In 1773, Dr John Coakley Lettsom and a small number of friends inaugurated the Medical Society of London. Soon, however—possibly because Lettsom’s attention was diverted towards the promotion of the Royal Humane Society and the Royal Sea Bathing Infirmary at Margate—the Medical Society of London lost momentum. The number of submitted papers declined, and disputes almost led to its dissolution. Under a new president, Dr James Sims, the society rallied temporarily, and benefited from the gift of the freehold property at Bolt Court, Fleet Street, and a library of six thousand books. However, increasing frustration at the oligarchic presidency of Dr Sims and the need for reform led in 1804 to proposals for new laws to put the society on a more democratic basis.

After a struggle during which the activities of the society practically ceased, the reformers resigned and in 1805 formed the Medical and Chirurgical Society of London. One of the regulations of the new society restricted the term of the president to two years, a clear reference to the difficulties with the leadership of the Medical Society of London. Membership was not cheap—six guineas admission fee and an annual subscription of three guineas. The aims of the new society included the formation of a library and a union of the various branches of the profession. Admission to membership was by personal nomination, followed by a ballot (three-quarters of votes in favour were required for election), although to help the establishment of the society the founders bypassed this system to elect some leading figures such as James Parkinson (who described his eponymous disease in 1817). A special category of honorary members was created for distinguished non-medical scientists such as Humphry Davy, who became famous for his invention of the miner’s safety lamp, first used in 1816. Initially the strength of the newly founded society derived mainly from the staff of Guy’s Hospital and from those associated with the Great Windmill Street School, and a smaller group was drawn from the London Hospital and its medical school. It was not until the 1840s that a substantial number of members came from other institutions.

The Medical and Chirurgical Society meetings were held at 2 Verulam Buildings, Gray’s Inn Road (Figure 1) from 1805 to 1810, at which point the owner evicted the society so that the building could be sold. After a period of cohabitation with the Geological Society at 3 Holborn Row, the Medical and Chirurgical Society moved to 30 and then

Figure 1  Gray’s Inn looking south. The Medical and Chirurgical Society’s first house was at the south end of the terrace in the left foreground

Figure 2  53 Berners Street, London W1
57 Lincoln’s Inn Fields, and finally in 1834 to 53 Berners Street (Figure 2). The removal of the society to 20 Hanover Square in 1889 was mainly prompted by the growth of the library.

In 1809, important papers that had been presented at meetings began to appear in the society’s journal, Medico-Chirurgical Transactions. The decision whether or not to publish a paper in the Transactions was the prerogative of the Council, and the reasons for acceptance were not given. Those assembled at the Council meeting were balloted and the outcome was final. It appears that some of the most interesting material was rejected. For example, Council decided against publication of Doucet’s experiment in which tetanus was said to have been cured by regularly pouring between 15 and 26 buckets of cold water over the patient. Examples of more important rejected works include a paper in 1824 reporting removal of one side of the jaw for osteosarcoma and the first description of the worm Trichina spiralis in 1833; Dr Thomas Addison’s paper, describing the disease that was named after him, was rejected repeatedly. In 1843, referees were introduced, to assist the Council in evaluating manuscripts. One of the more important items to survive the ancient peer review process was Dr Thomas Hodgkin’s paper in 1832 describing the disease that was to take his name. The Transactions faced many early difficulties, which included criticism of the large number of single case reports, frequent typographical errors, and the expense of printing. No volumes were published at all in some years. The journal was nevertheless to develop greatly, and survived until 1907.

Despite early tribulations, the Medical and Chirurgical Society and its Transactions flourished, and in 1812, with the support of the then president and King’s Physician Sir Henry Halford, the society petitioned for a Royal charter of incorporation. This was fiercely opposed by the Royal College of Physicians, who set up a committee to take whatever measures necessary. The College sent a memorial to the Privy Council opposing the society’s petition as injurious to the College and altogether unnecessary, and within months the society’s bid was rejected by the law officers of the Crown. A supplementary petition and counter-attack swiftly followed, pointing to the lethargy of the Royal College, which had failed to print a library catalogue for 55 years, restricted the use of its library to a small number of fellows, failed to publish anything since 1786, and allegedly held no useful meetings. A bitter dispute followed, the supplementary petition failed, and the society appealed to the Lords of the Committee of the Privy Council. Lawyers for the society and for the College of Physicians presented their opposing views in the Cockpit at Whitehall in 1814, the outcome being that the Royal College of Physicians succeeded in thwarting the ambitions of the society. Unsurprisingly, this outcome caused lingering resentment. In fact the Royal Charter was sanctioned only in 1834, the year of the move to Berners Street.

