

Prognosis



The periodical of the
Harley Street Medical Area
Launch issue / Summer 2016

Dame Professor Donna Kinnair

In conversation with one of the
country's most senior nurses

Rocket fuel

The art of the elite sports nutritionist

"I had a 12mm stone in my throat"

A patient experience

How does it work?

MRI scanner

**THE
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de WALDEN
ESTATE**



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The Estate's portfolio of rental properties, which includes some of the most beautiful Georgian and Victorian architecture in London, is uniquely varied, incorporating residential accommodation, office buildings and the Harley Street Medical Area.

The Estate is perhaps best-known for its ground-breaking

transformation of the area known as Marylebone Village, centred upon Marylebone High Street—one of London's most vibrant and attractive retail destinations.

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To find out more about the Harley Street Medical Area visit:
harleystreetmedicalarea.com

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Cover image:
The Harley Street Clinic

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Success for elite athletes demands commitment, sacrifice and intensive training. It also demands the right dinner. Prognosis hears from some of the country's top sports nutritionists



REUTERS/ADRESLATIVE

There needs to be an honest conversation about the role of the nurse within the field of healthcare: what nurses' responsibilities are and where nurses stand in relation to other healthcare professionals

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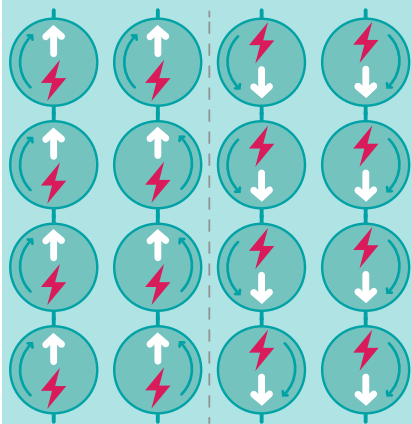
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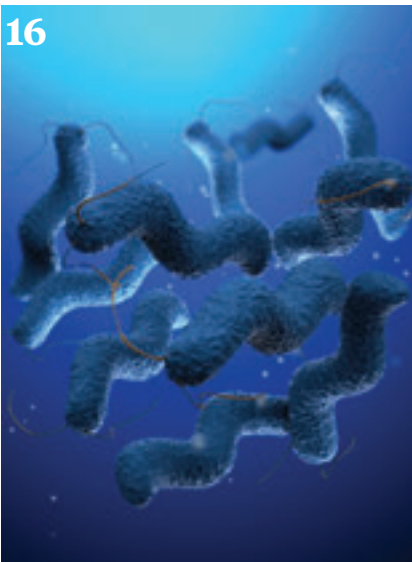
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In April 1890, John Merrick was found dead in bed. Though some said that he killed himself in misery, it's more likely that, as Frederick Treves writes, the elephant man had simply tried, for once, to be "like other people" and sleep lying down

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WELCOME TO PROGNOSIS

Simon Baynham,
property director at the
Howard de Walden Estate

Welcome to this launch issue of Prognosis: the periodical of the Harley Street Medical Area.

Not so long ago, a Harley Street Medical Area publication, packed with insights from some of the country's top medical practitioners, would not have been a viable proposition. Now it makes perfect sense.

As the freehold owner of the majority of the area's buildings, the Howard de Walden Estate—the publisher of this periodical—has helped shape Harley Street's fortunes since the first doctors began arriving in the area in the late 19th century. For many decades, this was the most renowned and in-demand medical area in the world. But, largely unchallenged in its status, there was a risk of complacency setting in.

As medical practices and international competition increased, it became increasingly clear to us that, for the Harley Street Medical Area to continue to compete on a global basis, history and reputation alone would not be enough. It needed instead to stand out for the sheer level of medical excellence found behind its elegant period facades.

Over the past decade, we have been working hard to turn this into a genuine powerhouse of modern medicine. The area's long established and justifiably famous tenants—The London Clinic (including its more recent London Clinic Cancer Centre, which houses some of the world's most advanced radiology equipment), HCA, King Edward VII's Hospital, Moorfields—have been joined by some exceptional new peers: Royal Brompton & Harefield Hospitals' brand

For the Harley Street Medical Area to compete on a global basis, history and reputation alone would not be enough. It needed instead to stand out for the sheer level of medical excellence found behind its elegant period facades



new diagnostics and outpatients centre; the flagship hospital of eye specialists Optegra; Isokinetic's Fifa-accredited rehabilitation centre; the multi-specialist London Claremont Clinic; leading orthopaedic clinic Fortius, whose patients include many world famous sports stars. And there are more to come: a proton beam therapy unit is awaiting planning, as is a London base for Germany's highly regarded Schoen Clinic.

Central to our strategy has been an understanding of the importance of maintaining a balanced community of tenants, consistent in quality but highly diverse in function. The Estate now works with a small group of external consultants to identify the areas of specialism that are currently missing and who the most respected operators are. Gone are the days when a refurbished medical property would simply be thrown out to the open market; instead we search the world for the right specialists.

To attract the right tenants we need to provide the highest possible standard of accommodation. One of the attractions of Harley Street is the aesthetic value of the period buildings, but the area's historic fabric is the source of some major challenges. Providing modern medical facilities in a conservation area filled with listed buildings is far from straightforward. Thankfully, the Estate's experience in this field gives us an unparalleled level of expertise and the quality of accommodation provided to our direct tenants is exceptionally high.

Medical excellence is the Harley Street Medical Area's primary selling point, but it isn't the only one. Perhaps the most unusual aspect of the Medical



Area is that it isn't an isolated enclave, filled with nothing but doctors. Surrounding the medical buildings, and even sharing the same streets with them, are restaurants and cafes, shops and cultural institutions. There are numerous hotels, some of which have developed close ties with the hospitals and clinics. There are quiet parks and attractive streets. For patients undergoing treatment, or for the family and friends supporting them, the Harley Street Medical Area provides an environment that is both comfortable and laden with welcome distractions.

Its Marylebone location also provides an unrivalled level of accessibility. Sitting right in the heart of a truly global city, it is connected not just with the rest of the UK but with the entire world. It is a short journey from several airports including, in Gatwick and Heathrow, two of the busiest and best served in Europe. It is closely tied in to London's enormous public transport network and is just a short hop from numerous mainline stations including the Eurostar terminals at St Pancras station. With Crossrail due to open on the doorstep in 2018, this is an area blessed with excellent transport connections.



All of these benefits make the Harley Street Medical Area a serious contender in the world of private medicine, but there is work still to be done in creating a more joined-up offering. In recent years, we have been working to bring clinicians together to offer a more cohesive service: the benefits of medical concierge businesses, which assist with every aspect of a patient's needs, are currently being explored, and we are working with clinics and practitioners to find ways of providing better information and more transparent pricing. The analogy we use is that the Harley Street Medical Area is like the world's biggest and best hospital, filled with doctors of global renown—now we need to ensure that it has a proper front desk and adequate signage.

Which brings me back round to the launch of this publication. This is just one more piece of the jigsaw—a way of showing the world the sheer depth of expertise contained in this small area of central London. We hope you enjoy reading it.

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KING EDWARD VII's
HOSPITAL

Having medical treatment can be stressful.

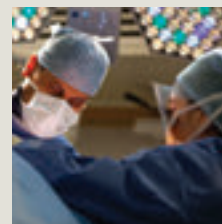
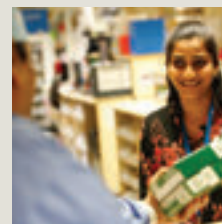
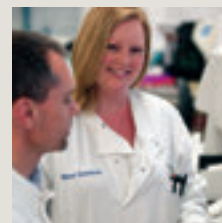
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NEWS



SEHR SCHÖN

A major new medical facility is set to open next year at 66 Wigmore Street. Plans have been submitted for a 56,000 sq ft building for Schoen Clinic London—a first British outpost of the renowned German Schön Klinik Group. The clinic, which specialises in orthopaedic problems and back pain, will offer diagnostics, radiology, surgery and non-surgical interventions in a state-of-the-art seven-storey hospital.

schoen-kliniken.com

DIGITAL FUTURE

A full bells-and-whistles website for the Harley Street Medical Area is currently under construction, ready to go live by the end of the year. The new site will provide background information on the area as a whole—how to get here, where to stay, how to find and access medical services—as well as detailed listings for the area's hospitals, clinics and practitioners.

harleystreetmedicalarea.com



GLOBE TROTTING

Earlier this year, a large contingent from the Harley Street Medical Area flew out to Dubai for the Arab Health—the world's second largest healthcare exhibition and congress. Fourteen HSMA clinics and two support services, together with the area's landlord the Howard de Walden Estate, shared a collective stand within the UK pavilion.

