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Journal of the Royal Medical Society

Contents

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RES MEDICA

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JOURNAL OF THE ROYAL MEDICAL SOCIETY

MANAGEMENT OF HIV+ PATIENTS

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EDITORIAL

Res Medica was to be scrapped at the last revision of the RMS laws. Yet despite its nonexistence for many years the suggestion to end it was met with a bizarre unease. Almost like 'pulling the plug on a pal on life support'. A number of articles were written for a celebration copy to be printed for the 250th anniversary in 1987. Insufficient funding hampered its early resurrection and the journal of the Royal Medical Society slumbered on.

Something stirred.

A combination of historical interest, on my part, and the relentless enthusiasm of the editorial team, the genesis of which was, well, a surprise, has revived the spirit of our journal. This is one ball which does not roll by itself.

We may be a wee bit sparse to begin with, but write to us. We will welcome articles on most topics, cartoons, artistic creations poems etc. There is enough material for a few more issues yet, but if the editorial team writes the rest we will not have the effect that entertains you the way it should. There is room for book reviews, course assessments in this climate of curriculum review, results from honours projects. We may not be 'Nature' but a publication is a publication and Res Medica is archived by the British Library.

Think on. Read on...

CONTENTS

Credits

EWEN SIM
CHIA-MENG TEOH
LOUISE SMITH

Res Medica is the Journal of the Royal Medical Society of Edinburgh.

Royal Medical Society, 5/5 Bristo Square Edinburgh EH8 9AL

Management of the HIV-infected patient before the Development of AIDS

James A Gray, Olim Præses

Dr. Gray was Senior President of the RMS in his day and during that time started the journal, 'Res Medica'. So we were 'well chuffed' when he offered to write an article for this resurrection of his creation, especially since it clarifies many of the incongruities presented in current literature concerning the clinical management of these special patients.

19th century and early 20th century physicians taught their students: "Know syphilis and you will know medicine." In this last decade of the 20th century, physicians could justifiably substitute the word 'AIDS' for 'syphilis'. Every aspect of human immunodeficiency virus (HIV) infection - whether the epidemiology, immunology, pathogenesis, diagnosis, management or prevention - presents an intellectual challenge to our profession. Politicians, educationalists, doctors and the lay public ignore this disease at their peril. We all have a duty to ourselves and to future generations to do everything possible to control and ultimately to eliminate HIV infection.

This article attempts to outline the general management of HIV-infected patients before they develop AIDS. To understand the philosophy behind such management, one must be conversant with the natural history of the infection. The Center of Communicable Disease Control (CDC), Atlanta, Georgia, has developed a system of classification which will be used throughout this article (see Figure1). Thus patients with the acute seroconversion illness which resembles glandular fever, if it is recognised for what it is - and often it is not or forgotten about - are classified as **Group 1**. There follows a long incubation period with a mean of 8-9 years (range 2-15 or longer) during which the patient remains largely well clinically (**Group 2**). This is the group upon which this article will concentrate. When the disease next becomes symptomatic the patient enters **Group 3** (formerly designated Persistent Generalised Lymphadenopathy or PGL) or else he or she develops full blown AIDS (**Group 4**).

New Classification System

Patients with AIDS may have minimal symptoms - say between attacks of opportunistic infection - or be desperately ill. The subgroups within Group 4 disease are :-

Sub-group A - fever persisting for longer than one month, involuntary weight loss in excess of 10% or diarrhoea lasting for more than one month without an alternative explanation. Sub-group A corresponds with the previously designated AIDS related

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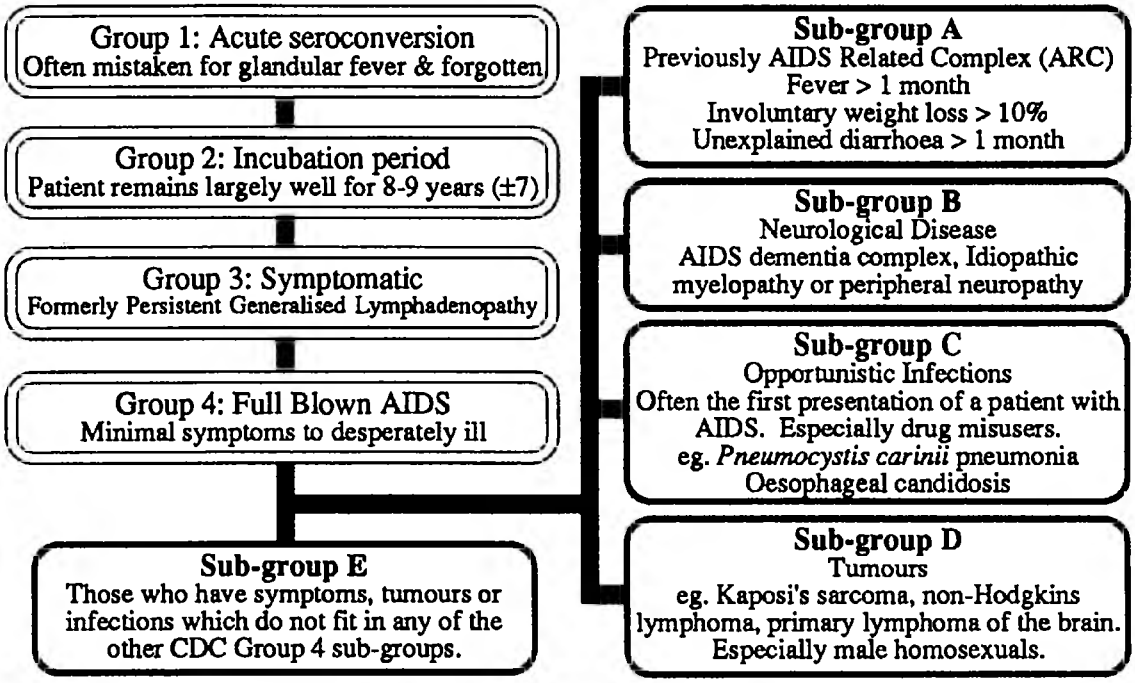


Figure 1: Abbreviated CDC classification of the natural history of HIV infection.

complex or ARC.

Sub-group B includes those patients with neurological disease like AIDS dementia complex, myelopathy or peripheral neuropathy without an alternative explanation.

Sub-group C represents those patients with opportunistic infections in the context of HIV infection or illness indicating a defect of cell mediated immunity. Many patients, especially those who have acquired their infection by intravenous drug misuse, first present with AIDS in this category by developing *Pneumocystis carinii* pneumonia (PCP), or other chronic or invasive parasitic, viral or fungal infections.

Sub-group D includes those patients with tumours such as Kaposi's sarcoma (KS), non-Hodgkins lymphoma or primary lymphoma of the brain. Many male homosexuals but very few intravenous drug misusers with HIV infection present with or are at some time affected by KS. The reason for this is not yet known.

Finally **Sub-group E** is a convenient category for patients with HIV infection whose symptoms, tumours or infections do not neatly fit into the other sub-groups of the CDC Group 4.

Without a clear knowledge of this classification, necessarily abbreviated here, the physician looking after HIV-infected patients who are asymptomatic to date cannot be aware of the many possible ways in which AIDS may present and so be able to investigate expeditiously and promptly treat serious disease when it does arise. Correct management of HIV infection is concerned with the intelligent anticipation of problems.

The length of any patient's stay in Group 2 (asymptomatic HIV infection) depends upon age, sex (including pregnancy), race

fitness at the start of the illness, lifestyle eg. persistent drug misuse, alcoholism, undernutrition, and probably also the infecting dose or doses of HIV and whether such insults are continuing. Ability to avoid other infections eg. sexually transmitted disease may reduce antigen load and also keep the patient asymptomatic for longer. Education is therefore an important factor in patient management, not only in reducing the risk of infection to others, but also in the encouragement of a lifestyle that will delay the onset of AIDS in that individual.