Under its new name of the Royal Medical and Chirurgical Society of London (RMCS), the society achieved maturity and status and flourished as an academic institution. Originally, reporters from other medical journals were banned from admission to meetings, but this rule began to be relaxed in 1842, and gradually others became free to print all or part of the society’s proceedings. This led to the official publication of the Proceedings of the society from 1856, and initially authors could specify whether they wished their work to be published in the Proceedings only or in the Transactions with an abstract in the Proceedings. Later Council withdrew this choice and made their own decisions.

Failed attempts in 1860–1861 and 1868–1870 to amalgamate the RMCS with the Pathological Society, the Obstetrical Society, and several other specialist societies left the RMCS divided and weak at the very time that specialization was at a peak. Whereas in 1800 there were twelve specialist charity hospitals and dispensaries, by 1890 there were a hundred. New specialist societies multiplied and defied amalgamation, which introduced an element of antagonism and competition for material to be presented at meetings. However, during the final decade of the century support for amalgamation developed, which resulted in a firm proposal in 1905, and twenty-six London medical societies were approached to see if they would be willing to amalgamate. Some welcomed the proposal whereas others hesitated. In 1907 it was agreed to name the new society the Royal Society of Medicine (RSM), and fifteen medical societies including the RMCS agreed to unite under this name.

The history of developments up to 1907 is covered in the first five chapters of Penelope Hunting’s magnificent and beautifully illustrated history of the RSM. Subsequent events occupy the remaining five chapters, about two-thirds of the book, where the development and notable achievements of the individual Sections and Forums are set out, Dr Hunting’s examination of the records having been enhanced by information from many senior Fellows. Although her book will be of special interest to Fellows, it also provides a gripping account of many of the most important medical developments in the past 200 years, with much material to engross any reader with an interest in medical history. It is profusely illustrated. For pure fascination it is hard to beat the radiograph of Dr John Hall-Edwards’ hand, taken a few days before the hand and arm had to be amputated because of radiation damage. Hall-Edwards, a radiologist and so-called X-ray and radium martyr, presented his own case to the Section of Electrotherapeutics (latterly the Section of Radiology) in
November 1908. But wherever you open the book you are sure to find something interesting and absorbing, whether it is the first report of cases of smallpox communicated to the fetus (reported by Dr Edward Jenner), the first description of hay fever (by Dr John Bostock), or the fierce controversy over whether or not rickets was the result of a lack of a vitamin (Dr Edward Mellanby), the importance of vitamins having been dismissed by some as merely ‘the latest dietetic stunt’.

**REFERENCE**


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**Drug War Heresies: Learning from other Vices, Times and Places**

R J MacCoun, P Reuter 470+xiv pp Price £18.75 (p/b) £50.00 (h/b)

ISBN 0-521-79997-X; 0-521-57263-0

Cambridge: Cambridge University Press, 2001

Doctors, whatever their gender, tend towards paternalism. The effect of this bias on our opinions is often exacerbated by immersion in the seamiest side of life. We see many sad schizophrenics whose steps downhill can be measured in ‘joints’; we rarely come across the busy person whose burdens are temporarily eased by a modicum of cannabis. We often meet gaunt, diseased, heroin shooters, but modern Coleridges or de Quincseys are mostly outside our professional experience. As a consequence, our urge to protect people from drugs is strong. Protecting people must surely translate into taking action to reduce the prevalence of drug use. How better to achieve this aim than by banning, or otherwise controlling, the availability of noxious substances? So we tend to think and, having thought, go home to enjoy a glass of whisky. Many politicians and other people reach similar conclusions. The trouble is, as this book shows, aiming to reduce usage prevalence may not be the best option when the welfare of all of the people is considered, while some approaches to drug control may cause more ills than they cure.

MacCoun and Reuter, a psychologist and an economist, are both American. Their main purpose is to explore likely consequences of changes in the present, draconian, American anti-drug legislation. On the face of it, there is certainly need for change. In 1996, for example, 401,000 people were in jail for drugs offences in the US, compared with 68,000 in 1985, while the prevalence of drug use had probably increased slightly over the same period. In pursuit of their purpose, they first look at the histories of attempts to control alcohol, nicotine, gambling and prostitution, as well as currently illegal drugs, then go on to examine the policies and drug experience of some other countries, especially the Netherlands. Their approach is thorough and appropriately cautious. Confidence in their reliability and good sense is quickly engendered.

