaged within 6 weeks and married six months later on March 3rd 1962. Her relaxed warmth, natural intelligence and informal nature was a perfect fit for him. Their mutual love of music, particularly opera, enriched their marriage greatly. Together they did much for Oxford’s links with the Welsh National Opera. He described her as the person who so enabled his professional and family life. He that he could not bear to be without her. He felt guilty in later life, that she put her career second to his, but every indication suggests that she relished her role. Sadly, she predeceased him, dying in 2013. He cared for her and bore the loss of her person and her life in their home. The house was a reverberation of their shared love and appreciation of music, their mutual love of opera, their mutual love of music and, indeed, laureates. In true Socratic tradition you always know

Obituaries

We hope you enjoyed this tribute from his 1981 house physicians for many of us: ‘Dear John, Many of us were lucky enough to benefit from your many extraordinary talents, especially those of us who worked with you in the NDM. You are a brilliant physician, clinical teacher, diagnostician, researcher, and author. You have also been a genuine, unfussy Washington Post, Dr. W. But what I know best is how to ask the right questions. Stimulated us to think and learn for ourselves. You will never know how many careers you have inspired, and how many lives you have touched.

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Obituaries
Kingfishers are reasonably common in the UK and with a bit of persistence can be found on most waterways. In the winter they move away from breeding areas and you can even see them from Hythe Bridge Street along the Oxford canal. They may draw attention to themselves with a high pitched whistle as they streak away in a flash of turquoise low above the water.