Another factor that may, in the future, help patients in Group 2 to keep well and delay the onset of AIDS is the judicious use of the anti-retroviral drug zidovudine (azido-thymidine, AZT or Retrovir). Antifungal, antiparasitic or other antiviral agents which are often used as *secondary* prophylaxis after AIDS has developed, may sometimes also be employed for *primary* prophylaxis. The decision about what drugs to use and when will depend on how the patient is, judged by *regular* clinical and laboratory screening. Whilst this monitoring and prophylaxis are proceeding, it is important to remember the psychological wellbeing of the HIV-infected individual who may also need the patient support of an experienced counsellor.

Expensive drugs like AZT are ill afforded even in the relatively affluent western world. In some parts of Africa where 30% of the population may be HIV infected, such therapy is simply unavailable.

A possible outline of management of the HIV-infected patient in CDC Group 2 follows, but it should be remembered that with our rapidly increasing understanding of the disease and the development of new drugs and strategies, this may require radical revision within months rather than years.

Zidovudine

At the time of writing the results of the British-French collaborative study (Concorde) on the use of AZT versus placebo in asymptomatic HIV-infected patients are not known. An American study by the National Institute of Allergy and Infectious Diseases reported in the summer of 1989 that 50 of the 713 participants who started on the study between 3 and 30 months before had progressed from early ARC (CDC Group 4 A) to more advanced ARC or full blown AIDS. Thirty-six of these 50 had been taking placebo and 14 of them 1,200mg AZT daily. AZT only seemed to benefit those with T4 lymphocyte counts of between 200 and 800 mm^{-3} (Normal range 500-1000 mm^{-3}).

AZT is better tolerated in asymptomatic patients fewer of whom develop bone marrow toxicity than when it is given to patients with AIDS. The theoretical risk of the development of AZT resistance by HIV *in vivo* has so far not been shown although it has been demonstrated *in vitro*.

It would therefore seem likely that CDC Group 2 patients could benefit from early treatment with AZT and that, despite the expense, not only of the drug itself, but also of the mandatory monitoring for toxicity that should accompany its use, it may in future be recommended at this stage of the disease. The dosage will depend upon the the results of the Concorde study but is likely to be less than that presently used. This will probably reduce dose-related toxicity and of course expense.

Clinical and laboratory monitoring

At each out-patient visit, perhaps every 3-6 months in the apparently well patient,

Symptoms to look for:

fever dyspnoea cough
skin rashes night sweats
weight loss oral thrush
reduced exercise tolerance
diarrhoea and vomiting
visual impairment

Less specific symptoms

headache poor memory
undue fatigue lethargy
malaise

Figure 2: Symptom checklist for CDC group 2 patient consultation.

enquiry should be made about symptomatology as detailed in Figure 2.

The patient must be weighed at each attendance. Examination should concentrate on a search for lymphadenopathy, skin rashes and tumours, an oral inspection for hairy leukoplakia and candidosis and finally ophthalmoscopy for evidence of retinitis caused by HIV itself, toxoplasma and cytomegalovirus.

If the patient is a known intravenous drug misuser, he or she must be questioned about any continuing habit and inspected both in likely and unlikely sites of venous access for puncture marks. Consideration may be given to registering the patient with the Home Office as a drug misuser and supplying him or her with maintenance methadone as a substitute for intravenously administered opiates like heroin.

Basic laboratory monitoring will depend upon whether AZT is being used in which case the patient should be seen every 1-2 months rather than less often. A full blood count, including platelets, should always be done and if available, a T4 lymphocyte count and a check for the HIV core antigen P24. A fall in peripheral blood lymphocytes (especially the T4 cells) or platelets, the development of anaemia, the presence of antigenaemia and elevation of ß-2 microgobulin and gamma-globulins generally suggest advancing disease.

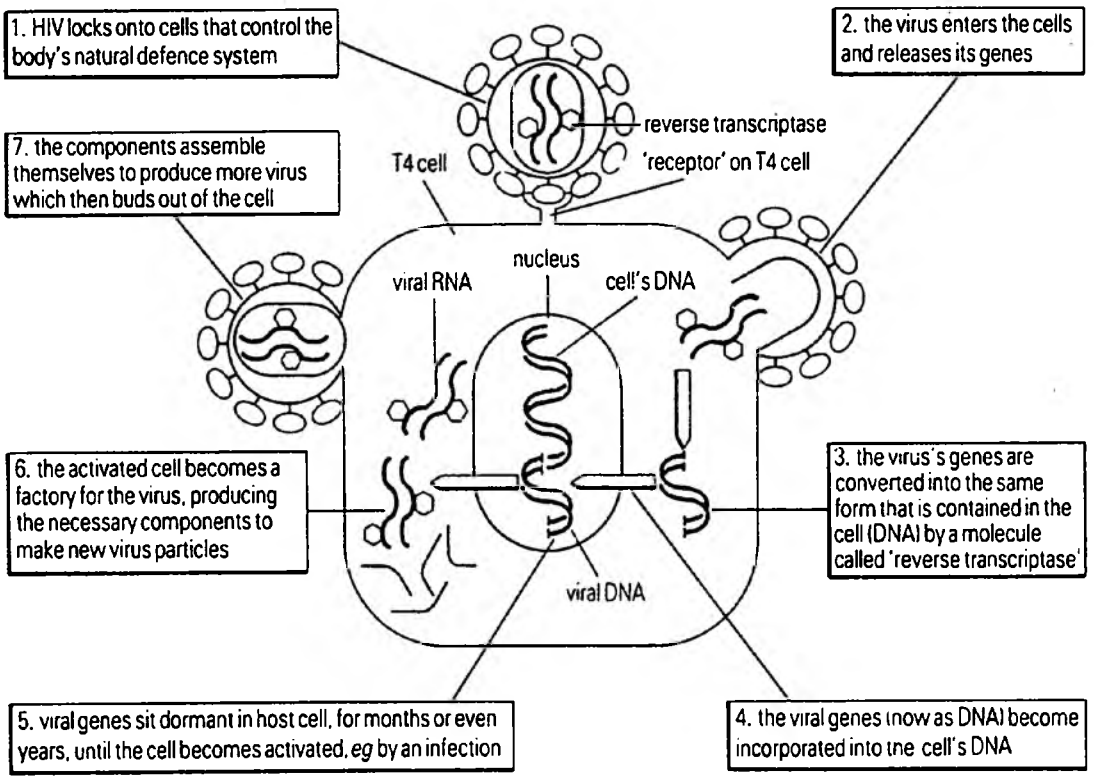
It may be necessary to stop or reduce the dose of AZT if the erythrocytes and granulocytes are much depleted. Transfusion of blood, platelets or the administration of gamma-globulin may be indicated. A haemoglobin below $8gdL^{-1}$ or a neutrophil count of less than $750mm^{-3}$ is an absolute indication for stopping AZT and for considering blood transfusion. AZT may be cautiously restarted in a reduced dose (i.e. less than the usual $3.5mgkg^{-1}$ 4hrly) if the haemoglobin has been well maintained after transfusion. AZT may be used occasionally as a platelet *booster*, but it is surprising how long HIV infected patients can tolerate very low platelet counts without bleeding.

The importance of monitoring T4 cells, other formed elements in the blood and antigenaemia is not simply to check for drug toxicity but also to anticipate if the patient is likely to be progressing towards CDC Groups 3 or 4 so that follow-up may be intensified and the general practitioner advised to refer the patient to hospital urgently if this seems appropriate. Early intervention in opportunistic infections is often life-saving but can only happen if anticipated. The earliest signs and symptoms must be recognised, investigated and appropriate treatment begun at once.