Such was their success in helping to raise the profile of the area with an international audience, plans are already underway for a similar delegation to attend next year's event (30th January–2nd February 2017).

arabhealthonline.com

ON BEAM

The planning process is currently underway for 143 Harley Street to be converted into a highly advanced proton beam therapy unit. This particular form of cancer treatment uses beams of sub-atomic particles, which pinpoint tumours with greater power and precision than conventional radiation therapies, causing significantly less damage to surrounding tissues.

The clinic, run by Advanced Oncotherapy Plc, is expected to open in 2017.

advancedoncotherapy.com

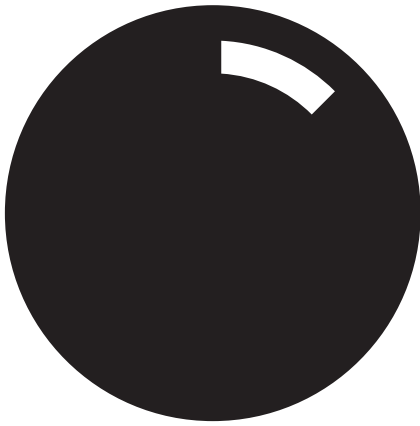
SCANNING THE HORIZON

A new outpatients and diagnostics centre has been opened at 77 Wimpole Street by Royal Brompton & Harefield Hospitals.

As well as providing consultations with the hospitals' consultants, the unit's services include an inherited cardiac conditions clinic, a heart screening clinic and advanced diagnostic imaging. It is one of only two centres in the UK, and the only centre in London, with a Rubidium PET scanner, which offers advanced cardiac diagnostic capabilities.

rbhh-specialistcare.co.uk





CRYSTAL BALL

Age related macular degeneration

Dr Clare O'Donnell, head of eye sciences at Optegra Eye Health Care, looks at how treatments for age related macular degeneration will evolve in the coming years

The state of play

Age related macular degeneration (AMD) is a condition that affects a part of the eye called the macula, which is responsible for our fine vision. If the macula begins to degenerate, the sufferer's ability to perceive fine details deteriorates over time. AMD is the leading cause of irreversible visual impairment in people aged over 60, with 10-15% of those affected suffering severe vision loss. In the coming decades, as life expectancy continues to rise, tackling this condition will become increasingly important.

There are two main types of AMD: 'wet' and 'dry'. Wet AMD is more aggressive and can progress quite rapidly. Dry AMD tends to be less severe and progresses at a slower pace. For early stage dry AMD, monitoring and

lifestyle changes such as modifying diet and stopping smoking are all that are needed. For wet AMD, however, things are different—and for many years the prognosis for those affected was poor.

However, recent advances in treatment and non-invasive imaging technologies used for retinal diagnosis have begun to revolutionise the field. We can now see the macula at much higher resolutions than ever before, and even create virtual 3D scans to show what is going on below the surface of the retina. This has helped hugely in early diagnosis of the disease, which is absolutely vital.

What next?

One area of research that led to real progress in treatment involves a technique called intravitreal injections, in which we inject drugs into the jelly-like substance in the eye known as the vitreous.

Wet AMD can cause the growth of new but weak blood vessels under the surface of the retina. These can leak fluid, which disrupts the workings of the macula, which has a serious impact on vision. Intravitreal injections allow us to treat this by injecting the necessary medicine straight into the eye.

One new and really exciting approach being developed involves a combination of intravitreal injections with other therapies, such as low dosage radiotherapy. These approaches are still in their early days but I believe there are some great treatments that will come from such innovation.

Other advances are being made through our ability to implant miniature telescopes into the eye, which help

One area of research showing real promise is a technique we use called intravitreal injections, in which we inject drugs into the jelly-like substance in the eye known as the vitreous

when the patient's natural lenses have deteriorated through age or illness. Doing this dramatically increases the eye's resolving power, which means that the macula is getting the best possible image to work with. The technology already exists, but it is still in its infancy.

On the horizon

If we are looking much further ahead, some of the most promising options we are exploring are based around gene therapy and stem cell therapy. Developing stem cell treatment is a complex and hugely challenging task, but the possibilities if we succeed will be remarkable. This will involve replacing the cells that have been damaged or lost due to AMD by reprogramming healthy cells to take over their job. People get very excited about this type of therapy because the potential is enormous—but then so are the challenges in making it work!

Working with our genes also offers what for me would be the perfect long term solution—the ability to identify people at risk of developing AMD before they begin to present any of the symptoms. This might then allow us to develop the appropriate treatment or understand the type of lifestyle modifications required without the patient developing the symptoms at all.

We have started along that road and have made significant progress, but there is still a long way to go.

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PP24



Dame Professor Donna Kinnair
One of Britain's most senior
nurses talks to Prognosis
about her roots in community
nursing, sitting on government
commissions and why
she believes the title 'nurse' is
in dire need of protection

HOW TO... Take a pulse Una Haddick-Flynn, senior nurse at The London Clinic



Where on the body is the best place to take your pulse?

Many people try the centre of the wrist, but the best place is actually on the inside of the wrist, just below the base of the thumb. We call this the 'radial pulse' and, as nurses, it is the one we would always go for first. It doesn't matter whether you try the left or right arm.

Take us through the process for checking your pulse?

To take your radial pulse, hold one hand out, facing upwards, with the elbow just slightly bent. Measure the pulse with your other hand, using the pads of your index and middle fingers. Do not use your thumb, because that has a pulse of its own, which can confuse your reading.

How long should you do it for?

Firstly, you have to use a watch or a clock, as it is virtually impossible to estimate time accurately while you are counting a rhythmic pulse. Take the pulse for 60 seconds. Alternatively, you can count for 30 seconds and then multiply by two.

Is 60 seconds better than 30?

In a normal healthy person, 30 seconds is fine. However, if the person is ill you should do the full 60. This makes it easier to pick out any abnormalities such as changes in the rhythm or strength of the pulse.

What if you can't find the pulse, or you keep losing it?

The first thing is to lower the arm so that it is hanging beside the waist. The blood will flow more freely then, which might make the pulse easier to find and keep.

Is there an alternative to the wrist?

That would be the soft hollow in the side of your neck, just below your jaw and to the side of your windpipe—this is known as the 'carotid pulse'. There are a couple of important differences. You need to apply a bit more pressure here than you would for the wrist, as you are pressing into a soft hollow as opposed to the firm wrist. Like the wrist, you can try either side, but it is very important not to try both at the same time. Compressing them both could restrict the blood flow to the brain.

What should you be noting when taking a pulse?

You should be noting the strength and rhythm of the pulse as well as the pace. The strength falls into four categories: weak, faint, strong and bounding. In a healthy adult in a resting state you want a nice strong pulse.

The thing to remember is that you will get the occasional missed beat or arrhythmical patterns in a perfectly healthy heart, so it is nothing to worry about initially. If you feel a missed beat, you should take your pulse once a day and take a note of the nature of the pulse. If it is happening on a regular basis you should go to your GP.

What is the expected pulse rate for a healthy person?

Between 60-100 beats per minute. But this will be lower if you are a fit person—some athletes can have a pulse rate of as little as 40 beats per minute. If the rate is consistently above 100-120 beats per minute or below 40—if you are not an elite athlete—you should get it checked by your doctor.

What are the best conditions for taking a pulse?

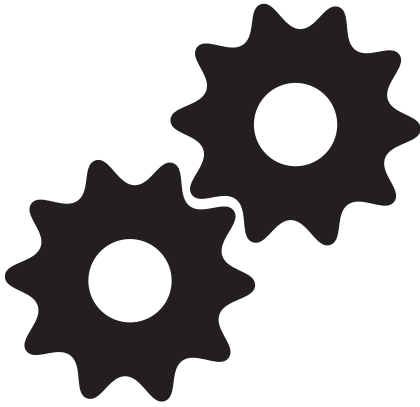
In a relaxed atmosphere at home. Preferable after lying down quietly for about five minutes. That would give you your resting pulse rate.

Anything you should avoid when taking your pulse rate?

Alcohol is something people often don't realise raises the heart rate, so it is best not to take it after a few drinks. Also, if you are on any medications check with your doctor as some will have an effect on the heart rate.

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HOW DOES IT WORK?