Perhaps the most important point made here is that very many sorts of harm, in addition to clinical ones, are associated with drugs. At least in the US, a numerically greater proportion of harms arises from the illegal status of drugs, and attempts to enforce the law, than from actual drug use. Therefore, MacCoun and Reuter suggest, the Netherlands’ overall policy of aiming for total harm reduction, rather than the more limited goal of usage reduction, may well be sensible. Decriminalization (the authors prefer ‘depenalization’)) of possession of small amounts of drugs would seem to be a sensible first step. This has had little effect on usage prevalence in places where it has already been adopted as far as cannabis is concerned, though some increase might be expected for other drugs. Even in Holland, where *de facto* legalization of cannabis use has occurred, the proportion of people taking the drug is apparently less than in the US. However, legalization, as opposed to the more limited depenalization, needs to be approached with extreme caution since it could so readily result in active and effective promotion of drugs by commercial firms.

All this is quite encouraging for the UK. We can be fairly confident that the proposed relaxation of the law relating to cannabis possession will do no harm, and it may prove beneficial. Are there any grounds for caution? Well, it is possible that the change will have no practical effect since arrest rates for cannabis possession in those US States where possession has already been depenalized are no different from rates in States where it remains illegal. More worrying, though, is the possibility that the evidence considered in this book may be too narrowly based to justify a ‘little or no harm’ prognosis. One of the most striking clinical characteristics of cannabis is its long half-life in the body. This means that chronic intoxication can readily occur even in people who are not daily users. Many of us suspect that intoxication usually manifests, not in any readily detectable clinical syndrome, but in a sort of fecklessness difficult to distinguish from ‘normal’ inner-city or adolescent behaviour. Widespread fecklessness can be expected to have highly non-linear, and hence unpredictable, social consequences. Effects of this sort may already have been seen in a wider historical context than that.
considered in the book. For instance, the original thirteenth-century assassins were said to have been fuelled by hashish. Colonial administrators in the Middle East eighty years ago regarded hashish as at least as much of a scourge as opium in the Far East. They prided themselves on their efforts to limit its use. Perhaps they were mistaken, or perhaps they had a preview of the sort of nasty surprise that cannabis may have in store for us if social contexts change.

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Risk of Arrhythmia and Sudden Death

Editor: Marek Malik
412 pp  Price £125  ISBN 0-7279-1581-9 (h/b)
London: BMJ Books

Cardiac arrhythmias are common, and some have a regrettable tendency to cause sudden cardiac death. Greater efforts are needed in defining the clinical epidemiology, pathophysiology, risk stratification, risk assessment and therapeutic strategies in this area. Sudden death is not simply due to ventricular arrhythmias; other arrhythmias can be associated, as can certain drug therapies and congenital syndromes.

Professor Malik has assembled a comprehensive treatise on this theme, with subject-matter ranging from risk stratification and assessment to trials of antiarrhythmic agents. The contributors do their topics justice while not assuming too much knowledge in the reader; so non-specialists will find the book useful. An enjoyable section on clinical assessment starts by reminding us that ‘one should never manage arrhythmias but patients with arrhythmias’.

The section on clinical studies is impressive, ranging from myocardial infarction and chronic heart failure to atrial fibrillation. With my personal biases towards irregularly irregular things, my book reviews tend to focus on irregular rhythms. A criticism of the chapter on persistent atrial fibrillation is that it deals more with ‘how to manage the problem’ rather than the specific issue of preventing sudden death. Regarding drug-resistant paroxysmal atrial fibrillation, enthusiasm for ablate-and-pace should be tempered by the knowledge that this intervention itself can cause sudden death.

Overall this is an impressive tome: the editor and contributors are to be congratulated for assembling a wealth of material in a digestible form. Most cardiologists (irregularly irregular ones, or otherwise) and their departments should have a copy.

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Decision Making in Health and Medicine: Integrating Evidence and Values

Myriam Hunink, Paul Glasziou, Joanna Siegel, Jane Weeks, Joseph Pliskin, Arthur Elstein, Milton Weinstein
388 pp+CD-ROM
Price £34.95 ISBN 0-521-77029-7 (p/b)
Cambridge: Cambridge University Press, 2001

‘Not another book on evidence-based medicine!’ must surely be the reaction that the editors and publishers of this text were trying to avoid. Evidence-based medicine (EBM) has become the new orthodoxy. All true believers (and even agnostics) no doubt possess a copy of the thoughts of sages such as Sackett. However, EBM has its critics, one of whose arguments is the essential need in clinical practice to consider the individual patient in front of you rather than probabilities. Decision Making in Health and Medicine attempts to overcome these difficulties by describing an approach to which the authors give the acronym PROACTIVE (problem-reframe-objectives-alternatives-consequences-advantages and disadvantages). The authors then lead us through chapters on probability, decision trees, utility assessment, Bayes’ theorem, decision trees with Bayes’ theorem, analysis of tests, analysis of data, cost-effectiveness analysis, state transition models, other advanced models and a final overview.

