Dying in Plain Sight

Let’s notice what nobody mentioned; we saw the Queen going through the ordinary stages of dying. As her body wearied, she needed to ration her energy, reduce her public engagements and delegate some tasks. But her mind remained crystal clear, her famous sense of humour undimmed. The changes began slowly. We realised that she was less energetic each year. This is the stage of dying when life expectancy is still usually measured in years. After Prince Philip died she was noticeably more tired, her appearances less frequent, her energy less reliable. Losing weight, walking with a stick, changing month by month, a stage that usually indicates life expectancy is measured in months.

She began to make clear her wishes. Charles’ wife was to be Queen Consort. The second in line, William was to move to Windsor. Her dresser and friend was to join the Royal household as her daily companion. Strength failing she had tasks to complete, managing to join some of the long awaited Platinum Jubilee celebrations. There was a new Prime Minister to be appointed, weeks in the making. She hung on. Many people do this, living longer than expected in order to see someone special or to celebrate a last important occasion or hear longed for news. Once at her beloved Balmoral, the break in tradition to ask the outgoing and incoming Prime Ministers to attend there was a sign that she was now too tired to travel.

Missions all accomplished, arrangements within the family in place, constitutional duties complete her energy was spent. Even as the family were gathering it was clear that she was in the last part of dying. She has demonstrated the phases of ordinary dying to us all.

How dying is mainly living after all. And how in the end we can all plan ahead, address the unfinished business in our lives and die with symptoms well managed, even in our own bed if circumstances permit. Dying in plain sight, camouflaged by briefings about mobility issues and medical advice to rest. Like anyone else the Queen was entitled to some privacy about her health and to die away from the public gaze. But we all saw the process..

Rest in peace Ma’am

Dr Kath Mannix graduated in Newcastle in 1982. She spent her career as a palliative care consultant. Her first book, With the End in Mind was featured in the autumn of this newsletter. Her second book, Listen, came out in paperback earlier this year. When Her Majesty Queen Elizabeth died Kath posted her reflections on social media and within a very short period of time it had 2 million hits.
Blue plaque unveiled to commemorate the life and work of Dr Dorothea Sinton

On Friday September 23 a commemorative plaque to Dr Dorothea Sinton was unveiled on the house in North Avenue, Gosforth where she lived as a young married woman. The Mayor was invited to perform the unveiling and as I was probably the last and oldest family planning doctor in Newcastle who remembered Dr Sinton I was asked to say a few words.

In the 1920s the subject of birth control was in its infancy. It was regarded by many as being on the very fringe of respectability and opposed by some on religious and moral grounds. In those days there was no NHS with its access to free medical care, no oral contraceptives or intrauterine devices but there was poverty and deprivation in many large cities of the country.

In 1929 Mrs Tamplin, a representative of what was to become the Family Planning Association, visited Newcastle with the intention of opening a clinic. She found four premises but her two major problems were to find a doctor and a nurse who were prepared to work in what was considered to be a very controversial clinic and secondly she needed financial backing.

At that time Dr Sinton, a Liverpool graduate, had recently married Mr John Harold Sinton and moved to Newcastle. She was a founder member of the Soroptomists, a champion of women’s rights and acutely aware of those women who already had large families but no access to contraceptive advice. She agreed to be the medical officer to the clinic. Finding a nurse was another problem which was solved by recruiting Mary Brookes, a fellow Soroptomist and they went on to work together for many years.

An initial donation of £100 was received from Lady Denham, a lot of money in those far off days and contributions from the Durham Miners Committee helped to get the clinic started.

The clinic itself found premises in an old pawnshop on Scotswood Road which was in a very run down area of the city. It was rat infested and all hot water had to be heated on a primus stove. There was no electricity. It certainly would not have met the stringent Health and Safety measures of today!

From the outset Dr Sinton received hate mail and threats, one directed at her husband when she was told that his reputation and his law firm would suffer if she continued with her work. Happily Mr Sinton was a very supportive husband and neither he nor his law firm suffered any ill effects.

It is interesting to note that one of the recurring expenses of the clinic was for replacing the glass in the windows damaged by protestors throwing bricks.

In 1934 the clinic moved to Shieldfield Green with greatly improved facilities. About that time Dr Sinton wrote to the Professor of Obstetrics and Gynaecology offering to talk to medical students about contraception and its need. She received a curt and very rude reply telling her not to bother him again and he had confined her “filthy” letter to the dustbin!

As the Lord Mayor was unable to attend, the Sheriff in full regalia including magnificent chain unveiled the plaque. Dr Sinton’s granddaughter Joanna shared her personal recollections of Dr Sinton as a granny.

It is inconceivable how attitudes and opinions on the subject of birth control have changed since Dr Sinton opened that clinic in 1929 and it is thanks to the Newcastle Soroptomists for organising the plaque to commemorate this pioneering woman who was never deterred by the many obstacles put in her way.

Dorothy Tacchi
Professor David Bates guest lecture at the AGM

A Neurological Detective Story

The Detective story has existed as an entity for more than 150 years. Some would claim the title of originator of the genre for Edgar Allen Poe who wrote of the amateur detective, Monsieur C. Auguste Dupin in The Murders in the Rue Morgue in 1841.

But the first true detective story, The Moonstone, with Sergeant Cuff as the detective was written by Wilkie Collins in 1868 (right) and the system of meticulously searching for clues, avoiding red herrings, excluding the impossible and identifying the only possible culprit, no matter how improbable, continues to intrigue to the present day.

In that same year of 1868, Jean Martin Charcot of Salpetriere in Paris first described Sclerose en Plaques which was anglicised by the New Sydenham Society, the publisher of his lectures, into Disseminated Sclerosis; in the 1950s it was amended by consensus to Multiple Sclerosis (MS) and continues to intrigue and puzzle into the twenty-first century.