MRI scanner

Dean Booth, head of imaging, and Valerie Curran, lead MRI practitioner for the Royal Brompton & Harefield Hospitals Specialist Care outpatients and diagnostics centre, explain the benefits and complexities of the MRI scanner

Magnetic resonance imaging (MRI) works with the basic elements of the human body by taking advantage of the fact that water molecules in the human body react in a predictable manner when magnetic fields and radio waves are applied to them.

Water molecules within the body have a slight magnetic polarity, with one end being slightly positive and the other slightly negative. For an MRI scan, we first use a superconducting magnet to align the water molecules in relation to the lines of magnetic force.

We then transmit radio waves through the area we want to scan. The energy in these waves excites the water molecules, which disrupts their normal behaviour and the levels of energy they possess, causing them to jostle about. The critical part of the process begins

after we turn the radio transmitter off. It is while the molecules are relaxing back into their normal state that the scanner's sensors detect a signal they give off, and it is these signals that are processed by computer to create the image we see. The crucial thing is that we are looking at the change in the energy levels given off by the molecules, not just logging the energy levels themselves.

Different types of tissue, such as fat, muscle or cartilage, will release different amounts of energy in different ways. The scanner records these energy signals throughout the time the molecules are calming down and each reading is given a number—so for example we could have a range of numbers going from 0 to 10. These numbers are then used to create a greyscale image, where black might be

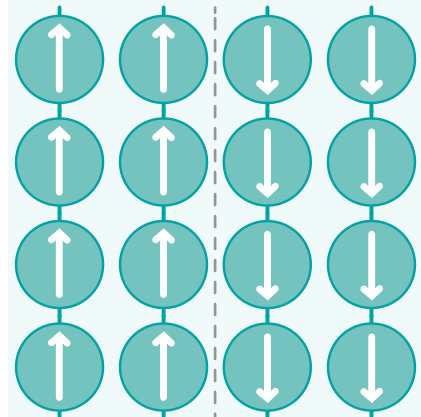
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Water molecules in the body have a slight north-south magnetic polarity and will spin according to local magnetic conditions.



02

A magnet in the MRI scanner is used to generate a magnetic field and the molecules align themselves with the north and south poles of this field.



represented by 0 and white by 10, and everything in between is a different shade of grey. The more accurate the recording, the more shades of grey you can define and the more detailed your final image will be.

One of the great things about MRI is that while many other scans will give you a static picture of an organ, an MRI can generate a moving image. This really comes into its own with heart scans because a moving image allows you to assess the functionality as well as the anatomy of the heart. The image resolution nowadays is wonderful and we can create a virtual 3D model of what is going on inside the heart, from tiny vessels within the heart right down to the structure of the muscle walls.

One of the things that makes MRI so powerful is that we can change the

parameters used to generate the image contrast in order to show us different things and focus in more closely on a particular tissue or area if we need to. The incredible level of spatial resolution you can get on an image allows you to manipulate the image to really narrow in on exactly what you want to see.

MRI can be used to scan most parts of the body. As well as the heart, it is used extensively in brain investigations to look for a wide range of diseases, including dementia. It is also very good at physical structures such as the knee, where we can get detailed images of bone, muscle, cartilage and blood vessels to build a complete picture.

The only real downside of MRI scanning is the time it takes. For example, some brain scans can take over



Imaging The process of creating visual representations of the interior of a body for clinical analysis

Superconducting magnet An electromagnet made from coils of superconducting wire which is cooled to below -150°C during operation

Spatial resolution The number of pixels utilised in the construction of a digital image. The higher the spatial resolution, the greater the number of pixels

Ferrous metals Metals that contain iron, and therefore have magnetic qualities

Neurostimulator An implant designed to modulate activity within the nervous system

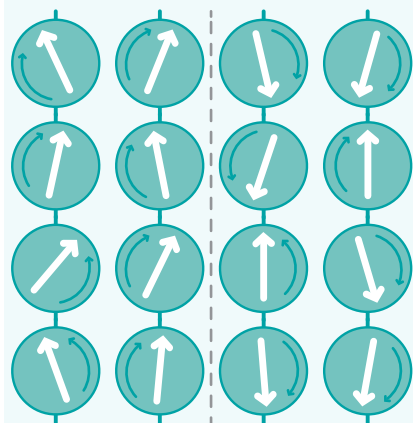
Contraindication A factor that serves as a reason to withhold a medical treatment, due to the possibility of the patient being harmed

20 minutes, and the longer the scanner is in use the more expensive it is to do the test. One of the real advances in MRI scanning in recent years has been the speeding up of how long a scan takes. It is better than it was five years ago, but this is always an ongoing process.

As with any medical procedure, there are patient assessments you have to go through before a scan. With MRI, most pacemakers, neurostimulators and ferrous metal implants can be contraindicated. The strong magnetic field can interfere with the function of the implant, and can disrupt, dislodge or heat up components with unfortunate effects. In itself, however, this is a very safe technique. After over 20 years of use all over the world, we are pretty certain that MRI scanning has no short or long term detrimental effects.

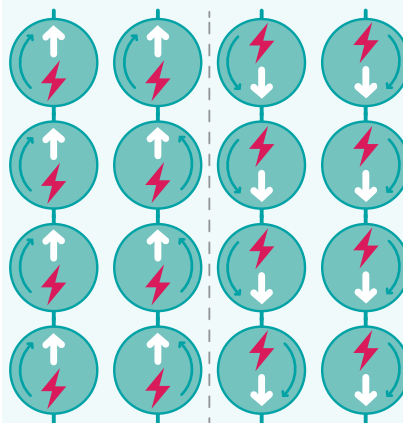
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Radio waves are then transmitted through the area which disrupt the molecules' normal behaviour, causing them to jostle about.



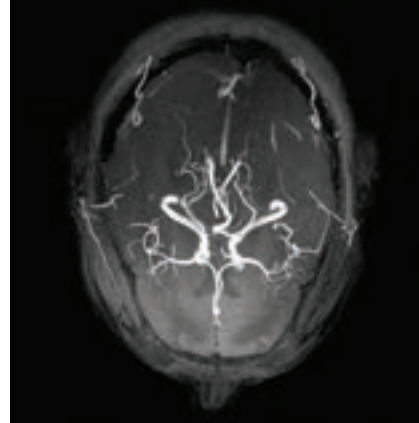
04

When the radio transmitter is turned off, the molecules return to their previous state. They generate an electrical signal as they do so.



05

These signals are detected by receiver coils in the scanner, which uses mathematical formulae to convert them into a greyscale image.



THINKING ALOUD

Mark Hughes

Founder and director,
Harley Street Dental Studio

Interview: Ellie Costigan

Portrait: Orlando Gili

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I decided early on I wasn't going to be a doctor. You don't have as much independence and it takes a long time to qualify. At school I had an aptitude for the sciences, biology in particular; I like working with my hands and have always had a bit of an entrepreneurial spirit—dentistry incorporates a lot of those things.

Root canals, fillings, implants, cosmetic veneers—I've had it all. Like a lot of people of my generation, who weren't particularly well educated about dental care, I ate a lot of sweets and drank a lot of Coke.

In our society, we possibly look down on the desire to make our teeth look better. But the paradigm is changing. Social media's come along, and people are increasingly concerned about how they look. Your smile and your teeth have a large influence on how you're viewed—how attractive you might be to other people, but also how healthy.

A lot of dentists, for want of a better description, are a bit OCD—we deal with micro-millimetres, so it helps to be a bit of a perfectionist. Dentists tend to be independent, quick on their feet, problem-solvers. They can also be quite opinionated and forthright, particularly when it comes to treatment for their patients.

I am hugely rewarded by what I do. The sense of satisfaction when somebody who's been in pain, or embarrassed about their teeth, leaves full of confidence is incredible. We see tears of joy and relief. That's very special.

We do get some unusual cases. A classic example is people opening beer bottles with their teeth; we deal with that kind of thing a lot. One patient raced another guy up a flag pole at university, but it was old and wooden and it broke. He tumbled 20 feet, landed on his face and lost his four front teeth. He's lucky to be alive! He was very embarrassed.

You must floss—or use something to clean between your teeth. You're only cleaning 60 per cent of your teeth if you're just brushing.

Being a dad is the best thing that's ever happened to me. I have two small children, one who's almost three and one who's 10 weeks old. A lot of my spare time is focused on family life. Having lived here for 25 years, we recently moved out of London and we have a dog, so there are lots of walks in the countryside.