Primary prophylaxis for opportunistic infections

As about 50% of patients who progress to AIDS do so by developing PCP, primary

HOW HIV HIJACKS THE BODY'S T4 CELLS



prophylaxis against this disease would seem appropriate. Whereas cotrimoxazole prophylaxis against recurrence of PCP has been well tolerated, the administration of cotrimoxazole to prevent a first attack of PCP has been associated with a very high incidence of side-effects.

It is possible that inhaled pentamidine which again has a good record in the prevention of recurrences of PCP may in future have a place in primary prophylaxis but at the time of writing there is insufficient evidence to recommend it routinely. Fortnightly or 3-weekly doses of 300mg inhaled pentamidine are generally safe. If bronchospasm occurs it can usually be controlled in the next administration by inhalation of 2.5mg salbutamol immediately before the pentamidine. An alternative to inhaled pentamidine is the weekly administration of one tablet of pyrimethamine/sulfadoxine (Fansidar) although skin rashes and even the Stevens-Johnson Syndrome can result.

Other possibilities for primary prophylaxis which are less contentious include the administration of acyclovir to prevent *Herpes simplex* and *Herpes zoster* both of which can occur in milder forms without technically advancing the patient's CDC classification to Group 4. Antifungal prophylaxis with ketoconazole is sometimes associated with hepatic toxicity and the newer fluconazole in a daily dose of 50mg is more acceptable and has the advantage of crossing the blood-brain barrier and so, theoretically at least, lessening the risk of cryptococcal

meningitis.

Primary prophylaxis against toxoplasmosis, cryptosporidiosis, cytomegalovirus and mycobacterial infection may be goals for the future but often present problems of toxicity when tried.

Counselling, support and education

In addition to the morale boosting and support that a trained counsellor can provide, opportunities frequently exist when risk reduction for the patient, relatives and consorts can be discussed and reinforced. The provision of condoms and instruction in safe sexual practices, the exchange of dirty for clean syringes and needles for the drug abuser who will not desist from his or her habit or the establishment of a maintenance methadone substitution programme are all areas that may need to be explored.

A combined team approach is essential to the good management of HIV infected patients at whatever stage of their disease they happen to be in. Patients in the asymptomatic stages can enjoy a reasonably satisfactory lifestyle for many years if they are given the benefit of expert care and advice. New therapies may be developed. HIV-infected patients should therefore always be encouraged with a cautious but realistic degree of optimism.

Suggestions for further reading

AIDS and AIDS-related Infections: Current Strategies for Prevention and Therapy. British Society for Antimicrobial Chemotherapy. London, Academic Press, 1989.

AIDS and HIV Infection: the wider perspective. Ed. A J Pinching, R A Weiss, D Miller. Brit. Med. Bull. 1988; 44: 1-234.

AIDS - Therapeutics in HIV Disease. Youle M, Clarbour J, Wade P, Farthing C. Edinburgh, Churchill Livingstone, 1988.

COMING EVENTS

Friday 5 October	FRESHERS' ADDRESS
Friday 12 October	INAUGURAL ADDRESS *Prisoners of Medical Technology* Professor A. Busuttil
Wednesday 24 October	PUBLIC BUSINESS MEETING Professor A. Fox Consultant Cardiologist
Wednesday 21 October	PUBLIC BUSINESS MEETING Mr. I.F. MacLaren Consultant Surgeon Chairman, RMS Trust.

THE DRIFE DIARIES

As readers will be aware, Teviot Row is alive with rumours that an ex-Edinburgh medical student is threatening to publish the diaries he kept during his undergraduate days in the "Swinging Sixties". His former colleagues, now distinguished medical men, are said to have offered large sums as "hush money" to "Doctor X", and several Edinburgh publishing houses have experienced burglaries and arson attacks, as well as telephone calls hinting at complications should the publisher ever need medical treatment. Undaunted, in what must be journalism's coup of the decade, ***Res Medica*** *has secured exclusive rights to these manuscripts, and after consultation with our lawyers (who advise us that their authorship must remain a closely-guarded secret) we now present the first extracts from* ***The Drife Diaries.***

APRIL 20th

Got up. Had breakfast. Corn flakes supply getting low again. Must get another gross of 16-oz packets, or learn to cook something different (think Sunday's luncheon-party fell a bit flat after the second course).

V. worried about autobiography - due to graduate next year and still hardly any sex and violence for Chapter One (high hopes re tomorrow night's party, though). Need more s & v if autobiog. is to be international blockbuster. Memo - also need to develop popular style. NBG to write like a medical textbook - just imagine if Shakespeare had been medical author:

MERCY

Qualities

* not strained
* droppeth as the gentle rain
  (ie. from heaven ⟶ place beneath)
* twice blessed:
  1. him that gives
  2. him that takes
* mightiest in the mightiest etc. etc.

Stuff like that won't wow John Menzies and the motorway caffs, so TODAY'S RESOLUTION: try out diff. styles to find the best one.

MAY 26th

Got up. Had breakfast. Doing Gen. Medicine so plenty of time to read my Sherlock Holmes Omnibus. That reminds me: must practise a new style each day...

I was roused from my slumber at a later than usual hour, and as I opened my eyes I beheld a look of the gravest anxiety on the handsome visage of my old friend and flatmate, Tony.

"Come!" he cried, laying down the ladle and tin basin he had been beating together over my recumbent head. "The game is afoot!"

"Dear heaven!" cried I in a fervour of dreadful anticipation. "Has this accursed thing happened again?"

My friend spoke not a word, yet even as I searched for the neck-hole in my kaftan I could not help but notice his tight-set lips and stern countenance. When he spoke, however, his voice was quiet and perfectly controlled: "Nev has locked himself in the bog again."

The words struck a chill into my very soul. "With the water-pistol?" I stammered.

Tony nodded , grim-faced. "And my catapult". He did not miss the change in my expression. "Yes, my friend," he sighed. "I had thought it well hidden. Would that I had banished it from this flat altogether as you so beseeched me!"

Our little toilet overlooked the garden of Mrs Dalgleish, our worthy but officious next-door neighbour. She it was who, only the previous afternoon, had engaged our volatile flatmate in a discussion of the utmost animation over the question of the rota for scrubbing the common stair. And she it was who, in but a few minutes' time, would carry into the garden a basket of washing, bend over and - unless Tony and I could effect an urgent intervention - suffer unthinkable revenge at the hands of the temporarily deranged Neville.

Twice before he had lost control of himself in this fashion after being bested in a debate by our sturdy neighbour, and she had promised that should a third attack be visited upon her, we would be prosecuted with the full vigour of the law. Who then would come forward to say that Neville's violent nature was but the dark reflection of a brilliant mind? Who then would care that he was destined to become one of Edinburgh's leading hae-

matologists? Naught but disgrace beckoned, unless Tony and I could persuade him to abandon his vengeful purpose.

"Come out, Nev, I'm bursting!" I cried, as we beat with our fists upon the stout oak door.

"Naff off, guys," came the response from within. "This time she's going to get it right between the ischial tuberosities."

Tony and I could clearly see that it was useless to reason with him

further while his mind remained inflamed with fury. Tony's classic profile darkened for a brief moment, and then became resolute once more. "Wait here", he snapped. "I'll wake the Hulk." In an instant he was gone, and there was no sound but a demonic chuckle from behind the closed door, and the twang of elastic as Neville essayed practice shots at Englebert, the Dalgleish tortoiseshell.

In a moment Tony had returned, and with him was the towering figure of our fourth flatmate, Douglas, known throughout Marchmont as the Hulk. In outdoor clothes he was an awesome sight, but now, dressed in his night attire of rugby shorts and anorak (for his was the coldest bedroom) he seemed to fill the tiny lobby with knees and shoulders.

"Kill, Hulk!" snapped Tony, pointing to the toilet door. In an instant the lock was shattered and we three fell upon the astonished Neville as he crouched with catapult poised at the open window. I caught a glimpse Mrs Dalgleish, inviolate and unaware of the titanic struggle being waged on her behalf, but at that moment the Hulk fell on top of me and I knew no more ...