King’s College, University of Durham and subsequently the University of Newcastle, Newcastle University, and now “NU” has a long and continuing role in exploring the enigma that is MS. The pathology of the disease involving loss of the insulating myelin from the neuronal conducting fibres or axons, originally described by Carswell in Edinburgh in 1838 and confirmed by Cruveilhier in Paris in 1841, was elaborated in the 1970s by the work of John Prineas, an Australian neuropathologist who worked with Henry Miller in Newcastle before moving to New York where, with the use of modern techniques in microscopy, he described the earliest invasion of the central nervous system (CNS) by aggressive T-cell lymphocytes from the circulation.

John later moved back to Sydney University and still recalls with pleasure his formative years in Newcastle upon Tyne.

At that time, largely due to extended use of the “animal model” of Experimental Auto-immune Encephalomyelitis (EAE), MS was thought to be caused solely by T-lymphocytes despite the long established diagnostic test with Lange Colloidal Gold Curve on cerebro-spinal fluid, a phenomenon which relies on the presence of the protein gamma-globulin, primarily antibodies, in the fluid indicative of B-cell activity.

This old test remains seminal in the diagnosis of MS in the 21st century but the eponym has been dropped and, with the use of immune-electrophoresis, is now refined and shows the protein as oligo-clonal bands (OCB) of Immunoglobulin G (IgG).

Subsequent pathological and imaging studies improved our knowledge of the cellular injury caused in the acute attack, not only to the myelin insulation of the axons but also to the conducting fibres or axons themselves, the former can be repaired, the latter damage is permanent thereby explaining the potential for recovery from relapses in most patients but the possibility of persisting disability after any relapse. The relapsing and remitting disease seen in most people with MS (RRMS) is explained by this temporary inflammatory damage to the conducting pathways, followed by repair of the myelin sheath and recovery of function. This knowledge of the acute pathology also explains why some relapses do not recover, or only recover partially. One of the unanswered pathological questions is what causes the slow deterioration, without evident relapses, seen later in disease in many people as secondary...
progressive MS (SPMS) and, in a small number from the outset as primary progressive MS (PPMS). A partial answer has been provided by two research fellows, Phillip Nichols and Helen Andrews, from the department of neurology working in Sir Douglass Turnbull’s laboratory who showed a massive increase in mitochondria in demyelinated axons, implying a large increase in energy needs and consequent death of the neurone and axon by exhaustion.

To define the cause of MS, we must understand and investigate those factors which may be involved, recognising that some which appear important may be “red herrings”. For example, most of the earlier suggestions of infection with spirochetes, bacteria and rickettsia which were prevalent early in the 20th century were soon disproven. During the past 150 years investigation into the genetics, the environment, and the immunology of the disease has been performed by many researchers and is the most productive area.

In the 1970s a relationship between MS and the Human Leukocyte Antigen (HLA) system was demonstrated by colleagues in London and confirmed by studies in Newcastle with Professor Roberts from Human Genetics. It was soon recognised the most important allele lay on chromosome 6 and two important genotypes were identified. During the past 50 years millions of pounds of research money have been spent world-wide studying the genotypes of thousands of people with MS and comparing them with a control population.

We now recognise more than 150 genes associated with the disease but HLA remains massively the most important. No individual gene or combination of genes identifies an “MS genotype” but recent research suggests epigenetics, that is minor and temporary changes such as methylation of individual genes, or changes in messenger RNA, may play a role in defining the unpredictability of phenotype in each person. This may also explain the intriguing finding that though MS is often seen in two generations of a family, and rarely in three it is not recognised in four successive generations. Nonetheless, genetics alone only accounts for about 25-30% of the causation of MS therefore “Nature” is not the whole answer. So much for Nature, what of “Nurture”?

Epidemiological studies of MS began with Sir Byron Bramwell, one time neurologist in Newcastle, who reported in 1903 a high prevalence of the disease in the North of England and Scotland, and were extended by Charles Davenport in the USA who noted higher frequencies of MS in the Northern States as troops returned home after the 1914-1918 war. Important contributions were made by Henry Miller and Kurt Schapira in Newcastle in the 1950s when they reported a high prevalence of the disease in the North East of England and some intriguing “hot spots” in villages in Northumberland and Durham with familial and conjugal cases of the disease, raising the possibility of an infective cause. Their studies and others around the world confirmed the high prevalence of MS in temperate climates and in people of Caucasian origin but were bedevilled by the movement of people and populations. Yet this migration of individuals and groups can be useful and studies of population movement suggest the risk of developing MS in a population may be established early in life, certainly before the age of puberty.

This, together with other studies of the disease in apparently naive populations raises the possibility of an infective or environmental precipitant for the disease; Epstein-Barr virus (EBV) is most likely candidate for the former; Ultra-violet light and vitamin D for the latter.

The most important clue in the causation of MS is the immune function of the individual and much of information in the last thirty years has arisen from studying the results of clinical trials with many immuno-active agents. Henry Miller ran one of the first controlled trials in MS in 1953 when he gave ACTH, the precursor of
cortico-steroids, to patients in exacerbation and showed they improved more speedily than a control group. He later, in 1961, reported a less successful but more aggressive trial of tuberculin given intrathecally; the beginning of the concept of altering immune function as the target of therapy. In the 1970s it was reported that diets high in animal fat and low in polyunsaturated fatty acids (PUFA) increased the risk of the disease.

In searching for environmental effects on the immune system we, David Shaw, Niall Cartlidge, Peter Fawcett and I, together with junior colleagues gave polyunsaturated fatty acids in high dosage to patients and showed some small benefit over a three-year trial, probably due to their effect on the immune system as precursors of prostanoids.

We co-operated in these studies with colleagues in Belfast and London, Ontario where a former Newcastle colleague, Don Paty, ran the equivalent Canadian trial. He had the advantage of the new technique of Magnetic Resonance Imaging (MRI), the beginning of objective measures of disease.

