
Oxford Medicine

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THE NEWSLETTER OF THE OXFORD MEDICAL ALUMNI



OXFORD MEDICINE • DECEMBER 2020



**Professor
Ledingham**
91 Not Out!

COVID Vaccines

**Frontline
Perspectives**

**Osler Rowing
Revival**

And much more...

Pictured: Professor John Ledingham

President's Piece



Dr Lyn Williamson
OMA President

So much is at stake. We stand at an extraordinary inflection point. But where to start?

'I would adopt an A to E approach' is the phrase currently used by young doctors when faced with a catastrophic problem, or when they have no idea what to do. I tried it with this edition: A - Anatomy and Augmented Reality; B - Brexit; C - COVID...then I thought about an approach I used as a young house physician - 'What would J Led do?'

Professor John Ledingham is one of Oxford's great clinicians and teachers. He has inspired generations of doctors, including many who have contributed to this edition. He shares memories of his career in an interview which is warm and honest, spiced with pithy anecdotes and words of wisdom. This interview introduces 'Recollecting Oxford Medicine,' a 10-year project by Dr Derek Hockaday and Dr Peggy Frith to preserve an oral history of Oxford medicine through interviews, archived as podcasts in the Bodleian library.

We pay tribute to another great Oxford clinician - Professor Peter Sleight who died earlier this year. Through extracts from his ROM interview, he shares his story in his own words.

Our frontline clinicians have learned to adapt to the constancy of change. Their voices are important. We hear from different specialities and different generations of doctors.

Professor Charles Bangham tackles the issue at the forefront of our minds - a vaccine for COVID. His elegant summary of immunology and vaccinology is a must-read for those of us who need help making sense of the many vaccines just around the corner.

Augmented Reality for anatomy teaching? Mr Tom Cosker and Matt Williams whet our appetites for this new teaching aid for surgeons and medical students.

Osler House in Berlin is something to look forward to in Europe post-Brexit and we are grateful to Professor Alastair Buchan for his update.

Dr Catherine Swales (DME) describes her mission to maintain excellent teaching at the medical school. The Osler Medical student reports are full of infectious energy, not least from the Osler House Rowing Club revival.

There is much to be thankful for. Oxford scientists and researchers have led the world in their response to the pandemic. The world looks forward their results. We congratulate Dr Keith Hawton on his CBE for work on suicide prevention, Dr Sarah Walker on her OBE for services to Academia and the CV response, Dr Ravi Gupta listed Times Top 100 for his work on HIV. There is a new edition of the Oxford Textbook of Medicine.

We feature contributions from forty alumni spanning EIGHT decades and by 'clicking on the links' you will be able to hear voices of OMA members, past present and future. Thank you all.

As the nights draw in and the second wave does its worst, I prescribe combination therapy:

- A heavy dose of nostalgia provided by early Osler House rowers and other Alumni letters
- A cocktail of clever, witty and thought-provoking pieces provided my family and friends from the 79-81 graduates.

In my 64th year, 'I got by with a little help from my friends'.

To use the 2020 sign-off: Stay well and take care everyone.

Dr Lyn Williamson

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Design by - Lucy Jonas (portfolio)

Vaccines for COVID-19: a primer



Professor Charles Bangham,
*Professor of Immunology; Head,
Division of Infectious Diseases,
Imperial College London. Lincoln
College 1977-80*

Charles qualified in medical sciences at Cambridge and clinical medicine at Oxford. In 1995, he was appointed Chair of Immunology, and since 2013, Head of the Division of Infectious Diseases, Imperial College Faculty of Medicine. Since 1987, he has conducted research on the immunology and virology of persistent viral infections, especially the human retrovirus HTLV-1. Charles is a Wellcome Trust Investigator and a Fellow of the UK Academy of Medical Sciences. He has chaired many national and international grant review panels. He was awarded the BMC Retrovirology Prize 2007, the International Retrovirology Association Basic Science Prize 2015, and the David Derse Memorial Award from the National Cancer Institute, USA, in 2018. He is a Visiting Professor, Kyoto University, Japan. In 2019, he was elected a Fellow of the Royal Society.

What can we expect of an anti-viral vaccine?

An effective anti-viral vaccine will prevent or diminish symptoms, severe disease, and onward transmission of the virus. Vaccines rarely – if ever – completely block reinfection of an individual with the same virus, as is shown by the production of a secondary immune response. The term “sterilizing immunity” is therefore probably a misnomer.

The immune response to viruses

The innate immune response is triggered within hours of infection. The most important component is the interferon response: almost all nucleated cells in the body are capable of producing type 1 (alpha or beta) interferons, which in turn activate the expression of a large number (c.300) of genes that combat the virus by several parallel molecular pathways. The complement system, cytokines and chemokines also contribute to the innate immune response. Finally, natural killer (NK) cells and dendritic cells (DCs) are the two main cellular components of innate immunity.

The innate immune response has two chief functions. First, it directly inhibits the growth and spread of the virus, via interferons, complement and NK cells. Second, it mobilizes and stimulates the acquired immune response, via DCs, complement, cytokines and chemokines.

Whereas the innate immune response is not specific to one virus, the acquired immune response consists of antibodies and T cells that are specific to the antigens in that virus. On first exposure to a new antigen, the frequency of antibody-producing B cells and T cells specific to that antigen is very low (around one in a million), and it takes around a week for the growth of sufficient numbers of B and T cells specific to the new antigen to mount an effective immune response. This first week of a viral infection is of particular importance in infection with SARS-CoV-2, the causative agent of COVID-19.

Antibodies are of critical importance in an efficient antiviral response. However, even in a secondary infection, antibodies alone are rarely sufficient to completely prevent an infection. There is a frequent misconception concerning the importance of neutralizing antibodies. Neutralizing antibodies are those that inactivate a virus in a short-term assay *in vitro*. But the standard *in vitro* neutralization assays fail to measure two major mechanisms by which an antibody can kill the virus *in vivo*: complement-dependent lysis and antibody-dependent, cell-mediated cytotoxicity (ADCC). Therefore, the protective value of antibodies *in vivo* may correlate better with the total titre of virus-specific antibody (including the neutralizing antibody) than with the titre of neutralizing antibody alone.

Many of the most effective antiviral vaccines are modified, attenuated viruses, derived either from the pathogenic virus itself or from a vector such as an adenovirus that expresses one of the genes of the pathogen. The reason that attenuated viruses are particularly efficient vaccines is because they elicit, in addition to antibodies, both helper (CD4+) T cells and cytotoxic (CD8+) T cells. The helper T cells are essential both to help the antibody response and the cytotoxic T cell response, and to elicit a high frequency of memory lymphocytes – both B cells and T cells – which can respond more rapidly to a reinfection with the same virus. It is the cytotoxic T lymphocytes that are usually essential to eradicate a virus from the body, by killing virus-infected cells.

How long does immune protection last?

The duration of protection differs widely between antiviral vaccines. Some, such as those against Yellow Fever and Measles viruses, provide excellent protection for many years, even life-long. By contrast, the protection given by the influenza vaccine typically lasts much shorter because the immune response that it elicits wanes relatively quickly and the influenza viruses continually evolve.

Apart from the highly pathogenic coronaviruses SARS, MERS and SARS-CoV-2 that have recently emerged in the human population, four endemic coronaviruses have circulated widely for many years. These viruses typically cause an asymptomatic infection or a mild head cold, although in susceptible individuals they can cause severe and even fatal disease. A feature that is not yet fully understood is that the immune response to these endemic coronaviruses typically wanes within one or two years, so we can be frequently reinfected with the same virus. Antibodies to SARS-CoV-2 can also decline in titre within three months of infection, but it is not yet known whether this results in a loss of protection, because T-cell immunity may last longer.

The efficiency of the immune response to SARS-CoV-2 may determine the risk of COVID-19

It is often stated that COVID-19 is associated with – and by implication may be caused by – an ‘overactive’ or ‘exaggerated’ immune response. However, it is important to distinguish between the inflammatory response and the immune response. Like SARS, COVID-19 is a biphasic disease. If an efficient innate and acquired immune response to SARS-CoV-2 is made during the first week of infection, the spread of the virus around the body is restricted and the risk of development of COVID-19 is reduced. Thus, any factor that limits the effectiveness of the immune response during the first week will increase the risk of COVID-19, which typically begins in the second week of infection.

“...SARS-CoV-2 express genes that inhibit the natural immune response, in particular interferons

An important feature of the pathogenic coronaviruses such as SARS-CoV-2 is that they express genes that inhibit the innate immune response, in particular interferons. As a result, interferons have significantly less impact on SARS-CoV-2 than on many other viruses, and the coronavirus can spread relatively unhindered in the first few days of infection. The efficiency of an individual's acquired immune response to any antigen is determined largely by genetic polymorphisms, especially the HLA genes. There is also evidence that the ABO blood group influences the susceptibility to COVID-19 and, confirming the importance of the interferon response, inborn errors in type 1 interferon immunity can predispose to severe disease. Common genetic polymorphisms, including HLA, probably account for part of the difference between individuals in the risk of COVID-19. Any such factor that reduces the efficiency of the innate and



acquired immune response, particularly during the first week of infection, will allow the virus to spread more widely round the body. SARS-CoV-2 infects many tissues; infection of the blood vessel endothelium may play a particularly important part in the pathogenesis of COVID-19. The widely disseminated virus elicits the inflammatory response that causes many of the severe manifestations of COVID-19.

So the immune events during the first week are critical in determining the course of the infection, and indeed the trajectory of certain inflammatory cytokines during the first week may be useful in predicting who will go on to develop severe disease. Of course, many other factors contribute to the risk of COVID-19, in addition to specific conditions or drugs that impair the immune response. Important predisposing factors include cardiovascular disease, respiratory disease, renal disease, diabetes, obesity and male sex; the mechanisms by which these factors increase the risk are not yet fully understood. Widespread hypercoagulation also contributes importantly to the severe forms of COVID-19: it is likely that infection of the blood vessel endothelium, eliciting production of the tissue factor, plays a large part in this process.

Are some people naturally immune to SARS-CoV-2?

There is evidence that both antibodies and T cells that recognize one of the four endemic coronaviruses can

cross-react with the antigens of SARS-CoV-2. It has, therefore, been suggested that frequent or recent infection with these endemic coronaviruses might confer a useful degree of immunity to SARS-CoV-2. However, it is not yet clear whether this immune response is effective. Indeed, there is a theoretical risk that a cross-reactive antibody or T-cell response might exacerbate the disease. For example, antibodies that bind to a virus but not sufficiently well to inactivate it can facilitate the entry of the virus into cells, and so enhance the replication of the virus. This phenomenon, known as antibody-dependent enhancement, plays a significant part in the severe manifestations of dengue fever. Antibody-dependent enhancement remains a theoretical risk in the case of SARS-CoV-2 and COVID-19, but it must be borne in mind, particularly when assessing the effects of candidate vaccines.

“...a vaccine might elicit a more effective immune response than that caused by natural infection...”

Anti-COVID-19 vaccines under development

Over 180 candidate vaccines are currently under development round the world. Of these, the great majority are based on the use of one antigen of SARS-CoV-2, the surface spike protein S, either as the whole protein or in fragments. There is good evidence that the S protein of SARS-CoV-2 can elicit antibodies, helper T cells and cytotoxic lymphocytes. The S protein may be administered either as a presynthesized recombinant protein or expressed from a gene in a virus-based vaccine or from messenger RNA. RNA-based vaccines are largely untested, but they have the theoretical advantage that they can be produced quickly and on a large scale. Early studies in humans indicate that they can elicit both antibodies and T cells. A new type of vaccine under development in Imperial College London uses a self-replicating RNA that expresses the S protein. Only a very small inoculum of the self-replicating RNA is required, which makes the manufacture and distribution of the vaccine more efficient. The Oxford/AstraZeneca vaccine, based on an adenovirus vector that expresses the SARS-CoV-2 spike protein, is showing excellent promise both in safety trials in humans and in protecting non-human primates.

Even an effective vaccine against SARS-CoV-2 may have to be given again every few years, if the immune response to this virus wanes as quickly as the immune response to the endemic

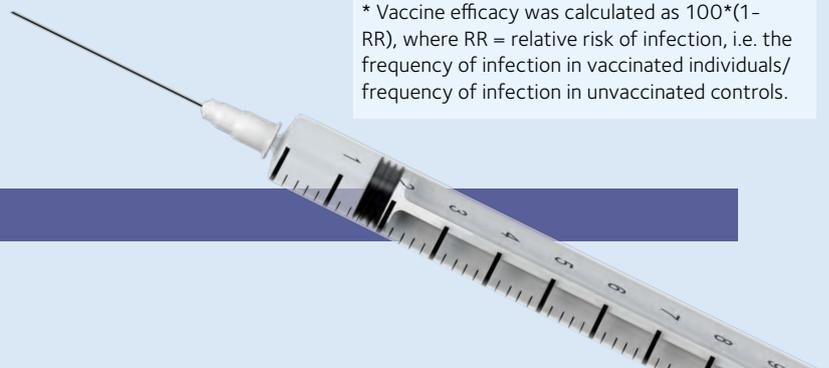
coronaviruses. However, there is an attractive theoretical possibility that a vaccine might elicit a more effective or more long-lasting immune response to the virus than that caused by natural infection, because the vaccine does not include the viral genes that inhibit the innate immune response.

The results of many phase three clinical trials are expected in the next few months. While a candidate vaccine might elicit antibodies and T cells in initial trials, the only meaningful criterion of a vaccine's effectiveness is whether it diminishes or prevents disease and transmission.

Even when a demonstrably effective vaccine is produced, there remain many hurdles in its manufacture, distribution and administration, and in ensuring the acceptability and adequate uptake of the vaccine in the population. If the vaccine has 100 percent efficacy, then since the basic reproduction number R_0 of the virus is ~ 2.5 , it will be necessary to immunize 60 percent ($= 1 - 1/R_0$) of the population to prevent transmission. If the efficacy of the vaccine is lower, the proportion of the population that must be immunized rises in measure.

The recently announced preliminary results of the vaccine developed by Pfizer and BioNTech are extremely encouraging. This vaccine, currently designated BNT162b1, contains RNA that encodes a particular fragment of the SARS-CoV-2 spike protein S. This fragment includes the viral receptor-binding domain (RBD) – the region of the S protein that binds to the ACE2 receptor which serves as the entry mechanism of the virus. To increase its immunogenicity, the RBD is trimerized, and it was reported in Nature on 22nd October that the vaccine elicited not only antibodies but also helper T cell and cytotoxic T cell responses, in the Phase 1-2 trials, in individuals between 18 and 55 years old. The Phase 3 clinical trial, involving a total of 43,538 people, demonstrated a vaccine efficacy* of 90 percent. While these results are exciting, certain questions remain. First, how well are the immunogenicity and the protective efficacy of the vaccine maintained in the elderly? Second, does a vaccinated person, infected with the coronavirus, transmit it less efficiently to others? Third, how long does protection last? Finally, can mutations in the spike protein lead to immune escape, causing loss of vaccine efficacy? The Oxford/AstraZeneca vaccine contains a larger version of the S protein, not only the RBD, and so it is likely to elicit a broader immune response, with antibodies and T cells that recognize several different regions (epitopes) of the protein: in principle this makes it harder for the virus to escape by mutation.

* Vaccine efficacy was calculated as $100 \times (1 - RR)$, where $RR =$ relative risk of infection, i.e. the frequency of infection in vaccinated individuals/frequency of infection in unvaccinated controls.



Preliminary results have also been announced of a Phase 3 trial of the Sputnik V vaccine in over 40,000 subjects in Russia. As in the case of the Pfizer/BioNTech vaccine, the full data have not been released at the time of writing. However, a press release (November 11th) reported that over 16,000 people have received both doses of the vaccine, and an interim analysis shows the vaccine has 92% efficacy. Whereas the Pfizer/BioNTech vaccine consists of RNA encoding the S protein, Sputnik V consists of two doses, three weeks apart, respectively of two different recombinant human adenoviruses (Ad26 and Ad5), each one expressing the S protein. The successive use of two different adenovirus vectors lessens the impact of the immune system on the vector, and in principle increases the focus of the immune response on the shared components, including the S protein. The questions noted above concerning the Pfizer/BioNTech vaccine also apply to Sputnik V. However, again these results, albeit preliminary, provide further assurance that it should be possible to devise effective and safe vaccines against SARS-CoV-2.

Finally, the preliminary results have been announced of a second mRNA-based vaccine against SARS-CoV-2, produced by the company Moderna. In a Phase 3 clinical trial in some 30,000 subjects, a total of 95 cases of COVID-19 were reported: of these cases, only five had received the two doses of the vaccine, and the other 90 received a placebo; of the five who developed the disease, none was critical. The Moderna vaccine has the reported advantage over the Pfizer/BioNTech RNA-based vaccine of less stringent requirements for cold storage. However, as in the other recently reported studies, it will be necessary to see the full data to make full appraisal of the efficacy, and to follow the vaccinated individuals for some months to understand fully the duration of protection and any possible adverse effects.

Further, it is reported that the Moderna vaccine is effective in the elderly. Immune responses to both natural infection and vaccines are often less efficient in the elderly. The reasons for this are still poorly understood: the frequently used term *immunosenescence* merely gives a name to a phenomenon we do not understand. Since the case fatality rate of COVID-19 rises very quickly with age*, it will be of particular importance to compare the efficacy of these emerging vaccines in the elderly.

* COVID-19 approximately doubles the age-specific death rate, across all ages from childhood upwards.

“...even when an effective vaccine is available, Long Covid syndrome may impose a significant health burden in the future.

Long Covid

It is now clear that, while most people infected with SARS-CoV-2 have an asymptomatic or mild illness, and a minority develop the acute disease COVID-19, a proportion of infected people go on to develop persistent symptoms that can be severely debilitating. Patients report a remarkably wide range of symptoms, which characteristically vary widely not only between people but within one person over time. Because of the protean nature of this condition, which has become known as Long Covid, it is very difficult to define precisely. In consultation with Public Health England and the WHO, NICE is currently developing a working definition of the syndrome, to enable systematic investigation of its incidence and pathogenesis, and to assess possible treatments.

While the pathogenesis of severe COVID-19 appears to be mainly due to widespread inflammation and hypercoagulation, the pathogenesis of Long Covid is still obscure. Because new symptoms can develop some weeks after the acute infection, it is possible that a secondary mechanism, distinct from the inflammatory processes in the acute infection, causes the Long Covid syndrome. It is not yet known whether there is persistent low-grade infection by the virus itself, causing a chronic inflammatory response, or whether an immune phenomenon, perhaps including an autoimmune reaction, contributes to the pathogenesis. This possibility, albeit theoretical, must be kept in mind when following cohorts of vaccine recipients. Even when, as we hope, an effective vaccine is available soon, it appears that the Long Covid syndrome may impose a significant health burden in the future. Research is urgently required to find effective treatments and to identify the mechanisms of pathogenesis of this curious and disabling disease.

For a more comprehensive review of Long Covid by CB, visit:

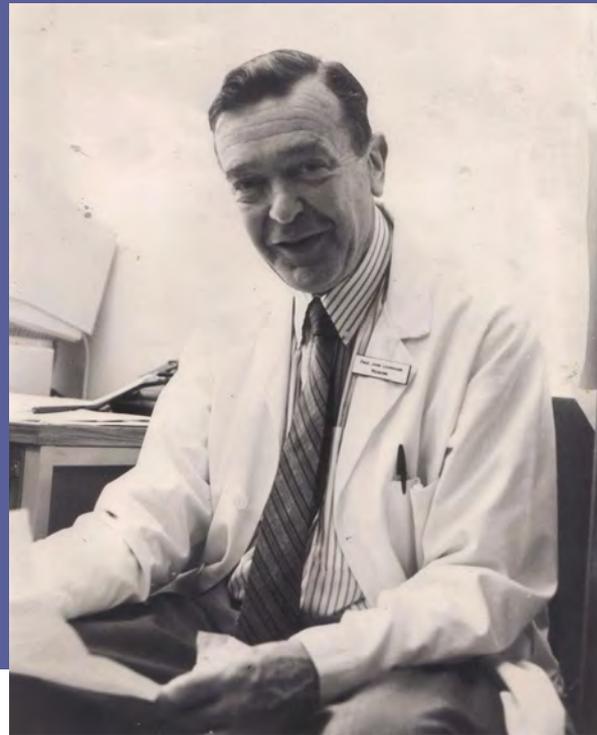
<https://royalsociety.org/-/media/policy/projects/set-c/set-c-long-covid.pdf>

Professor John GG Ledingham - 91 Not Out!