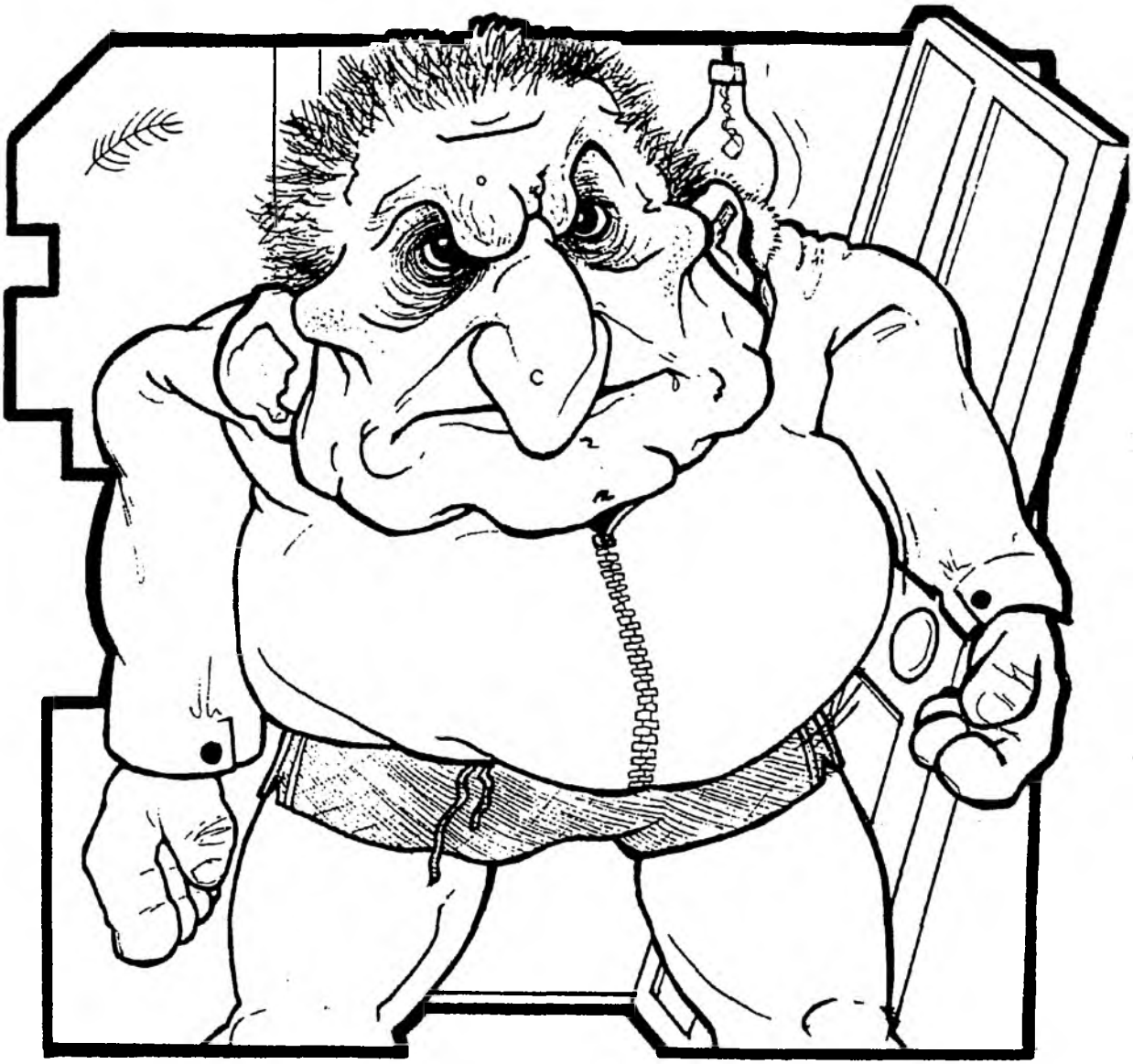
JUNE 15th

Got up. Had breakfast. I'll say one thing for Neurology at the Northern - plenty of opportunities for study. Superb hospital library with several Jeeves books..

With a discreet cough, the ward maid shimmied into Sister's office bearing a salver with a much-needed pick-me-up. "Down the hatch!" I croaked, screwing up the pallid features and downing the steaming brew in a single gulp. For a moment nothing happened, and then all h. was l.l. I felt like a patient whose sigmoidoscopist had suddenly developed St. Vitus' Dance. "I say!" I yipped, gazing around me with a wild surmise and preparing to head for the wide open spaces.

"Steady, lad", said Sister, laying a restraining hand on my knee. "I know hospital coffee takes a bit of getting used to." She gazed at me over her half-glasses and under her bushy eye-brows, and slowly the internal maelstrom subsided. Dunking a thoughtful chocolate digestive, she continued, "I understand you're in a spot of trouble".

Under normal circs., of course, a gallant scion such as myself does not unburden himself to those of the distaff persuasion. Stiff upper l. and all that.



But there was something about Sister - the row of medal ribbons, perhaps, or the flash of Hunting Stewart when she crossed her legs - that invited confidence. "Yes, actually," I stammered. "Well, sort of."

"The election, I believe?" she said, still skewering me with the steely gaze like Rob Roy interrogating a captured Redcoat, It was pointless to resist.

"Mmm, ya", I replied, spraying crumbs of Rich Tea over her starched lap. "I think I've blown it".

"Fiddlesticks!" she snapped, in the voice that had caused sudden loss of tone in many a consultant sphincter. "Would William Wallace have said that? Or Robert the Bruce? Or John Reith?"

"Dash it," I riposted with spirit. "None of them tried to become Moderator Ludorum Laetitiarumque".

"Who dares wins," Sister murmured calmly. "Who else is in for it?"

"Andrew Burton." I hissed the name between clenched teeth. The ghastly Burton had been my arch-enemy ever since we shared a body in the Dissecting Room. When I tell you that this fiend in human form had nipped up there during a lecture, replumbed the coeliac trunk, and waited sniggering behind his Scotsman crossword while I traced the superior pancreaticoduodenal artery into the gall bladder, I think you will have pretty clear idea of the kind of villain I was up against."

"Andrew Burton?" said Sister, frowning. "I seem to remember the name."

"Tall fellow," I prompted. "Very smooth".

"Ah yes," she nodded. "My nurses call him Andrex. Well now, we can't have a chap like that becoming Moderator Ludorum Laetitiarumque. You'll have to stop him, laddie!" She prodded me in the solar plexus with a ball-point pen inscribed 'A present frae Kyleakin'.

"But Sister," I gulped feebly. "He's like a cross between Al Capone and Terry Wogan. There's simply no stopping him."

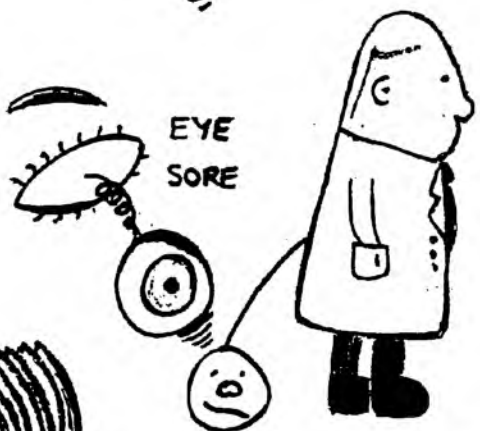
"Snap out of it, laddie!" Her tone was chilled steel. "Where's your backbone? Are you a man or a mouse?" I opened my mouth to protest that this was no time for a Basic Sciences viva, but something in her eye stopped me. I stood up and brushed the crumbs from my cagoul. My jaw was firm. My eye almost certainly glinted. This woman's words had turned me from a jellyfish into a superbly engineered fighting machine.