The chief lessons from these trials were that the existing measures of disease activity, exacerbations and disability, were not ideal and the natural history of MS is so slow that observation must be continued for years and involve large numbers of patients. We had to learn, as Robert McNamara said, "To measure what matters, not to make what can be measured matter" and to develop multi-centre studies.

In the early 1980s it was suggested that hyperbaric oxygen alleviated symptoms and disability in MS on the basis that the recognised peri-vascular siting of the lesions was likely to be helped by reduction of ischaemia. Newcastle was well positioned to explore this possibility thanks to the huge hyperbaric chamber belonging to Professor Dennis Walder in the Department of Surgery.

He was most obliging and allowed access to his machine so we were able to treat or give placebo to twelve patients at a time and enabled us to achieve results well before colleagues in London, Ontario and Sweden using single patient machines.

All three studies showed there was no effect of such treatment, yet hyperbaric chambers remain available, at a price, in the UK and we learned the lesson of the futility of scientific studies in the face of heartfelt belief in a therapy and persuasive advertising.

Sadly, but understandably there have been many red herrings in the field of “cures” for MS; treatments such as arsenic, the “Russian Vaccine”, snake venom, and foetal stem cell injections; all failed to be confirmed.

Therapeutic trials in MS took a huge step forward with the improvement in Magnetic Resonance Imaging (MRI) in the 1980s. For the first time small lesions in the brain and spinal cord were visualised in life with a technique which was non-invasive and could be repeated to monitor disease in the individual. The only problem was the cost of such machines and testing which meant that future trials needed support from “Big Pharma”. In 1993 the first dramatic MRI evidence of a significant effect of Interferon beta, an anti-inflammatory agent, led to the first licenced therapy and gave rise to many studies of immunoactive treatment with other interferons and potential blocking agents.

There was concern, within the UK about whether such therapy was cost effective and the NHS, with Big Pharma, funded a huge Risk Sharing Scheme of the Interferons enrolling thousands of patients.

Newcastle was the major contributor to the study and my successor, Dr Martin Duddy, is now lead author of the papers publishing the results of that trial which, despite early uncertainty, have now clearly confirmed the benefit and safety of early treatment with interferons and glatiramer acetate.
As the 21st century dawned three important events occurred which affected the interpretation and development of clinical trials; the criteria for MS diagnosis were redefined to include early MRI changes; pathologists discovered the importance of B-cell lymphocytes in MS which had been overlooked for a century despite the longstanding recognition of Oligo-clonal bands in the Cerebro-spinal fluid of people with MS; and dramatically effective immune-therapies were developed. The changes in diagnostic criteria made the natural history of the disease appear to change, becoming less severe and making assessment and comparison of therapies less easy. The recognition of the importance of B-cells paved the way for new potential therapies, and the development of mono-clonal antibodies directed against specific receptors provided more effective and rational therapies. More of the underlying immunological causes of MS are now identified, and two variants of inflammatory demyelination, Devic’s Disease or Neuromyelitis Optica (NMO) and anti-myelin oligodendrocyte glycoprotein syndrome (anti-MOG) have been shown to be antibody mediated, respectively due to anti-aquaporin 4 and anti-MOG with different pathologies and responding to different therapies. We now have very effective therapies for MS; one monoclonal antibody blocks the entry of immune cells to the central nervous system (CNS), another suppresses both T- and B-cell precursors in the marrow, and a third specifically targets B-cells. There are novel small molecules which alter intra-cell signalling, and others which block T-cells within lymph nodes, along with more traditional cyto-toxic agents. Recently success has been shown with Autologous Hematopoietic Stem Cell Transplantation (AHST).

But all aggressive immune therapies carry potential risks such as opportunistic infection, neoplasia and disorders of the immune system and the problem now is in identifying which patient should receive which therapy; today’s physician must assess the risk-benefit ratio for each patient, and at each phase of the disease. We are limited by the fact that someone with aggressive disease causing many lesions within the cerebrum may not be as affected or disabled as a person with only a couple of lesions one of which is in the cervical spinal cord causing tetra-paresis. We still lack biological markers in terms of clinical findings, imaging, genotype, or molecular measures that will define which person is likely to have benign and which aggressive disease. We now know much more about causation and have much better treatments for MS than we had thirty years ago, and yet our detective story does not have a denouement. But remember, some famous detective stories are unfinished like that written two years after The Moonstone, The Mystery of Edwin Drood by Charles Dickens.

Biography
David Bates was born and raised in Sunderland where he attended Monkwearmouth Grammar School. He was a Scholar at Downing College Cambridge and qualified with a First in Tripos and a Distinction in MB BCHir. After house jobs at the Middlesex Hospital and RMO at the National Heart Hospital he became SHO to Henry Miller, David Shaw and Peter Hudson at the RVI in 1970. He was locum First Assistant in Medicine to DNS Kerr in 1973, then a Harkness Fellow at the Mayo Clinic, before becoming First Assistant in Neurology in 1976. He was appointed Senior Lecturer in 1977 and awarded a Personal Chair in Clinical Neurology in 2001.

He was Chairman of the MRAC to the MS Society of GB and NI from 1989-1995 and served on the Advisory Committee of the International MS Society until 2010. He was Chairman of the International MS Forum from 1993 to 2006 and Editor of the International MS Journal. He was Convenor, then Chairman of the Joint Committee of the Royal Colleges on Brain Stem Death and the Vegetative State from 1995-2002.

He retired in 2010 and has since attempted to reduce his golf handicap, walked in the Lakes, and undertaken heavy gardening chores at the behest of his wife, Linda. His three children are all doctors, in Primary Care, A&E and Cardiology.
From The Editor

Welcome to the autumn 2022 edition of the DNMGA newsletter, Issue 57.

It is slightly later than usual but never the less I hope you find something to interest you. The publication relies on you to submit articles or ideas for these. I will chase up any ideas which are sent. There have been several delayed reunions and we hope you will be able to spot old friends.