May Reader in Medicine, 1974–95, Professor of Clinical Medicine, 1989–95, and Director of Clinical Studies, 1977–82 and 1991–95, University of Oxford; Fellow of New College, Oxford, 1974–95, Emeritus, 1995–2000, Hon. Fellow, since 2000; Hon. Clinical Director, Biochemical and Clinical NMR Unit, Medical Research Council, Oxford, 1988–95.

Professor John Ledingham, New College 1950, remains one of Oxford’s most respected and inspirational clinicians and teachers. A giant amongst giants who has cast a long and fruitful shadow.

He was one of the first to take part in the Remembering Oxford Medicine Interviews which allowed him to tell his story, in his own words, with his own voice: <https://podcasts.ox.ac.uk/interview-john-ledingham-professor-clinical-medicine-and-former-director-clinical-studies> This selection was chosen by his friend and colleague Dr Derek Hockaday.



When did you decide to study medicine?

I fought very hard against it, having not only two parents in medicine, but also two uncles, a surgeon and a GP, while a great-aunt had been a midwife. On the other hand, my mother’s family were distinguished in journalism, including the Editor of the *Observer*, a deputy Editor of *The Times*, and Literary Editors of both the *Observer* and of *The Daily Telegraph*, so I had notions of a career in journalism. But I wasn’t a creative writer and so, during my National Service as an Army Officer in Hong Kong, turned to medicine. Out there I bought Grove & Newell’s Biology and Stead’s Electricity and Magnetism. Then I had six months in a cram school in Eccleston Square before coming up to tackle Natural Science prelims in my first year in Oxford. So, I had four years in New College.

Dr Creed on Staircase One was my tutor for everything, except for Biochemistry with Carter at Queen’s. They were both very old-fashioned and told me what to read very wisely. They gave the sort of advice that doesn’t exist now. For instance, Creed said ‘Oxford is an experience that you want for the rest of your life and Medicine is a hard taskmaster and it takes time, but there are so many other things to do in Oxford which you must do; it can be sport, or art, or debating, or going on a bicycle ride, but don’t chain yourself to work’. Again, ‘No one can do useful academic work for more than four, perhaps five hours a day, so if you get up early, there’s never any reason to work after lunch’. And when Carter, on enquiry, learnt my hockey was shaping up, he said ‘Well, getting a Blue’s more important than your degree so no need to write an essay if you don’t want to’.

You’d been at several London teaching hospitals, and then Columbia Presbyterian in New York. How did Oxford compare when you arrived as a consultant in 1966?

I was shaken when I came. I thought I’d be coming to sleepy old Oxford from prestigious centres, ‘hot spots’, and the absolute reverse was the case. The first time my firm was ‘on-take’ Brian Prout, the Senior Registrar, rang up about 7pm and said, ‘It’s customary here for the consultant to do a round on the patients who’ve been admitted’. I’d never heard of that. Nothing like it ever occurred in London...the consultants had their set rounds twice weekly, and students weren’t taught on them apart from set rounds. There was a sense of invigoration, we thought we were in an exploding place and it was fun. In London you didn’t argue with the boss, even if you knew him to be wrong. Here it seemed consultants treated students as their intellectual equals and wanted their opinion, and they gave it. So, to a good question you’d say, ‘That’s interesting, I don’t know the answer, but perhaps you could look it up and tell me tomorrow’.

It was George Pickering who really got things going, in two ways. When five new NHS consultants, three physicians and two surgeons, were appointed within a few months in 1966, George took us to dinner and told us he wanted to create a medical school in which there was little or no difference between the NHS consultants and the academic units. And he offered us, if we’d abjure private practice, two research sessions a

week, laboratory space and £500 a year for research expenses, together with a university lectureship. All five of us were capable of benefitting from that, and indeed took up the offer initially, though all had left it before retirement, Peter Sleight and myself to University appointments, the surgeons to private practice, and Derek Hockaday to the NHS Sheikh Rashid Diabetes research unit. Paul Beeson supported George very much in thus bringing together the NHS and University teams. Some people attribute a lot to Richard Doll but I wouldn't, because it had really got going before he came.

And secondly, Pickering saw the need to increase the number and quality of clinical students. Most Oxford and Cambridge undergraduates went to the London teaching hospitals for their clinical training, and it was Pickering who saw the chance of getting some from the bigger Cambridge pre-clinical school to come to Oxford, so he launched a campaign, carried on by Michael Dunnill as Director of Clinical Studies, and later, when I'd succeeded him, I'd talk to Theo Chalmers, effectively the Director of Clinical Studies in Cambridge, whom I'd known at the Middlesex.

“ *...consultants treated students as their equals, and wanted their opinions...* ”

Then there were your two stints as Director of Clinical Studies; what are your key memories of those times?

Well, I suppose you have to ask, 'What is the Director of Clinical Studies there for?', and people would have different views. My feelings were to try to get the best clinical students you could, but then mostly to be there to represent them against the University, if you like. I regarded myself as the students' friend both times I did the job, and possibly took this to excess. I certainly wanted to know them all and used to get into my office at about 7.45am every day to have open house to students until 9am. I saw all the new intake between October and Christmas each year. I also built up a critical liaison with people in other medical schools, so that if I recommended one for their first clinical jobs, they'd take them at Guy's renal unit, at the Brompton, at St Thomas' ITU, at Newcastle, etc.

You had to keep the consultants in order too. A surgeon had XY as a student on his second surgical firm. X came to me and said he'd done a first attachment in surgery for three months and would like to complete his book on membrane physiology, and therefore could he attend surgery rather little? I left him to make his own choice. In due course the consultant sent me a note that Y could not be signed up for BM as he hadn't attended

sufficiently. But I agreed to sign him up but also that all the examiners should be told he hadn't attended, that his viva could be for as long as 40 minutes rather than the usual 20, and that he'd be the last to be examined for the surgical clinical cases so there could be extra time to explore any deficiencies. The consultant said, 'That's no good, as he's sure to pass', and indeed he did. That's an illustration of how I saw the DCS job.



1979, Brazil

Then there was the funding of Osler House. I was on the University committee looking at the possibility of founding a new college with a particular interest in medicine, which was entangled with the problem of entitlement to college fellowships for medics; we were thinking of a 'Radcliffe College'. Then Doll did all his work with Cecil and Ida Green who made an offer of two million conditional on immediate acceptance, and work on the buildings had to be done straightway too. Of course, everyone accepted immediately. But though the students were said to have been consulted and to have accepted the idea of a college on the premises of what had been Osler House, Alastair Buchan, who was President of Osler House and their spokesman, denied it. Osler House was then an independent club of the University subject only to the Regius and the Medicine Board. Where were the clinical students not in Green College to go? As well as the common room and the bar, there were tennis and squash courts. I was then a senior member of Osler House together with Bent Juel-Jensen, and we had to take the students' part as they felt their home was being taken. It was very difficult, but I wasn't nearly as rude as Bent, who was very direct and publicised his views.

Tell me your views on women in medicine. I think the NDM always had at least two women out of the four HPs.

Going back to picking medical students at age 18, there were polished young women with a bit of charm against acne ridden, almost unable to speak, shy, retiring chaps, so I used to say, 'You've got to give the chaps a 50 percent bonus to get any in'. Having had my mother, wife and a daughter in medicine I've no prejudice against women in medicine but I also think in the long run one has to consider what a woman wants to do. A number of women with stellar medical school careers say, as it were, 'I've loved medicine, it's a great hobby, but actually I want to marry and have children, and I have no wish to be a Professor of Medicine at the Hammersmith. I know I could be, but I don't want to'. And of course, in my time, when a man had a wife who was also in medicine, the concept that the wife had an equal career wasn't to be thought of. I mean, Elaine and I got married when she was an SHO in Obstetrics and wanted to be an Obstetrician but within a year we had a child, and she was doing part-time general practice. I can't remember what Gillian Sleight did; I think it might have been pregnancy advice service, or school medical officer. Judith Hockaday on the other hand did pursue a career, but for some time got held back. One of the sins at Oxford was to find there were wives 'to be made use of' and weren't going to leave because their husbands were there, and so the wives weren't given the recognition they needed.

What do you think makes a good doctor?

One has to have a very, very broad and intense experience which no longer happens. I believe that the 'Colditz' in which we grew up was in many peoples' minds a dreadful era, but by the time I was a consultant I'd seen almost everything that could turn up. The

current working hours that so reduce experience are, I think, nothing short of a disaster for the doctor and for patients. As a houseman I had six hours out of the hospital in the first year, other than two weeks' holiday. You learned not only clinical medicine but also how to talk to people and be personal with them.....[teaching] communication skills, you don't need that, you learned it the hard way by sitting and communicating endlessly. Early on, in London, there was a 26-year-old woman with lactating carcinoma of the breast, who would soon be dead. She wasn't sent home, she wasn't sent to 'Sobell House', she remained as the responsibility of the team to look after until her dying day. So, I learnt about how to handle people who were dying; it was much better than having an actor and a list of things about how you hold hands, make eye contact...So what you need are, first, experience and personal responsibility, not handing it over to someone else; and spending every hour of the day seeing people. But even when you do all that, there are some people who have what I think is a clinical gift. In my day you usually had to make decisions from totally inadequate evidence, and some people had the right feeling which way to jump. So, role models are essential because you learn from them how to behave, how to think.

“ ...in Oxford... the emphasis was on you thinking for yourself and not believing in dogma

My father, who was an Aberdonian medical graduate, said, as I moved from the NHS to the May Readership, 'When you reach my age of 70, you'll realise that even if you can make diagnoses everyone else has missed or



Family gathering for Professor Ledingham's 80th birthday in Cornwall



make new discoveries, all will seem like vanity compared with the experience of sitting with a patient with an illness that is untreatable, talking to them and leaving them feeling so much better'. Now that I'm 80 plus I tend to agree. I fear this skill may be going, but not entirely because Weatherall did it better than anybody, with all his science to add...and there must be others.

What else?

Perhaps something to finish with. What really turned me on in Oxford from start to finish compared to school was the emphasis on you thinking for yourself and not believing dogma and not taking facts unless they were really sound. And one of the things that really inspired me was Robb-Smith on the Path. and Bac. course. He taught on blood coagulation and said, 'The first part of the morning I'm going to teach you the dogma of blood coagulation, how you would act as a clinician and how you would answer exam questions, and then we'll have coffee, and then for the second half I'm going to tell you why it's likely all of that is wrong'. Teaching of a sublime nature!

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 Nuffield Department of Medicine. You are a brilliant physician, clinical teacher, diagnostician, researcher and author. You have also been a generous, funny, compassionate and approachable mentor, who provided wise counsel to thousands of former students, including many professors, distinguished figures of the medical profession and, indeed, laureates. In true Socratic tradition, you always knew 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.

At 91, a birthday celebration can last all year and beyond. The Oxford Medical Alumni community wish you well, from the bottom of our hearts.

Mary Ryan and Lyn Williamson HPs 1981

The Spirit of Brexit: Past, Present and Future



Professor Alastair Buchan, Professor of Stroke Research, University of Oxford and Director, Oxford in Berlin. University College 1977-80.

What did we talk about before COVID-19? Well, it was Brexit. The last four years or so have provided the UK with a multiplicity of talking points. What is clear, some two months before the end of the UK's transition period, and after much ink has flowed and much speculation indulged in, is that the future is still unclear. But let me hope to shine a little light on the readiness of our alma mater for what comes ahead.

Oxford, and the rest of the UK's university sector, has been pretty much as one on the striking benefits of membership of the European Union. Since I was here at Osler House as a Medical student in the late 1970s, Oxford has changed enormously. In every corner of Oxford, the presence of thousands of excellent European students, together with European academics and researchers across all disciplines, and perhaps most



importantly, the benefit of the European framework programmes for our research, have had an enormous impact. The European transformation of a largely Anglophone institution that admitted mainly English undergraduates to turn out into British professional life, was, by 2016, complete. Oxford is today a genuinely international research institution, possibly the best in the world. Is it likely to remain as one?

I think so. Since the outcome of the Brexit referendum, Oxford has taken a number of steps to safeguard its international future. Following my time as Head of the Medical Sciences Division, I became Pro-Vice-Chancellor for Brexit Strategy, and then, in October 2018 the Founding Director of Oxford in Berlin <https://oxfordinberlin.eu>. This Oxford-Berlin Research Partnership involves four leading research

institutions: the Freie Universität Berlin, Humboldt-Universität zu Berlin, Technische Universität Berlin and the Charité – Universitätsmedizin Berlin, the largest and arguably best (after the John Radcliffe and OUH) teaching hospital in Europe.

During 2018 and 2019, the five partners have between them supported over 48 multidisciplinary workshops, involving some 1200 faculty members, researchers and students, and seed-funded 57 research projects, to the total tune of almost 1.2M euros. Several of those projects have now gone on to gain larger competitive research grants from the EU or other European funding agencies.

In 2018, a University subsidiary company was established: Oxford in Berlin gGmbH. We have a centre and open lab space housed at the Museum für Naturkunde, Berlin's Natural History Museum, that now provides Oxford's faculty, visitors and students with workspace when they are in town. Aside from our main relationship with the Berlin University Alliance, as our first four partners are now known, we have flourishing links with many research institutions within Berlin-Brandenburg.

Our original partners have been designated as a Consortium of Excellence by the Federal government, and are receiving considerable additional amounts of research funding, with some of which they are establishing a virtual Oxford-Berlin Centre for Advanced Studies. Its first thematic research programmes will be focussed on Social Cohesion and Global Health, but there will be programmes in other disciplinary areas over the coming years including Quantum Computing, Climate Change and the Digital Future. We are working closely with the Einstein Foundation, which will be supporting several major research initiatives and funding a new programme of Oxford-Berlin Einstein Exchange Professorships, fellowships and studentships for the coming years.



Glienicke Palace – The Future William Osler House in Berlin

So why Berlin, and why not other major cities or universities within the EU? It seemed to us that our partners in Berlin offered many advantages in terms of research excellence, comprehensive disciplinary scope, and a local administration that was willing and able to help us. Berlin has considerable convening power in science and research (just ask the Gates Foundation or the Wellcome Trust who have also created Berlin offices for their EU operations). And, of course, Berlin is very much at the heart of the European Union that the UK

has just left.

Of considerable interest for Oxford medics is the opportunity to work with colleagues at the Charité. This was true in William Osler's time with his Berlin colleagues, Robert Koch and Rudolph Virchow. Osler had many of his so called "Brain dusting" sabbaticals in Berlin. As many of you will know, Germany's efforts against the COVID-19 pandemic are being led by Christian Drosten, a virologist who was recruited to the Charité in 2017 who along with the Robert Koch Institute Director Lothar Wieler are both well known to Chris Conlon, Adrian Hill, Tim Peto and Derrick Crook. But beyond the current focus on COVID, the Charité provides the perfect docking station with Oxford's Medical Sciences Division, right across the range of research activities. And Berlin's hosting of the World Health Summit, and its willingness to lead on Global Health with its international partners, means that Oxford's medics will continue to be at the centre of international research excellence within the EU.

“ *Berlin a new home away from home for Oxford students* ”

In addition, we have now been offered the use of the Glienicke Palace, near Potsdam, <https://www.spsg.de/schloesser-gaerten/objekt/schloss-glienicke/>

The Einstein Foundation is taking on the lease at Glienicke to serve as its administrative headquarters, and the property has the capacity for flexible accommodation and conference space. This will establish an "International house" for academic visitors to Berlin. This is my next big project a "William Osler House", in Berlin.

The Einstein Foundation has now made three appointments of Oxford academics to its Visiting Professorship scheme (two in Social Sciences and one in Medicine). Plans for a reciprocal visiting professorship scheme between Oxford and Berlin are now being pursued, using, on Oxford's side, philanthropic funding sources with a Berlin match. We hope to see plenty of Oxford academics in Berlin and to welcome Berliner's to the Berliner Haus now established near Osler House on the Woodstock Road.

Augmented Reality for Anatomy Teaching

...a very 21st century approach to teaching the modern surgeon



Dr Matthew Williams, *Academic Foundation Doctor, Oxford University Hospitals. St Catherine's College, 2014*



Mr Tom Cosker, *Orthopaedic Surgeon, Nuffield Orthopaedic Centre, Oxford. Mr Cosker works at the Tumour Oncology Unit with a specialist interest in Upper Limb and Reconstructive Surgery. His term as Director of Human Anatomy at Oxford University from 2014, finishes at the end of December 2020.*

By its very nature, anatomy is a highly visual and tactile subject that demands a firm grasp of the three-dimensional arrangement of anatomical structures and their relationships between one another to convey the fundamental principles of clinical practice. At the University of Oxford we retain a classical approach of cadaveric demonstration to provide medical students, and aspiring surgeons, with a formal anatomy education. However, increasingly, we are investigating novel technologies for use in our anatomy curriculum, to augment traditional teaching practices and to inspire the next generation of clinicians and scientists.

The last decade has seen extraordinary progress in the development of both virtual and physical 3D technologies, including immersive virtual (VR) and augmented reality (AR), and 3D printing systems. Since VR provides real-time immersion in an entirely simulated environment rendered by digital graphics, the success of a VR platform is dictated by its ability to block out real world stimuli in their entirety. As a result, we have found locally, clinical applications of VR are often limited by lack of real tactile feedback, reduced haptics, and reliance on complex digital graphics that are often unrealistic. Instead, alongside our uptake of 3D printing, at the University of Oxford we have adopted the use of AR, which mixes digital information with real

world stimuli to create a mixed reality environment. This allows the user to interact with virtual information in the context of their real-world surroundings.

AR technology has already found utility in the field of surgical teaching due to its ability to provide tactile feedback within the context of the real world. Display systems are widely commercially available and can either be head mounted like the Google Glass and Microsoft HoloLens, or stationary like the Miracle Magic Mirror. With widespread uptake of this exciting technology there is no shortage of developers working on tailored software packages, as well as off-the-shelf products. Given the accessibility, and success of AR technology described at a postgraduate level, we were eager to offer this exciting learning modality to our undergraduate medical students.

“ *Users interact with virtual information in the context of their real world surroundings.* ”

This year, through collaboration with Case Western Reserve University, we are integrating The HoloAnatomy System (figure 1), running on the Microsoft HoloLens V2, into the Oxford anatomical curriculum. HoloAnatomy is a versatile platform that has been developed through collaboration between anatomists, artists, programmers, instructional designers, and scientists. Following the successful introduction of HoloAnatomy at Case Western, we have implemented the musculoskeletal module in our cohort of students on their orthopaedic specialty rotation as they progress through their fifth year of medical school. Our introduction of HoloAnatomy has been met with much enthusiasm and support by the student body, and we are currently looking to expand its use to other areas of the curriculum.

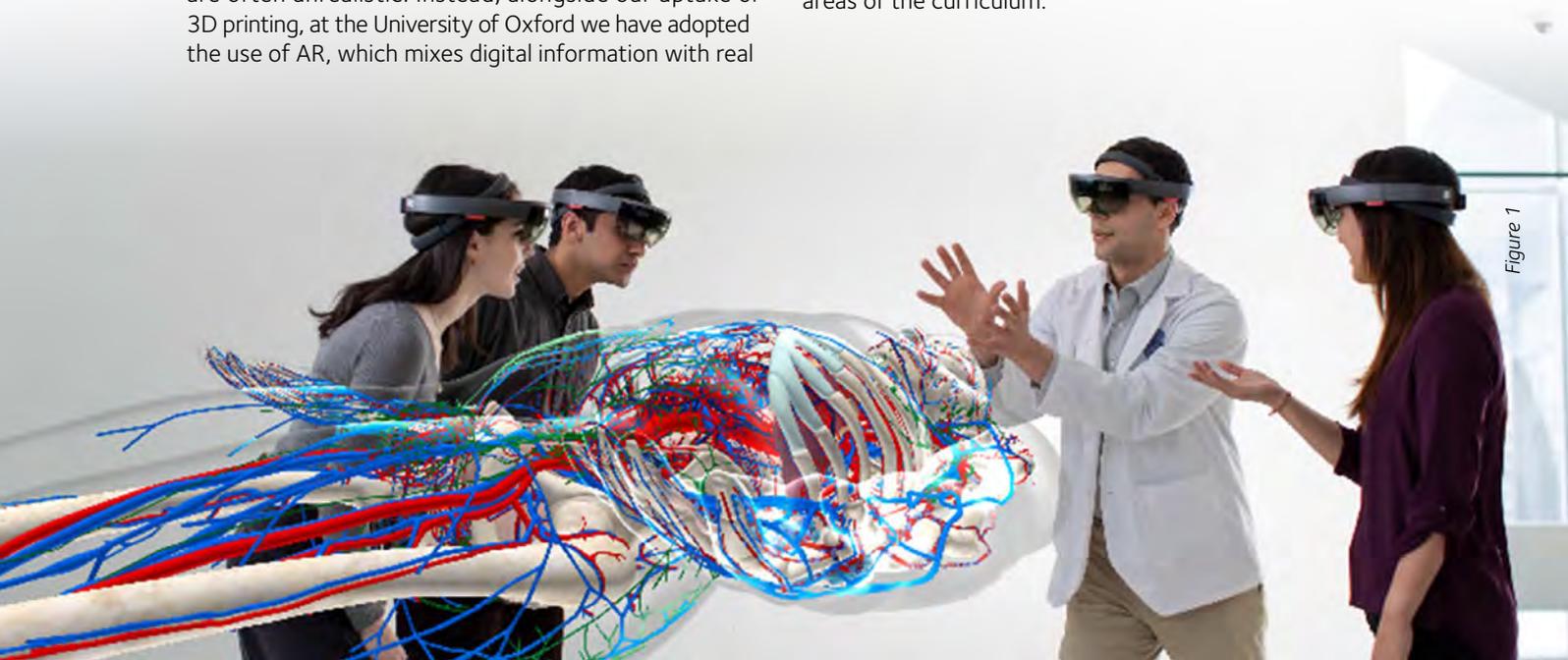


Figure 1



Alongside our uptake of AR technology, we continue to develop our own physical 3D modelling process that utilizes the process of stereolithography. 3D printing, which already demonstrates great promise in surgical planning and device development, in our experience has also proved to be equally useful in the field of surgical anatomy education.