"Golly, Sister", I rapped, "How can I ever thank you?"

She looked up at me and her bosom heaved under the navy-blue serge. "Kiss me, you fool," she breathed.

(to be continued in the next issue of Res Medica)

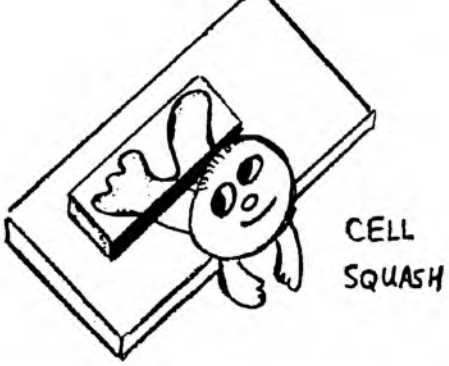
THOU



In this poem ***Graha***
an unusual look at
preclinical me

Woke up late again on Thursday morning,
I think last night was just too much for me!
Ran into the lecture hall still yawning,
Just ahead, the flowing Doctor T.

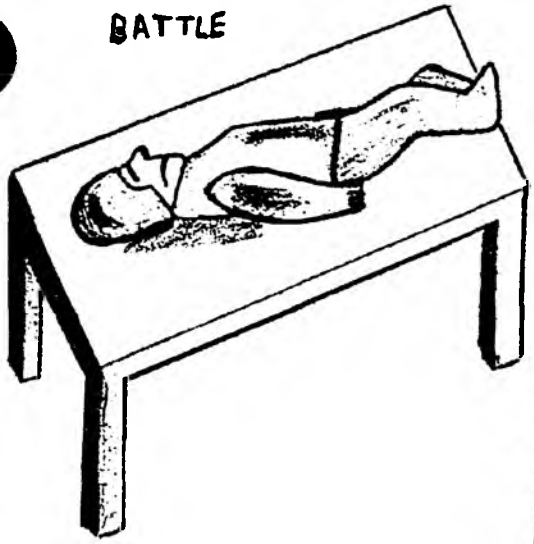
Five past nine, words of wisdom, pens in tempo, facing forward,
Eyes directed, cells detected, Doctor T. goes on and on.
Minutes pass as clocks are watched, and legs start twitching,
feeling awkward.
Time to go as seconds stumble, eyes are lifted; she has gone.



Out all night, each night until the
Friendly faces welcome you, to
Julie asks to dance and helps to get th
Hours fly by in dancing tempo; words

GHTS

n Mackenzie takes
day in the life of a
lical student.



Doctors with white coats and their dilated pupils climb sky high,
Hands in gloves in pockets, shiny blades within the acid haze.
Dark and hidden figures linger as the living pass them by;
Dense and creeping fumes traverse the room; they start to float
and fly away.

Chemical attractions flow between us, force attention,
The mind and soul entwined within the bounds of lifeless bone.
The sparks of love and lust we feel, the cause of apprehension,
Explaining what it means to us to be and feel alone.

hurch bells hail the break of day,
arties which will "change the world".
: party under way,
and actions move entwirled.

HISTORY RECOLLECTION AND CONJECTURE

The RMS Library has long played a central role in the history of the Society. ***Dr. JJC Cormack M.D.*** *(Honorary Librarian) takes a look back on how the Library has shaped the present day RMS.*

Imagination has to fill in the gaps (and there are many) of recorded history. Even recorded history may not be accurate, but imagination can lead one seriously astray. In researching Library Committee minutes while preparing my dissertation many years ago I remember finding that in the years 1917 - 19 the business of the Library was incorporated with that of the other Committees in a conjoint Committee due to the small number of members available during the First World War. "There was a suggestion that the society should not meet during the hostilities, but research into old records revealed that the Society had continued to meet during the battle of Prestonpans in 1745 and this was considered to be due and sufficient precedent." This serves, it seems to me, to place the early days of the Society in some sort of historical context - or should have done so had I not realised very recently that in my mind's eye the members of the Society were debating during the stirring days of the Jacobite uprising in the green and gold Hall at Melbourne Place - a completely anachronistic picture as the Society in 1745 had no settled home, or if it had it was in a room in the Old Infirmary and not by any stretch of the fancy in Melbourne Place. Such tricks does the imagination play.

Was the society, one wonders, riven with political controversy between adherents of the doomed but romantic Jacobite cause, like its early member Sir Stuart Threipland, physician to the Young Pretender, and ardent Hanoverians like the estimable Andrew Duncan who was later to write some execrable poetry in praise of the Germanic monarchs who had inherited the throne of Scotland? Which side, from today's perspective, would we have sup-

ported? Or were such differences sunk in shared interest in the art and budding science of Medicine and the knowledge that both Stuarts and Hanovarians shared some of the genes of Robert the Bruce? Another anachronism - our founding fathers knew of inheritance but nothing of genes.

So where did they meet, these eighteenth century students whose spiritual genes at least we inherit in the RMS? They met at first, of course, as we all do as medical students, over a corpse. What a strange bond of shared experience is this macabre but necessary ritual which stretches back down the years and generations.

The annals of the Society's foundation read "After having finished our dissection in which we employed the greater part of that month, we agreed to spend a social evening at a tavern." Where the tavern was we have not been told so here the imagination (and perhaps a touch of whimsy) must fill the gap. In 1977 I was invited to talk at a joint meeting of the Royal Medical Society and the Scottish Society for the History of Medicine in the RMS meeting hall in Bristo Square on the subject of the origin of the RMS - a talk I entitled 'There is a Tavern in the Town". It was at this meeting that I drew attention to the taverns which existed in the early eighteenth century in the suburb of Easter Portsburgh just south of the city wall and close by the College's buildings. "It would be quite natural for this group of six friends on the evening of their last day in the anatomical theatre to have left the College by its western gate, proceed through the Potterow Port a walk of some two or three minutes up the Potterow to the tavern, perhaps on this very spot (the site of the present RMS meeting hall). Maybe this is but idle speculation, but it seems to me a

pleasing thought, that the Royal Medical Society might by chance have returned to its original spiritual home.

From this academic and scientific beginning (the hours spent in the anatomical theatre) and the convivial gathering of the founding sextet in that Edinburgh tavern sprang the idea of a permanent society, which was formally constituted in 1737. In August 1736, shortly before the formal constitution of the Medical Society, King George II granted a Royal Charter which incorporated the Royal Infirmary of Edinburgh: at that time the 'little house' at the head of Robertson's Close. Sometime between its opening and 1753 the Managers of the Infirmary granted the use of one of its rooms to the Medical Society, thus giving it its first permanent home. Gray records that "an entry in the Infirmary minutes of the year 1753 shows that a library was being accumulated there with the funds which had previously paid for the tavern accommodation." Thus history appears to be silent on the question of where it was that the members of the Society met during the battle of Prestonpans: a tavern or a hospital room - we shall probably never know and imagination can have its freedom, but possibilities are narrowed down.

The accumulation of a library and the patronizing of taverns need not be mutually incompatible activities and one suspects that our predecessors happily engaged in both. The Society's library was to continue to influence decisions about the Society's accomodation for years to come.

What books did the Society collect to form its library in these early days? Again, alas, history is silent although the classic works of Hippocrates, Celsus, Galen, Vesalius and Paré must have featured along with more recent works by Boyle, Newton, Willis and Sydenham. Whatever books it was that the Society acquired, it was noted in 1771 that the library was "not in such a situation as could be desired either with regard to conveniency or preservation", and this was adduced as one of the reasons for appealing for funds for the Society to build its own Hall. It was in 1775 that William Cullen lay the foundation stone of the Medical Hall which was to stand for nearly eighty years as the Society's first (and only purpose-built) home, on the west side of Surgeon's Square, part of the old Blackfriars' Monastery site and abutting High School Yards. Shepard's print and at least one fine painting remind us of this gracious and elegent building, the only known relic of which remaining to us being that foundation stone, which currently rests by the platform in the Meeting Hall.