There is a great deal of knowledge and information in these chapters, presented with masses of detailed mathematical and statistical analysis. The pages of equations and formulae were quite offputting to me, an average clinician, and beyond my grasp of mathematics. I did find the formula for how to calculate mortgage repayments quite fascinating though and the sort of thing to impress your bank manager or accountant with. The method of deriving the solution of an algebraic equation by the use of geometry was again novel and impressive to me though I must confess to not really understanding the proof (QED and all that).

I suppose therein lies my disappointment with this book. The cover states that it is ‘user friendly’, ‘clearly explains’ and is ‘of immense practical value’ to ‘all those charged with decision making in medicine.’ As I soldiered on through hundreds of pages of dense academic prose and intricate equations, the thought that I was gaining a new practical insight into clinical decision-making, albeit only at my rudimentary level of understanding, kept me going. However, on p. 372 the authors state they ‘do not make a decision tree for every patient that consults us. On the contrary; it is more the insights that we have gained from . . . the PROACTIVE approach that have been helpful.’ It is exactly those sorts of insights from the authors’ own experience of analysing and researching medical decision-
making that practising clinicians might find of most interest and relevance, rather than detailed mathematical proofs.

The accompanying CD-ROM gives perhaps a truer representation of the readers likely to understand and benefit most from the approach described. The CD contains lists of references, useful websites, two decision analysis programs and a programming language which readers can use to design their own software for decision analysis. We are told that Fellows in Decision Analysis at the New England Medical Center have used these programs. Notes are also available from one of the editors for those involved in teaching others these techniques.

Overall, this text seems of most interest to those studying or teaching medical decision analysis as an academic subject or considering developing software models. Therefore I regard the cover as quite misleading. Of course, some doctors and students may wish to read this sophisticated mathematical treatise simply for the intellectual challenge.

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The Biology of the Skin
Editors: Ruth K Freinkel, David T Woodley
432 pp  Price £64.96; US$97.95  ISBN 0-85070-006-5 (h/b)

Dermatology registrars are required to attend the Cambridge ‘biology of the skin’ course at an early stage of their training, to learn the basics of skin anatomy and function. Freinkel and Woodley’s book, with a similar emphasis on core knowledge, would be an excellent companion to the course. The primarily American authorship covers the structure and function of the skin in a systematic way, from gross anatomy down to molecular biology and genetics. The editors’ overall aim is to ‘teach skin biology in the context of practical settings’.

The chapter on the eccrine sweat gland is excellent, detailing the important thermoregulatory role of these glands. A little known fact is that collectively they can produce an astounding 4 L of sweat per hour. Up-regulation is part of acclimatization in a hot country, but as this process takes three to four weeks the average holidaymaker does not benefit.

The complex process of cutaneous wound repair is handled well, with detailed descriptions of the three phases of repair— inflammation, proliferation and remodelling. One of the puzzles of recent years has been how re- epithelialization is achieved, or in other words how keratinocytes migrate from the edge of a wound to cover a defect. It is now known that keratinocytes migrate by flattening their normal cuboidal shape and developing lamellipodia. In addition, actin filaments, working as drawstrings, pull the keratinocyte across the wound.

The important topic of skin ageing is discussed and the authors emphasize the distinctions between intrinsic ageing (happens to all) and photoageing (ultraviolet-light-induced). With intrinsic ageing, skin becomes thin, smooth, finely wrinkled and more transparent whereas photoaged skin is thickened, sallow and yellow and coarsely wrinkled. Throughout adult life the collagen content of the skin declines by roughly 1% per year. Sagging occurs because of disintegration of elastin fibres. Fortunately, help is available for photoaged skin since topical tretinoin can reverse some of the connective tissue changes by inducing collagen formation. However, prevention by avoiding too much sun is preferable.

There are a few curious editorial omissions. Eccrine sweat glands and sebaceous glands have their own chapter but apocrine glands get only the briefest mention. This is a pity since a discussion on pheromones would have been interesting. Subepidermal immunobullous and genetic disorders such as bullous pemphigoid and epidermolysis bullosa are covered well in the chapter on the basement membrane zone but similar important intraepithelial disorders such as pemphigus vulgaris and paraneoplastic pemphigus are not discussed. My only other gripe is that the discussion of investigation of skin disease ought to cover immunofluorescence in detail since this is the standard investigation for immunobullous disorders.

This is an excellent book that will be a welcome addition to any dermatology library. It succeeds in covering basic biology with a clinical perspective. Most dermatology registrars will wish to have a copy, because it contains all the information that we really ought to know but probably don’t.

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