“ *High fidelity 3D printed models from real in vivo patient anatomy* ”

“The Oxford Method” allows us to produce high fidelity 3D printed models from real in vivo patient anatomy. This is achieved by taking anonymized clinical images, either CT or MRI (both either with or without contrast media), semi-automatically segmenting them by tissue type, rendering a 3D mesh using a computer aided design (CAD) tool, and finally printing in three dimensions to any scale we wish. As part of the CAD process, we can choose to stylize the model – this includes adding “windows” to allow students to view deeper structures. An example of this can be seen in the bladder of figure 2b where a window was placed to allow students to view the trigone.

In Oxford, our use of 3D printing continues to grow, both in the educational and clinical environments. For the purpose of education, we have found 3D printing allows us to digitally store anatomical variants that may rarely come through the cadaveric demonstration suite, in addition to printing models on demand and rapidly when required.

This explosion of new technology presents an exciting opportunity to the surgical innovator. In a field that is dominated by centuries old tradition it is essential that the training of modern-day surgeons embraces the possibilities of the 21st century; technology must not replace but can certainly augment long established technique.

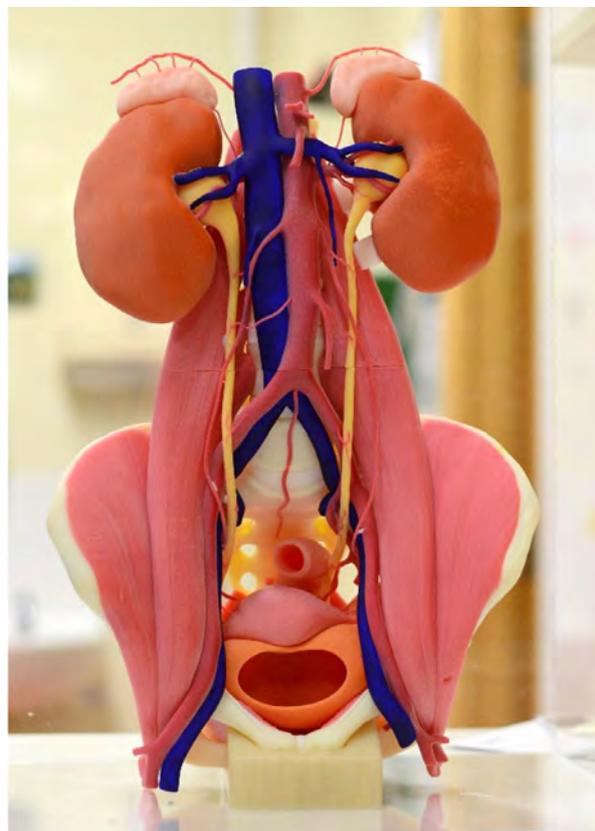


Figure 2

COVID-19 in Oxford Update



Professor Chris Conlon,
Professor of Infectious Diseases, Nuffield Department of Medicine, Oxford. New College 1974-77. Returned to Oxford in 1989 as a consultant in infectious diseases and general medicine. Currently

Professor of Infectious Disease in the NDM and Chair of the Centre for Tropical Medicine and Global Health.

Oxford University Michaelmas term

A lot has happened since the beginning of term. Most students returned in October and, not surprisingly, there was an increase in new cases of COVID-19, particularly among the undergraduates. There is little evidence of transmission in departments or via teaching sessions. Most infections have been in social gatherings and within households. Fortunately, large outbreaks have been avoided with the help of the University's testing service (EAS). Those with symptoms are tested and isolated fairly quickly, thus limiting the number students needing to self-isolate at any time. Numbers peaked towards the end of October and have fallen steadily since, possibly helped by the national restrictions currently in place. The focus is now on getting students home for Christmas as safely as possible. Researchers in Oxford, along with scientists at Porton Down, have validated rapid testing kits which are now being rolled out nationally. These provide a result within 20 to 30 minutes, with high specificity and acceptable sensitivity. The University plans to use these tests to help assure students that they do not carry the virus home with them.

Oxford Led Clinical Research - Highlights

The Recovery Trial result showing the efficacy of dexamethasone in COVID-19 was rapidly adopted as standard of care in the NHS and indeed international, saving lives and ITU beds. The trial also demonstrated that hydroxychloroquine and lopinavir/ritonavir were ineffective. The trial continues now to evaluate the role of antibody therapy and can be further adapted to investigate new treatments if they emerge.

The Principle Study continues in the community, looking at repurposed drugs for mild disease, and another study, run by Prof Mona Bafadhel is evaluating inhaled steroids in mild cases in the community.

Professor Fergus Gleeson, **using a novel imaging technique with inhaled xenon**, has shown that there is lung damage post-COVID-19 in those who have been in hospital, and he is now setting up a study

to investigate those with minor symptoms. The lung problems that xenon imaging reveals are not visible with conventional imaging and this might explain some of the problems encountered by those with 'long COVID'.

Vaccine News

The exciting news in recent days has been that two candidate vaccines, based on messenger RNA technology, have shown excellent efficacy in preliminary results. Much more detail about these results is needed but the fact that two different companies have shown such promise provides much-needed optimism for the coming year.

The Oxford University – Astra Zeneca ChAdOx1 nCoV vaccine trial is proceeding and results are expected soon. If the results from this are similar to the other vaccines, it is possible that regulatory approval could be obtained soon and vaccination programs start before the end of the year. Vaccination will initially be targeted at healthcare workers, care workers and the clinically vulnerable. The good news for the older alumni is that the vaccines seem to produce good immunity markers in those over 60 years old.

Medical Students

Medical students, particularly those in the clinical school, have had a lot of disruption this year. Nevertheless, many have helped, and continue to help, with various research studies and with COVID-19 testing. They are now allowed back into the hospitals and able to see 'real' patients, and to join in the work of the hospital. Some clinical teaching is online and most of the Lab Medicine course for the fourth years is virtual. Attachments have been shortened, Finals will be delayed until later in 2021 and, unfortunately, electives have had to be cancelled. Despite all of this, the students remain enthusiastic and realise that these extraordinary times are providing an important part of their medical education.

John Radcliffe Hospital

The Hospital is starting to get busy again, with about 50 COVID-19 cases in at the time of writing, but not many have needed ITU. Most of the hospital staff are tired but the hospital is better prepared than in the spring, and there is sufficient PPE to protect staff and reduce the risks of nosocomial transmission. Nevertheless, it is going to be a difficult winter. The hope is that 'flu vaccination, along with social distancing and other restrictions, will reduce the number of 'flu cases and take some of the pressure off the system.



Surgery during the COVID-19 Pandemic



Professor Neil Mortensen, *Professor of Colorectal Surgery, University of Oxford Medical School, and President of the Royal College of Surgeons*

At the end of February 2020, I was, and I say was, about to take a long weekend trip

to Milan. A very good friend and colleague there had arranged a terrific cultural weekend. Five days before we were due to depart, he rang me “Tomorrow, Lombardy will be in lockdown and it’s going to be really bad”. There followed the terrible scenes from Milan and Bolsano, but possibly like you I had optimism bias, and that was not going to happen in the UK. It was around this time I was elected President of the Royal College of Surgeons of England. And then, suddenly, everything changed.

In early April, NHS England brought non-urgent planned surgery to an abrupt halt and with it, most surgical training. The priority was dealing with COVID-19 patients and especially those needing ventilator support. Trainees were re-assigned to emergency room or ICU care and some surgeons acted as first assistants to ICU consultants.

Emergency surgery continued, although there were fewer trauma cases since the roads were empty during lockdown. Some patients with appendicitis, for

example, were treated with antibiotics rather than surgery. Surgeons, anaesthetists and theatre staff were scared, and it soon became apparent that the cumbersome and uncomfortable but very necessary personal protective equipment was not always available. There was so much that staff at the sharp end did not know, such as how dangerous was surgery in a COVID-19 positive patient, how dangerous was it for the surgical team, and which procedures were the most dangerous?

“ *Better to delay or modify treatment plans than have a patient go to ITU after surgery* ”

In the autumn of 2019, in Wuhan China, a neurosurgeon carrying out pituitary surgery via a nasal approach died of what subsequently was recognised as SARS COVID-19. The first two surgeons to die in the UK were ENT surgeons. The worry was that any aerosol generating procedure, for example intubation for general anaesthesia, gastroscopy, high speed drilling into bone or a tooth or even laparoscopy as well as examining the nose and throat was high risk. Calculations were made about circulation times for the air conditioning in theatres resulting in prolonged delays between intubation and the start of surgery, and

further delays at the end of a procedure. Throughput was down by at least 75 percent. Wearing PPE is exhausting, donning and doffing took ages and everything an effort. But curiously there was a sense of excitement too. Enterprising and inventive anaesthetic and surgical teams were freed to come up with local solutions and much surgery did keep going.

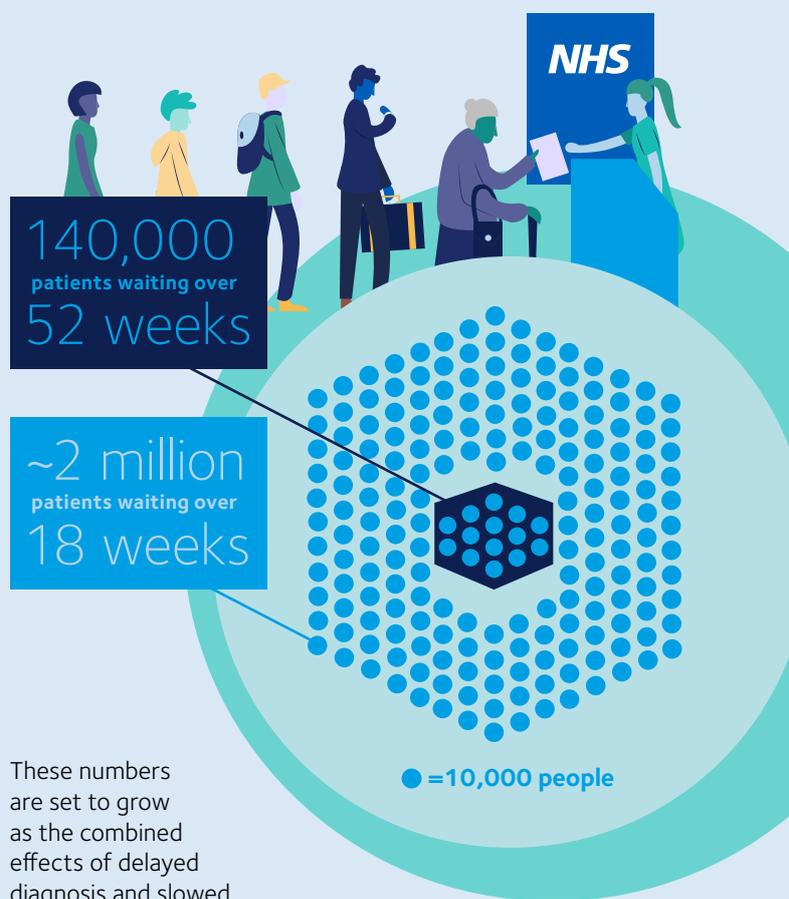
“one day....the many little miracles of surgery will resume

Much as in medicine, surgical research with a COVID-19 theme exploded. One of the early international snapshot studies reported a 10-fold increase in mortality rate for COVID-19 positive patients having major surgery. Treatment plans were modified. For oesophageal cancer and rectal cancer, more patients had primary radiotherapy as a holding treatment, and there were more stomas made and a massive decrease in the proportion of patients having laparoscopy or keyhole surgery. Better to delay or modify treatment plans than have a patient go to ITU after surgery or with complications. Fortunately, subsequent studies have shown that in COVID-19 negative patients there has not been any excess mortality or morbidity.

In Oxford there have been some excellent initiatives. Most breast cancer treatment continued undisturbed using the Manor private hospital with four sessions a day contracted NHS patients. The bigger cancer cases have been continuing at the Churchill Hospital and a recent review showed that no patient has developed COVID-19 and good outcomes. A similar approach was employed in Central London where the major private hospitals undertook the bulk of cancer surgery, with NHS staff moving with their patients to these facilities. At the NOC, a national study run by the hand surgery team showed that cases could be carried out under regional anaesthesia avoiding the need for intubation and keeping up throughput with excellent results. The common theme here is the use of a non-emergency site where as far as possible the patients and staff are kept free of COVID-19. So, by an accident of geography and policy, Oxford had the perfect logistic arrangement, keeping planned surgery and a second separate ITU facility on different sites. It is possible to create so called green pathways within an acute hospital but there are many difficulties, and previously COVID-19 free wards rapidly become COVID-19 positive as soon as the prevalence rises.

Slowly, elective activity recovered over the summer. In some places this approached 90 percent of normal but varied by specialty and region. The true effect has only just become apparent with the publication of the

latest waitlist figures. The NHS has reported that there are now 140,000 patients waiting over 52 weeks, 10 times increase in a year, and there are nearly two million waiting for more than 18 weeks. It is difficult to see any easy solution.



These numbers are set to grow as the combined effects of delayed diagnosis and slowed activity are felt. Now the second wave of COVID-19 has again stopped surgery in many places.

My command-and-control centre has not been the President's Office at the Royal College of Surgeons in Lincoln's Inn Fields but my desk at home. Suddenly, I am in the world of multiple Teams meetings, rapidly changing situations and a huge responsibility for surgeons and trainees across the country. The College has a respected voice independent of government, but we share many meetings with senior figures in the NHS and DHS and the other Royal Colleges. We jointly developed priority guidance for all surgical procedures. We have had to lobby hard for adequate PPE, for regular and swift testing of surgical staff and patients, for the wider use of COVID-19 light sites and continued independent sector capacity for elective surgery. None of this is as intellectually exciting as discovering a new treatment for COVID-19, a new testing method, or a vaccine, but one day the world will be COVID-19 secure and the many little miracles of surgery will need to resume at an even faster rate.

Dr Sarah Lowndes



COVID-19 in perspective

The effect of the pandemic on cancer care has been one of the most widely discussed impacts of the coronavirus response. It is through this prism that I have experienced working on the front line as a consultant medical oncologist.

There was a great deal that was unknown in March as cases began to be reported. The trust soon began to prepare in earnest in mid-March by grouping all the medical staff into one of five defence watches: airway, emergency care, front door, women's and children's services and ward care, with their own rotas to go live on 30th March.

Medical staff in oncology were initially planned to join these defence watches, which would potentially mean leaving behind a large cohort of patients receiving chemotherapy totally unsupervised, and no access to chemotherapy for new patients. I am immensely proud that the Great Western Hospital decided to take the approach of safeguarding vital chemotherapy services and a bold plan was developed to move our whole day-case unit to the private Ridgeway Hospital several miles away. It required an enormous amount of planning and organisation; preparatory work by our IT team creating sufficient wi-fi bandwidth to support electronic prescribing from a small village in Wiltshire, pharmacy organising the delivery and dispensing of chemotherapy, new phlebotomy services, not to mention moving all of the infrastructure required to deliver chemotherapy such as chairs and giving sets to the hospital gym, with medical and nursing staff taking on new shifts and rotas.

Our day-case unit also treated medical outpatients, so whilst our colleagues from other specialties remained at the Great Western Hospital, we took over the supervision of a wide range of treatments for other medical specialties. This was important not only to keep vital services going, but also to feel we were supporting our colleagues on the Covid front line. There was a great sense of camaraderie and wartime spirit.

“ For a fit patient, an untreated malignancy is a far more fatal disease than coronavirus.

Another positive development was the creation of a hospital clinical ethics committee, encompassing a wide range of voices, on which I served. We discussed issues such as how to manage the hypothetical situation of limited oxygen supplies, the ethics and practicalities of virtual visiting, decisions on who should be able to access intensive care in the situation of a shortage of beds, and the presence of relatives in PPE at the bedside of a dying patient. Many of the situations we discussed thankfully did not transpire, but a robust forum was established for developing policies and dealing with ethical situations in the future.

However, in the oncology clinic I also developed concerns about some assumptions and decisions being made nationally during the pandemic. Whilst many sensible pragmatic decisions were made, such as moving to shorter courses of treatment and oral

Front line

Perspectives

Winter pressures, backlogs of urgent cases, mental and physical weariness all contribute to the challenges faces by our friends, family and colleagues who are coping with the 'second wave'. Clinicians from different generations, and different specialties, from the most senior to the most junior, share their perspectives



Ridegway (Private Hospital) Gym
made up for Chemotherapy

therapies where possible, national prioritisation lists were cascaded where the vast majority of my patients, having adjuvant and palliative treatments for colorectal cancer, were not a priority for chemotherapy. Surgery and radiotherapy were extremely limited.

Oncology is one of the most evidence-based specialties, applying the results of systematic research over many decades to improve cancer outcomes. We spend much of our time balancing risk; the risk of recurrence, the benefit of chemotherapy and the risk of death from chemotherapy, all based on robust data. I took the view that whilst we still had the capacity to treat, for a fit patient, an untreated malignancy is a far more fatal disease than coronavirus, so we should continue to offer chemotherapy to patients after an open discussion of the possible risks. Most patients decided to accept the risk, some declined, all appreciated that they were given the choice. With other vital services such as surgery suspended, I actually found myself extending my chemotherapy remit in treating some patients with primary tumours or liver metastases who could not have their curative surgery, to prevent progression during the lockdown.

A number of my patients contracted coronavirus whilst on chemotherapy, several with advanced disease; all but one had mild illnesses, and none died. My colleagues noted the same pattern, leading to our collective sense that perhaps the milder chemotherapies were protective from the cytokine storm that manifests in severe Covid disease. Most patients were on dexamethasone. We contributed data on our patients to the UK Coronavirus Cancer Monitoring Project which published in the Lancet in late May and did not find any evidence that patients on chemotherapy or other

systemic anticancer treatments were at increased risk of mortality from coronavirus.

“ *...no evidence that patients on chemotherapy...were at increased risk of mortality from coronavirus.* ”

Other concerns I had for my patients were the effects of social isolation and shielding particularly in the last year of their life, the neglect of the issue of quality versus quantity of life in the Covid response, and the whole scale shift to telephone consultations.

We moved our chemotherapy service back to the Great Western Hospital over the summer. We have kept some of the new patterns of working we gained, we have forged new links with other specialties and demonstrated the ability to move a whole service in a weekend. However, our workload of new cases has increased. There is a sense of more late presentations of malignancy and therefore a hope that with this second wave, using the data collected from the first, we can keep services open and a balanced approach to risk for all our patients.

Dr Sarah Lowndes, *Consultant Medical Oncologist and Trust Chemotherapy Lead, Great Western Hospital. Merton College 1992.*

Dr William Seligman



As the second wave rolls in...

There was an inevitability about what happened at the peak of the COVID-19 spring pandemic. Elective surgery ground to a halt, patients with strokes, heart attacks and internal bleeding vanished. Even the mindless plague of stabbings that continues to maim teenagers in our inner cities seemed to stop.

Emergency departments, general medical wards, and intensive care units (ICUs) soon became inundated with patients with COVID-19 – a disease we knew little about, let alone how to treat.

This time around, things feel different. It is government edict that elective surgery, and outpatient clinics (albeit now virtual) should, wherever possible, continue even as we are well into lockdown at the time of writing.