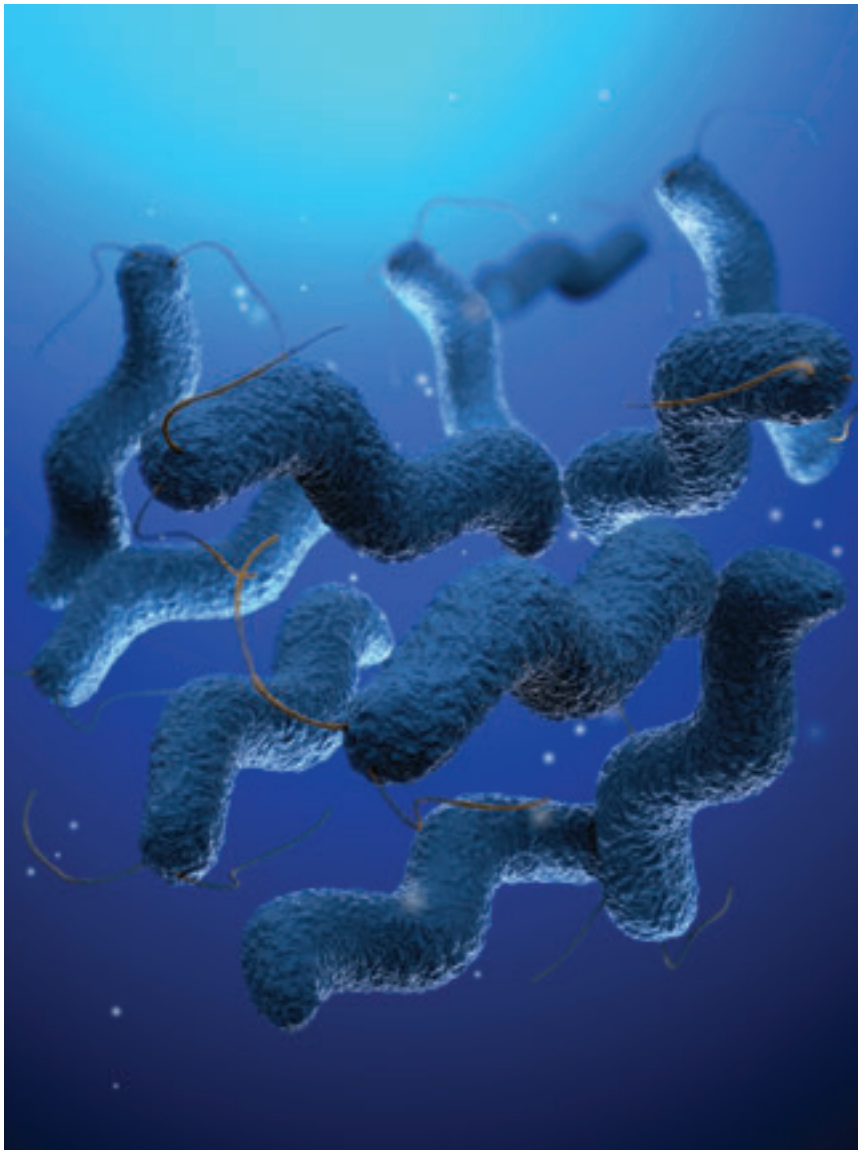
I did a bit of screenwriting—nothing's made it to the movie screen yet, but it's a hobby. I like clay pigeon shooting. I have an interest in cars, wine, food and travel. Photography is a passion. But it's finding the time to do all these things.

Going to the dentist can be a nerve-racking experience. Having surgery in your mouth while you're awake is quite invasive, so it's not surprising it frightens people. A lot of patients are very nervous, have high demands, there's a time pressure and things don't always go to plan. It can be a stressful job, but it's all part of what we do.

There's still a huge lack of clarity about what underpins dental health. Everybody thinks 'if I brush my teeth, I won't get cavities'. Actually, it's about your diet and reducing your sugar intake. They are both equally important: brushing looks after your gums; your diet affects your teeth.

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PROFILE OF A PATHOGEN

Campylobacter

Campylobacter is—unfortunately—a genus of bacteria familiar to doctors everywhere as one of the most common causes of food poisoning in the world. The technical name for a disease caused by campylobacter is campylobacteriosis, and while this is very rarely life threatening for most of the population, the symptoms can be unpleasant to say the least, responsible for millions of days off school and work every year.

People usually start feeling ill two to five days after infection, but this can be as much as 10. The most common symptoms of campylobacter infections include diarrhoea, abdominal pain, fever, headache, nausea and vomiting, with the symptoms typically lasting three to six days.

The reason for the bacteria's success is that they live happily in intestinal

tracts of poultry, cattle and pigs—our most popular sources of meat—while causing the animals themselves no harm. It is only when ingested by humans that bad things start to happen.

The presence of spiral-form bacteria in the stools and large intestines of diarrhoea sufferers was first described in 1886 by German-Austrian paediatrician Theodor Escherich. The genus was first described in 1963, although the organism itself was not isolated until 1972.

There are—as we speak—17 species and six subspecies of the campylobacter genus. This not-so-happy family comes in a variety of shapes and sizes. Look at them through a microscope and you will see spirals, s-shapes, curves, and rod-shaped bacteria swimming happily around in front of your lens. The real troublemakers as far as humans are concerned are campylobacter jejuni and campylobacter coli, which are found in the majority of cases of human campylobacteriosis.

Most bacteria prefer a micro-aerobic environment containing between 3-10% oxygen, and unfortunately for us parts of our lower gastrointestinal tract sit nicely between 2-7%, making us the perfect hosts for these unwelcome guests.

With a bit of care, it is easy to neutralise campylobacter before it gets into your system and starts setting up home. Buy your meat from a reliable source—dodgy slaughter practices can be a factor in infection—and make sure it is cooked properly. This does not mean serving up meat that looks like it has been pulled from a blast furnace—just ensure it is cooked through to the middle. It is easy to find the minimum temperatures different meats should reach. If you also wash your hands often when handling raw meat, any risk of getting ill will be greatly reduced.

Once campylobacteriosis is up and running there is not much you can do. Just let the disease run its course, drink lots of water and accept that your resolution to never, ever eat meat again will only last a few days longer than the symptoms you are suffering.



Pathogen A bacterium, virus, or other micro organism that can cause disease.

micro-aerobic environment An environment in which the concentration of oxygen is less than that in air.

Gastrointestinal tract The organ system responsible for transporting and digesting food and drink

MUSEUM PIECE

Bullet extractor

Royal College of Physicians
Museum

These three elegant but slightly alarming objects, owned by Sir Francis Prujean, president of the College of Physicians from 1650 to 1654, were used for the decidedly gory task of extracting bullets from the human body. The hooks were designed to hold open the wound, but it is the middle object—the extractor—that's of real interest. The handle at the top rotates a steel rod inside the tube, which has a sharp, corkscrew-like tip. As bullet material was softer than steel, the tip would bore into the bullet, and once there was a secure connection it could then be pulled out: simple, effective and all done without any anaesthetic.

Beth Wilkey,
museum curator



ROYAL COLLEGE OF PHYSICIANS

HARLEY STREET HERO

Lionel Logue (1880-1953)

Speech therapist at
146 Harley Street

Words: Sasha Garwood

Many people's introduction to speech therapist Lionel Logue came with the 2011 film *The King's Speech*, where Helena Bonham Carter's Elizabeth, then Duchess of York, rings the bell at 146 Harley Street to implore Logue (Geoffrey Rush) to cure the future George VI's stammer. Although real life is not quite like the movies, and it wasn't a desperate Elizabeth of York but the formidable Baron Stamfordham, private secretary to George V, who facilitated the pair's introduction, luckily for George—and, arguably, the rest of us—Logue rose to the challenge. Thus began a lifelong friendship between monarch and migrant that may have been somewhat more formal than the film would have it, but was no less warm and heartfelt for that.

Born in College Town, Adelaide, South Australia in 1880, Logue was the son of an accountant. Unsure what to study at Prince Alfred College, he was inspired by the rhythms of Longfellow's *Hiawatha* to focus on elocution, and before long was giving his own recitals in Adelaide to substantial public acclaim. He taught in Kalgoorlie and Perth before embarking on a worldwide research tour with his wife Myrtle in 1911. On his return, he set up a practice treating shell-shocked World War I veterans with speech impediments. Then in 1924 he set out for a 'holiday' to England that would last the rest of his life.