Once again we have a few obituaries which is one result of our ageing membership. We do get a trickle of new members and we would urge you all to seek appropriate graduates and contact Lawrence Bryson. We believe it is good value at only £10 per year.

We had our first AGM for three years in October, Peter Moran stood down as chairman and he has been replaced by Peter Wright, Dorothy Tacchi remains our President and I thank her for spotting opportunities for contributions to the newsletter. The future of DNMGA was discussed at the AGM and the committee will be looking at this in the forthcoming months,

He also had an obituary in the Daily Telegraph which included a reproduction of paintings which the physician Alastair Brewis had made to celebrate one of Hugh’s major birthdays. He was rarely to be seen outside without his dog and the paintings of Hugh on Embleton Beach really encapsulates the character of Hugh. I am grateful to Mary Brewis for allowing me to publish the paintings.

Hugh Brown spent his career as a plastic surgeon at the RVI. He graduated from Durham in 1949, He was a popular and well known figure both in the hospital and in Jesmond where he lived and in Embleton where he had a small bungalow for many years. He died 21st May 2022 and had a memorial service at St George’s church on Osborne Road and two eulogy’s are contained within this edition.

I have taken the opportunity to add (above) a photograph taken by a drone of the children of Embleton Primary School taken on the beach with their sand art depicting each class, orca, puffin, starfish and seal. Embleton Primary School is a small rural school which four years ago was threatened with closure as it only had 13 children. Today it has 72. More about this in a future edition.

Finally, Professor David Bates gave an excellent guest lecture at the AGM and a full report is produced within this newsletter.

Alan Craft (69) a.w.craft@ncl.ac.uk
**Obituary: Lesley Lord**

GP Halifax  
b 1943  
q Newcastle 1967  
DOBst RCOG,  
FFFLM,  
DMJ (Clin) Soc Apoth Lond,  
Died 25 June 2022  
Acute myeloid leukaemia

Immediately after qualifying Lesley Craft married David Lord. She organised her own GP training while following David, who was in the army. In 1973 they settled as GPs in Halifax. Lesley became a police surgeon and was the doctor on call when the Bradford football fire occurred. She had to deal with the identification of 56 bodies, and this led to her doing postgraduate training in forensic medicine, gaining the diploma in medical jurisprudence, and becoming a founding fellow of the newly formed Faculty of Legal Medicine of the Royal College of Physicians.

Music was a shared passion with David, and both were active in their local church. Lesley leaves David, two sons, and five grandchildren.

**Obituary: Shirley Emerson**

GP Durham  
b 1935  
q Durham 1958  
Died 13 April 2022  
Aortic heart disease and infirmities of old age

(Margaret) Shirley Emerson (née Atkins) was a Geordie from a family of pharmacists and the first of the family in medicine. She married David and together they served as GPs in Cambridge for 30 years. Their Mill Road practice was renowned for lunchtime meetings and constant filter coffee. Shirley founded Cambridge Advisory Centre for Young People and championed women’s and young people’s health.

She loved the company of family and friends, especially when cooking and Burgundy were involved. She walked across Scotland 14 times and ventured to the Himalayas. At 50 she started running marathons, participating in triathlons, becoming the national netball team doctor, and inspiring many women into sport. Predeceased by David in 2020, Shirley died at home and leaves four children and seven grandchildren.

**Obituary: Alan Lee**

Consultant psychiatrist  
b 1947  
q Newcastle 1976  
MA Camb, FRCPsych)  
Died 23 June 2022  
Cerebrovascular Accident

Alan Lee qualified in medicine by a circuitous route. Having obtained a scholarship to Cambridge in mathematics, he changed to philosophy and psychology and then became a probation officer in County Durham, before entering Newcastle medical school, where he qualified in 1976. After junior hospital appointments, he trained in psychiatry at the Maudsley Hospital, where he conducted a landmark long term study of depressive illness.

He was editor of Advances in Psychiatric Treatment and a book editor of the British Journal of Psychiatry. He was an honorary senior lecturer at Nottingham Medical School and a postgraduate trainer and examiner.

He was an honorary adviser to Samaritans and Nottingham Relate. Alan leaves his wife, Helen (née Meade), an adult psychodynamic psychotherapist and former nurse.
Michael Thompson graduated in 1976 and went on to be a surgeon in Bristol. He asked his great nephew, Elliott, a first year medical student in Newcastle to reflect on his first semester

My First Semester

Overall I have thoroughly enjoyed my first Semester studying medicine. It has been filled with variety and has been both challenging and rewarding.

We started the semester with some of the basic get to know all the staff and how the med school works, followed up by some rather awkward forced icebreaker sessions for students to get to know one another and bond. It didn’t have nearly as much effect as meeting other med students whilst on a night out!

After the initial introductory week, we leapt straight into our foundation lectures which covered some of the basic scientific principles we would need throughout the course such as an introduction to pharmacology and pharmacodynamics, a very brief introduction to anatomy, some basic genetics, cellular biology, infection and finally some nervous system lectures. Alongside these lectures we had seminars regularly that covered topics such as communication skills, professionalism, medical ethics and basic history taking (involving practice with volunteers).

Three weeks in we began the Case based learning approach which is the structure that we would use throughout the rest of the course. It is an approach that I personally quite enjoy as it takes a case (for example our first case was hypertension) and it broadly covers multiple aspects of the case, we learn clinical skills, anatomy, physiology, mechanisms involved, how to diagnose and treatments. The main methods for learning were the lectures and the self-directed learning, the latter being online and done remotely from pre-made resources and recordings.

To provide more detail, with our first case being hypertension we learnt how to measure blood pressure and what the readings meant, how to examine pulses, we learnt about heart and great vessel anatomy, we covered blood vessel physiology, mechanisms controlling arterial blood pressure, the formation of atheromas, which antihypertensive drugs should be used (and the variability in response to them as well as some pharmacokinetic calculations) and finally other treatments of hypertension.