And so I find myself conflicted. On the one hand, I know that the only reason the NHS coped in the spring was that essentially all other hospital activity ceased, allowing staff and equipment to be moved to ICUs to help cater for the increased demand. But the true cost of this pandemic cannot be measured solely by the number of patients who caught the disease and succumbed to it, but also by the number of delayed cancer treatments, unmet mental health needs, heart attacks and strokes ignored to avoid coming to hospital and risk catching the virus.

We can't afford to stop all hospital activity this time around. There will be less ICU capacity for COVID-19 patients if, for example, we continue doing complex cancer surgery which requires ICU admission post-operatively. Cooperation between different hospitals across regions becomes essential to meet patients' needs, wherever they present, even if that means being transferred somewhere else.

Creating 'Green' (COVID-free) and 'Red' (COVID-positive) hospitals simply won't work. This seemingly sensible solution to allow urgent and elective surgery to continue in Green Hospitals ignores the fact that virus does not understand green and red. Significant

numbers of critically ill patients would need inter-hospital transfers. The high incidence of asymptomatic infection and false negative tests risks outbreaks of disease in COVID-protected hospitals.

In my opinion, the right approach integrates: testing of all patients and staff, on arrival at hospital, and throughout admission; strict segregation of COVID areas and non-COVID areas (ideally with separation of staff); hospital trusts remaining nimble enough to adapt and predict bed and ICU capacity using regular modelling two to three weeks in advance. Patients understand of the huge pressure the NHS is facing and must not be scared to come to hospital if they are unwell and turning up to appointments if they are going ahead.

“...as we start donning our PPE once more, there is real reason for optimism.”

There's no doubt that this will be a difficult winter, but the glimmer of light at the end of the tunnel shown by the vaccines mean that we must get through it with as few deaths from COVID (both direct and indirect) as possible. We are better at treating patients with severe infection helped by routine use of dexamethasone and anticoagulants. More nuanced ventilation techniques, differentiating different phenotypes of COVID induced respiratory failure and tailoring ventilatory management accordingly to prevent ventilator-associated lung injury.

So, as we start donning our PPE once more, there is real reason for optimism. Things will be different this time around for sure. But it will be the efforts of the public in the face of 'lockdown fatigue' that will make the greatest difference in determining how the NHS copes over the winter months ahead.

Dr Will Seligman, Specialist Registrar in Anaesthetics and Intensive Care Medicine, London. Magdalen College 2000.

An SHO Takes PACES in Full PPE

After the first wave of COVID settled, I have spent my time in a similar fashion to many medical SHOs: seeing many patients with delayed diagnoses, learning how to work Microsoft Teams (and developing new anxieties about whether I've left my microphone/camera on), frantically trying to catch up on the training requirements we were told not to worry about in March that have suddenly reared their ugly heads, mutated by social distancing and virtual environments, and gambling on where I might be able to go on holiday without risking having to self-isolate when I return.

Alongside many others, I have also attempted to bring some normality back to my training, which for me has meant tackling my PACES exam. This exam, challenging at the best of times, has had a few fresh hurdles thrown into the mix with PPE and the communications stations being conducted

Dr Hannah Thould



virtually. Whilst I appreciate the RCP has had a tricky time balancing social distancing, the risk to patients and our on-going training, I can tell you that sitting in a waiting room for an extra hour prior to your exam with the words 'can you hear me?!', 'oh no, we've lost the examiner' and 'turns out the examiners at home haven't actually been sent any of the paperwork' drifting through the wall definitely does not help with pre-exams nerves, nor does desperately trying to avoid making eye contact with the examiner on your screen whilst attempting to break bad news to your virtual patient. At least however we are now all well accustomed to wearing PPE (and the tricks to avoiding looking like a fool as your stethoscope gets caught in the plastic apron) and there was some light-hearted entertainment in being ranked on how quickly you could put on your gloves after washing your hands with alcohol gel.

“ Oh no, we've lost the examiner!

Now as we head into the second wave and adjusting to a new hospital's way of tackling COVID, I am battling anxiety on two fronts – whilst mostly concerned about case numbers and beds and oxygen saturations and dexamethasone doses, I do also have a niggle at the back of my head about my own career and training and what on earth the next few years are going to look like, whether I'll catch up, what I'll have missed.

Dr Hannah Thould, CT1 Internal Medicine Trainee, Bristol. Exeter College 2009 and Green Templeton College 2012.

A Foundation Doctor Reflects: Changes and Constants

From Emergency Deployment to 'Regular' F1

Dr Bernard Bukala



When I wrote for this newsletter several months ago, much was different. Globally, coronavirus was just about to surge for the first time, we stockpiled groceries and argued over the supposed benefits of public mask-wearing. Now, mid-November, we have gone

through lockdowns and waves, and as the grim impact of the pandemic became more evident, definite glimmers of hope have begun to appear. We are now trying to determine which elements are on their way back to normal, and which have become the *new normal*. Personally, back in May, I was graduating from medical school and being inducted into the newly created Interim Foundation role. Since then, I have made my way through three hospital departments and settled into the job as a junior doctor. While the tasks have remained similar, my knowledge, confidence, and feeling of responsibility increased greatly, albeit in a subtle and incremental way. The worries caused by the unknown of COVID and the mystery of being a doctor made way for striving to do my job well. As the world and society transformed almost daily, so have I, on my own small scale.

“ As the world and society changed almost daily, so have I.

What stands out to me most, however, is what remained unchanged. Just as in the beginning, the virus causes destruction, but also incredible mobilisation and focus. The wheel of world affairs keeps turning, with the never-ending drama of politics and cycles of economy. The NHS staff are still as motivated and determined to do things right by their patients. My own learning curve was steep as I started on the job, and equally there is much more to learn every single day. I grew to appreciate that even though we never know what awaits around the next corner of history, we can rely on others – those near us, and those across the globe – to find a way through crucial moments. I hope that by making an effort to learn from them, we might turn future corners with increased agility.

Dr Bernard Bukala, F1, ITU & Anaesthetics, Buckinghamshire Healthcare NHS Trust. Worcester College 2014.

Alumni Letters



Memories from 'the Wittery'

It is good of Julie Neale to mention me as some sort of pioneer woman house physician to Professor Witts, but I think my two medical aunts, one on each side of the family, might have had

something to say about that. (Why are medical relatives currently unfashionable?)

My memories of some patients on 'The Wittery' take me through a few of the notable events of the 20th century. The first had been in the force that relieved Mafeking in the Boer War. He admitted looting. When I asked him what things, he replied 'Ostrich feather fans and coloured silk scarves' which I found a bit of an anti-climax, but presumably he had been a young man with female friends to impress.

A siege from the opposite viewpoint, those besieged, the siege of Kut, was experienced by another man. The first World War included a campaign against the Ottoman Empire in the Middle East. My father, a student in Aberdeen, once in hockey trials for Scotland, used to say he learned to play the game because so many local men returning home had played it on the dry earth of Mesopotamia (Iraq). Indian troops with the British in Kut could have promoted it. This garrison was besieged for over half a year. Relief columns failed. 'We were reduced to eating blades of grass' my informant told me.

My third adventurer had operated in a different climate. During the Russian revolution, he fled the Bolsheviks in a sledge across a frozen lake. Leningrad (St Petersburg)

when besieged in the second World War, received a few supplies across frozen Lake Ladoga.

There was a route for escapers from Siberia. They came down through Persia (Iran). A British Military Commission was apparently allowed to visit the camps to recruit. Many Poles joined. The woman I encountered had tuberculosis. Almost everyone from those dreaded camps had it.

Dr Carole Robertson, Lady Margaret Hall 1952 (Retired)

Carole typed this letter in May 2019, stamped and posted it to the OMA office where it hibernated through one office relocation, and changes of alumni relations officers. I tried to calculate whether Carole should have tied the letter to a snail and sent it from Swindon to Oxford instead. Snails travel at a speed of one metre per hour and only at night. So real-snail-mail would have taken 15 years to deliver the letter!

Apologies Carole. Your carefully constructed, witty and wise letter is an exemplar for us all. Thank you. p.s. please ask you family to set you up with a computer for Christmas so that you can attend the OMLecture Club, listen to the online Podcast Interviews and watch the medical student Christmas videos. You can also read the previous editions of *Oxford Medicine* <https://www.medsci.ox.ac.uk/get-involved/alumni/publications>

This letter is in response to an article by Dr Julie Neale on page 17 of *Oxford Medicine*, May 2019, which can be found via the weblink above.



Perspectives: An old duffer's tale

In 1985, Brian, my elderly senior partner, could talk about slum clearances, standpipes, huge families, child mortality and deferential nurses in the Wolverhampton of his

early days in practice. He had tales of midnight visits to the terminally ill and daily attendance on patients with quite severe medical conditions like heart failure, stroke, hepatitis, and of course various strands of COPD. Confident with the wisdom of four years' hospital work, I knew that many such merited admission. Brian duly guided me to improve home management of many conditions but agreed that this was still imperfect,

forced on us by circumstances and the ethics of resource management.

He retired within three years of my arrival, oddly, leaving me in charge. And my first resolution was not to develop into the old medical bore with lurid accounts of sleepless heroics and bizarre crises. This phase lasted until comparatively recently, but I now find it necessary to educate the young in just how tough and resilient we had to be in those uncivilised and harsh days. And as for the patients, they had to be even tougher.

In 1980, my first house job was working for a manic urologist in Bolton in which our general surgical take included desperately ill patients with chest injuries

who really needed ITU but there was none except Manchester, fifteen miles away, and they were always full. Later, working in other poor areas, like Stoke on Trent, the hospital resources were also unbelievably stressed with rampant corridor clerking, hot bedding and heavily rationed radiology. Overcrowding in outpatients even at the Radcliffe until 1978 meant several patients in one room, barely any confidentiality or dignity. We were very aware of these deficiencies at the time, and there were plenty of avenues of protest though shamefully perhaps not pursued with sufficient vigour. No beds, no appointments, just get on with it.

The NHS has never been out of crisis mode in my working life as an inner-city GP. It has rarely had sufficient capacity and certainly in the eighties it was often hard to get past the jaded registrar to secure a bed. Because the system was inquisitorial, a game was played in which one added further medical details into the history, drip-feeding his or her anxiety until usually defeat was conceded. On a night visit to a sick

patient, one might have to ring several hospitals, from the patient's phone or a phone-box, then ambulance control and finally despatch the patient with a note of justification. Dialling 999 was considered the nuclear option and a poor show. There was then little point in admitting those who clinically had an uncomplicated MI or stroke and had someone at home to nurse them as they'd be sent back. Pulmonary oedema was handled with a brutal shot of furosemide at home. COPD patients, often old before their time, could also be home managed, living room strewn with oxygen cylinders, where of course they preferred to be, near the cigarettes.

It is not as if this was the last century. Well, technically it was but this was but 40 years ago and so when one reads today of Covid-driven bed crises, or huge waits for physio or the useless cataract service or whatever, there is nothing new. And frankly that is outrageous.

Dr Tim Crossley, retired General Practitioner
Wolverhampton. St Edmund Hall 1974-80.

Tingewick Remembered



The title of 'Flash Gordon in Star Wards' reflected two science fiction films released the previous year - 'Flash Gordon' with a soundtrack by Queen and the second of the Star Wars franchise 'The Empire Strikes Back'. The transcription as T1-NJ W1-1K

alluded to R2-D2 and C3-PO, the Star Wars robots, and the subtitle '2001 - a space occupying lesion' was a trope to '2001: A Space Odyssey'.

The character of Flash Gordon in T1-NJ W1-1K was based on Gordon Stirrat, then Nuffield Reader in Obstetrics and Gynaecology and a Scotsman. Although I came from Northern Ireland, over the 45 years I have been in England I have frequently been mistaken for a Scotsman and as I had no prior experience of acting, the only reason I can have been invited for an audition was because I sounded like Gordon Stirrat. Among the leading lights in Tingewick that year were Anthony Berendt and Adam Finn and I vividly remember them auditioning me in an upstairs room in Osler House. I can still recall my embarrassment at being asked to imitate someone breaking wind and to demonstrate the appropriate facial contortions. Mortification was hardly the response of a confident actor.

Whatever their misgivings, I was given the part of Flash Gordon and Michaelmas term 1981 was very busy indeed. My paediatric attachment was in Reading and I had to return to Oxford frequently for rehearsals. I think the time devoted to T1-NJ W1-1K impacted on my studies as I had an underwhelming paediatric viva. I was asked about cerebral spinal fluid findings in different



types of meningitis and was completely flummoxed went Sir Peter Tizard asked me whether the cell counts I quoted were per microlitre, per litre ... per gallon ... or perhaps per elephant? Was the eminent professor alluding to Rita?

The show was a great success, raising money for charity and providing entertainment for staff and students. Tingewick certainly gave me a taste for hospital pantomime. I subsequently had the part of the wall in 'A Midsummer's Night Scream' at Queen Square Hospital (where I later had spinal surgery), directed 'The late, late Christmas show' at UCLH (where I later had shoulder surgery) and played Lord Lootalot at the Queen's Medical Centre in Nottingham (where I later had my collar

bone screwed together). Well, they do say 'break a leg'.
 Martin Burton, now an ENT surgeon in Oxford, directed the music for Flash Gordon. He reminded me that I sang in the opening song 'Flash' from the original film soundtrack and also a rewrite of Tony Bennett's hit 'Girl Talk' with the line "But that's a Dane, they're all the same, it's just a game". This lyric, and the song 'There's nothing like a Dane' from 'South Pacific', referred to my New College tutor Dr Bent Juel-Jensen. On the back of the sheet music is written "parody is expressly forbidden". Something we ignored. Oh dear - a 40-year-old probity issue for us all!

Adam Finn is now a professor of paediatrics in Bristol and I see him from time to time. Martin kindly invited me back to a dinner at Balliol College where I met up again with Anthony Berendt, then Medical Director of Oxford University Hospitals, for the first time in over 30 years. Fond memories of T1-NJ W1-1K 40 years on.

Professor Sir Terence Stephenson, Nuffield Professor of Child Health. UCL Great Ormond Street Institute of Child Health, University College London. Honorary Consultant Paediatrician, UCLH and Great Ormond Street Hospital. New College 1980.



The Healing Power of Music Where it's Needed Most - Finding Your Own Voice

Hello to all Alumni from a drizzly mid-Devon. What follows is neither very medical nor cutting-edge science but it is connected to a growing interest in the contribution of the arts and creativity to people's well-being, underpinned by some scientific research and a broadening evidence base.

Odd for someone who really can't sing, except on my bike, and who doesn't 'get' opera, I have become a passionate advocate for the healing power of music as part of an unusual musical charity. **Health: Pitch (<https://www.healthpitch.org/>)** brings bespoke, high quality, participatory operatic musical theatre productions to unlikely settings, such as care homes, hospices, mental health wards, brain and spinal injury rehabilitation centres, housing associations, universities and conferences. The audiences are small and diverse ones of between 10 and 50 people. Our essential ingredients are beautiful professional operatic voices, carefully crafted musical theatre, a resonant narrative, humour, surprise and laughter.

Performances are delivered in atypical places like cupboards, lobbies, dining rooms, chapels, cafes, museums and gardens, as well as in theatres. Prior to COVID-19, we had delivered over 50 live performances reaching more than 2000 people. People are reached in complex ways, often opening them to profound emotion and connections. They can build or strengthen relationships, encouraging dialogue and collaboration, especially on things that people find hard to talk openly about.

An Arts Council grant helped Health Pitch creatively adapt during the pandemic to allow people in challenging situations, coping with ill-health or disabilities to be reached. A strong online presence gives access to historic recordings, as well as new works which explore current themes like uncertainty, unemployment and loneliness. One of our singers, working with the University of Turin, is evaluating the impact of live operatic performances on the well-being of staff and residents. *Links with the Music as*

Medicine Foundation at The Erasmus Medical Centre in Rotterdam are producing high quality, robust evidence about immediate and lasting benefits of singing and listening to singing.

'Finding Your Voice' is our new program. A professional opera singer working in small groups who discover surprising, often hidden abilities to 'train' their own singing and use their voice expressively. We hope to develop this into a national initiative focusing on the carer workforce, paid and unpaid.

We have just started a programme called 'Finding your Voice' in which small groups work with a professional opera singer, discovering surprising and often hidden abilities to 'train' their own singing and to use their voice expressively. We are in discussion about rolling this out as part of a national initiative on workforce well-being, with a plan to focus on the paid and unpaid carer workforce.

It probably sounds bonkers. In many ways it is bonkers, but it really makes a difference to people and brings joy and laughter, when and where both can be in short supply.

Dr Mary Ryan, General Practitioner. St Hilda's College 1974

Mary worked as a GP in Leeds and Exeter before becoming a consultant in Palliative Medicine in Exeter and north Devon. Wilderness years with depression and suicidality contribute to her passion to improve mental health care services, to foster hope and talent in people at the margins of society and to bring compassion and humanity to the fore in caring professions. She now works in academic research, leadership development and quality improvement, promoting collaborative change with citizens and communities.

Her passion for Health Pitch arises directly from personal experience. Being at one of their performances was profoundly impactful. It led directly to a better understanding of her childhood self, the healing of wounds and a journey she is only at the start of, one to discover meaning and beauty in the sung voice and in singing.

Hal-le-lu-jah! Hal-le-lu-jah! Hal-le-lu-jah. Hal-le-lu-jah! Hal-le-lu-jah!

Tales from the Land of Oz

*A Brief Guide to
Medicine in the Land
Down Under*



A decade since leaving Oxford, a few of us have called Australia home for the past eight years. It was only meant to be for six months, or a year at most. A refreshing gap-year after Foundation Training. Like Oxford, but sunnier...?

Naively, we started our medical adventures down-under with the idea that practice would be very much the same as working in the NHS. We speak the same language, we share a cultural heritage, patients get the same diseases, and there is a public-funded hospital system. It turns out that these are only half truths.

Glossary of terms

“Strayan”	English
G'day, how're you going?	Hello, how are you, nice to meet you.
You alright?	Is everything okay, you look terrible!*
She'll be right, mate	It'll be okay
No worries	Not a problem
Right-O	I agree with what you're saying
Yeah, nah	No
Nah, yeah	Yes
Average	Terrible

Some of you may have contemplated a stint working and living in the Lucky Country. It's a wonderful place to experience as a medic. However, Australia has its own unique quirks and challenges. There's the language barrier of Australian-English (“Strayan”), the Australians themselves, the vast distances, and the fact that virtually every living creature on the continent is dangerous or poisonous.

We hope that we can provide a mini-guide to budding OMA adventurers to the Antipodes. Firstly, an English-Strayan glossary of commonly encountered patient jargon, followed by few clinical anecdotes about uniquely Australian medicine.

Ordinary	Awful
Sook/Sooky-la-la	A wimp/cry-baby
She lives in Woop Woop	She lives in the middle-of-nowhere
Cactus	Dying
Crook	Unwell
Crook as Rookwood	On death's door
Feral	Extremely busy / Chaos
Bogan	An uncultured person
Too easy, mate	I can manage that

*This is a common mistake that Brits make when they first arrive in Australia, by greeting Australians with “alright?”

Clinical Anecdotes of recurrent themes we encountered *(with names altered for anonymity and stereotyping)*

Taking Aussie History - remember wildlife

Doctor: "How did you manage to do this Bruce?"

Bruce: "Fell off the back of a Ute, mate.", "Got punched by a Kangaroo.", or "Rode my Quad-bike at night into a barb-wire fence".

A patient presented to the emergency department with a snake bite. He was accompanied by his friend who was carrying an Esky (ice-box). Both were tipsy. Snake-bites can be life-threatening, and we were stressed, working quickly to control the situation. Suddenly the friend exclaims "D'ya wanna see the snake?". In slow-motion, we recoil, shouting "Noooooo!" as old-mate opens the Esky, to reveal a very, very angry Tiger snake. He was trying to be helpful.



The "Code: YELLOW".

Emergencies are categorised as coloured "codes" in Australian hospitals. They are often announced over the tannoy speakers. Code blue is a crash-call or cardiac arrest. Code Black is an armed or physically aggressive patient or visitor. Code Yellow is an internal emergency. LW's first experience of a Code Yellow was when over the tannoy came the announcement "Code: Yellow... bush-fires approaching the back car-park, hospital on standby to evacuate". The last row of cars in the carpark all melted. Around Christmas-time there was another disconcerting announcement: "Code: Yellow... snake in the hospital... last seen heading for pathology...". The hospital security guard, dressed in a Santa hat, manage to subdue the snake by trapping it under a mop. True story, I was there.



Dr Luke Williamson, Rheumatology Advanced Trainee at Westmead Hospital, Sydney. Returning to the UK for a Fellowship in Adolescent Rheumatology in August 2021. St Hugh's College 2004.