Two years later, he established his Harley Street practice. Egalitarian to a fault, Logue charged wealthy clients significant fees whilst treating poorer clients for nothing. Therapeutically, his success was immediate—particularly with stammerers—so he began to specialise. Historian and speech

therapist Margaret Eldridge describes his techniques thus: "His method consisted in establishing in each patient a firm belief in the possibility of ultimate release from the stammer, achieved through effort of will, courage and determination... The practice of exercises in breathing, voice and speech, and the performance of speech-situation assignments were the means by which self-confidence was gradually established. There is no doubt that Mr Logue's own character and personality—his gift of practical sympathy allied to common sense, his humour and his charm—were important factors in the success of his treatment."

Charming and effective enough, then, to save a king from his demons. Logue's notes on the future George VI—then Albert, Duke of York—describe a man sorely in need of practical sympathy; with "acute nervous tension... brought on by the defect. He is of nervous disposition... Contracts teeth and mouth and mechanically closes throat... an extraordinary habit of clipping small words—and saying the first syllable of one word and the last syllable of another."

Logue's bill, drawn up on 31st March 1928, shows that the pair met for 82 appointments over 14 months between 20th October 1926 and 22nd December 1927, by which time the duke evidently considered his malady largely cured. Not irrevocably so; besides Logue, whom he continued to call on throughout his life, many reports speak of Elizabeth helping him with breathing exercises or to remove tricky consonants from his speeches, so perhaps *The King's Speech* is not so far wrong after all.

On George's death in 1951, Logue wrote to his widow with condolences. "Since 1926 he honoured me, by allowing me to help him with his speech, and no man ever worked as hard as he did, and achieved such a grand result." Elizabeth's reply stands testimony to the profound influence Logue had upon her husband: "I think that I know perhaps better than anyone just how much you helped the King, not only with his speech, but through his whole life and outlook on life. I shall always be deeply grateful to you for all you did for him." The new Elizabeth II personally sent Logue a gold snuffbox as a personal memento of her much-missed father. But by then, Logue's own health was failing, and he died of kidney failure on 12th April 1953, leaving a nation incalculably richer for his presence behind him.

24:00

A DAY IN THE LIFE

Joana Santos, senior theatre nurse
at The London Clinic

Interview: Clare Finney
Portrait: Joseph Fox

To most patients, we're almost completely invisible. When a patient is called for their operation, they're anaesthetised before they get to us. When they wake up, they are already in recovery, unaware of everything that has happened.

This invisibility can sometimes feel a bit strange, but it doesn't make us any less important: many patients come here to have surgery of some sort, so the theatre is really at the heart of the hospital. Some of the surgeries are very simple, like a hernia repair, but some are pretty complex, like major laparoscopic surgeries or those involving robots. It still feels odd, passing instruments to a machine.

Of course, the surgeon still controls the robot—they've not replaced them yet, and they've not replaced us either! But using robots minimises the chance of infection because no one is touching the patient, and a big part of our job is to eliminate infection risk wherever and however we can. In fact, the very first thing you learn as a theatre nurse is how to scrub up—that is, to wash yourself and put your gown on without contaminating anything, and to remain sterile throughout the whole procedure. Scrubbing up is the first thing I do when I arrive at work for my shift, after checking the schedule for the day.

The whole process has become routine for me now, but it took some getting used to at first. It sounds simple, but there's a real technique to washing your hands, nails, fingers and forearms in a surgical way, and it takes a lot of training. Then there's the fact that you have to remember throughout the surgery that you can't, for example, scratch your nose with your sterile gloves. It's like pulling out in a car without indicating or checking your mirrors—you simply don't do it. Likewise, needing the loo or feeling hungry during a long operation—you learn not to, because it means leaving the theatre and then scrubbing up again when you return. I've found that porridge is the only breakfast that sees me through the morning.

After scrubbing up, we set the trolley. We'll have our basic materials and tools—swabs, gauze and so on—but we'll also have the instruments for the specific surgery on a triple-wrapped tray. The outer wrap will not be sterile, the inner wrap is sterile, and the middle one acts as an insurance layer. This means we can transport the instruments without ever compromising what's inside. Only once the patient is in the theatre, anaesthetised on the table, do we open these trays: the first layer is




ENT A specialism involving medical and surgical treatment of the ears, nose and throat. They are often studied as a combined unit because the structures are closely interconnected.

Laparoscopic surgery A surgical technique in which operations are performed through small incisions, also known as keyhole surgery.

Micro-surgery Surgical field where specialised operating microscopes and precision instruments are used to perform procedures.

Recovery room A room where a patient is taken after surgery to safely regain consciousness and receive appropriate post-operative care.

Surgical sharp The name given to any instrument used for cutting or piercing during a medical procedure, such as a scalpel or surgical scissors.



In surgery, it is a respectful environment, of course, but we do chat about normal things. Some surgeries can last for as long as six hours, so it is important that you stay mentally lively—and humour can be a big part of that

When it comes to closing up, the most important rule is that what went in must come out: every swab, every sharp, everything. If you could hear us finishing up, all you will hear is endless counting as we sew up each layer. We count, and we count again, and every number is checked up on a board



opened by an 'unscrubbed' nurse outside the theatre, then a theatre nurse proceeds to open the second and third layers to access the instruments and pass them to the surgeon as and when they're needed.

As theatre nurses, our first concern is to look after the consultant—to ensure he or she arrives at the surgery to find the right tools in the right places. The consultants who come to our hospital practice all over London and are often internationally renowned. They have a right to expect the best and we do everything we can to make sure they get it. Consultants are extremely focussed and being able to communicate with them efficiently in theatre is an important skill.

Each consultant works in a different way according to where they trained—a surgeon from The Royal Marsden, for example, will work in a different way to a surgeon from St Thomas'—and you have to spend time getting to know them. After a while it comes naturally; you know what they need. A lot of them return to the hospital so we end up building a very trusting relationship.

One consultant in particular is very funny—time flies when we're working with him. People are surprised to hear it, but it is very rare to go into a theatre and it all be quiet and sombre. It is a

respectful environment, of course, but we do chat about normal things. Some surgeries can last for as long as six hours, so it is important that you stay mentally lively—and humour can be a big part of that. With as many as six people working in a confined space—anaesthetists, radiographers, specialists, other theatre nurses—it is also essential that we all get along well.

The variety of surgeries we assist with is enormous. I think I must have seen just about every organ in the body by now. I don't consider any surgery too challenging—we're very highly trained—but some are certainly pretty complex: for example, even the most experienced theatre nurse would find it hard to scrub up for ENT if they had not done it before, as the instruments are very different to those you would use for general surgery.

Another rather complex operation which we do here is the deep inferior epigastric perforator—the DIEP—for women who have had a mastectomy. It is a long procedure: a bit of plastic surgery, a bit of microsurgery and a bit of reconstructive surgery all in one. In it, we take a piece of skin and fat from the tummy and put it on the breast. It is

probably the best we could hope for in terms of breast reconstruction.

Throughout any surgery we follow protocols, non-stop. These are designed for best practice. In that respect, sometimes very different operations can feel exactly the same. When it comes to closing up, for example, the most important rule is that what went in must come out: every swab, every sharp, everything. If you could hear us finishing up, all you will hear is endless counting as we sew up. We count, and we count again, and every number is checked up on a board. We are very, very vigilant.

Once the patient is in the recovery room, we set things up for next patient. We are aiming for a turnaround time of 20 minutes. Then we scrub up and start all over again with the next one. Each shift lasts about seven hours, but if an operation takes longer, you stay longer of course. I love what I do. It's funny: when I was doing my nursing course I always said I didn't want to be a theatre nurse. Now I can't imagine doing anything else.

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SECOND OPINION

Should statins be routinely prescribed to patients with high cholesterol?

**No: there are lots of
other things you can
do first to try to reduce
your cholesterol**

Dr Martin Saweirs

Statins are very effective at reducing your cholesterol and they will do this very well for the majority of people. However, my feeling is that they should not be routinely prescribed to someone who presents with high cholesterol.

Split the population in two: people who have had a cardiac event such as heart attack or stroke, and people who haven't. For the first group, you are trying to prevent another event, and for them there is pretty robust evidence that prescribing statins is an excellent treatment.

But for everybody else—the majority of the population—you are trying to stop the event in the first place. For those people, lots of research is being directed at how effective statins are at reducing the risk of a heart attack or stroke. Currently, the evidence isn't conclusive.