To compliment the case-based approach we also covered some more general topics such as clinical reasoning and health inequalities that weren’t case specific. We then transitioned nicely onto myocardial infarction as a case and again covered a wide range of topics that were all related to MI, both practical and academic. Overall, we did five cases in our first semester, those being: hypertension, MI, kidney disease, anaemia, diabetes.

As mentioned before, alongside the lectures and seminars we have regular clinical sessions and anatomy sessions. Like many others I was excited to go to my first clinical skills session (all sessions are in full PPE), only to find out it would be an hour of how to properly wash hands.

The clinical sessions after that were much more interesting, for example intravenous practice on the dummy arms, pulses examinations on our peers, first aid sessions and more.

The anatomy sessions were also in full PPE, in the first session they showed us some examples of the cadavers and organs we would be looking at as there is only prospection. The sessions aligned with the current case we were on, for example with our hypertension and MI cases we explored the mediastinum.

The final part of our course was our Early Clinical and Community Experiences visits. They consist of three GP visits and three Hospital visits in the year, so far, I have done one of each. The first was to the James Cook Hospital (one of the many that I could have been allocated to), we put on our scrubs and were given a tour of the hospital and some introductions to the various scrubs meanings and the staff within the hospital. We spoke to some recently discharged patients via video call and asked them some general questions to practice our recently learned history taking skills.

My GP visit was to the Burn Brea Medical Group in Hexham. We spent the day shadowing the GPs as they did their usual consultations and got the opportunity to go on a home visit.

---

Michael Thomson & Elliot Preece
On May 18th twenty medical graduates from Durham and Newcastle Universities, together with ten wives and husbands and one ‘boomerang’ in the form of Keith Baxby, who departed the year in order to obtain a B.Sc. and therefore graduated in 1968, met for lunch in the Great Hall at Jesmond Dene House Hotel to celebrate the fifty-fifth anniversary of their graduation.

I had thought to call Keith ‘prodigal’ but the true meaning of the word is ‘wastefully extravagant’ and one could never accuse anyone from The North of such behaviour.

In 1962 the medical curriculum was extensively restructured to break down the barriers between preclinical teaching and clinical teaching and between individual subjects, so that structure and function were taught as an integrated whole, and teaching was based on the systems of the body.

The graduates of 1967 had the distinction of the first year to be taught using the new curriculum.

As one of those graduates I believe that we had a training which was second to none and which taught a comprehensive, dare I say ‘holistic’, approach to those in our care.

In 1963, our second year, the federal University was dissolved and what had been King’s College, Durham University, became the University of Newcastle upon Tyne, allowing us to choose either a Durham or a Newcastle medical degree, hence “medical graduates from Durham and Newcastle Universities”.

Following an enjoyable and lively lunch the sun coaxed everyone into the hotel grounds for a group photograph and tea.

After the anxiety and deprivation of the pandemic and the continuing sadness of news bulletins, it was such a welcome privilege to be able to spend time in the company of good friends, sharing their news and memories but, most of all, enjoying the laughter.

Pat Pearson
The much anticipated “Golden Reunion” sadly postponed for a year due to COVID took place over the weekend of 17th - 19th June in Newcastle.

Forty one colleagues and guests attended out of a year of seventy graduates—a very convivial group. Friends arrived from all parts of the UK and some travelled from as far away as Perth Australia and Illinois USA!

The weekend tee’d off (so to speak) at Northumberland Golf Club where an intrepid group (four!) showed off their golfing skills! This was followed by a Celebratory dinner when the Golf Club catering did us proud.

We never stopped talking and drinking (some things don’t change!) One group even went to the wrong Golf Club but found us in the end! Almost the whole group were staying at the Malmaison Hotel on the Quayside and spent Saturday revisiting favourite haunts of 50 years ago—although in many cases unrecognisable— the Quayside being “out of bounds “in our day except for the more intrepid students.

The weather was kind and we reconvened at 6.30pm at Trinity House, Broad Chare on the Quayside for a Champagne reception and guided tour of the 16th century building originally constructed by the Charitable Guild of Seafarers to support the city’s growing maritime population—the original annual peppercorn rent being one red rose which was later increased to half a gallon of wine!

In 1576 Trinity House gained it’s first of seven Royal charters from Henry VIII and a school opened in 1712 to educate the children of mariners. Trinity House now enjoys Charitable status and is well worth a visit.

Dinner was an extremely lively affair with much reminiscing and proved that we have changed very little (apart from physically)! Personality traits of 51 years ago remain sometimes reinforced with age! Following a delicious meal in an ancient hall where the walls were bedecked with huge naval portraits and seascapes

Professor Sir Alan Craft gave a thoughtful and very entertaining address extolling the virtue of grasping an opportunity when it arises—you never know where it will take you in life. It has certainly taken him a long way! Alan’s after dinner chat rounded off a delightful evening.

We were extremely grateful to Alan and his wife Anne who had travelled from their home in Embleton Northumberland to be with us. Conversations and recollections continued along the Quayside and into the Hotel a short stroll away.

We gathered in Gosforth on the Sunday for lunch and eventually parted company with sad farewells and plans to repeat the process in four years time, we look forward to it!

Who would have thought that a meeting in Lecture theatre six 51 years ago would result in such deep lasting friendships, long may they continue.

Sandra Winterton
Eulogy of Professor David Bates remembering Hugh Brown

Newcastle Brown

I first met Mr Brown as a colleague when I came to Newcastle in the 1970s, I was a neurologist and Hugh held neurologists in low esteem. He claimed we listened carefully to our patient’s description of symptoms, then translated the symptoms into Latin and presented them back to the patient as the diagnosis.

We were later fortunate to have his daughter Catherine as one of the best SHOs in our department; Hugh’s comment when I told him of her success was that she must have learned Latin.

One of Hugh’s abiding passions was anatomy; I recall asking his advice about a man with a benign tumour on the sciatic nerve in the buttock, we called it a “neurofibroma”, from the Greek, not the Latin.