Andrew Duncan must have been one of the most familiar figures visiting the Medical Hall which he was largely instrumental in planning and where he must have overseen the Society's accounts as its treasurer and frequently offered advice and counsel to his younger colleagues as one of the Society's oldest and firmest friends. Here it was that the discussions must have taken place which culminated in the Petition for the Royal Charter which included the phrase: "That the Society, by contribution of the Members, have gradually made a collection of Medical Books, which is daily increasing..." The Charter was granted in 1778: it is the Society's title to its privileges as a corporate body - it does not, as it is sometimes thought entitle the Society, properly called the Medical Society of Edinburgh, to call itself the Royal Medical Society, although the latter title is sanctioned by long usage and custom.

The Medical Hall's immediate

Above: Shepard's print (1829) of the South-West corner of Surgeons' Square. On the right is the original Hall of the Royal Medical Society. On the left is Surgeons' Hall, while the building with pillars in the centre contained the Lecture Rooms of the anatomists Barclays and Knox. ***Previous page:*** *The former Royal Medical Society Library at 7 Melbourne Place.*

neighbour on the west was the Royal High School and the Society's minutes record many complaints made to the Town Council demanding payment of the cost of repairing windows broken by the boys. Imagination might allow us to wonder if some shattering of glass might have originated from the youthful hands of Walter Scott, Henry Cockburn, Francis Jeffrey, Henry Brougham or Alexander Monro Tertius. Perhaps some of history's tantalising gaps are best left unfilled.

Addison, Bright, Hodgkin, Hastings, Simpson, Syme, Christison and Darwin all knew the Medical Hall, but before Lister's name was added to the roll the Society had moved to a new home. The Society was 'about to be hemmed in by the Infirmary improvements; the access had become intolerable, and there was no longer space for [its] admirable library ... now amounting to 14 000 volumes selected with care unexampled in any other institution.' By now the Society's library would include works by its own members and teachers, many of them donated and suitably inscribed - volumes by and from William Cullen, James Gregory, Charles Bell, Benjamin Rush, Andrew Duncan, Mark Roget and William Withering among them.

In November 1852 the first meeting was held in 7 Melbourne Place, a tenement

building on the site of Gourlay's House in Old Bank Close. The exterior was surmounted by a fine stone eagle, still in the Society's posession and alleged to have been a relic of earlier use of the premises as Prussian Consulate. Here in Melbourne Place (the site now covered by Lothian Region's Council offices, but suitably marked by a wall plaque) the Society's business was carried on by Lister, the Bramwells, Chiene, Phillips and Dunlop and many other men of lesser fame but perhaps of equal worth.

In the early 1960's (shortly after women were first admitted to membership of the Society) 7 Melbourne Place was subject to a compulsory purchase order and the Society was forced to move out of the Hall it had inhabited for more than a hundred years. Thanks to the generosity of the Royal College of Surgeons premises were made available at 3 Hill Square, and here the Society moved in 1966. The Society appealed for funds to acquire a new home but the proceeds of that appeal, though generous, along with the money raised from the sale of Melbourne Place, were insufficient for the purchase of a new building.

An ad hoc Library Committee was set up to discuss the possibility and indeed the advisability of selling the library in order to raise further funds. It was finally decided that the Library should be auctioned by Sothebys in London.

A number of important conditions were made : the unique and valuable collection of Dissertations (some 168 volumes) was to be retained, along with any volumes not duplicated in any of the medical libraries in Edinburgh, and in addition a small collection of 300 or so books to represent the core of the Library of which we were about to dispose was to be kept. This small historical selection was to mirror as far as possible the history of the Society.

The auction of the RMS Library went ahead at Sothebys in 1969 and the six day sale, which was one of the most important sales of medical books on record, raised the very large sum of £120 000, thus effectively securing the Society's move to a new home.

The Society moved to its new home in the Student Centre in Bristo Square in 1975. The residual historical collection of books was stored in the University Library until in 1979 the RMS Trust generously provided three handsome lockable bookcases for the Low Room and underwrote an extensive programme of rebinding so that the books could be returned to their rightful home in a condition which enabled them to be handled, admired and cherished as part of the heritage of the Society. A number of volumes, unique to Edinburgh, continue to be held in the University Library on permanent loan. The books in the Society's rooms, though small in number, is still an important historical collection, the representative of our once very extensive library. The Collection now consists of our Dissertations and 334 volumes in our own care, with a further 51 volumes in the University Library.

In 1977 the Society kindly invited me to succeed Dr Robin Thin on his resignation as Honorary Librarian. This continued and continuing association has given me immense personal pleasure in the opportunities it has provided for making new friendships and reviving old ones, and that, along with continuing to be a sudent and decent conviviality are what I think the Society should be all about. I still can't decide which side I'd have supported at Prestonpans!

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The Medical Faculty Ball

The R.M.S. was in charge of this year's "ball of the season", on Valentine's Day, in the Assembly Room's. As usual it was a best seller with most of the 770 people buying their tickets in the first week of sales.

The organisation of this monumental task was taken on by the ebullient, but lovable, Edi Albert; ably assisted by a team of intrepid helpers.

One of the changes made this year was to introduce a couple of speeches. We are very grateful to Professor Carter for accepting the challenge of speaking to such a rowdy bunch - he felt a bit like an old lamb on the way to the slaughter when he heard the reception that Edi got. Still he rose to the occasion and provided a very amusing and well received address (for those that listened!!)

Following the dinner the entertainment for the evening started, a wide range of music was enjoyed including a ceildh (with the dance floor packed out); Sophie Bancroft sang

with a jazz band, while "Zoot & the Roots" provided a funky alternative. A new attraction this year was a ca-

sino, the proceeds from this will go to charity.

Several of the prizes have not yet been collected from the R.M.S. office. Those people are: Tam Evans, David Newton, Alison Lewis, Robert Lim, and someone called "Watson".

Finally many thanks to everyone who helped with the organisation, and to those who came along. Hope you enjoyed it!

FROM THE INSIDE

We are often told, "You don't know what it feels like." This is often true, to imagine the plight felt by someone facing the consequences of a terminal illness will more than stretch empathy. Edinburgh medics face a newer, more intense form of this human misery, a cohort of young, vital people, cornered by drug addiction and threatened by AIDS. We present here a moving letter sent to RES MEDICA by a local drug user with HIV.

There is no "philosophy" behind the taking of drugs and no one with any intelligence would suggest otherwise. Therefore it is indefensible. One cannot justify a personal vice with no basis for defence.

So, as a drug addict who who has come to realise this, I am distressed to discover day to day consequences of the fact. I am a drug addict. From this I know certain likely things about my behaviour, and even mode of thought, under certain specific circumstances. Naturally these circumstances have to do with the availability , quantity etc. of drugs. So when drugs are at issue I can say reasonably accurately how I will think and behave. This is so partially because under such circumstances my behaviour and its motivation are greatly simplified.

A problem arises when I myself misinterpret, or simply refuse to see how my behaviour is changed, or even that the circumstances required for the change currently exist.

But there is another problem, more insidious and less often recognised; others, particularly the medical profession, are also aware of an addict's behavioral peculiarities, and so believe that they too can predict and somehow even control the addict because of their knowledge of typical behaviour. But they forget that any prediction is only possible when drugs are indeed the point at issue, and that outside of an addiction a drug addict is, like everyone else, complex, varied and motivated by an endless variety of variables. This later problem is particularly dangerous and widespread because it has become a mental habit which most of society as well as the medical profession share.