As doctors, we look at something called 'numbers needed to treat'—that is, how many people you would need to give a medicine to in order to prevent one negative event. In this case, how many people would need to take a statin every day for five years in order to prevent one heart attack or stroke? At the moment it is about 60 or 70 people which is a relatively high number to prevent that one person having a cardiac event.

No medication is without side-effects, and with statins, these sit in a spectrum from muscle aches to actual muscle breakdown. Muscle breakdown is extremely rare, but muscle aches are more common. The issue is complicated by something called the 'nocebo' effect. This is when you inform a patient of the potential side-effects and they go on to develop them through psychological mechanisms rather than chemical ones.

As a doctor you are duty bound to notify patients of potential side-effects and if a patient tells you they are suffering, you have to treat it as a reaction to the medication. This is just another reason to avoid prescribing statins if you don't have to.

So taking the 'numbers needed to treat' approach, statistically you are giving a great many people daily medication

with potential side-effects, all to prevent a single outcome. And who is to say whether that is a reasonable risk? Some people may decide it is, others may not.

There are lots of things you can do to reduce your cholesterol. The big one is giving up smoking. I would also suggest exercise. We are not talking about training for a marathon, just two to two-and-a-half hours of light exercise, or 90 minutes of intense exercise, every week.

Changing your diet can also be effective: cutting down on processed sugars and eating more oily fish, which have beneficial effects on your cholesterol. Eating more fruit and vegetables each week—which I know from personal experience can be difficult to maintain over a long time—is well worth the effort.

Doing these things can have enough of an effect on cholesterol levels for some people not to need to go on medication. It is the ideal solution because not only is their cholesterol getting lower but their cardiovascular and general fitness improves, with all the benefits that brings.

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Yes: everyone, whatever their cholesterol levels, should take statins after a certain age

Dr Laurence Gerlis

I am a very strong believer in statins. In fact, I believe them to be one of the greatest medical advances of the 20th century. There has been a lot of debate about the side-effects of statins, with a possible link to diabetes and muscular problems. But while these questions must be investigated, we should not abandon the drug.

My wife's brother died of a heart attack at the age of 33 while playing football. He was active, very fit, a non-smoker. He only had one risk factor for heart disease: an inherited high cholesterol level. And it killed him, leaving a widow and three children. Had he been on statins, they would have dramatically reduced this risk. But while I admit there's an emotional aspect to my stance, I believe it is backed up by the data.

Like any medication, I do not prescribe statins lightly. Cholesterol comes in two types: high density lipoprotein (HDL), which is good, and low density lipoprotein (LDL), which is bad, and the ratio between the two types is vital. HDL cholesterol is actually protective of the heart and some people naturally have high HDL levels, which causes their high cholesterol reading. If this is the case you don't have to prescribe any medication.

Lifestyle choices also affect people's cholesterol levels. You can reduce cholesterol with changes in diet, and sometimes this is enough. I also look at other risk factors for heart diseases: do they smoke, are they overweight, do they have diabetes or high blood pressure, and so on. If action is needed on any of these I will advise accordingly.

But if after about 10 weeks their LDL is still elevated, I will start a patient on statins, even if none of the other risk factors are a concern. I would also choose a high enough dose to have an effect as soon as possible. Once you start treatment, you should do so aggressively so that the patient starts to get the benefits as soon as possible, and then fine tune the dose later.

I would start them on one of the simpler ones like simvastatin, but if they

developed side-effects I would try a different type. There are a wide variety of statins to choose from, so you should always be able to find one that works.

In fact, my belief in statins goes further: I believe that everyone, whatever their cholesterol levels, should take statins after a certain age. We have an ageing population with increasing cases of dementia. Most age-related dementia is actually caused by hardening of the arteries in the brain causing mini-strokes which kill brain cells. This is linked to cholesterol, so statins could improve the lives of thousands of families. I would start thinking about this when people reached their mid-30s, before they start furring up their arteries.

I take statins myself. I am on my third different type because I suffered some unpleasant side-effects from the first two, so I am not pretending that they are a panacea. However, I believe they are a first class, life saving drug, and making the most of them would lead to huge public health benefits for the country as a whole.

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THE BIG INTERVIEW

Dame Professor Donna Kinnair

One of Britain's most senior nurses talks to Prognosis about her roots in community nursing, sitting on government commissions and why she believes the title 'nurse' is in dire need of protection

Words: Viel Richardson
Portraits: Orlando Gili

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CHRIS REDGRAVE

“To be honest, I wasn’t exactly sure what a damehood was when I got the letter,”

says Dame Professor Donna Kinnair as we sit at a round table within the Marylebone headquarters of the Royal College of Nursing. *“One of my sons had to research exactly what it meant. It was a huge surprise once I realised the honour that was being bestowed. The letter had been sitting there for three weeks as I had been away in America, so I had to get a move on with the reply in case they thought I was turning it down.”*

It was validation of a career with deeply personal roots. Dame Donna’s father was chronically asthmatic and she saw first-hand the impact that good quality nursing could have on a patient. This left a deep impression on her—but it wasn’t a straight line from childhood dream to nurse’s uniform.

“My brother died when I was about 14 years old and I didn’t think I wanted to be around illness and death,” she says. It was not until she was working in Marks & Spencer, having decided to drop out of a maths degree, that she again crossed paths with the nursing profession.

Having married her childhood sweetheart, Donna was pregnant with her first child when a visit to the company’s occupational health nurse changed the direction of her life. *“I was telling her how much I had wanted to be a nurse as a young child, when she looked at me and said: ‘You still could be.’ I realised then that the desire had never really gone away. As soon as my son was born, I entered nurse training.”*

She knew instantly that she had made the right decision. She loved the patient contact from the beginning, and nursing satisfied that academic part of her nature that had been left unfulfilled by university. *“I am one of those people who likes studying and this career has given me the opportunity to study as much as I want to, over a wide variety of areas,”* Dame Donna continues. *“I remember spending a lot of time improving my understanding of the brain during training, simply because it happened to interest me.”*

She recalls using that knowledge to draw a diagram of the brain for a patient who had suffered a minor stroke. The patient was trying to understand why the problem had not been flagged up during initial tests. *“It helped the patient understand what had happened to her, which eased some of her anxiety.”*

For Dame Donna, this is a wonderful example of the two sides of nursing coming together: technical knowledge and emotional intelligence. *“There is a real sense of satisfaction when you make this kind of connection,”* she says. *“You can see the good you are doing for another human being.”* She believes that these moments of communication lie at the very core of nursing.

Dame Donna’s career has given her a clear-headed view of what is needed to do the job well. There is no place for misty-eyed romanticism about *“gentle angels mopping fevered brows”*; dealing with illness can be dirty, physically demanding and emotionally draining. And while there are patients who develop good relationships with

nurses, there are others whose reactions range from stubborn non-cooperation to outright hostility, and a nurse needs the ability to deal with it all.

Nursing calls for a special kind of person: someone who can combine critical thinking with compassion, and whose central concern is always the welfare of the patient.

Such people are not as easy to train as some would have you believe, says Dame Donna, and those we have are often not valued enough. While some—notably, she says, some of those in Westminster—would disagree with these statements, everyone can agree on one thing: the NHS does not have nearly enough of them—a situation which has led to an over-reliance on agency staff.

One of the aspects of this situation Dame Donna finds most frustrating is that the present state of affairs is neither new, nor unforeseen. In 2010, she was invited to sit on the prime minister’s commission on the future of nursing and midwifery. Its purpose was to look at the state of nursing from recruitment and training, through to the challenges nurses face on the ward and out in the community.

“One of the really interesting strands of the discussion was, for the first time, the government really thinking about the role of the community nurse and how care could be integrated into the community,” she says. *“A community nurse sees a patient with Alzheimer’s, say, only occasionally, but the patients’ families live with them full time. Part*

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There are fundamental attributes which underlie nursing everywhere. Can you observe when a patient is deteriorating and needs some assistance or an intervention to get them back on track? Can you understand their recovery path from whatever illness or procedure they have had? Can you spot if they are struggling emotionally as well as physically? Do you have the empathy skills to help them through a difficult patch?

**Dame Professor Donna Killair**

Director of nursing, policy and practice,
Royal College of Nursing (RCN)

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inquiry into the Victoria Climbié murder case
Taught medical law, ethics and child protection
in Britain, New Zealand, Russia and Kenya

of the role of the commission was to discuss how we could work with carers in an effective way, to support the nurse in providing high quality care for the patient while not leaving the family isolated and exhausted."