Mr Brown agreed to operate but explained the difficulty in approaching the deep lesion because each of the five muscles in the buttock runs in a different direction and if approached directly the muscles would be badly scarred and weakened. He had to divide each muscle along its length and repair each layer at the end of the procedure. The tumour was removed without damage to muscle or nerve and the patient returned to normal.

I learned of the early import of anatomy to Hugh when Professor John Davison described Hugh’s major role in the Anatomy Department in the late 1950s when he covered the interregnum between two Professors; Hugh was an excellent teacher who always made time for students by whom he was much admired.

He certainly impressed one student, a Miss Ann Crump from Durham whom Hugh, in true Geordie fashion, described as “the girl from the South”; she qualified, and Dr Crump became Mess President of the House at the RVI, she booked Hugh as guest speaker for each of the six, monthly dinners and became Dr Ann Brown.

Hugh’s renown in Anatomy spread beyond Newcastle, during his Fellowship at New York University in 1965 his chief recognised his ability and asked him to teach anatomy to the other junior doctors. He was so successful that he was invited back to NYU for many years to run the teaching course. He was also valued as an examiner in Fellowship at home and abroad. Most of my meetings with Hugh were over lunch.

In the olden days the Consultant’s Dining Room at the RVI was a welcome respite and venue to discuss cases and listen to advice and anecdotes from our seniors; Hugh was one of the stalwarts. After retirement he persuaded the administration to provide a monthly lunch for retired consultants served in a committee room off Peacock Hall. When this arrangement was withdrawn, he provided a new venue, at the Northern Counties Club, and became the organising secretary and unofficial chairman of this eclectic group of surgeons, physicians, pathologists, radiologists, dentists, psychiatrists, and even neurologists.

We spent many enjoyable lunches being regaled by Hugh with stories from his time as a student and his love of rowing, his National Service in the King’s African Rifles, which some of you will remember he described as a unique regiment, and as anatomist, surgeon, examiner, High Sheriff, Vice Lord Lieutenant, you can imagine his modification of that title, and Queen’s Honorary Surgeon.
He rarely spoke of his success as a surgeon but he was rightly proud of the team of surgeons, nurses and ancillary staff who made up the Plastic Surgery Unit based on Ward 5.

One story he did recall followed the groundbreaking hand replantation in 1977 when he recalled Mike Neville of the BBC interviewing the fortunate patient one year later and asking what she was going to do next; she replied, "Oh, now I'm having a baby thanks to Mr Brown".

One of Hugh's duties as QHS was to attend investitures and he was present when the wife of one of the recipients fainted, she was carried into a side room and Hugh, wearing his regalia, leaned over to help just as she regained awareness, she cried out at the vision in front of her and Hugh was concerned he had caused anxiety.

It was the practice of the Queen to have a word with the staff after the Ceremony and Hugh explained his concern at the lady's discomfiture. "Oh, don't worry" said HMQ "She will dine out on that story for years!"

Hugh was a most clubbable man and despite his increasing disabilities over the last few years he continued to organise the lunches at Northern Counties and ring round all attendees each month. Covid ended those meetings in 2020 and the last time I saw Hugh and Ann was when my wife and I met them ending their perambulations on the Little Moor in 2021 by which time he had considerable difficulty with mobility but remained stoical about his problems and in good heart with his wonderful sense of humour.

I shall close by quoting from a letter of condolence, this from Dr N R Rowell a fellow student and Emeritus Professor of Dermatology at Leeds: He wrote, "When I was President of the British Association of Dermatologists in the 1980s, I chaired a meeting in London and an American Surgeon asked me where I trained. When I replied "Newcastle" he asked if I knew Hugh Brown because "He taught me all I know about hand surgery"". I

There will be many surgeons and physicians around the world who owe a similar debt to the genuine "Newcastle Brown".
Eulogy given by Brigadier Banerjee at the memorial service for Hugh Brown in St George's Church Jesmond, 26 June 2022

Colonel Hugh’s military career started at medical school in the Officer Training Corps and continued at the age of 23 immediately following his house-jobs when he accepted his deferred National Service in 1950.

Following basic training at Royal Army Medical Corps Aldershot, much to his delight, he was offered a posting with the King’s African Rifles in Kenya as their medical officer. Responsible for the care of 750 Africans and their families, he was based in Lusaka acting more or less as their GP. He covered Child Health and Obstetrics whilst also learning the rudiments of Swahili and Chinyanja languages.

January 1952 saw the Malayan Emergency reach a peak with the assassination of the High Comissioner. The British government dispatched a force under General Templar to fight the guerrillas and Colonel Hugh deployed with 3 battalions of his African soldiers by sea from Mombasa to Bentong in the Malaysian jungle. He was the Medical Officer of a small hospital situated in a jungle clearing adding poisonous snake identification and tiger tracking to his CV. He experienced jungle warfare being tasked on occasion to go out on patrol to extract injured or ill people. The end of his tour saw a long sea passage home with him diagnosing meningitis and doing his first solo appendectomy enroute. He disembarked in Liverpool thus completing his National Service and was promptly presented with orders to report to Fenham Barracks where he joined First Northern General Hospital, Territorial Army. He served for 20 years in the TA ending his time as the Commanding officer from 1970-73.

Hugh enjoyed his tenure of command with the highlight being annual camps which were in BAOR, Germany where he proudly recalls his unit being the best in Europe at setting up a 1000 bed field hospital. Along with this feature of the cold war he was responsible for the emergency plans, to be activated for war with the Soviets, to move the RVI and NGH to a 1000 bed hospital at a secret site in Northumberland.

During his TA service he was appointed a Queen’s Honorary Surgeon providing medical cover for public engagements such as investitures and Royal garden parties.

The Royal appointments continued in later life when he was appointed Honorary Colonel to 201 Field Hospital by the Queen in April 1982 for a tenure of 5 years supporting Commanding Officers at Fenham Barracks. During this time, he was appointed as a Deputy Lieutenant to the Lord Lieutenant of Tyne and Wear representing the Queen at civil and civic engagements.

