

Looking back

Great Ormond Street 50 years ago

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I was appointed house physician at The Hospital for Sick Children in 1937. In retrospect I can see that I was there at a very particular time in the hospital's history, because 1937 was to mark the end of an era. A decade or so before, the fame of Great Ormond Street had depended on a generation of physicians of the calibre of Still, Garrod, Batten, and Poynton. But the staffing of the hospital and the way the work on the medical side was carried out had changed but little in the 20 years between the wars. Change, however, was afoot and by the following year, 1938, the picture was at last beginning to alter, as will be explained.

I was one of only two house physicians, and my appointment was to Drs E A Cockayne and Donald Paterson. These two gentlemen had not been on speaking terms for years. So they had come to a tacit agreement whereby each took it in turn to appoint the shared house physician.

House physician jobs at Great Ormond Street were highly competitive, and it was understood that to stand much chance of success an applicant should have the Membership of the Royal College of Physicians, and should also demonstrate his keenness by having made one or more previous applications. I did not have the Membership, and indeed was very junior, having been qualified less than a year. However, I did possess one crucial asset—I came from the right medical school, the Middlesex, for Dr Cockayne, whose turn it was to appoint, was 'on' at the Middlesex as a general physician. Hospital chauvinism was a powerful force and to it, unworthily, I owe my entry to Great Ormond Street.

The two chiefs I found myself working for each had a ward of about 26 cots, but the two firms had little else in common. The senior of the two, Dr Cockayne—Cocky—was a shy eccentric; it was my loss that I never felt able to get onto his wavelength, or to know how to respond to the curious little giggles which accompanied the remarks that he would drop, often after a disconcertingly long silence, in the course of his twice weekly ward round. But my successor, Dick Bonham-Carter, became a devotee of his, and says: 'Cockayne was an Edwardian bachelor, who did not care for

women. This attitude was compounded by the fact that he had to teach female medical students from the Royal Free Hospital at Great Ormond Street. Furthermore he had had rooms in Lancaster Gate when the building had been bought by London University and turned into a female students' hostel. He was very fond of children, but his life and his original work were devoted to genetics. His OBE was awarded for his work in entomology; he was President of the Royal Entomological Society, having made his name by cataloguing the Rothschild's collection of British moths, a genetic study. In human genetics his *Inherited Diseases of the Skin and Appendages* was a classic. His knowledge and memory were remarkable. A physician at Hammersmith Hospital rang up to ask me to tell Dr Cockayne that he had admitted an 18 year old girl with pseudo-xanthoma elasticum. "That will be Vera Green," he said, and of course it was. He was intrigued by my own pedigree, because I had an English name but a Scottish home. "Poltallock, Argyll?" he said, "Ah, yes, the white woodcock in the Natural History Museum." (It was shot and presented to the Museum by my grandfather.) No wonder I was fond of him and thought he had the best intellect on the staff at Great Ormond Street. But he was odd.'

I saw far more of my other chief. Donald Paterson was a Canadian who, armed with the vigour, confidence, and drive that were considered to be typical of the products of the New World, had come to this country when quite young. In no time he had established himself as the best known children's physician (no one then called himself a paediatrician), had written several books, and published plenty of papers—mostly pot-boilers, for he was no medical scientist. He ran a flourishing practice from his house in Devonshire Place, at a time when no other physician was able to make a living if confining his practice to children.

To the archaic atmosphere then pervading the medical wards at Great Ormond Street, DP brought a whirlwind of activity—stimulating without being inspiring, was Dermot MacCarthy's not unfair description. His ward sister, Sister Manley, had

perfectly adapted herself to DP's highly individual style and tempo—*allegro molto con brio*. She would explain to the new house physician how long experience had taught her how to manage this man, 'and if you do what I know he wants, we shall all get along'. I was well content to fall in with this pragmatic policy. However, the fact that my appointment had manifestly been made by the unmentionable Dr Cockayne started me off on the wrong foot. I was dreadfully inexperienced and my deficiencies were relentlessly exposed and commented on by a tyrannical DP. After three weeks I resolved to tender my resignation, on the grounds that my work was always going to dissatisfy him. I tackled DP to this effect before the next ward round. To my great surprise he denied any such dissatisfaction, and spoke warm words of encouragement. From that time on we got on well, and I profited much from his large clinical experience.

The resident staff totalled seven, with two house physicians, two house surgeons, a resident surgical officer, a casualty officer, and an anaesthetist. This last was a woman, the first ever appointed (apart from the exceptional days of 1914–18). There was a medical registrar (George Newns) who was non-resident. His job rather surprisingly included doing all the postmortems. George Newns was available for help and advice during the day, but during the night hours when, as all know, most of the emergencies and crises happen, there was no one the house physician could turn to. It would have been unheard of to bother one of the chiefs. So the resident surgical officer (David Waterson), when not engaged in the theatre as was usually the case, was the one experienced person in the hospital. He it was who saw me through my first emergency tracheotomy.