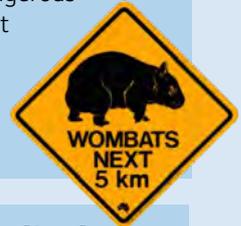


Dr Adam Skinner, Staff Specialist Emergency Medicine, Port Macquarie, New South Wales. Corpus Christi/Green Templeton College 2004.

Discharge planning involves wildlife again

Nurse-in-charge: "Doc, you can't send Sheila home, it's nearly dark, and she lives in.. [insert far away – rural place that you've never heard of, and have to zoom out three times on Google Maps – here (e.g. Mount Buggery)]"

This is a very real issue for many Aussie patients. They may have had to fly to get to your outpatient clinic, or may have been transferred to a number of smaller hospitals before reaching yours, and would commonly have to travel for 7+ hours to get home again. Also, if they are driving at dusk, then the local marsupial wildlife can be a significant menace. Wombat vs Car = Write-off. Unless one is driving a tank, then many roads become dangerous and not worth the risk of travelling at night. Therefore, especially in rural hospitals, patients may have stay overnight because it's too far or too dangerous for them to get home.



Treatment decisions politely declined

Doctor: "Bruce, you need to be admitted to the hospital so that we can treat your heart attack."

Bruce: "Yeah, nah, she'll be right mate..."

Anyone who has worked in Outback Australia will have had patients like this. They present to your tiny hospital significantly unwell. They will happily accept treatment for a few hours in the emergency department but will politely decline the offer of admission to hospital, and heavens-forbid a transfer to the regional base hospital. They are far too busy on their farm to be admitted for something as minor as a NSTEMI, severed digit, or pneumonia. Country patients are a joy to care for. They are tough-as-nails, uncomplaining, and respectful. However, sometimes managing their own health is very low on their priority list.

We hope that this English-Strayan dictionary and anecdotes serve as a flavour of what Australian medicine has to offer. Many of the challenges that we face in healthcare are universal. However, some things are unique to the far-away, enormous, and diverse island of Australia. We wish you all the very best from Down-Under. We will miss you this Christmas, and our thoughts are with you all. P.S. Shortly after writing this, my whole house burned down in a bushfire...Luke

Recollecting Oxford Medicine

We are delighted to ‘unveil’ the first 18 Recollecting Oxford Interviews. A history of clinical medicine in Oxford captured through the memories of clinician. The podcasts are now freely available to listen to and we encourage you to enjoy them.

University of Oxford podcast series, where all interviews can be heard: <https://podcasts.ox.ac.uk/series/recollecting-oxford-medicine-oral-histories>

Blog post: <https://blogs.bodleian.ox.ac.uk/archivesandmanuscripts/2020/09/24/newly-available-recollecting-oxford-medicine-oral-history-project/>

Dr Peggy Frith and Dr Derek Hockaday share their 10-year journey to creating this unique and invaluable archive:

A project to gather some memories of the Oxford medical school from older alumni began 10 years ago when Peggy Frith, then chairman of the Oxford Medical Alumni Committee, recognised an important opportunity, as alumni aged, of gathering memories of the Oxford Medical School, both pre-clinical and clinical; the latter started in the 1940s. She approached Derek Hockaday, who had time to collaborate in the gathering of oral history via face-to-face interviews with past members of the School, whether doctors, nurses or engineers. The Bodleian had already made notable collections of the memorabilia of such outstanding figures as Sir Walter Bodmer, Sir Richard Doll and Sir David Weatherall, but it was felt these could be supplemented by less complete but substantial memories of past staff. The aim is to build a website to make readily available this broader background material.

Any such project depends on its funding, which took off thanks to a most generous grant from an anonymous donor together with Peggy contributing one annual OMA Chair’s discretionary fund of £1,000. These enabled purchase of a portable recorder and interviews got under way by Derek and Peggy, with one each by John Oxbury and Jayne Todd, and now total over 40. Their rate depended on funds available to allow transcription of the electronic recordings, the tabs from which were transferred to CDs by Robin Frith, a kindly volunteer; and the CDs were sent to a transcriber who produced a PC version which could be printed out.

When all went well, this could result in three versions of each interview, the CD, the PC, and the printed, with the Bodleian’s preferred version varying with time.

When the Bodleian were told of our project early on, they were most encouraging and saw a joint project as the best way forward. Hence the material has always been deposited with them, with the aim of its being available on their website, as well as to those visiting the Library. They believe firmly in the interviews being available completely unaltered, including the repetitions, ums and ahs, and diversities of ordinary speech. However, they are anxious about inclusion of potentially libellous material and their rigorous checks demand considerable staff time, and we carry all the financial cost. More recently they felt the material to be best stored in an ‘electronic cloud’. It was hoped that the necessary work there would be covered by the very generous decision of the Oxford Medical Alumni Advisory Board to allocate a windfall of over £6,000 to this work with the Bodleian. However, the archiving work is painstaking and expensive, and only eighteen of the fifty interviews have been archived. We now need further funding to complete the archiving of existing interviews and continue to interview others.

The fun side of the project, eventually entitled ‘Recollecting Oxford Medicine’, has been the interviews themselves, and our thanks are due to all those who agreed to endure them, for while usually quite enjoying the face-to-face time, they’re often horrified when seeing the transcript, and learning how indirect is our daily speech (including the interviewer’s). They’ve provided splendid insights into many developments, such as the crucial enlargement of the Clinical School in the ‘60s, the move to the JR, and the development at the Churchill of Sir Michael Sobell House and of the Oncology centre.



Dr Derek Hockaday, Retired Consultant Physician and Endocrinologist. Brasenose College 1947.



Dr Peggy Frith, Retired Consultant Medical Ophthalmologist and former President of the Oxford Medical Alumni.

The Oxford Textbook of Medicine, sixth edition



The Oxford Textbook of Medicine (OTM) is deeply integrated into the medical DNA of many who have passed through the Oxford Clinical School and John Radcliffe Hospital in the last 30–40 years. Amongst many other things, John Ledingham was a prime mover in the birth of the OTM, and in this edition of *Oxford Medicine*, featuring contributions honouring him, it's very good to be able to report the birth of another edition.

From its first edition in 1922 to its twelfth edition in 1978 the main British postgraduate textbook of medicine was Price's. By its fifty-sixth year it was perhaps getting a little tired. One overseas reviewer, recognizing that the editor of a previous British textbook getting long in the tooth was the Queen's physician, had unkindly but memorably hoped that God would save the queen. Others raised doubts as to whether there was any place for a general textbook of medicine in the 1980's.

Oxford University Press turned to David Weatherall for advice and help. The result was the first edition of the Oxford Textbook of Medicine (OTM), published by Weatherall along with Ledingham and David Warrell in 1983. Further editions were produced in 1987 and 1996, before Weatherall and Ledingham stepped down, to be replaced by Tim Cox (Professor of Medicine in Cambridge) and me. I'd been frightened of Warrell when I was a medical student, and I think Tim knows more medical facts than anyone else. I was clearly out of my depth, but better players had not been available during that transfer window.

David Warrell skilfully led editions of the OTM in 2003 and 2010, and I think Oxford medicine owes him a great debt for carrying the torch for five editions. As my fear lessened, I learned an enormous amount from him, notably about tropical diseases (one of the most distinctive and impressive sections in the book) and snake bites (his piece de resistance), not to mention broader aspects of the lives of many well-known physicians.

“ The OTM is deeply integrated into the medical DNA of Oxford Medics. It is good to report the birth of another edition

Since 2010, the OTM has been published online and updated regularly. With Chris Conlon (well known to readers of *Oxford Medicine*) joining Tim and I in the editorial team, the discussions we had about whether or not to produce another print edition were very similar to those held in the early 1980's, and the answer was the same. In a world of 'fake news' there is more need than ever for reliable and authoritative accounts, and this is what we think the sixth edition of the OTM provides. As can be seen in the accompanying picture, the 2020 version is about twice the size of the first edition. I would argue that this is due to the growth of medical knowledge over the last 37 years, also expansion of coverage in some areas, but less generous opinions may suggest an alternative diagnosis of lax editing, which I refute.

Dr John Firth, Consultant Nephrologist, Cambridge.
Senior Editor. Lincoln College 1978–81

Pictured above: A picture taken a week before the first COVID lockdown. Editors meeting for a celebratory lunch, when such things were legally possible. From left to right, editors of the sixth edition of the OTM, John Firth, Tim Cox and Chris Conlon, with the editor of the previous five editions, David Warrell.

Osler House Boat

There was a joyfully enthusiastic response to the Osler Rowing Revival appeal from Alumni from all over the world. Many of you sent in snippets of recollections about rowing, coaching, coxing and cheering from the towpath. The emails were bubbling with happy memories, amusing anecdotes and some photographs of oars. From the early years there are no written records of the rowing teams, and very few photos.

Osler House Boat Club News



Jennifer Holmes, 2018
*St Hugh's College and OHBC
Alumni Officer*

I am delighted to announce that this year has brought the resurgence of Osler House Boat Club. We are already lucky to have a strong contingent of enthusiastic college rowers ranging from the university development squads, college first boats and people who picked up a boat amid FHS projects. There certainly was the momentum to get the club going again; thanks must go to Jack Woodward, Jessie Morgan and Beinn Khulusi who made it once again possible to take the Sir Peter Radcliffe eight back out onto the water.

September saw over 50 medics sign up for sessions, ranging from fourth year students, to clinicians returning to Oxford for PhDs. Alongside these experienced rowers, we saw a fantastic group of novices try rowing for the first time and get well and truly hooked. Clinical school's extended terms were a blessing with the river empty for those early September mornings, allowing us plenty of water time before the dark and cold weather arrived.

In these strange times, OHBC has provided an important space for our medical students. With fourth year students having remote learning this Michaelmas term, Osler rowing provided a much-needed way to meet the unknown 'other half of the year' and socialise with our friends. However, as with the rest of life rowing did not remain untouched by the pandemic. We saw coxes wearing silly glasses to meet the new requirements, and more rowers having experience in a coxed four as households had to isolate.

Currently, British Rowing has closed all club boathouses and landing stages and zoom pub quizzes have been replaced by coxing seminars. With outings cancelled, members have been meeting up for walks and runs to get their dose of fresh air. Nonetheless, as soon as restrictions lift, we are in a prime position to jump back into boats for those early mornings again.

Looking ahead to the rest of the year we anticipate a strong and competitive campaign with our woman's and mixed crews. I for one cannot wait to give the novices a taste of what we all enjoy most – the thrill of Oxford bumps. Alongside racing, the Club is also a fun bunch of people and as soon as safe to do so we look forward to welcoming alumni and students to social events. So, watch this space!

In the meantime, please get in touch with us to: be on our mailing list, help support us, or to share memories of your time with OHBC.

ohbc.president@ox.ac.uk

Instagram: @ohbc_oxford
Facebook: @ohbc.oxford



Can you help?

OMA and the Osler Rowing Club would like to create a History of Osler Rowing from gentle beginnings in the last 60s, through the glory years of the 80s, 90s and early 2000s. If you are interested in helping with the archive, please contact us. The recent decline (to near extinction) of OHBC is set to reverse with more than 40 medical students, many experienced rowers, keen to compete in Torpids and Eights and forge a new Golden Age. To compete effectively, they need a new boat, coach, boat house storage...funds and support. Dr David Springs is taking over from Professor Neil Mortenson as Senior Member. Contact the students (oslerhousebc.president@gmail.com) or OMA if you can help.

Club Revival



Osler Rowing Beginnings



Prof Simon Smail CBE, Emeritus
Professor of Medical Education,
Cardiff University. Worcester
College 1964.

The origins of Osler House Boat Club are, rather sadly, a bit lost in the mists of time; but it all began

around 1968/9. I was a clinical medical student at that time, and there were quite a few contemporaries who had rowed in College boats; I had rowed both at school and at Worcester College and was used to competing at regattas, the Bumps etc. Many of us had missed rowing when we became clinical students and discussions in the bar led to an initiative to start rowing at Osler House. Chatting to senior members led to offers of help – even some funds (!) – and we then began looking for a boat to borrow and a space in a boathouse to use. Before long we had some tentative outings on the river with Mr Barry Fearn riding his bicycle along the towpath with megaphone, trying to get us into shape. Then began the more serious business of setting up the boat club officially, which meant applying for recognition by the Amateur Rowing Association, designing a logo to put on the oars – snake and serpent, naturally – and getting recognition by the Committee of the University Boat Club which ran the Spring and Summer Bumps. I had been a member of that Committee myself when an undergraduate at Worcester College, so that helped in steering us all through the bureaucracy of setting up an ‘official’ boat club. I do recall minutes of meetings of the newly-formed Boat Club being taken, and we had to fulfil all the requirements to satisfy the regulations required by the national regulatory bodies for competitive rowing.

We had huge support from many Senior members, financial as well as practical and after some success on the river in Summer Bumps (starting very low down, as newbies) we had a celebratory dinner at Keble College attended by several senior members, notably Sir John Stallworthy (Gynaecologist) and Dr Renwick Vickers (Dermatology), both of whom were very generous in their support. Renwick Vickers’ son (now Sir Roger Vickers) was a contemporary of mine at Osler House so that might have helped...a bit!

I understand that there are no early records of the Boat Club in existence, although others may have better recall than me. But the happy photo shows not only the joy of the student members, but it is testimony to the staunch support of more senior staff in the medical school without which the Boat Club would never have existed.

“I was senior member very briefly...I mentioned the dinner, and the towpath running...the latter was not so very taxing – because (with experienced rowers from various colleges) our boat bumped and over-bumped its way from the bottom, rapidly. Nevertheless, I am delighted to hear of the new life being breathed into the Clu and reiterate my promise of future support.”

David Speller, Bristol

“I was never an oarsman but was an avid supporter of OHBC from the riverbank right from the earliest days”

Peter Teddy, Melbourne

“My recollection is that Theo Schofield was in the boat, and Nigel Thomas, and John Talbot. Not sure about Keith, but if he was seated behind me, I was likely so anoxic as to never have noticed”.

Clive Taylor, California

1 Barry Fearn 2 David Speller 3 Derek Jewell 4 Simon Smail 5 Sir John Stallworthy 6 Dr Renwick Vickers 7 Bob Reichenbach 8 David Read 9 Michael Silburn 10 Van Hegon 11 Bheeshma Rajagopalan 12 Al Carruthers

The late 1970s – the Beginning of the Golden Age



Dr Patrick Carroll, *Magdalen College 1974. Dr Carroll is a staff physician Redcliffe Hospital (Queensland, Australia).*



Dr Graeme Rocker, *Christ Church College 1972. Professor of Medicine, Dalhousie University, Halifax, Canada.*



Dr Lesley Starr, *St Anne's College 1976. Dr Starr is a retired General Practitioner from Bath.*



GR: 'At the finish Ray Dawes ran off to find something to eat. The rest were stunned and exhausted, mostly dead. What on earth had he been doing for the last 40 miles?'

PC: The season passed with enjoyable, intensely sociable training on the river by Port Meadow, coached superbly by John Rayne and Bill Platt from Oxford City. We attended various Regattas with Bob van Hegan's BMW, providing transport for three or four or more rowdy passengers. The crew of 1977 proved how well that hard work paid off. They gained 4 bumps—the photo shows them catching Oriel II outside their boat house gaining their 4th bump.*

PC: 'The abiding memory of eights' week was not the four bumps, but the sheer exultation of Graeme, after the last bump.'

LS: Rumour has it that among enthusiastic celebrations later in the day, some who were incompletely clad cavorted in the fountain in front of the old Radcliffe!

Osler House Boat Club, from its beginnings in 1968, entered a golden age in the late '70s, rising rapidly through the ranks. In 1976 Graeme Rocker, captain of boats, describes how he and others from the rugby club (Grant Bates (2), Bill Case (3), Barry Taylor (6)) –created a very "sociable" crew with Dave Slator (4), Ray Dawes (5) and Dr Ronnie Barber (7). Celia Duff, Cambridge Blue, was their cox and would call the eminent bow, John Chadwick "stupid boy" for the most minor of errors. They were bumped on day 1 but got two back and thoroughly enjoyed themselves celebrating with Pimms on the green bank. After that, three of the crew (with Mark Vincent at stroke) made up the 'Tin Pot' Bow Four and won the coxed 4 novice event at Oxford City Regatta.*

New, international talent arrived in 1976 with Patrick Carroll as stroke and John Bell as captain of boats. Pathologist Bob Van-Hegan, Oxford Blue, augmented the 'engine room' at 5. The first eight was soon doing well, despite the ancient equipment. John tracked down a second-hand shell and managed to fund its purchase with great creativity - this included a 40-mile sponsored row to Henley.

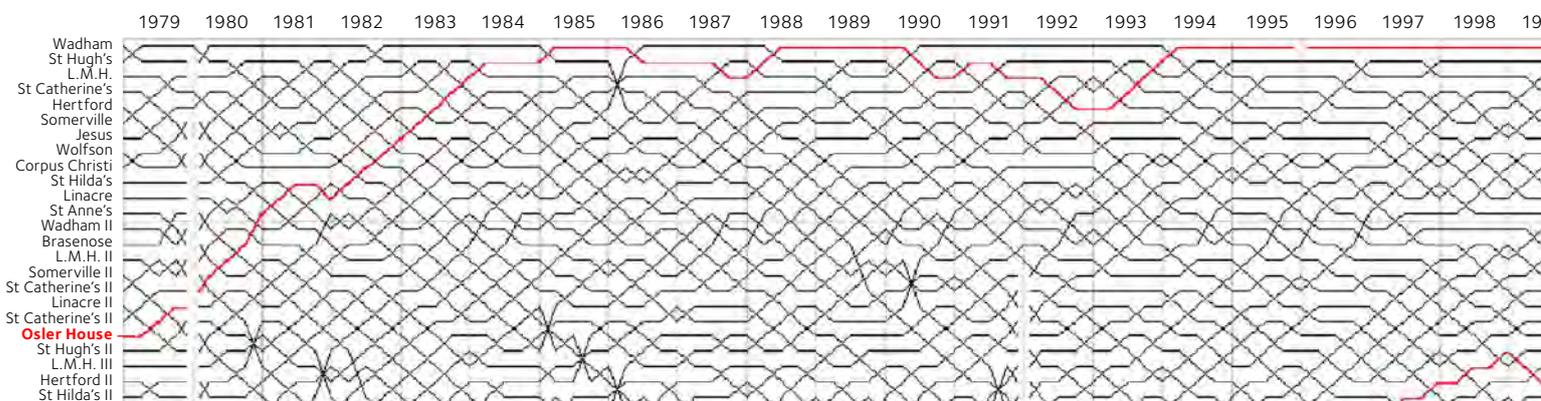
PC: 'It was undoubtedly the happiest boat I ever sat in, and the tone of the crew was set by the ebullient and endlessly enthusiastic Graeme Rocker at 2. What brave venturers we were, setting off early in the morning with bubbling spirits, and loud noises of every variety, and what silent pilgrims eventually drifted in to Henley, the oars making only the quietest and occasional splash, until number 2 demanded the appearance of enthusiasm for our arrival, which we managed under his urging.'

Another 1977 Osler House boat, the third boat, also gained their oars with 2 bumps and an over bump to move up 4 places. The Club, in gaining a total of 11 bumps between its three crews, was going places!

1978 was more professional, and more sedate. There were four men's crews. The first eight managed to maintain their place on the river after being bumped and bumping one boat. By 1979 the first boat was moving up strongly again with 4 bumps and with both men and womens' crews competing, the Osler House Boat Club was firmly into its golden age...

We are creating an OHBC archive. More photos and stories: www.medsci.ox.ac.uk/get-involved/alumni

** Photos on back cover*





The very first Osler Ladies First Eight



Dr Lyn Williamson, (Thakurdas), *Hon Consultant Rheumatologist, Swindon. OMA President, St Anne's 1974.*

This photograph captured the very first Osler Ladies First Eight waiting for the five-minute gun on Saturday of

Eights. Unexpectedly, we had gained three bumps and were hoping for a fourth. Starting near the bottom of the bottom league, no one could have predicted Osler Women would rise to dominate Oxford Rowing for the next 20 years. (Hopefully, they will again, very soon). Before 1979, Osler men rowed, Osler women coxed or covered their work. It was the way. The men bought a new lightweight fibreglass boat, and after delicate negotiations we women were granted shared use of the old wooden clinker 'The Sir William Osler'. It was only free in the evenings so, as a novice womens eight, we practiced on the river at 5pm, dodging the splendid-speedy-and-sleek First Eights. We overcame our embarrassment, practiced hard and enjoyed every moment. As a non-athlete, it was the first time I had ever been part of a sports team. The river, the fitness, the team - it felt truly glorious!