In 1992 he served as the High Sherriff to the shrieval county of Tyne and Wear representing the Sovereign in upholding all matters relating to the judiciary and law and order. This was followed shortly thereafter being the Vice-Lord Lieutenant from 1993 to 2002.

At the age of 75, after some 52 years of service to his Queen, his country and his region, Hugh retired from the formal element of public duty. On behalf of My Lord Lieutenant, the Armed Services and the people of the North East we acknowledge his outstanding commitment to society and express our sincere gratitude for his selfless dedicated service.
'All patients are entitled to a good doctor'.

Sir Donald Irvine
Blue Plaque

The Royal College of General Practitioners through their Heritage Committee have designated a small handful of GPs over the last 20 or so years as having a commemorative blue plaque to mark their achievements.

The late Sir Donald who died in 2018 was the latest to receive this honour.

Donald was brought up in Ashington in the family home at Lintonville which was also his father’s practice premises, working from his own home during a bygone era, He was central in driving a new vision for general practice based on training, quality and standards.

He was among the architects of modern general practice and ushered in the era of professional assessment across the whole of medical practice.

He kept in touch with what he felt were the essential requirements of general practice; the attributes of a good doctor and the centrality of the patient. He put this succinctly, ‘All patients are entitled to a good doctor’.

His passing diminished further the number of north-eastern GPs who were once considered the powerhouse of general practice thinking and whose influence stretched across the world during the 70s and 80s. Sir Donald will perhaps be remembered for being the first (and only) GP President of the GMC, from 1995 to 2002.

Dame Clare Gerada, current president of the RCGP attended a ceremony on 13th September 2022 to unveil the plaque.

Dr Colin Hunter, Chairman of the Heritage Committee spoke to outline the purpose of celebrating a very select number of Fellows of the College.

Lindsay Gillfinan, current senior partner in the Lintonville practice talked about his work in Ashington. Sir Donald’s eldest son Alastair was also in attendance and talked about growing up in the practice and finally Clare Gerada said some warm words acknowledging Sir Donald’s enormous contribution to medicine.
Tricia Cresswell and the post-retirement novel

When colleagues started talking about their plans for retiring, my flippant response was always that I would travel and write a novel. Family illness intervened and I ended up retiring two years earlier than the master plan, mainly so that Hugh (Ferriman, also class of '79, married '83) and I could cram a lot of travelling into a few years. Which we did.

In the few months’ run up to retirement day, I managed to get a place on the part-time MA course in Creative Writing at Newcastle University (the alma mater again). The application required 1000 words of fiction: a challenge which made it very clear to me that I needed to learn the craft of creative writing.

My career in medicine was eclectic, but I spent the final 20 years in Public Health medicine mainly as a Consultant and Director of Public Health in various NHS bodies, all of which have now disappeared. Latterly I worked in communicable disease and emergency planning: six years bookended by the flu pandemic in 2009 and Ebola in 2015. I was employed initially by the Health Protection Agency (organisationally a good idea), which became Public Health England (a bad idea), which is now the Health Security Agency (who knows?). There is a much longer and gloomier article to write about the idiocy of the sequential re-disorganisation of NHS institutions in the last 20 years, worsened obviously by massive defunding since 2010.

Producing factual reports and papers had been a large part of my work for those 20 years, including DPH Annual Reports, NHS Board papers, academic papers, statutory reports, quasi-legal submissions and internal policies. I knew how to write a lot of words to often tight deadlines, and for different audiences, but absolutely none of it could be ‘made-up’!

I started the MA three weeks after I retired. The timing wasn’t great as we had a long trip to New Zealand already booked for late November, so I had to miss part of the first term. I coped with being mildly reprimanded for taking an ‘unauthorised absence’. Harder was coping with submitting the written pieces for that term using Turnitin, an astonishingly clumsy online process. Although I was one of the least qualified (in the literary arts), and one of the oldest, I loved the MA course and studying the craft of writing fiction. It was a real pleasure to learn alongside younger people and an interesting challenge in not being the expert.
I began to understand both the art of writing creatively and how to do it, and then I found the story I wanted to tell. The Midwife evolved from my final dissertation for the MA and was published on 17 February 2022.

The Midwife is set in 1840. It begins as a dual narrative: two characters, both living shadowed lives, survive through their work and their commitment to it. One is a well-respected male doctor in London with secrets to hide, the other is a woman in Northumberland who has lost her past but finds her skills as a midwife. The narratives inexorably come together in the final section of the book. This was a time of massive social divide. Marriage was the norm and pregnancy was both a required duty and a source of real fear.

There were two separate inspirations for the novel. There was a specific moment - the sound of boot heels on a cobbled street in Alnwick, Northumberland - which gave me an image of one of the characters and the idea for time and place. The main inspiration though was outrage, as a public health doctor, at the renewed attacks on women’s reproductive rights. How could I communicate how fearful childbirth can be if women do not have access to services and support?

It was also important to me to create settings which were rooted in the physical reality of the time, not only the death and disease but also the smells and the sounds, and the contrast between the cold and hunger of the poor and the opulence of the newly built London squares with their gaslights and cobbled roads.

My characters evolved within that reality and were shaped by it. I also wanted them to express the many additional constraints on women’s
lives: the rigid social structures, the enforced roles, and the conflict between identity being defined by motherhood and the fear of childbirth itself.

**The public health message!**

In 1840, the UK maternal death rate is estimated to have been around 700/100,000 live births. In 2017, by WHO (World Health Organisation) region, the lowest maternal mortality rate was in Europe (13/100,000) and the highest was in Africa (526/100,000). Meaning that maternal death rates in parts of Africa now, today, are not much better than in the UK in 1840.