The hospital was then in the course of rebuilding. Cocky's ward was still in the old building in Great Ormond Street, while DP's ward was temporarily housed in the top floor of the new nurses home in Guilford Street. (The latter arrangement made it tempting for a houseman to add interest to his late night ward round in the form of an occasional clandestine assignation.) The two wards were far apart—five minutes at a fast run—and inevitably a crisis in one of the wards would find me in the other.

There was a brisk turnover of cases in DP's ward, a good number of the children having been seen by him privately. It was sometimes hard to keep up, and a mongol (sorry, Down's syndrome) or other retarded child was warmly welcomed, as it blocked a cot for a week or two while being 'investigated'. This would probably include a request for Dr Wyllie's opinion. Dr Wyllie was in the unfortunate position of having the reputation of an interest in neurology;

this he tried strenuously to play down, claiming that the only children he was ever asked to see were those with mental defect. Arriving to see such a case in the ward, he would approach with a resigned air, draw from his case an ophthalmoscope of the simple type sold to students, make a few perfunctory shots at scanning the child's fundi, and the visit was complete. A ritual performance? Yes, but in those days when medical knowledge was relatively scanty, much that passed for medical practice was largely ritual.

Asthma was then as now a common disease. DP sent these children in to be dealt with on a routine plan. Each child had an x ray of chest and antra (the latter often leading to an antral washout), a blood count, and sedimentation rate. Frenetic activity on the part of Sister Manley was required to ensure that all these had been done and the results to hand by the time of DP's next visit. The child was then sent home or to a spell of convalescence at Tadworth, to receive a course of injections of Bencard's Mixed Inhalants.

For the really severe asthmatic we had one sovereign remedy, to send the child to Davos in Switzerland for a period of months or years. The Davos scheme continued for many years, and required a paediatrician to make occasional visits. For a long time this not very exacting duty was happily undertaken by Richard Dobbs, whose visits were carefully timed to coincide with the most favourable ski conditions.

Gastroenteritis played a large part in our life; many acute cases were admitted, while cross infection within the ward was a continual worry. It was all too common for a well baby to come in for some minor procedure such as a hernia operation, only to go out in a coffin. Treatment usually involved an intravenous drip, which meant a cut down at the ankle, a houseman's reputation depending much on his expertise at this procedure. I gradually improved but never relished the tricky job of getting a cannula (Bateman's needle) into a minute vein, under the dim light of a torch held by a nurse. The only intravenous solution was normal saline (no potassium) infused in somewhat arbitrary amounts.

Meningitis was not only common, but often seen at a late stage when a meningococcal infection had become chronic ('post-basal meningitis') with the pathetic picture of a grossly wasted baby in extreme opisthotonos. Sulphonamides were just coming into use, but Prontosil, an intense red dye, was the only soluble form. I have memories of wrestling with a desperately ill baby at some ungodly hour of the night, one hand holding a needle inserted into the baby's cisterna magna and the other holding the infusion of Prontosil connected to the needle.

This was an era when the idea of focal sepsis was popular, and an adult with rheumatoid arthritis was likely to suffer a dental clearance. Analogously in the paediatric field, enteral disease was considered often a symptom of infection elsewhere in the body—'parenteral infection'. Cryptic infection in the middle ear was held to be particularly important in this context, and when in doubt it was thought wise to incise the ear drum. It was not unusual for the houseman to perform the myringotomy in the ward, having first himself anaesthetised the child with ethyl chloride given by mask. I had just completed the myringotomy in this way on one young child with an intractable diarrhoea, when the nurse said quietly, 'I think he's dead'. She was right. I was overcome by misery, knowing that my actions had been impetuous, incompetent, and probably unnecessary. The fact that I received sympathy from my seniors rather than the censure I felt I deserved mortified me. At the coroner's inquest, held in a courtroom in Marylebone, I had to listen to the unctuous tones of the coroner as he assured the bereaved parents that the doctor concerned had selflessly laboured and used all his admirable skills in a fight to save their child's life. The proceedings ended with the clerk to the court handing me my fee as a witness: two guineas. As custom demanded I pocketed the two pound notes and handed back to him the two shillings. I walked back to the hospital and there discovered that I did not have the two pound notes; I must have thrown them away in my utter disgust.

DP's famous 'circus' on Friday afternoons was an enjoyable feature of the week, when cases were demonstrated to any who cared to come. DP, something of a showman himself, liked his staff to show a case with some panache. Sometimes an expert was invited to speak, and in this way I met some of the medical celebrities of the time.

Less enjoyable was the weekly whooping cough clinic which fell to my lot to run. Whatever its original aim can have been, its purpose was now totally obscure. The scene was a sort of Dickensian version of Dante's *Inferno*, with a roomful of coughing, spluttering, whooping children supported by weary, distraught mothers. My regular assistant on these occasions was a porter of exceptionally lugubrious mien, who, armed with a mop and a bucket of sawdust, impassively dealt with the pools of vomit. Diagnostic tests included a leucocyte count, from which I at least learnt that a sky-high lymphocyte count—my record was 200 000—does not always mean leukaemia.