It required taking an honest look at the number of qualified nurses available, asking if their training was up to the task and if it wasn't, what action needed to be taken. *"One of the phrases I clearly remember from that commission was 'carequake'. Both on the ward and in the community, we did not have enough nurses, which meant they were under increasing pressure to deliver a wide variety of types of care. Unfortunately, this is now something nurses are experiencing on a daily basis."*

In the end, the timing of commission meant it fell foul of the political cycle. An election led to a change of government—one with different priorities. The commission's final report was, however, published, with recommendations that were grouped into seven areas, all of which need urgent attention. One in particular resonates deeply with Dame Donna, because she believes it lies at the heart of many of the issues currently faced by the nursing profession—the suggestion that the title 'nurse' should be given statutory protection.

"In some ways it's difficult to define a nurse, because they can work in so many fields—neonatal units, care homes, intensive care, accident and emergency, cancer units—each of which require different and often specialist skill sets," she explains. "But there are fundamental attributes which underlie

nursing everywhere: can you observe when a patient is deteriorating and needs some assistance or an intervention to get them back on track? Can you understand their recovery path from whatever illness or procedure they have had? Can you spot if they are struggling emotionally as well as physically? Do you have the empathy skills to help them through a difficult patch? Finally, if their prognosis is terminal, do you have the ability to work with them psychologically so that, wherever they are going to, they arrive in peace."

The British public holds nurses in high regard, which according to Dame Donna, can sometimes be a double-edged sword. *"The NHS is a very easy target for politicians, and with nurses making up the highest percentage of NHS workers, making pronouncements about nurses can be a shortcut for talking about the NHS as a whole,"* Dame Donna explains. *"Politically, you can play games with the term 'nurse', as it is not currently protected."*

At present, the training programme produces four types of nurse: adult, children's, mental health, and learning disabilities nurses. However, people who have not passed a nursing degree course can still use the term 'nurse' in their title—something Dame Donna feels is unhelpful. She explains that what the Royal College of Nursing wants to guard against is the public being confused about whether the person attending to them is a nurse who has undergone three years of training, or a healthcare worker who has not.

I am one of those people who likes studying and this career has given me the opportunity to study as much as I want to. I remember spending time improving my understanding of the brain during training, simply because it interested me

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What we can expect from the NHS in the future? What can it fund, and how are we going to change the structure to do what we think is necessary? As the people most often in contact with patients, it is vital that nurses' voices play a role in the debate

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“The government wants to introduce what is called a ‘nursing associate’,” Dame Donna explains. “At the RCN we are not keen on this title, because while the final level of training they will need is yet to be finalised, it looks like it will be below that of an enrolled or state registered nurse.” While it is still early in the process, the current proposal is to make these nursing associates band four healthcare professionals, meaning they have some kind of healthcare qualification, but crucially have not undergone nursing training, so can only work under the supervision of a qualified nurse. “If this does end up being the final position, they could have had no formal nursing training, yet still have the word nurse in their title,” she says with a hint of frustration.

The healthcare landscape is already crowded with ‘nurses’. Many healthcare workers do vital work supporting physiotherapists or rheumatologists, for example, but while there is no real nursing involved in their duties they are routinely referred to as nurses.

Dame Donna sees political benefits in a growing profusion of ‘nursing’ titles. *“At the moment a politician can claim to be increasing the number of people in nursing by including these roles. While technically true, it is misleading and can lead to confusion about the real level of action needed to redress the current shortage of trained nursing staff.”*

Of course this discussion is not taking place in a vacuum: the world in which nurses operate is continually changing, and as it does so, new challenges are emerging. One of the biggest we are facing at

the moment is an ageing population, with the growth in dementia-type conditions that come with it. The country as a whole will have to find a way to meet this challenge, but it is healthcare professionals, and nurses in particular, who are going to be at the sharp end, managing the conditions and supporting families.

“For me one of the biggest challenges is that of rising expectations. What we can expect from the NHS in the future? What can it fund, and how are we going to change the structure to do what we think is necessary? These are difficult questions and as the people most often in contact with patients, it is vital that nurses’ voices play an important role in the debate,” she says with real feeling. “The public value nurses immensely, but the relationship between nurses and politicians is very different. There needs to be an honest conversation about the role of the nurse within the field of healthcare: what nurses’ responsibilities are and where nurses stand in relation to other healthcare professionals.”

While the issues facing the profession are serious, and Dame Donna is working hard to tackle them, a twinkle is never far from her eye as we talk. While it is no doubt stressful at times, in essence her job is to find creative ways to make things better for those that work in a profession she loves. Any success makes the lives of thousands of her fellow nurses better.

“I try to make sure that any conversations I have—whether it is with government ministers, representatives from other countries, or nursing leaders from around the

UK—are positive, and that they inspire confidence in nursing,” she tells me. “I want to make sure that people understand that we do have wonderful nurses in this country; nurses who develop practice that is cutting edge, and becomes the benchmark.”

The Royal College of Nursing spends a huge amount of time exploring good practice around the world—what is being done elsewhere that the UK could learn from, how good practices developed in this country can be shared elsewhere, how new challenges such as antibiotic resistance are being met and how safe practices can be developed for working with epidemics such as the Zika virus, protecting nurses and patients alike.

While the implications of her work may sound a bit dramatic, Dame Donna is happy with her lot. *“Personally, I have had the time of my life as a nurse,” she says with a smile. “I have totally loved my career. It has been very diverse and has given me the opportunity to manage things, to use my love of academic study, shake things up, work in child protection. There is huge possibility for diversification into different fields. If you have fundamental knowledge of how to nurse and think about why you’re doing things, I think it is a fantastic career.” ■*

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ROCKET

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Success for elite athletes demands commitment, sacrifice and intensive training. It also demands the right dinner. Prognosis paid a visit to the Royal Society of Medicine to hear how food and athletic performance go hand in hand

Words: Mark Riddaway

FUEL



REUTERS/ADRES LAFIT

At the 2008 Olympics in Beijing, the Great Britain women's hockey team did what they had almost always done in major competitions: finished among the also-rans.

Sixth place—not a complete disgrace, considering they'd failed to even qualify in 2004, but hardly the kind of performance to spark wild celebrations and open bus tours.

Afterwards, when the team gathered together in the Bisham Abbey sports complex to discuss their goals for the 2012 games, a decision needed to be made. According to Alex Danson, the star striker who made her international debut in 2001 and remains a vital member of the squad, this proved to be a pivotal meeting. *"I remember being sat in a room, and our coach said to us: 'What do you want to achieve in London.' One of the players said: 'Gold. Let's go for a gold medal.' And I'll be completely honest, I remember thinking, in the history of the women's game we have never won a World Cup medal, we haven't won an Olympic medal in 20 years. Who are we to think we can compete in three years' time?"*

But think it they did. And while they didn't win gold, they came mighty close, losing a tight semi-final to Argentina

before powering to a bronze medal.

Four years on, their goal remains the same: victory, nothing less. That transformation, from mediocrities to genuine contenders, required Alex and her teammates to change their approach to any number of things: how they train, how they think, how they travel, how they sleep—and how they eat.

"The key for me was understanding how important nutrition was to enable me to do the required strength and conditioning work—it's horrible and it's hard, and I can't do it unless I'm fuelled correctly," says Alex. "It was the biggest shift in my whole career as an athlete. Until I had access to a nutritionist in the build up to London, and even more so now, I never quite realised how connected the two were."

Alex, appearing on stage with her team's nutritionist, Emma Gardner, and strength and conditioning coach Ben Rosenblatt, offers this insight as part of a day-long symposium at the Royal Society of Medicine, which has gathered together some of the top practitioners in the world of elite sports nutrition, many of whom will have a direct influence on Team GB's medal haul in Brazil this summer. Organised by James Collins, president of the RSM's food and health



Glycogen The form in which carbohydrate is stored in the human body

Lipid metabolism The synthesis and degradation of stored fats to create energy

Nutrition periodisation Matching energy and macronutrient intake on a day-by-day, meal-by-meal basis

Some of our established ideas about nutrition simply don't stack up when applied to highly trained athletes. Would you or I benefit from exercising while starving hungry? Absolutely not. Would an elite road cyclist? Almost certainly

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forum and head nutritionist at Arsenal, and Mark Ellison, lead performance nutritionist for Manchester United and GB Boxing, its panelists represent the cutting edge of this fascinating field.