Former President Trump’s expanded ‘Global Gag Rule’ in 2017 blocked US global funding to organisations providing information, referrals or services for legal abortion in their own countries. Although this policy was rescinded by President Biden in January 2021, its impact in poorer countries was enormous and has led to the collapse of many local contraceptive and maternity services for women. Women’s rights to safe abortion remain under threat. It was only last year that women in Northern Ireland secured access to services, fifty years after the rest of the UK, but in the same year Poland banned abortion and Slovakia restricted access to abortion services.

Of greatest concern is the position in the USA: the Texas State Senate Bill 8 effectively banned most abortions after six weeks of pregnancy in Texas. The US Supreme Court (with its Trumpian judges) then ruled to keep that law in place. Other states are introducing similar restrictive laws. There is now a real possibility that the landmark Roe v. Wade judgement, which underpins abortion rights in the USA, will be overturned.

**Getting published**

There are lots of hoops to go through to get a novel into a bookshop. Having learned the craft of writing there is the hard slog of getting the
words out. Then there is the pain of rewriting and editing and always the words of my excellent tutor on the MA in my head - “tighten up, lighten up, take the words out!”

Mid-2019 I started the even worse slog of finding an agent. The rejections were encouraging and polite, with some thoughtful comments, but they were still rejections. I was used to having academic papers turned down, but it feels different, more personal, when it’s a creative piece.

So, in May 2020, in that terrible time, our lovely grandson was born far away and we couldn’t go to see our daughter and him. Two days later Debbie Taylor from Mslexia magazine phoned to say I had won the Novel Competition. At first, I didn’t know how to respond: too much good news seemed to be tempting fate. I am of course very grateful. Through that I was found by my wonderful agent Charlotte Robertson and she found a publisher – Pan Macmillan, also wonderful. The whole process of structural edit, copy edit and proofs, then cover design was not too onerous. It was more like the sort of work I had done on reports and papers in my old life.

What have I learned?
I retired in 2015 from a professional career which to a large extent defined me. I have other longstanding roles as a mother (and now grandmother) and wife and carer. I am a trustee for three charities and, as Campaign Manager, helped to get one of the two new Green Party Councillors elected to Northumberland County Council in May 2021. I also returned to work with PHE for four months in 2020 and then had much more fun as a volunteer vaccinator in 2021. Somewhat belatedly, I have realised that I am not actually retired. Writing is a new career, and I’m very lucky.

Tricia Cresswell

Consultant perinatal haematologist
b 1938;
q Durham 1960, FRCPath, FRCPCH, FRCOG,
d 18 October 2021
Cerebral incapacity

Elizabeth Alin Letsky ("Liz") moved to London after house jobs. Appointed registrar at Great Ormond Street, she worked with children who had thalassaemia and haemophilia.

In 1967 she was appointed to the Veterans Hospital in San Francisco to do research.

On returning to Great Ormond Street Hospital she undertook the earliest clinical trials of iron chelation therapy in the UK for patients with thalassaemia.

In 1983 she was appointed to the new post of consultant haematologist at Queen Charlotte’s Hospital.

Liz regretted not having children of her own but took comfort from the fact she was responsible for the healthy birth of many children who might otherwise not have survived.

She leaves her sister, Nadia, and two nephews.

Nadia Ellis / Michael de Swiet/ BMJ
Obituary:

William Grieves Donald

GP Broomhill
b 1934
d Newcastle 1958
FRCP

Effects of vascular dementia

("Bill") followed house posts in Newcastle Royal Victoria Infirmary with a three year commission in the RAF. After three years in a Norfolk practice that did not share his patient centred philosophy and a brief period in his father's business, Bill settled in the rural practice of Amble and Broomhill in Northumberland for 24 years, retiring in 1994. In 2003 Bill and his wife, Madeleine, moved from Warkworth to Brafield-on-the-Green, near Northampton, to be near family. Bill’s last few years were tainted by dementia but his calm, benign personality remained, and was cared for at home by Madeleine, supported by his three children and nine grandchildren.

David McKinlay / BMJ

Obituary:

Jessel Josephs

GP South Shields
b 1924
q King’s College
Durham 1947
MRCGP
d 8 May 2022
Fruity of old age

Jessel worked in South Moor, Stanley, immediately before the founding of the NHS. After conscription and serving in the Royal Army Medical Corps, he formed a successful GP practice in South Shields, where he worked until his retirement in 1985. During his career he, together with his partner, handled upwards of 300 “home confinements” per year as well as general medical practice work. During his career he served as chairman of the local BMA branch and worked on establishing and running a postgraduate centre. Predeceased by his wife and his daughter, he leaves a son, a daughter in law, two grandchildren, and two great grandchildren.

David Josephs / BMJ

Reunion of 1966 Year

The Covid delayed reunion was held over the weekend of May 13th-15th 2022 at the Copthorne in Newcastle. After an informal gathering on Friday evening there was a choice of a visit to the Guildhall or to Trinity House. Saturday evening saw a more formal dinner and although bereft of official speeches, several of the year spoke. In particular, remembering those who had recently departed including Jim Turley who was a staunch supporter of the year reunions. The whole event was most enjoyable. Everyone left with a promise to return in four years for the 60th anniversary of graduation.

The attendee names dont align to the photo. In attendance: Steve Anchor, Alice Arrowsmith (nee Robinson), Mike and Linda Black, George and Margaret Bone, Niall and Margaret Cartledge, Dave and Mary Clarke, John and Sarah Coles, Dave and Chris Collin-Thome, Steve and Brenda Craddock, John and June Davison, Pauline Dimpil (nee Upton), Amanda Fegggetter, Jeremy Fegggetter and Su Stuar, John and Jean Ferguson, Alan and Maureen Fortune, Roger and Dorothy Gamersall, Jack and Ann Greener, Bill and Margaret Hall, Richard and Carol Jackson (nee Crack), Sue Jones, David and Gill Knox, Christopher and Margaret Lynch, Graham Maddick, John and Joy McCollum, Sheila Rosen (nee Saville), Tom and Rosemary Scott, Ian and Michelle Thompson