That Saturday we rowed over, chasing an over-bump in front of the boat houses. Intense pain. Disappointment at not getting a blade. We did the ritual things - threw Simon Wesley into the river and joined the men for the last black-tie Boat Club Dinner in the Doctors dining room at the Old Radcliffe. We left before 'cigars', their euphemism for bawdy behaviour....

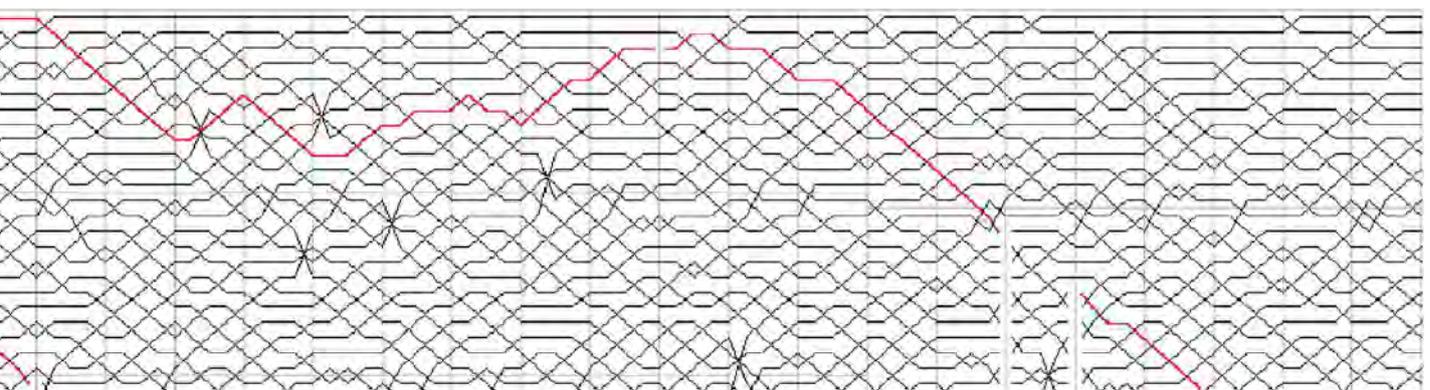
We had had fun. We were a team, and we look after each other. Laura, Me (Lyn), Helen, Pam, Judy, Marion, Anne, Christine, Simon.

Sadly, Marion (Roberts) Scrine in August died this year from metastatic carcinoid. Her husband Les sent us this photo to share. Her neat handwriting is on the reverse. Rest in peace, Marion, and thank you for bringing back these happy memories.

Below: Timeline showing position of Osler Women's First Boat from 1979-2019: http://eodg.atm.ox.ac.uk/user/dudhia/rowing/bumps/osle/osle_wea.html

Osler Men Rowing History: http://eodg.atm.ox.ac.uk/user/dudhia/rowing/bumps/osle/osle_mea.html

1999 2000 2001 2002 2003 2004 2005 2006 2007 2008 2009 2010 2011 2012 2013 2014 2015 2016 2017 2018 2019



Wolfson
Pembroke
Wadham
University
Christ Church
S.E.H.
Keble
New College
Hertford
Oriol
Balliol
Magdalen
Jesus
St John's
Linacre
St Anne's
Somerville
St Catherine's
Trinity
Mansfield
Green Templeton
Lincoln
Wolfson II
Merton

Two Cox and Hull Stories



Dr Tim Crossley, *retired General Practitioner Wolverhampton. St Edmund Hall 1974-80.*

It must have been a desperate Osler eight who asked me to cox. Not only was I over 63kg (which in those days was called 10st) but I had form. As an undergraduate I had lost my coxing no claims bonus by writing off at least the bow end of the Teddy Hall third eight by ramming the bank at some speed at the start of eights week; we'd subsequently been relegated to a clinker and sank steadily, as it were, in the league table. But I liked the fresh air, just not the work, the points on my licence were ignored and so it was agreed.

Coxing is learnt by having minimal instruction, a quick demo, and being left to get on with it. This education method may sound familiar to medical students. The pleasure is the momentary and entirely artificial authority over eight men or eight women, all smart and



Dr Sally Hope (Hirsh), *Retired General Practitioner. Jesus College 1975-81.*

My finest hour was coxing the Osler House second boat with such luminaries as Doug Walker, David Sprigings, as the serious powerhouse propelling the boat through the waves. It also had Hamish Simpson, Dicky Watts and Rhodri Davies in the middle giggling at the scurrilous things Steve Chiverton and Chris Mason said at the far end. Very annoyingly they spoke too quietly for me to catch most of the conversation, except when I accidentally steered into a submerged willow root, or a barge so big I really didn't see it coming. Then Chris was very audible. I still feel bad about that one. Sorry.

The surprise to me was that in our very first race, we were actually catching up the boat in front. I'd never raced before. It was really rather exciting, so different from all the calm practises up and down the Green Bank stretch of the river at 6am, with just a quiet mist stealing over the icy grey waters, and the occasional irate swan.

assertive, opinionated and informed, having to submit to the hoarse bawl of a grumpy tyrant. This has not been achieved since, I may add. Coxing does not develop one's leadership skills in the end, as demonstrated by the laudable tradition of hurling the cox into the drink at the end of the week. For health and safety reasons it was felt necessary to project me some distance from the bank, so there was no danger of being impaled on the wharf.

I can recall no race we won, but we didn't lose them all either. The intensity of effort and endorphin rush of a bumpless race pumped me up as well as the heaving rowers, and the benefits of such quasi-military teamwork were noted. However, a lifetime in the NHS followed whereas you know, ill-disciplined crews are far more the norm.

Neither I nor in due course my children went to schools which rowed but its elitist image is undeserved. Long may the Osler boat float, so long as they remember that the Cox is King, and to check on his swimming proficiency.

Half way up the course we were within a yard of the boat in front.

'Give it ten and we can bump them,' I screamed gleefully.

'Yer, yer, pull the other one', came from someone in the boat, in disbelief, puffing between strokes. It had always struck me as foolish that rowers could never see river ahead.

We really *did* gain on them, and I was shouting.

'Acknowledge the bump. Cox, please acknowledge the bump', I had understood one was always courteous.

I can't remember which college it was, but he would not acknowledge our win, so we started to overtake.

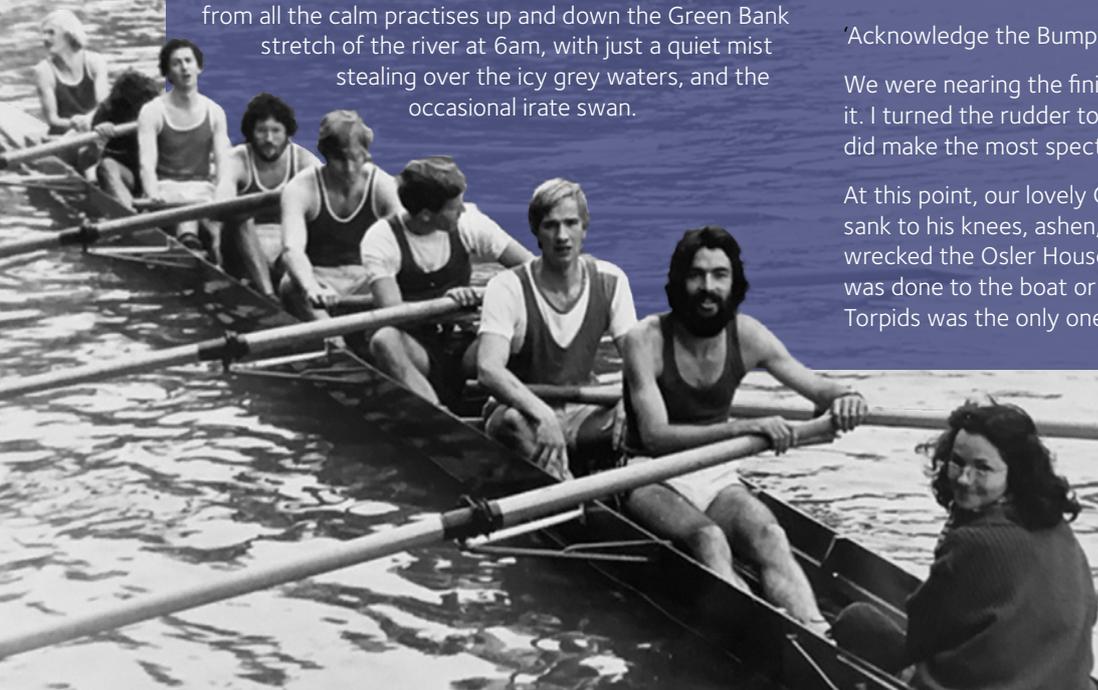
'**** me, I can see their cox': came our Bow end.

This galvanised our crew with superhuman effort redoubled and we came up neck and neck to them, with me and all our crew shouting:

'Acknowledge the Bump' or similar phrases.

We were nearing the finishing line, so I just thought this is it. I turned the rudder to crash broadside, oars to oars. It did make the most spectacular, wonderful sound.

At this point, our lovely Captain of Boats, John Rawlinson, sank to his knees, ashen, on the towpath, thinking I'd wrecked the Osler House boat. Fortunately, no damage was done to the boat or oars, for the later races. That Torpids was the only one I coxed, can't imagine why.....



Congratulations



Professor Keith Hawton, Oxford Health Psychiatrist, awarded CBE for services to Suicide Prevention

Congratulations to psychiatrist Professor Keith Hawton, Balliol College 1966, who has been awarded a CBE in the Queen's Birthday Honours List 2020 for services to Suicide Prevention. Professor Hawton is a Consultant Psychiatrist at Oxford Health NHS Foundation Trust and Professor of Psychiatry at the University of Oxford.

Among a lifetime of achievements, Professor Hawton's work led to changes to the types and volumes of painkillers available to buy over the counter. He has written hundreds of papers, written key books and supported numerous PhD students who have themselves gone on to make important contributions to suicide prevention.

Professor Hawton said: "I am absolutely delighted to have been recognised in this way. Having been in psychiatry in Oxford for virtually all of my working life I'd like to thank the many colleagues, including clinicians, mentors and research staff, who have supported my work on suicide and self-harm during this time. I'd particularly like to thank the trust for its support over so many years."



Professor Sarah Walker, Professor of Medical Statistics and Epidemiology at the Nuffield Department of Medicine, is appointed OBE for services to Academia and the Covid-19 response.

'It has been a privilege to be the Academic Lead and Chief Investigator for the UK's national surveillance study, the COVID-19 Infection Survey, working with the Office for National Statistics. This would have been impossible without everything I have learnt from many talented and committed people at the University of Oxford and the MRC Clinical Trials Unit at UCL over the last 25 years,' says Professor Walker. 'This award reflects their contribution, as well as that of many working tirelessly at the Office for National Statistics, IQVIA, the University of Oxford and the Lighthouse Laboratories, to deliver the study, which is producing results every week for the government.'



Professor Ravi Gupta included in 2020 TIME100 list

Professor Ravi Gupta has been included in **Time magazine 100 most influential people list 2020** for his work on HIV and stem cell transplantation culminating in the world's second HIV 'cure' in a patient.

Professor Gupta is Professor of Clinical Microbiology and Wellcome Senior Fellow in Clinical Science at the Cambridge Institute for Therapeutic Immunology and Infectious Diseases at the University of Cambridge. His group has recently introduced the SAMBA II point of care test into clinical practice at Addenbrookes for rapid diagnosis of COVID-19.

Professor Gupta led a four-year long study culminating in the report of the world's second HIV 'cure' in an individual, 'London Patient', who underwent stem cell transplantation with cells from a donor who was homozygous for the CCR5 delta 32 mutation (Gupta et al, Nature 2019; altimetric score 1437; 220 citations). Gupta designed and executed the study, which involved interruption of antiretrovirals in the patient following allo transplant despite ongoing immune suppression, with extensive measurement of HIV reservoirs, cellular characterization, viral replication assays using autologous reconstituted viruses in both primary cells and cell lines expressing either CCR5 or CXCR4.

Congratulations, admiration, and gratitude to the 100s of Oxford Scientists, Researchers and Clinicians whose focus and collaborations have created so many leaps in technology, understanding and treatments for CV-19 for the whole world.

Obituaries

Professor Peter Sleight (died 07 October 2020)

Credit: Lizzie Maughan



It is with great sadness that we learnt of the death of Professor Peter Sleight, aged 91, a distinguished research cardiologist, and a much loved and admired figure in the department and beyond.

Professor Sleight studied Medicine at Cambridge University and at St Bartholomew's Hospital Medical School. From 1964, he worked as a consultant physician and cardiologist in Oxford and went on to become the very first Field Marshal Alexander Professor in Cardiovascular Medicine, a position he held until 1994. He retired from this position in 1994 but continued to work at the John Radcliffe Hospital in Oxford. During those time, he was a mentor to many people who are now senior leaders within the Division of Cardiovascular Medicine.

Dr Brian Gribbin, Consultant Cardiologist (retired): "I first met Peter in 1968 when I arrived in Oxford to take up a junior position at the Radcliffe Infirmary working under Sir George Pickering (RPM) and it was made clear to me that I had to be involved in research. I was fortunate to be accepted into Peter's research unit, studying baroreflex function and blood pressure control. Some studies were done during the night and even then Peter was very much 'hands-on' as well as continuing his clinical duties. In the late 70s he was pre-eminent in the field of baroreceptor and hypertension and organised successful international conferences in Oxford. He took the view that no matter what the problem was, there was always someone in Oxford who could help and he arranged for equipment to be made that was used in a study of arterial distensibility in normal and hypertensive subjects – at the same pressure. He continued to give me advice and support over the years and, of course, the Wheatley hospitality was well known and we as a family were more than fortunate in that regard."

Professor Hugh Watkins, Radcliffe Professor of Medicine and Head of Department "Peter has

long been a father figure to many in cardiovascular research and clinical care in Oxford and will always be remembered with huge affection and admiration. And of course, his impact goes round the world, he was truly a giant in our field. It's extraordinary to consider that we won't all be able to attend his funeral. I am sure that there will be a memorial when circumstances permit. I count Peter as one of the most important influences in my career and am one of very many who do so."

Professor Barbara Casadei Consultant Cardiologist Oxford "Peter was a man whose personality was large enough to fill a plenary auditorium – let alone a room. He was enthusiastic, unfailingly positive, and always upbeat: nil desperandum, was his usual comment when we had a paper or fellowship application rejected." "As a proud Yorkshire man in Oxford, he came across as unstuffy and mostly unfiltered. All aspects of academic research were for Peter an endless source of fun and a way of making great friends – it was the greatest endorsement to choosing an academic career path I have ever had."

Professor Sir Rory Collins, Head of Nuffield Department of Population Health and BHF Professor of Medicine and Epidemiology "Those who knew Peter will remember him for his support, his humour and, in tandem with Gill, his hospitality. However, perhaps the best memorial of all is the very many people in countries around the world who unknowingly owe their lives to his leading role in the ISIS trials which demonstrated that thrombolytic and antiplatelet treatments can halve mortality in acute myocardial infarction, paving the way for non-pharmacological approaches to opening coronary arteries in this setting."

Excerpts from Recollecting Oxford Medicine Interview of September 2013. Peter speaks about his life in his own words.

What was it that led you to come to Oxford in 1964?

It was a four-month visit from Julius Comroe's lab in California to work with John Widdicombe on the Bezold reflex, because he was an expert in 'picking the fibres' from the nerves serving the heart; and 'fibre picking' was top of the tree then, like molecular biology now. It's a long story, so I'll start much earlier.

I had good hopes at St. George's of being raised from a 'first assistant' to Consultant, but that post went elsewhere. In 1961 I was advised to go to the States to get my BTA (Been to America), almost essential for a teaching hospital consultancy then. I chose Maurice Sokolow because he was the furthest away. After a month he said, 'I can't teach you anymore clinical

cardiology, you'd better work with Julius Comroe Jr in the Cardiovascular Research Institute'. My first idea proved fruitless, but then I asked Julius if I could use their animal lab in the days between their big studies with big flow meters, which took some time to reset. He agreed, and I worked hard for a year and rediscovered an old reflex, the Bezold, but it was thought nobody knew where the receptors were, but I'd found them mainly in the left ventricle. So, I was awarded the Young Investigators' Award of the American College of Cardiology. You could say, it was all downhill from there!

I wanted to return to the UK, but 'Uncle Julius', as he was known, said 'Why don't you stay and do another year's work here?' and it was to further that that I came back to Oxford, supposedly for just four months.

But things evolved?

Indeed. John and I got records of C fibres from the heart, which hadn't been done before, and that was published in *J. Physiology*. Then, by some fluke, George Pickering and Lindor Brown, the Professor of Physiology, were dining together and over the port bemoaned the lack of links between pre-clinical and clinical medicine in Oxford. But Lindor said, 'We've got Sleight, who's a respectable physiologist now but he's really a clinician'. So, George sought a meeting and soon he invited me to apply for a three-year senior MRC fellowship in Oxford with consultant status in the hospital and a lab in Physiology. I asked George if he'd back me for the consultant job said to be coming up at the Radcliffe in three years. He looked at me steely eyed, but then said, 'It's a deal'.

Before that, how much clinical work had you been doing?

Grant and I headed up this new Cardiology department together. We were NHS honorary consultants. But I was finding it very hard to keep up with the fibre picking side of things, so I fixed a year's study leave in Australia. I got some nice new results, turning to the carotid baroreceptors.

And after Australia?

Well, while I was there Paul Beeson wrote that Oxford was to advertise the first Chair in Cardiology founded by the British Heart Foundation, largely negotiated with them and the Oxford authorities by Grant Lee. At first, I thought it wasn't for me as I might end as a NHS consultant working with Grant as the boss, rather than jointly as before. But Gillian said, 'Why don't you apply?' so on the very last day for posting airmail, Gill and I put together the 20 copies needed.

I guess that was about the time of the move to John Radcliffe Phase II.

A complete mess. Grant and I had planned a proper Cardiac department, and when I came back from

Australia, I found that the other powerful beasts had taken over. I mean, Peter Morris took over our beds and they came up with the idea that Cardiology should stay down at the RI. I was devastated, our plans had been wiped out, and I remember to this day feeling sick to my stomach about what the hell was going to happen. But the new Outpatients there, was huge compared to the RI. I said to Sister Out-Patients 'What are you going to do with all these rooms?' she replied, 'I've no idea, we can't possibly fill them'. I said, 'I'll help you'. We got 17 rooms there. And then I raised Acute Coronary Care with the On-Take Physicians, and they said 'Oh, I think that will be up here, you see'. So, I listed expensive equipment that would have to be duplicated, like ultrasound echo, and they finally saw the light and said, 'Oh, come up'.

You were quite well known for travelling, can you tell me a bit about that?

This is from early on, but when two Russian visitors to Oxford heard that I was going to a World Congress in Cardiology in New Delhi in 1966, they said 'Why don't you come via the Soviet Union? You can get to Delhi via Tashkent and Kabul, so I thought 'Why not?'. And we used to work with Edgar Schuster, an MRC scientist retired to north Oxford. He'd built my first oscilloscope camera for physiology. When he heard about the Russia trip, he insisted on funding Gillian to go with me.

Now when I'd published the Bezold work, I got a letter and a reprint from a Russian called Tchernegovski who wrote 'We done the same thing, but in rabbits, but it's clearly the same reflex'. I wrote to him and asked if it'd be possible to visit him in Leningrad, where the flights went from Helsinki. I got no reply, but when we came out of the airport there, there was Tchernegovski, who proved to be the fourth most important scientist in USSR physiology, and who'd gathered a big group of his colleagues from all over for a three-day conference at which I was to talk. Even worse, he said 'We've missed this technique of dissecting nerve fibres. I would like you to demonstrate how to record a nerve fibre, my laboratory is at your disposal. So, I went for rabbits, as they're plentiful, and with all his technicians on their amplifiers, on day three I got a single baroreceptor fibre. After that, we had an Intourist car and went everywhere.

When you came to do clinical ward work in Oxford, how did it compare with the London and American hospitals you'd worked in? What was its standard?

Good. I thought it was a very good hospital. I liked it because it wasn't inward looking, like most medical schools then who only had their own people. It was unique in taking people from all over the place on merit, and I thought that was terrific. And the nursing was very good.

And you must have interacted with the surgeons.

When I first came, the cardiac surgery had a high mortality. So, one day I asked Celia Oakley, who was at the Hammersmith, about any up-and-coming young surgeons, and she said, 'If we have a really difficult case, we wait until the evening and then Steve Westaby, who's the Senior Registrar, does it as an emergency, and he's very good'. We got some funds together, and he came, and he's been a controversial bloke, but the mortality went from about 25 to three percent. He's remarkable as a surgeon, technically terrific.