It is frequently forgotten that drug addiction only exists because society at large makes the drugs and distributes them. Of course the manufacture and distribution of drugs is essential to modern medical practice, but that is not the fault of the addict who is presented with drugs from the earliest possible age as commodities which will make him feel good (take away the pain, allow sleep etc.) and which are available in one form or another through millions of outlets.

Behind this is a huge pharmaceutical and research industry, both of which it is in the medical practitioner's interest to maintain

and enlarge. This is not to say that I endorse the conspiracy theory; the facts stated above may be regrettable but they are nevertheless undeniable. Nor is it my intention to suggest that the incalculable benefit derived from pharmacology is in any way morally wrong. All I would urge is that these facts create conditions for the existence of addiction and that those afflicted by it cannot be blamed for this. Such things simply *are*, and there is no point in despising the inevitable result. The problem must be seen in context and then tackled.

When AIDS came along it was viewed in the same terms, except that it was fatal (sympathy vote), and because it had already a separate, easily identifiable sector of society and so addicts could not, as homosexuals briefly were, be blamed for bringing the disease into the Western world.

The big and vocal homosexual organisations of the cities, after a long well fought and fluently articulated fight succeeded, to some degree, in convincing the world that AIDS was not of their making and that they were capable of greater restraint and social responsibility than the straight community. Drug addicts are generally not well organised, and seldom have funds. Seldom are they fluent or even capable of understanding their own predicament; whereas for "gays", AIDS *is* the predicament, for needle users, it is just another unpleasant side-effect of a malaise which will ruin their lives and kill without the addition of a fatal virus.

So, while heterosexuals continue to indulge in unsafe sex of unimaginable, though protected kinds, and almost everyone carries on drinking, smoking, hang-gliding, rock-climbing, driving fast cars (sometimes drunk), and trying to live impossibly stressful lives at work or on the dole, but receiving deep sympathy, support and practical help by legislation, drug addicts are reminded that they are at *fault*. They are wholly responsible for what they have done to themselves, that continuing financial and medical problems, including AIDS, have afflicted them because of their own criminal and despicable social perversion. The most valuable of those to whom they should turn is the medical profession, but because of the already discussed attitudes ingrained in the profession, addicts cannot rely on the one body with power to really help them.

Medical professionals are guilty of inductive reasoning in this respect. They assume that because an individual has behaved in such a manner before, then he will necessarily do so again. This reasoning is manifestly false. More importantly, medical professionals, despite real expectations and protestations of enlightenment from others, like society at large, believe that the addiction is the addict's fault alone, that it could be given up - in the same way that the 19th century fathers believed that they could make their sons give up homosexuality - and that because the addict often behaves in an unpredictable manner when drugs are at stake, then he will probably extend such behaviour into every aspect of life. For example, "addicts are liars" is axiomatic; thus one cannot believe anything an addict says - ever.

Drug addicts - from those who were prescribed pain-killers and tranquilizers on long-term prescription and who did not even know exactly what the drugs were supposed to do, to the classic junkie, are like alcoholics in that they are always drug

addicts. If they are lucky then they are not using drugs at a given time. This whole homogeneous set of people must go through the same torment with grudging, inadequate help, if any, from the very set of professionals, experts and carers to whom they ought most readily be able to turn.

Until the underlying attitudes that make the addict so despised an object can be modified, there is little hope that help for those already afflicted will be as effective as it could be, and perhaps even less hope for addicts in the making; the Wellcome Foundation and the G.P. are pushing paracetamol linctus into the same mouths which could be receiving AZT in the future.

This letter is not a condemnation. Addicts, with or without HIV, need to be separated from their illness and treated like "normal people", as far as possible. We must learn to regard injuries and diseases which spring from addiction in the same light as we now see damage caused by a climbing accident - the unfortunate result of dangerous recreation. Please let us have no more withholding of sufficient pain-killers from addicts in car-accidents lest they might enjoy the dose. Let us all get what we need.

Journalscan

This is a short collection of interesting items pertinent to medicine and science in general. It gives a taste of some of the current work in hand around the world. We would welcome any contributions of this nature, just a short chatty narrative of an interesting or amusing article that you have seen or read.

Breast Results ?

Edinburgh was one of the centres entered in the UK Trial of the Early Detection of Breast Cancer (TEDBC), the seven year mortality results of this huge trial have just been published (Lancet 1990; 335:241-6).

The main objective of this trial is to compare the mortality from breast cancer in areas in which screening was offered to that in other areas. Unfortunately the results after seven years are inconclusive, since the reduction in mortality(17%) is too small to be significant. This statistic includes in the study population all those women who were invited to attend a clinic for screening; only 61% attended initially and this number fell each year (to as low as 47.6% in 60-64 age group). This absolutely apalling attendance should be compared to Sweden where the response rate from women was 74%.

It is now extremely rare there for any women to present with advanced and inoperable disease in comparison to this country in which 35% of women fall into this category. Surely vast improvements are desperately needed in education, without this any full scale screening programme would be a vast, expensive disaster. It will however be several years before the final effects of this trial are measurable since the detection rate for cancer in the screened population was higher than in controls; hopefully a reflection of earlier detections in screened women. Perhaps it is still possible for some positive result to emerge from this extensive trial.

Just a Nibble...

On a slightly lighter note, a fascinating report on "Traumatic Love Bites" (Br.J.Surg. 1990, vol 77, 100-101) discusses some unusual problems! Given the choice, my advice to the reader would be to be bitten by a dog in preference; while dogs mouth's are normally sterile, the range of potential infections following human bites includes alpha-haemolytic streptococci and *Bacteroides* species.

Seven cases are reported, including a young man who presented with a bleeding neck. Although the bleeding itself was trivial the bite marks were deep enough to traumatise the external jugular vein. A second example was of a man with a supraclavicular, hard, non-tender mass with a central hole. On excision a broken plastic tooth was removed, this was later found to have originated from a love bite by a lady dressed as a vampire at a Halloween party a year previously!

Phaging Phat

The understanding of the aetiology of atherosclerosis has spawned a bewildering array of theories but no single causative method yet mooted has held much water on its own merit.

Two papers in Nature (1, 2) may have changed that. A group in Massachusetts have been working on scavenger receptors on macrophages found in atherosclerotic plaques which may lead to their accumulation of low density lipoprotein (LDL) from the blood. The receptors detect a change in the charge of LDL caused by the acetylation of lysine moieties on the particle, this effect is also mimicked by the oxidation of the complex constituents of LDL. Result the macrophages chomp up these altered blood components and become chubby little foam cells.

Trouble is that the oxidised lipoproteins might cause these corpulent corpuscles to release polypeptides to stimulate a local tissue reaction that is not best contained in the cramped confinement of an artery wall. That is just the start of the trouble... What is more, oxidised LDL seems to accumulate and transfer lysolecithin, an amphiphile, to arterial endothelial cells producing a selective unresponsiveness to endothelium dependant vasoregulatory stimuli *in vitro* (3) this closely equates to the vasoregulatory impairment observed in atherosclerotic vessels. Anyway, guess what can best oxidise LDL in the blood, yup, you gottit, cigarette smoke. Down the cancer stix guys.

1. Kodama, T. et al. Nature 343, 531-535 (1990)

2. Rohrer, L. et al. Nature 343, 570-572 (1990)

3. Kugiyama, K. et al. Nature 344, 160-162 (1990)

Heated topic

Well, I'm doing anaesthetics at the moment and have just been told about malignant hyperthermia, a potentially lethal condition which can be triggered by anaesthetics (or caffeine, ooerr!) in some individuals. It has an autosomal recessive or codominant inheritance and the condition gives rise to a sustained contraction of striated muscle chewing up masses of ATP and evolving lots of unwanted kiloJoules. Result the bod is cooked, and it tends to ruin the anaesthetist's usually unfettered day with a dead patient. Testing up to now has been by muscle biopsy, impractical in large numbers, but now there is the hope of a recombinant DNA technique to indicate susceptibility (1). The gene locus responsible has been localised to chromosome 19q12-13.2, quite a big chunk below the centromere, still it is a good start. Better still one group has found that the gene for susceptibility is snuggled up to a gene for a calcium ion release channel, perhaps even the two are the same. Sounds sort of positive to me, they also confirm that the gene that they are looking at is on chromosome 19, more specifically in the q13.1 band (2). Check it out.