Two recent publications had claimed that large doses of vitamin C curtailed the symptoms of pertussis. The clinic provided an opportunity to set

up a controlled trial (the placebo was a spoonful of cod liver oil and malt); vitamin C was shown to be without effect. DP, a keen advocate of the publish-or-be-damned theory, persuaded me to write up for the *BMJ* this non-world shaking finding.

The other pair of medical firms at Great Ormond Street were those of Dr Frew and Dr Pearson, for whom I also did a stint as locum house physician. Dr Pearson was absent for long periods for health reasons, so his influence was slight. Dr Frew was chiefly remarkable for his skill in avoiding ever committing himself to any definite opinion about any of the children he was shown on his ward round. He was nearing retirement and was rumoured to be writing a textbook on the diseases of children. This seemed unlikely, but to everyone's surprise the book did appear. Surprise turned to shocked horror when readers discovered that according to the senior physician at Great Ormond Street, almost every disorder from enuresis to encephalitis was the result of a hitherto undescribed lesion—hyperphlebaemia, or overfilling of the veins. Strangely, that word had never been heard on the author's lips during the long years he had attended the hospital.

Besides the four physicians 'with beds' there were the outpatient physicians, W G Wyllie, Bernard Schlesinger, Wilfrid Sheldon, Reginald Lightwood, and Alan Moncrieff, from whom were to come many of the leading men among the postwar generation of paediatricians. From their outpatient clinics would arrive on the wards children labelled 'For admission this day', with a provisional diagnosis attached. The latter, with the irreverence of youth we were apt to demolish out of hand. Reggie Lightwood was famed for the vagueness of his diagnoses, one of which ran: 'vomiting,? '?'.

The surgical side of the hospital was active and flourishing at this time, with a team of bright young surgeons, of whom the acknowledged star was Denis Browne (the only surgeon in London who confined his work to children). He was a man brimful of original ideas, and with the necessary drive to implement them. His cleft palate results bettered those of the plastic surgeons, and his contributions to orthopaedics, notably talipes, were becoming accepted internationally. We always tried to steer our pyloric stenosis babies to him for operation, which he did under local anaesthesia with an ease, delicacy, and speed which was wonderful to watch. He was said to have done over a thousand Ramstedts. 'Pylorics' were then usually diagnosed very late, and these babies came in wasted, dehydrated, and alkalotic, so ether anaesthesia, used by the other surgeons, was liable to be the last straw for them.

Nursing was of a very high standard, as a nurse could only start her children's training after becom-

ing a state registered nurse. I was often painfully conscious of the disparity between my own experience and that of the nurses I was working with. Then as now there were never enough nurses, and the ward sisters seemed to be chronically at war with 'the office' where Matron was supposed to have any number of nurses, wilfully refusing to send out any of them to 'special' some particularly dire case.

The prevailing attitude to mothers is epitomised in the immortal words appearing in Sir Robert Hutchison's *Lectures on Diseases of Children*, '... these are apt to be loquacious persons, but it is always worth while to listen patiently to all they have to say. . .'. Visiting was limited to Sunday afternoons, and was discouraged altogether for the toddlers because they would be 'upset' by seeing their mother. I do not remember that any facilities were made available to enable a mother to breast feed her baby. But DP was unique in regularly setting aside time at the end of his ward round to see the parents.

Looking back on my time at Great Ormond Street half a century ago, I recall the sheer enjoyment and exhilaration of working there, but also the periods of overwhelming exhaustion. In part this was due to the work of looking after more than 50 sick children and the lack of sleep, but also to the excessive clinical responsibility that I as a house physician was landed with. Time off was virtually confined to alternate weekends. On one of these I reached home at teatime on the Saturday, fell into bed, and surfaced again next afternoon 22 hours later, just in time to set off back to the hospital.

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A particularly sapping part of the job was the system by which I would be woken by a porter early in the morning with a message that Mr and Mrs Brown were waiting to be seen at the porter's lodge. Gradually it would dawn that Baby Brown, whom I had been up with the last few nights, must have died. Bleary eyed, half asleep, and irrationally resentful, I had to interview the stricken parents and, before signing the death certificate, ask their permission for a postmortem. It was all too much.

But a great deal was about to change, and in 1938 the number of house physicians was doubled to four, one for each ward. Two new posts were established with the somewhat portentous title of resident medical assistant and clinical pathologist, and these were filled by Ronald Illingworth and Elaine Field ('Another woman? What's the place coming to!'). More important still, a resident assistant physician was appointed (Dick Bonham-Carter), counterpart to the resident surgical officer, so at last a house physician would have someone at hand to consult.

There must be many people who, though greatly devoted to their parents, yet look back on their childhood and realise that their upbringing had been far from ideal. So the upbringing I received from my alma mater, Great Ormond Street, may have been less than ideal, but somehow it left me with a deep and abiding affection for the place.

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Queuing for admission to the outpatient department at Great Ormond Street in the 1930s.