Did you do paediatric work?

Only at first. You know we were talking about the Russia trip and New Delhi conference, well, the day I left for that, I'd had to catheterise a 'blue baby', with complete transposition of the two circulations but it was kept alive by also having a VSD (ventricular septal defect), but at seven days old it was wizened and less than its birth weight. In Delhi, Bill Rashkind gave a talk on treating transposition by using a balloon on a catheter to rip through the atrial septum to create an ASD. I cabled Oxford to ask them to get a Rashkind catheter, and Jim Johnson got one from the States. And when I got back, I did the baby, barely alive at seven weeks. When I pulled on the balloon it was incredibly worrying because in the oscilloscope you saw the whole heart going down into the belly, before it ripped. The baby suddenly became pink. And Eileen Jones, who was the catheter sister and a pretty hard-bitten nurse, burst into tears. The baby lived for 30 years before dying of pulmonary hypertension.

You were involved in a lot of clinical trials?

Indeed. One of the first was 'Isis I', well, we were doing a small pilot first, and I said, 'Before we really go ahead, we must see Richard Peto'. He did some back of the envelope statistics and said, 'You're going to need several thousand patients to say whether

this beta-blocker versus placebo would work'. I said, 'We don't have that number of patients, I'll be dead before we know the answer'. But he said he'd been involved in multi-centre cancer studies in London, so why didn't I set up a network? And that's how the Isis trial network began, it was Richard's suggestion. So, Salim Yusuf went off to the continent and round the country to recruit other centres. Salim had come from Southern India near Bangalore. I think I was about his third choice as a supervisor. I'd just come back from a meeting in America where Braunwald and Burton Sobel were arguing about the best way to measure infarct size, was it the changes in the enzymes released into the blood after an infarction, or was it better done by dense electrical mapping, with 35 chest leads? I recommended that Salim use both methods with 100 patients in our Coronary Care Unit. He had to collect blood every four hours. And after two years he got good results for his thesis, and it meant that we could use the simpler method for a trial of an intravenous beta-blocker for cardiac infarction. ICI had this new drug, Atenolol, for hypertension, but thought it might be dangerous after a coronary thrombosis. So John Cruickshank a medic at ICI funded the trial out of all sorts of different pockets the ICI bosses didn't know about. That's the genesis of Isis-1.

So all told I guess you're glad you came to Oxford

After marrying Gillian, coming to Oxford was the best thing that's happened to me.

Further obituaries can be read in The Guardian:

www.theguardian.com/society/2020/nov/02/peter-sleight-obituary

And The Times: www.thetimes.co.uk/article/professor-peter-sleight-obituary-z38p33djj



Dr John Spalding (1917 – 2020)

It is with great sadness that we report the death of Dr John Spalding, New College 1936, former consultant and research neurologist for Oxford United Hospitals. We will commemorate the life of Dr Spalding in the next edition of *Oxford Medicine* (June 2021). You can listen to John, giving his own account of his life and career, on the following podcast: <https://podcasts.ox.ac.uk/interview-john-spalding-former-consultant-and-research-neurologist-oxford-united-hospitals>



Dr Timothy James Padley (1961-2020)

We are writing this tribute to honour our wonderful father, Timothy James Padley, who passed away on 23 March 2020. Dad often spoke with fond

recollection about his time at Oxford in the early 80's during more recent family visits to the city. Clear was his appreciation for some of the more distinctive features of the University and student life there, whether it was the unique history of a specific college, or the peace and tranquillity found in a courtyard or library. There were also many amusing anecdotes involving his lively, intelligent (but rather eccentric) house mates. After graduating and moving through his junior years, Dad worked briefly as an anaesthetist, before joining Dean Cross Surgery in Plymouth where he worked tirelessly as a GP for around 30 years. He retired three years ago aged 55.

It is quite clear that Dad's compassionate, caring and meticulous attributes made a considerable contribution to his success as a GP. This is evidenced in part by the barrage of personal and heartfelt messages he received from hundreds of patients and colleagues alike on his retirement. He was an equally brilliant father, and husband to our wonderful mother. We will all miss Dad's constant support and advice, unwavering moral compass, and kind-hearted nature for the remainder of our lives.

Thank you for taking the time to read this short tribute to Timothy James Padley, who was a medical student at St Edmund Hall from 1979 to 1985.

Miss Geraldine Ashworth (1944-2020)

Geraldine Ashworth studied at Somerville College from 1973-79. She was well known as a plastic surgeon at the Radcliffe Infirmary, particularly by Tim Goodacre and colleagues of his era. She remained in Oxford after her retirement and enjoyed sailing, as well as contributing significantly to the work of St Martin in the Fields.

Dr Jennie Turner (1939-2020)

Long-standing friend of both *Oxford Medicine* and Green Templeton College, wife of the late Professor Robert Turner, Jennie sadly died on November 25th 2020 on the Stroke Unit at the John Radcliffe Hospital in Oxford. For many years Jennie, together with Professor Terence Ryan's wife Anne, welcomed and supported generations of new arrivals to our Medical School. They ran the New Comers' Club for incoming Oxford professors' partners and spouses, which was based at the real house of Osler, also known since Osler's days as 'the Open Arms', at 13 Norham Gardens : <http://www.newcomers.ox.ac.uk>

In Memoriam

Dr Brian Gardner died November 2019 (*The Queen's College 1967*)

<https://spirit-charity.co.uk/remembers-brian-gardner-consultant-in-spinal-cord-injury/>

Dr Jason Victory died May 2020 (*Merton College 1988*)

www.justgiving.com/fundraising/jason-victory

Dr John Talbot died October 2020 (*Pembroke College 1962*)

Dr Leonora Helen Goulty died January 2020 (*Somerville College 1944*):

<https://www.familynotices24.co.uk/low/view/4732174/dr-leonora-helen-goulty-frcgp>

Dr Marion Scrine (Roberts) died August 2020 (*St Hugh's College 1975*)

Dr Martin Claridge died December 2019 (*New College 1945*)

Dr Rosalind Bearcroft (Chamberlain) died January 2019 (*Somerville College 1946*)

Dr Rosemary Millard (Troughton) died December 2019 (*Somerville College 1950*)

Professor Thomas (Tom) Arie CBE died May 2020 (*Balliol College 1952*)

<https://cambridgeoapconf2010.wordpress.com/speakers/prof-tom-arie/>

Please contact the OMA team (oma@medsci.ox.ac.uk) regarding any obituaries of friends or colleagues you would like to be considered for entry into the next edition of *Oxford Medicine* (June 2021).

News from the Medical School



“We are where we are”. If I had a penny for every time I’ve heard that expression, I could single-handedly fund the tranche of minus 80 freezers we’re going to need over the next few months. But here we are and will be for a while. It’s not exactly what it was, nor exactly what we’d all imagined

this time last year – but the students are learning, placements are happening, exams are being planned (and re-planned when we realise plan A won’t work), and the world both large and small keeps turning.

The start of the academic year is always so exciting – and this one, despite its oddities was no exception. Not least because it marked the end of what many of the GE2/ year five students told me was “the longest year in history!”. And finally, they’re finalists – with all the ups and downs and somewhere-in-betweens that this year brings. Job applications are done (website crashings notwithstanding) and for the first time many are thinking of what life will be like when they leave – although many choose to stay, and many more choose to go only so they can return again. “Keeping hold” of your graduates is always seen as a positive metric – but I’m not so sure. Six years is a long time to be anywhere; I believe in the power of movement, and what better time to explore a different place and different life? But COVID has made people cautious, and I fully understand the sense that now of all times is when you stay close to what you know best. And for those applying for an AFP, they’re making full use of my academic-destination map – linking our current students with “one of our old ‘uns out there” for hints and tips on the interview and a friendly face/mentor for when they start for real. Handy for them, but lovely for me: to link up again with those who graduated last year or the one before feels like a happy wave from the past – and at the start of great futures. It makes me smile every time.

“ *Brain and Behaviour - the new course linking neurology and psychiatry*

And for those moving up into GE3/ year five it’s time for the specialities. Moving at what feels like breakneck speed from paediatrics to women’s health, GP to orthopaedics...and into the new course Brain and Behaviour – linking neurology and psychiatry as a shared endeavour, with commonalities but independence (and a new humanities thread). All good things. This year will be the first one with the ‘synoptic’ exam at the end of the year, rather than individual ones

as they hurtle through each rotation. A chance to really explore the interdisciplinarity, the linkages that we all must make – to think outside the box, to explore more than the obvious, and above all, to see our patients as the complex and sometimes fractured whole that they (and we) are.

“ *This year will be the first with the 'synoptic' exam at the end of the year - a chance to... explore more than the obvious, and see our patients as the complex, and sometimes fractured whole that they are*

As for the newbies – GE2/ year four... yes, I miss the “face-to-face” terribly. That first week, shuffling and smiling in the lecture theatre, waiting around to be arranged for the photo, the talks and chats and getting-to-knows. And lab med online is a very different beast – but running brilliantly. And three years is time enough. There is compression and rarefaction in all experiences, and we have space ahead of us to make it special, I have no doubt about it.

“ *Our first cohort have started their CRUK-funded MB DPhils.*

And so, the world turns, and it’s a not all COVID. We are designing new diversity work packages, and sustainable health care teaching too. Our new Educational Supervision program is up and running, we’re improving our Reporting Concerns systems and our first cohort have started their CRUK-funded MB DPhils. There are all sorts of good things too – amongst the weariness, contingencies and demands on the students. They learn, they smile, they get stuck in, they help (each other and the community), and I owe them all so much. Onward, and stay well!

Dr Catherine Swales, *Director of Clinical Studies, Oxford. Wadham College 1997*



Students gifted Fitzherbert Books by OMA

In September 2020, OMA presented every new clinical student with a signed copy of Rosie Fitzherbert-Jones' beautiful book *Oxford Medical Heritage: The People Behind the Names*.

In this era of digital learning and online tuition, we wanted to offer them something tangible to connect them to the key figures in Oxford Medicine. The great clinicians, researchers, and benefactors who forged and nurtured medicine in Oxford and gave their names to the hospitals, wards, buildings, and laboratories. The

book is warm and engaging, alive with vivid details of the people behind the names, and their achievements.

OMA hope the students, who are the future of Oxford Medicine, will enjoy this link to its past.

Oxford Medical Heritage: The People Behind the Names, Rosie Fitzherbert-Jones (ISBN 9780955272516 £10.00).

Final Honour School Prizes Hilary 2020

LEDINGHAM PRIZE IN MEDICINE

Susan Honeyman (*Green Templeton College*)

MORTENSEN PRIZE IN SURGERY

Elizabeth Fox (*University College*)

FINAL YEAR MEDICINE & SURGERY EXAMINATION PRIZE

Phoebe Tupper (*St Anne's College*)

GEORGE PICKERING PRIZE

Gabriel Bickler (*Wadham College*)

MEAKINS MCCLARAN MEDAL 2020

Prize awarded for the outstanding overall performance of a student admitted to the medicine course leading to the degrees of BM BCh (Oxon):

Oliver Skan (*Keble College*)

MEAKINS MCCLARAN MEDAL WINNERS REUNION 2022

Professor Meakins and Dr Jacqueline McClaran will welcome Oxford Gold Medallists to celebrate their 15th reunion on Friday 16 September 2022. Before dinner, each honouree will have the opportunity to

speak briefly about his or her work since leaving Oxford and inspire each other for future horizons.

Professor Jonathan Meakins, formerly The Nuffield Professor of Surgery while a Fellow at Balliol, and Dr Jacqueline McClaran, formerly Assistant to the Director of Clinical Studies in Faculty Development while a lecturer at Balliol, had the privilege of establishing the Medal in 2008.

PREVIOUS MEAKINS MCCLARAN MEDAL WINNERS

2008 Cherry Alviani, Green College

2009 Edmund Naylor, New College

2010 Daniel Stubbs, St John's College. Proxime accessit: Jonathan Wordsworth, Green College

2011 Kathryn Wright, St Hugh's College

2012 Catherine Taylor, Green Templeton College

2013 Mary-Ellen Lynall, Magdalen College

2014 Emily Brown, St Catherine's College

2015 Michael Shea, St Hugh's

2016 Nicholas Black, Merton

2017 Harriet Brown, Green Templeton College

2018 Emily Groves, New College

2019 Matthew Sliney, Magdalen College

News from Osler House

“Another openin’, Another show”



Thomas Brockwell, *President, William Osler House. Oriel College 2016.*

Except there was no opening. The dreaded lurgy had cancelled Tingewick, struck bops off the calendar, and lanced the prospect of any gathering; even the Cairns library was out of bounds! Epidemiologically underscored puritanism had set in up the hill. The black fog descended. Such restrictions were set in place that no mome raths could outgrabe.

Yet, a glimmer of hope appeared. The indefatigable spirit of Osler shone through to touch the heart of Oxford’s medics. Our LGBTQ+ Rep Anne upped her hand at acronym scrabble, laying claim to the as-yet-unfilled IT Rep position and coding our snazzy new website (www.oslerhouse.co.uk). Then, having barely finished the Great Migration up Headington Road, our new fourth years, perusing the new online Sports & Socs page, signed up to a rejuvenated Boat Club in such droves that we’ve gone from zero to three full women’s eights.

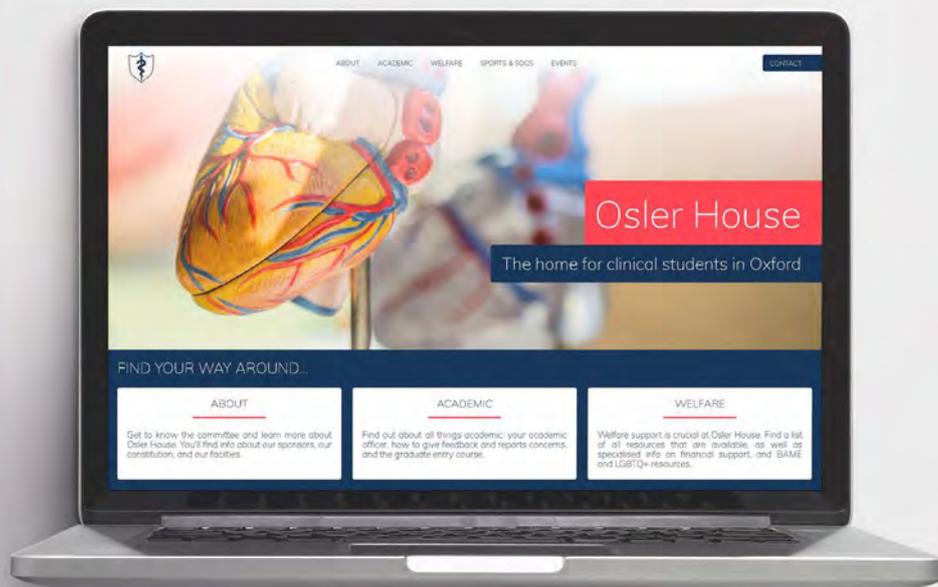
Our Entz Reps, Katie and Lewis, conjured plans to run socially distanced activities to bond the new intake: Come Dine With Me, remote cocktail making, and Oxopoly around the pubs of the city. They were backed up by Treasurer Helen and VP Ahmed who formed a lethal duo diverting the wallets of various medico-legal and consulting firms towards subsidising prizes including video cameras, bottles of spirits and, perhaps most usefully of all inter-lockdown, a haircut at Walter’s.

“It takes more than a pandemic to chill the soul of medics

Within the wider clinical school, vast swathes of my cohort continued to donate their energies to the COVID-19 response, retraining as everything from surrogate phlebotomists and PPE transporters to greengrocers and carers. Indeed, mid-lockdown, it could feel like booking into asymptomatic staff testing was the best social catch up you could have all week: blood taken by your Tingewick ‘sex dance’ partner and throat swabbed by your Med Ed sibling. Any method to catch up with friends...

Looking to the future, we have a bank of similarly fabulous, similarly virus-friendly social plans to action before Christmas and the most impressive society speaker term card that Osler House has seen. We’re cranking the cogs to get Osler House reopened, and we’re set to announce the winner of our COVID Commemoration Art Project so that when it opens, things will look a little less, well, clinical.

It takes more than a pandemic to chill the soul of medics. From the ashes of Skype, Zoom and Teams, phoenixlike, Osler House rises.



Tingewick News

Tingewick in a time of corona



Madeleine Oliver, *New College 2016. Producer of Tingewick 2020.*

The annual Tingewick Society Christmas Pantomime is central to the clinical school experience at Oxford. For the past 81 years, Oxford medical students have put on a Christmas pantomime or revue which features hospital staff as characters - and where our mascot, the pink elephant Rita Tingewick always arrives in the nick of time to save the day.

The Tingewick Firm medical students fundraised over £20,000 for Oxford Hospital Charity and SeeSaw. Cycling 7200km, making a charity single music video "Don't Go Out" to encourage people to follow lockdown rules, and creating a range of t-shirts with designs of Oxford's hospitals are just a few of the projects we undertook. We are releasing a Christmas charity single and music video, as well as a range of Christmas cards which you can buy at our website to support Oxford Hospitals Charity and SeeSaw.

“ Rita Tingewick is still alive and trumpeting!

In March, as one of the 27 fifth year medical students who make up the 2020 Tingewick Firm, it didn't cross my mind that this would impact our Christmas pantomime. But because COVID19 has had a far longer lasting impact than anyone ever expected, the show we have been planning for since January can of course not go ahead. A 150-person play in a hospital is clearly not possible in Christmas 2020. And while the cancelling of a Christmas show is a trivial matter compared with the tragedies suffered across the globe this year, it is with some sadness that we reflect that this is the first year in 81 that Oxford medical students have not put on a Christmas pantomime. However, with a script fully written and ready to go, we are looking forward to putting on our show as soon as restrictions loosen and keep the Tingewick flame burning. Rita Tingewick, our pink elephant mascot, is still alive and trumpeting!

Keep safe, have a wonderful Christmas, and see you all at Tingewick next year!

<http://www.tingewick.org/>
 7200km Cycle for our NHS: <https://www.youtube.com/watch?v=63-aDM48pkw>
 "Don't Go Out" music video: <https://www.youtube.com/watch?v=ZIGrB-QBTD4>

A poem, *Twas the night before Tingewick*, can be read on *The Tingewick Archive* website: <https://www.medsci.ox.ac.uk/get-involved/alumni/the-tingewick-archive>



Christmas Quiz



Dr Neil Snowise, *Visiting Senior Lecturer, Institute of Pharmaceutical Science, Faculty of Life Sciences and Medicine, King's College London. Corpus Christi College 1974–80.*

Neil worked for 21 years in the NHS, becoming

senior partner in a GP Practice in Bath and Lecturer in General Practice at Bath University. He then embarked on a second career as a pharmaceutical physician, largely in respiratory clinical development at GSK. He is currently Visiting Senior Lecturer in Pharmaceutical Medicine at King's College London.

Round 1: Doctors' Behaviour...according to BMJ Christmas editions

1. In a UK multi centre prospective study comparing anaesthetists and orthopaedic surgeons, which group had a) better grip strength and b) higher intelligence?
2. An American observational study investigated fast driving amongst doctors. Which speciality had the highest rates of extreme speeding (based on tickets)?
3. Another study assessed the accuracy of surgeons (plastic and orthopaedic) and anaesthetists in predicting the time it takes them to complete an operation or procedure on their lists. Which group were the most accurate?
4. Golf is often perceived to be a popular sport with doctors. According to a US observational study, which specialities play most commonly and who has the best performance?

Round 2: Animals and Medicine

5. Banting and Best are attributed with the discovery of insulin in 1921. Which animal species had they experimented on, to demonstrate that injecting pancreatic extracts effectively lowered blood glucose levels?
6. Until the 1950s, which animal was routinely used to assess human pregnancy, by injecting urine containing HCG (and if positive) causing ovulation?
7. The first-ever animal to human transfusion of blood was performed around 1667 by Frenchman Jean-Baptiste Denis who transferred blood from which animal to a 15-year-old boy and a woman in labour.
8. Which animal did Edward Jenner use in his pioneering work on developing vaccination? Bonus question – what was its name?
9. Which is the only mammal that does not have a pleural space? Bonus question – why not?

Answers to the quiz and crossword are on page 46.

Round 3: Oxford Medicine

10. Who founded the post of Regius Professor of Medicine at Oxford?
11. Can you identify these Oxford physicians?
 - a. A physician and one of the most generous benefactors of Oxford, he was also elected Member of Parliament for Bramber, Sussex in 1690 and for Buckingham in 1713.
 - b. Prior to coming to Oxford, in 1889, he accepted the position as the first Physician-in-Chief of the new Johns Hopkins Hospital and was one of the four founding professors.
 - c. In 1860 he accompanied the then Prince of Wales as his personal physician on his tour of Canada and the United States. He also took a leading part in the revival of the Oxford medical school and in introducing the study of natural science into the university.
12. Which of these three physicians did not become Regius Professor?