1. MacLennan, D.H. et al. Nature 343, 559-561 (1990)

2. McCarthy, T.V. et al. Nature 343, 562-563 (1990)

Blue Genes

There is work afoot to perform human gene therapy in the US for children with the fantastically rare severe combined immunodeficiency who lack the gene for a deaminase which normally mops up toxins that destroy the immune system. Solution; readminister T-lymphocytes, the sort nobbled by HIV, that have been genetically repaired with the correct gene and then souped up with a

course of Interleukin-2 which gets them into a fighting fit state. The therapy may fail, give a temporary or even a lasting effect. We will never know if the Recombinant DNA Advisory Committee of the National Institutes of Health gives the trial the thumbs down. Peel your peepers.

1. Gershon, D. Nature (News) 344, 2 (1990)

Cold Comfort

Sniffling? 50% of colds are caused by rhinoviruses which enter cells via an interaction with a cell membrane bound receptor called Inter-Cellular Adhesion Molecule-1 (innovative eh?) or ICAM-1. A US group has chopped the intra-membrane and intracellular moiety off ICAM-1 and found that the sICAM-1 (soluble) will inhibit the cytopathic effects of rhinoviruses but not other viruses.

Wait though, the stuff has to be proved in vivo and then the problems of sensitivity to the new protein may cause anaphylaxis (immediate severe allergy, may be life threatening) or more sinister, may provoke an autoimmune response. Best is that it is a novel approach to the production of antiviral drugs that up till now have concentrated on koshing the bug after it has got into the cell.

1. Marlin, S.D. et al. Nature 344, 70-72 (1990)

Trial tried

Trials for a new drug to combat HIV have taken on a new guise in St. Mary's Hospital in London. The drug is dideoxyinosine (ddI) which inhibits reverse transcriptase, and, to date shows no advantage over AZT, the current drug therapy for AIDS victims. The trial is novel in that it allows patients to choose whether they may have placebo or not, this overcomes fears that drug trials may withhold therapy from some patients. Option A is a standard randomisation into placebo, low dose and high dose ddI groups, Option B just excludes the placebo group. Some patients are already booked into option A.

1. Aldhous, P. Nature 344, 95 (1990)

Chili chomping

A letter to Nature mentioned that research in remote areas can be hampered by animals chewing cables and equipment. In Britain the critters would probably be shot, poisoned or electofrazzled, however workers in Alaska devised a more subtle and devious ploy. They sprinkled 'Tabasco' sauce onto the installations, lo and behold no more technochomping, it seems that wildlife is incapable of the 'hedonic shift' present in crazy humans who gulp gallons of the concentrated nerve poison.

1. Nelson, F.E. Nature 344, 115-116 (1990)

Blood Feud

Interesting things have been happening in New York with regard to patient rights. A Jehovah's Witness was given a blood transfusion against her wishes after a massive post-partum haemorrhage on the basis that her child would be harmed through being deprived of her care. S'prise, s'prise, she took it to court and won the right not to have had a transfusion in that other family members have been deprived of the opportunity to show that they could have cared for the child should the woman have died. Confused? I think they all are. It is now an absolute 'right' in New York to refuse a blood tranfusion.

1. Charatan, F. BMJ 300, 491-492 (1990)

Whiter than White?

It seems that some of the ecoconcern of the modern world is tripping over itself rather. Modern washing methods are energy-conscious, low temperature and environment-friendly, low tripolyphosphate. All well and good, but the wily Italians have shown that our sox and undies et al. can develop the most tenacious collections of organic gunge on a microscopic level. What the eye cannot see etc. But the bugs and greublies don't care, it is their first foothold to gnashing the fibres and jumping onto warm and moist bodies. The main problem is to get an adequate detergency to scoop the gloop and reduce the bug farm on your wardrobe without turning the rivers into algae holiday homes and stagnating lakes.

1. Dixon, B. BMJ 300, 528-529, (1900)

Choleconfusion

I was just in the States (gloat) and I noted an intense interest to reduce salt and cholesterol intake and stuff as much bran in as could fit. That's OK, but it was pathological in some parts of the country, 'You can tay'll when th'yrall from California 'cos th'yall ask for caffeine-free herbal tea and vegetable flakes.', quote from New Orleans waiter. Well studies show that lowering cholesterol intake has a minimal effect on blood cholesterol levels and that high bran diets, or low fibre wheat supplements for that matter, lower cholesterol concentration by the same amount, simply by the fact that the subjects reduced their intake of cholesterol and fat while on the supplements. What can we do. The old story...sensible eating, less saturated fat an more fibre. Cut the overkill folks.

1. McBride, G. BMJ 300, 560 (1990)

Coffee Crisis

Well it *is* certain that high blood cholesterol correlates with a raised risk of coronary heart disease, it is now becoming certain that coffee consumption has a relationship with raised plasma cholesterol concentrations, and more...

A recent study has examined death from coronary heart disease and related this to coffee consumption (1). There is a clear correlation, but worse than that the effect due to coffee seems to be a little, but significant, bit more than the cholesterol raising effect alone.

So, while I remonstrate over the rim of my cup about cigarette smoking, I am now left with the potential consequences of my own vice of >9 cups of treacle like coffee a day. I must move onto tea. I have one theory why Scandinavians drink so much coffee, its because they make such awful tea. Ignorance! you might say, but how would you like tea made in a filter coffee machine?

I said there was more...Another group is suggesting a link between parental coffee consumption and the genesis of insulin dependant diabetes mellitus (2) some demon drink this!!

1. Tverdal, A. BMJ 300, 566-569 (1990)

2. Tuomilehto, J. BMJ 300, 642-643 (1990)

If you have a contribution for Journals*can* send it to the RMS office for the next issue addressed to the Editors, Res Medica and see your name in print.

What goes on in the Low Room??

Well, here it is ... the chance to find out what has really been going on behind those mysterious doors. I'm talking, of course, about Council and Trust meetings.

For those not familiar with the set-up in the RMS, the Trustees look after the Society's investments and control the purse strings so that the vast sums of money required to run the RMS are available.

There have been a few changes in the Trustees this Session, with Professor Calder and Mr Macnicol taking on the job and with Dr Montgomery becoming Joint Treasurer. We are very pleased that they have accepted their posts.

One of the major decisions this year is that the Appeal Fund is to provide bursaries for Society members undertaking an intercalated Honours year. Watch this space for further details. It is also hoped to provide more money for the Travel fund, and this along with the Cross Trust award (£1000 for each block) makes the future look good for prospective elective students.

A problem that both Council and Trust are trying to address is the ever-increasing cost of running the Society. You can do your bit to help by turning off all those lights and by making sure the library books stay in the Library!

Council is the student group who run the RMS on a day-to-day basis (with AP's help of course!!). Apart from the usual events such as the Inaugural Address and Annual Dinner, we organised the Medical Faculty Ball this year (and a good night was had by all!). We have also acted as host for a series of open days for prospective medical students, and have been involved in the curriculum review meetings - to make life easier for the prospective students when they get here.

On the material side of things the Computer Assisted Learning equipment has arrived and should be installed in the Audio-visual room soon. The new-improved photocopier is doing good business in the office too.

We are also doing our best to re-educate the medical publishing world with a number of student groups meeting with representatives of Churchill Livingstone. This is proving interesting for both sides.

Well, I think I have just used up my space. A final word must go to thank those involved in resurrecting Res Medica. Good work!

Aileen McKinley
Praeses

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