Round 4: What medical conditions did these famous people suffer from?

13. A condition that affected which one of Queen Victoria's children? Which of her other children were genetic carriers?
14. Which chronic disease did President J. F. Kennedy suffer from?
15. What disease is said to have caused the Madness of King George III? Bonus question – who starred in the role of King George in the 1994 film?
16. What medical condition did Charlotte Bronte die from?

Round 5: Memorials to Memorable Doctors

17. Which medically qualified poet has a statue in the grounds of a London hospital?
18. Saving thousands of lives by his pioneering work on vaccination was originally celebrated with a statue of Edward Jenner in Trafalgar Square, but why was this removed and where is it now?
19. Whose achievements in both public health and anaesthetics are commemorated by an eponymous pub and also representation on the coat of arms of a Royal College?

20. The inventor of the stethoscope worked in Paris at the time of his invention. Who was he and where he is originally from?

Round 6: Oxford Hospitals (past and present)

21. Which hospital was originally called Oxford Lunatic Asylum, opened in 1826?

22. This hospital started out as The Wingfield Convalescent Centre in the 19th Century. It was a military hospital in both World Wars and became a regional centre in 1950. What is its current name?

23. Until its closure in 1998, what was the originally named Oxford County Pauper Lunatic Asylum called?

24. Which hospital, opened in 1942, was initially leased to the United States Army medical services?

Round 7: Medical Miscellany MCQs

25. According to a BMJ publication, which surveyed members of the Sword Swallowers' Association International, which of the following are true:

- a. Training requires repeated insertion of objects such as paint brushes and knitting needles down the throat, to desensitise the gag reflex

- b. Around 15% of the association had died from sword swallowing injuries

- c. It is possible to swallow more than one sword at a time

- d. Perforation or major haemorrhage commonly occur

26. In 2016, Thorax published the first case report identifying fungal exposure, from a musical instrument player, as a potential trigger for the development of Hypersensitivity Pneumonitis. What instrument was responsible for causing the disease?

- a. French horn
- b. Tuba
- c. Bagpipes
- d. Flute

27. And finally, a festive question...which of the following are true, concerning Christmas Disease:

- a. The disease is also known as Haemophilia A due to Factor VIII deficiency

- b. It is named after Dr. Stephen Christmas, the haematologist who made the initial diagnosis

- c. it was first reported in the British Medical Journal in the Christmas edition of 1952

- d. All daughters of a father who has the defective gene will be Christmas disease carriers.

Christmas Medical Crossword



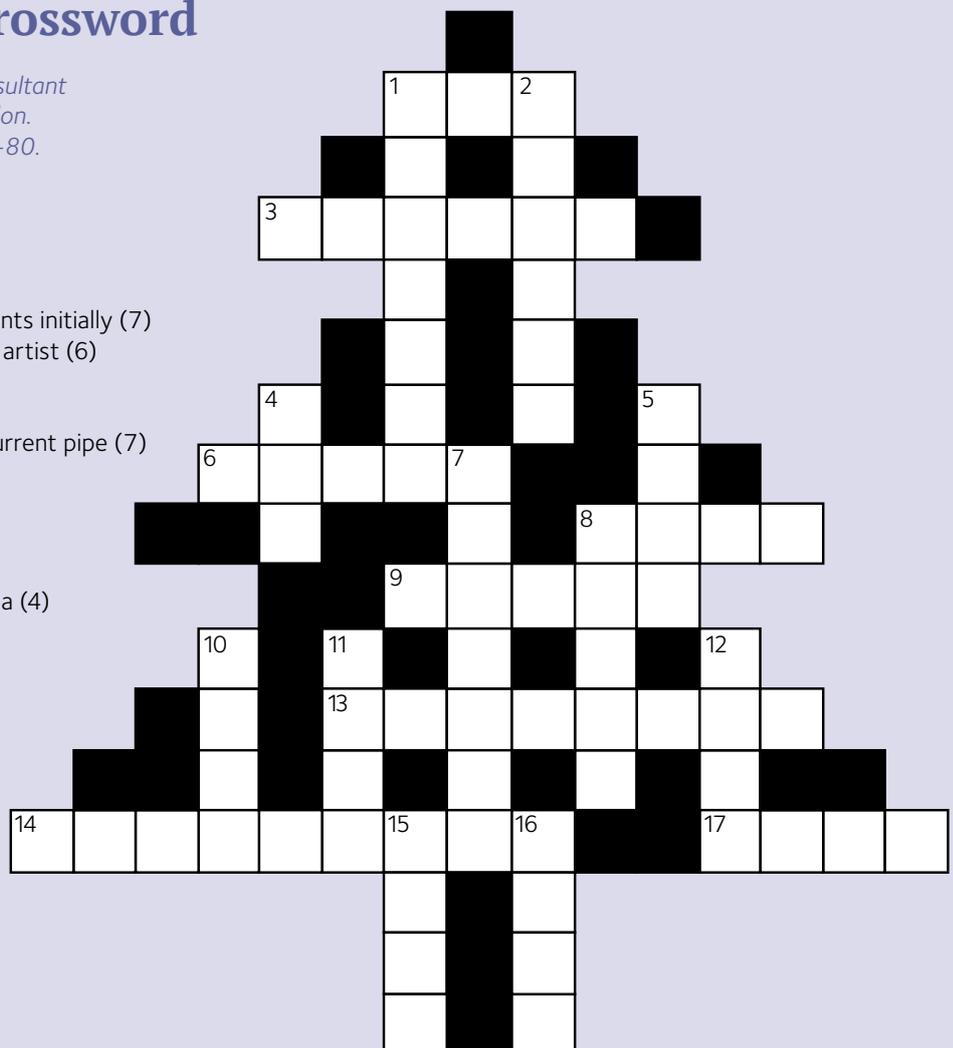
Mr David Williamson, Consultant Orthopaedic Surgeon, Swindon.
Corpus Christi College 1974-80.

DOWN

- 1 Cutter of milled coin is within requirements initially (7)
- 2 Passage for wild cat going around rising artist (6)
- 4 Where a teacher sleeps? (3)
- 5 Musical animal, we hear (4)
- 7 Earth turned over and implanted with current pipe (7)
- 8 Drops amend rates (5)
- 10 Furtively tail a pair of ankles (4)
- 11 Performers get plastered (4)
- 12 Lamé sort of cream (4)
- 15 Cell seen in corpus callosum astrocytoma (4)
- 16 Spike and reject – no Pole (4)

ACROSS

- 1 Tablet used without quiet makes you poorly (3)
- 3 Monitor disc (6)
- 6 Middle pump (5)
- 8 Vector sounds neurological (4)
- 9 Mixed-up Lap, er becomes more anaemic (5)
- 13 For a mother, a well-worn plaque (8)
- 14 A seasonal disease? (9)
- 17 Does this illness help you walk? (4)



Optimistic Poem

From two thousand and twenty we cannot forget
How lifestyles and values have now been reset.
We must now look forward at what has improved,
Horizons have altered and hopes are renewed.
The planet was helped as we cancelled our flights
And holidayed here to enjoy local sights.
The roads were much clearer- we worked from our homes
More birds in our gardens- less poisonous fumes.
We saved lots of money by eating at home
As no-one could join us- we partied alone.
We didn't waste time thinking what we should wear
Or try to disguise the grey streaks in our hair.
Face masks meant no one could see crooked teeth
Or what shade of lipstick you wore underneath.
No blemish was hidden when chatting on Zoom
So cosmetic procedures then started to boom.
We walked and explored to get fit in fresh air
Found pathways and sights that we'd not known were there.
We cycled more safely on new cycle lanes
And hoped that this sensible planning remains.
We spent more time weeding or cutting the hedge
We're healthier now on our own fruit and veg.
With Facetime and WhatsApp and Skyping and Zoom,
We now knew the décor in everyone's room.
We've taken up hobbies and crafts to keep going-
From painting and drawing to crochet and sewing.
We learned a new language and made our own bread
Wore pyjamas all day and then also in bed.
We looked out for neighbours and helped lift their mood
As we phoned for a chat and went shopping for food
We clapped for the carers and our great NHS
Hoping one day that we'd all have less stress.
So here's to the future -a world Covid-free
Or at least with a vaccine (though there's no guarantee).
Put your woes in perspective -and don't get the blues
Our lives will get better-just don't watch the news!



Dr Lesley Starr,
*General Practitioner (retired), Bath.
St Anne's College 1976-79.*

Oxford Medical Alumni Update

Oxford Medical Alumni (OMA) promotes good fellowship amongst Oxford Medical Sciences alumni, bringing together those who share a common interest in medicine. OMA supports regular meetings in Oxford, and elsewhere, for continued learning, exchange of ideas, networking and socialising.

Events and Reunions

The decade reunions are a core function for OMA. During 2021 we plan to combine year groups to include those who missed out this year. Should pandemic restrictions remain, alumni will need to be more creative about how they reconnect. If you qualified in one of the years listed below and would like to join a small group of Year Ambassadors to help us trace friends and colleagues, please contact us.

2021 Reunions

- **Decade Reunions** in 2021 are planned for those who qualified in 1970/1971, 1980/1981, 1990/1991, 2000/2001 and 2010/2011.
- **Preclinical Oxford Students** - we aim to invite both preclinical and clinical students to reunions
- **5th Anniversary Reunion** for those doctors that qualified in 2016/17 (new)
- **60+ Reunion** for those who matriculated prior to 1960/1 (new)

Meeting Minds Oxford 2020 delivered a successful virtual meeting in September. Professor John Bell, Regius Professor of Medicine, delivered the Osler Lecture. The whole lecture series can be accessed online: www.alumni.ox.ac.uk/meeting-minds. You will need to create a My Oxford Online account in order to see them (they're behind a firewall) accessed via our website: www.alumni.ox.ac.uk/my-oxford/my-oxford-online

The BM BCh graduation celebration was postponed until 2021. The latest up-to-date information regarding reunions is on the events page of our website: www.medsci.ox.ac.uk/get-involved/alumni/events-and-reunions/oxford-medical-school-reunions

Oxford Medical Lecture Club

The popular Oxford Medical Lecture Club, normally held on at Osler House (John Radcliffe site), invites distinguished, entertaining, and interesting speakers to talk about their speciality and the latest developments in clinical and scientific research. The lecture series re-started via the Zoom platform and continued successfully during the summer. If you are interested to receive notifications of the meetings, please do contact OMA by phone 01865 272538 or email oma@medsci.ox.ac.uk.

Mentoring

Oxford University has recognised the particular difficulties and dilemmas facing medical doctors and is upgrading the Oxford Alumni Community professional networking

platform. The networking platform is self-run, and alumni choose whether to sign up as mentors or use it to network and re-connect. You can sign up by entering your details and alumni number (either email or LinkedIn profile if you have one). There is now an Oxford Medical Alumni group set up within the platform which already has around 94 members. If you feel you are able to mentor fellow medical alumni, particularly graduating students and young doctors with issues such as career choice, or career progression, please have a look at the website www.oxfordalumnicommunity.org/ to sign up or contact OMA for more information.

Reconnecting with friends and colleagues

OMA are here to help bring people together. If you would like to reconnect with friends and colleagues you have lost contact with over the years, please email us at oma@medsci.ox.ac.uk and we will try our best to help.

Contact Preferences

Many of you may have out-of-date contact preferences, contact emails and addresses on our database. Please let us know if any personal details have changed or go to the website to update yourself. www.alumniweb.ox.ac.uk/oxford-medical-alumni/

Contributions to Oxford Medicine

We welcome your contributions to future editions of *Oxford Medicine* and look forward to including letters, reviews, recollections, and reflections from our Alumni, new and old, near and far.

Members of OMA Advisory Board (OMAAB)

Dr Lyn Williamson – President, OMA
Dr Roger Bodley – Honorary Treasurer

Board Members: Professor John Morris, Professor Sir John Bell, Professor Gavin Sreaton, Dr Catherine Swales, Dr David McCartney, Ms Christine Fairchild, Professor John Stein, Dr Tim Littlewood, Dr Kevin Windebank, Professor Denise Lievesley, Dr William Seligman, Dr Shing (Tom) Law, Dr Zoi Alexopoulou.

We are very grateful to Miss Colleen Devine and Mrs Nicola Choules-Rowe for all their help during the past year and wish them all the best for their future.

Contacting OMA

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Answers to Christmas Quiz

Round 1: Doctors' Behaviour...according to BMJ Christmas editions

1. Orthopaedic surgeons had both greater intelligence and grip strength. Bit worrying for their anaesthetic colleagues – the authors suggested they need to find new ways of making fun of the surgeons! Caveat – this was a study of men only, maybe the results cannot be extrapolated to female anaesthetists!
2. Rates of extreme speeding were highest among psychiatrists. The same study found that cardiologists were the most likely specialists to be driving a luxury car!
3. Orthopaedic surgeons were the most accurate – they overestimated by a mean of only one minute.
4. The highest proportions of golfers were all surgeons – orthopaedics, urology, plastic surgery and otolaryngology. The lowest proportions were in internal medicine and infectious disease. Perhaps not surprisingly, surgeons were also the best golfers, with about 15% better golf performance (by handicap) than specialists in endocrinology, dermatology, and oncology. Orthopaedic surgeons seem to score highly in these BMJ studies. I hope they did not use undue influence on the BMJ Editors!



Round 2: Animals and Medicine

5. Dog
6. Frog
7. Sheep
8. Cow
9. The elephant is the only mammal whose pleural space is obliterated by connective tissue. This has been known for 300 years but never explained. The elephant is also the only animal that can snorkel at depth.

The resulting pressure differences require changes in the pleural membranes and pleural space, but it is unclear if this is an adequate reason for no pleural space.

Round 3: Oxford Medicine

10. The Regius Professorship of Medicine at Oxford was founded by Henry VIII in about 1546
- 11a. Dr John Radcliffe
- 11b. Sir William Osler
- 11c. Sir Henry Acland
12. Dr John Radcliffe

Round 4: What medical conditions did these famous people experience?

13. Queen Victoria's son Leopold was a sufferer of haemophilia, making his daughter Princess Alice, Countess of Athlone a carrier as well. Queen Victoria's sons Edward, Alfred, and Arthur were not haemophiliacs; however, her daughters Alice and Beatrice were confirmed carriers of the gene.
14. Kennedy was diagnosed with Addison's disease in the 1940s. In 1955 he was diagnosed with hypothyroidism; both may have been a manifestation of autoimmune polyendocrine syndrome type 2.
15. This has been widely attributed to acute porphyria. The theory formed the basis of a long-running play by Alan Bennett, *The Madness of George III*, which was later

adapted for film starring Nigel Hawthorne in the title role. However closer scrutiny has cast doubt on this condition and other suggestions include mania and subsequently dementia.

16. Charlotte Brontë was the last to die of all her siblings. She became pregnant shortly after her marriage in June 1854 but died on 31 March 1855, almost certainly from hyperemesis gravidarum, although her death certificate states tuberculosis as the cause of death.

Round 5: Memorials to Memorable Doctors

17. The romantic poet John Keats trained as a surgeon-apothecary at Guy's Hospital, where a statue in the grounds celebrates his life.

18. Sculpted in 1858, the statue was unveiled by Prince Albert, the Prince Consort, in Trafalgar Square. Many thought it inappropriate to have a non-military figure in a location which celebrated Britain's military success. Saving countless lives worldwide did not compare well with the lives of military heroes. The Times supported his removal and it was demanded in Parliament. The statue was moved to Kensington Gardens in 1862 where it still stands.



19. John Snow was an English physician, a leader in the development of anaesthesia and a founding father of epidemiology. His name is inextricably linked with tracing the source of the infamous 1854 cholera outbreak in Soho, London. Snow is one of two supporters of the arms of the Royal College of Anaesthetists crest.

20. Rene Laennec invented the stethoscope while working in Paris. He has been described as the most famous Son of Quimper, Brittany, where his statue sits outside the Town Hall.

Round 6: Oxford Hospitals (past and present)

21. The Warneford Hospital
22. The Nuffield Orthopaedic Centre
23. The Littlemore Hospital
24. The Churchill Hospital

Round 7: Medical Miscellany MCQs

25. a) True b) False c) True d) False
26. c) Bagpipes
27. a) False – It is Haemophilia B, due to an inherited mutation of the gene for factor IX, and resulting in a deficiency of factor IX. It is less common than factor VIII deficiency (haemophilia A).
b) False – It is named after Stephen Christmas, the first patient described with haemophilia B.
c) True – The first report of its identification was published in the Christmas edition of the BMJ.
d) True as the defective gene is carried on the X chromosome.

Answers to Crossword

DOWN

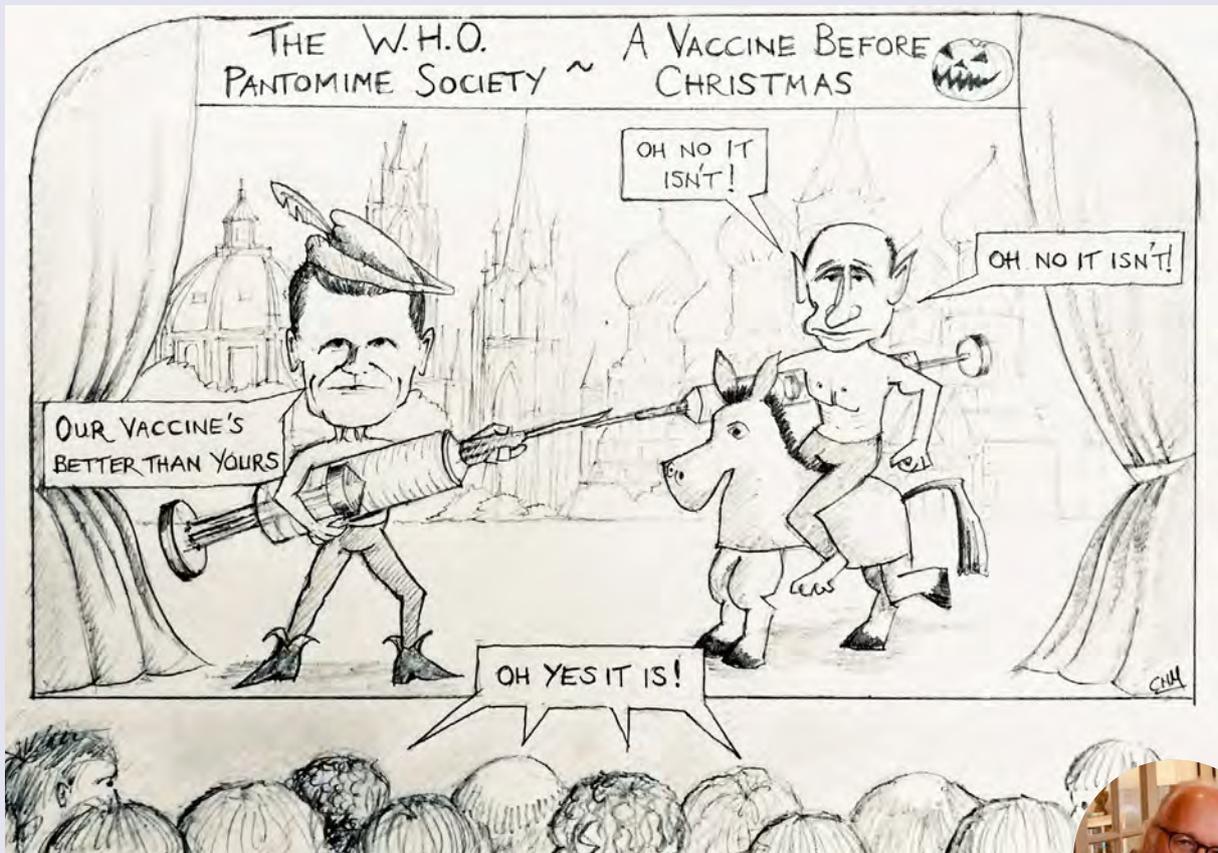
1. Incisor
2. Larynx
4. Bed
5. Hair
7. Trachea
8. Tears

10. Tali

11. Cast
12. Emla
15. Mast
16. Spur

ACROSS

1. Ill
3. Record
6. Heart
8. Tick
9. Paler
13. Atheroma
14. Christmas
17. Aids



Dr Chris Mason, Consultant Histopathologist, Exeter. Worcester College 1977-80





Photos mostly supplied by Dr Chris Roberts, (Rtd) Cons Anaesthetics and ICU, St John's College, Oxford 1977-80 (developed in the College dark room)