It is also, without doubt, the fittest, leanest group of British medical professionals ever to have sat together in a single room—at the lunchtime buffet the fruit salad is wolfed down with abandon, while the girl serving the bread and butter pudding stares listlessly into the middle distance. Of the many conclusions to be drawn from a fascinating day of discussions, one is that sports nutritionists largely practice what they preach.

At its root, the job of the sports nutritionist is a simple one: to enable athletes to reach their highest potential on the day of competition by providing them with the right fuel and nutrients for both training and performance. This may involve shaping body composition and triggering training adaptation to increase speed, power, flexibility or stamina. In the case of weight category sports such as boxing, rowing and taekwondo, it may involve careful but rapid weight loss in the days before competition. And in any instance it will require the provision of the necessary

fuel to maximise performance on the day and recovery immediately afterwards. But beyond these generalisations, elite sports nutrition appears to be a deeply complex mix of science and psychology.

As the event unfolds, several key themes develop. The first of these is that while sports nutrition is rooted in hard, experimental science, researchers working at the elite end are constantly hampered by the gaps between what can be measured in the lab and what actually takes place in the bodies of this tiny subset of people, with their extraordinary, hyper-trained physiology. As Dr James Morton, a researcher at Liverpool John Moores University and the head of nutrition for the Team Sky cycling team, puts it, *“what we know about fuel use in exercise is unfortunately restricted to the laboratory situation; the real world is completely different.”*

Sticking someone on an exercise bike in a university, no matter how hard you make that subject work, is never going to replicate the experience of competing in the Olympics, with an audience of billions looking on and the stresses of competition jabbing their tendrils into the brain and muscles. Similarly, attempting to wire Mo Farah to a load of monitoring machines while he attacks the final lap of the 5,000 metres is clearly a non-starter.

As a result, some of our established ideas about nutrition simply don't stack up when applied to highly trained athletes. Would you or I benefit from exercising while starving hungry? Absolutely not. Would an elite road cyclist? Almost certainly, or so James's research would suggest.

Another example: Dr Graeme Close, who works a lot with power athletes such as rugby players, describes as *“nonsense”* the frequently cited ‘fact’ that the body can only process 20g of protein in a single meal. *“That might be true in the context of a study done using 70-80kg students doing a single leg exercise,”* he says. *“But what happens when you're working with genuine power athletes? People who've done this training for years, when I've suggested 20g is enough, they've said, 'Yeah right, you try getting to this size on 20g of protein.' They've been saying the real number is 40g or 50g.”* Graeme believes that the scientific literature is only now beginning to catch up with the practical experiences of athletes who have managed to pack on muscle by training like Trojans while

ingesting quantities of protein that would cause the eyebrow of a regular nutritionist to twitch.

Every sport is different. *“You have to really understand the energy demands of a particular sport before you can assess the nutritional needs,”* insists Graeme. For example, we know, generally speaking, that the body burns fat during extended periods of moderate exercise and uses carbohydrate to fuel bouts of intense exercise, but for anything other than the most straightforward of sports—the 100m sprint, for example—the balance between the two is likely to be bewilderingly complex. Grand tour cyclists, for example, oscillate quite naturally between periods of gentle cruising and bouts of crushing intensity. These shifts have to be minutely understood for an effective nutrition plan to be implemented.

The more work a nutritionist can do in the field, the better. *“Rather than researching for practice, I've always been interested in engaging with practice in order that we then ask the right questions in the lab,”* says James. Graeme talks about the value of gathering muscle biopsies from willing athletes—essentially removing a tiny slice of muscle from the same area before and after exercise to examine changes in its biochemistry. This is a world in which gathering proper data is absolutely essential, and that requires the constant cooperation of the athletes.

To make things even more complex, you also have to understand the individual athletes and their lives beyond the training ground. Graeme cites the example of a rugby club whose players had their energy use measured across the course of a week. Despite undergoing the exact same training programme, some burnt an average of 4,500 calories per day, while others averaged 6,500 calories—a huge disparity, mainly down to lifestyle.

It's not enough, therefore, for a nutritionist to wander into a training camp and hand out the same photocopied plan to every member of a squad. Periodisation and personalisation: these are the watchwords.

Understanding the science, understanding the sport, creating personalised food plans: all are essential parts of the sports nutritionist's role. But without the athlete's buy-in, it's all just numbers on a spreadsheet and colour bars on a calendar. Food is more than the sum of its nutritional components—it is a basic human need, and one that stirs



REUTERS/ANDREW WINNING

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**STICKING SOMEONE ON AN
EXERCISE BIKE IN A
UNIVERSITY LAB, NO
MATTER HOW HARD YOU
MAKE THAT SUBJECT
WORK, IS NEVER GOING
TO REPLICATE THE
EXPERIENCE OF COMPETING
IN THE OLYMPICS, WITH
AN AUDIENCE OF BILLIONS
LOOKING ON AND THE
STRESSES OF COMPETITION
JABBING THEIR TENDRILS
INTO THE BRAIN AND
MUSCLES**

up all kinds of emotional responses. There are things we like and dislike, things we crave beyond reason. Some people enjoy cooking, others don't. Some athletes can robotically follow a strict eating plan, day after day, week after week, while others just really want to eat a Mars Bar.

Michael Naylor, lead nutritionist at the English Institute of Sport, groups athletes into four fairly self-explanatory categories: the scientists, the questioners, the dinosaurs and the bored. Of these, the dinosaurs—those highly decorated older athletes who fondly remember the days when chicken curry was on the pre-match and who deride their nutritionist's advice as airy-fairy nonsense—are the toughest to work with (*"Sometimes you just have to let it be..."*)—but the others can be coached along the right path in various ways.

Michael offers some examples from his work with Southampton FC. *"There were some foods in the kitchen that weren't great, and we wanted to nudge the players to make the best decisions. We didn't want to just scrape everything, take all the treats out; we wanted to give them the skills to make the right choices, rather than just policing them all the time."* This involved plenty of education and some subtle steps in the canteen: putting the veg out on the counter before the carbs, drawing an infographic on the homemade yoghurts flagging up their high protein content, leaving the lid off the nut butter in a way that invited consumption. This is all as much a part of the nutritionist's role as the number crunching.

According to Emma, the GB hockey team's nutritionist, team sports present a particular challenge. *"Teams spend a lot of time together and they influence each other,"* she explains. *"Sometimes in positive ways, but sometimes we have to do some myth busting."*

When she first started working with the women's hockey team, there was, she says, a cluster of athletes who were quite carb-phobic in nature—unsurprising given the compelling but deeply flawed 'carbs are bad' narrative that plays out daily in newspapers and diet books. *"We had to re-educate the girls on what hockey performance looks like,"* says Emma. *"Hockey is characterised by high intensity bouts of exercise which are reliant upon glycogen. When it comes to the crunch, you have to eat carbohydrate."*

The key, she says, is for nutritionists to work hand in glove with strength and

IS TRAINING WHILE HUNGRY THE FUTURE FOR ENDURANCE ATHLETES?

While it may sound counterintuitive, one of the most promising areas of research in endurance sports involves deliberately restricting the calorie intake of athletes while training. Dr James Morton explains: "Even though a lot of people probably think it's ludicrous, I really do believe that to drive the endurance phenotype we should be deliberately periodising aspects of training where we calorie restrict—not just carbohydrate restriction but actual calorie restriction."

conditioning coaches to ensure that nutrition is viewed in the context of performance. It was this integration of the two disciplines that saw the hockey team really turn a corner.

During an intensive overseas series, Ben, the team's strength and conditioning coach, measured the players' power throughout the trip, while asking them to fill in a food diary. For those athletes who weren't among the strongest in the squad, there was a clear correlation between a low carb diet and a significant decrease in power as the series went on. *"We were able to say, there's not many in the squad at this point in time who are particularly strong, and if we want to be able to preserve our physical performance we have to have the appropriate nutrition to fuel and recover appropriately,"* says Ben. *"We were able to provide them with the evidence to make better decisions."*

This performance-led approach is particularly important when it comes to discussions around body composition. Telling an athlete that they need to change their body shape isn't easy unless there's a quantifiable reason for doing so. *"The girls in particular often want a rationale,"* says Emma. *"It can be a very awkward*

The theory is that exercising in a fasted state, but one of high protein availability, activates the molecular pathways that regulate muscle adaptation, resulting in a muscle that has more mitochondria (which supply cellular energy), more capillaries with higher blood flow, and a greater capacity to use fat as a fuel. "You then turn up on race day, put carbohydrate back in, and you get the best of both worlds—you have a muscle that's adapted to training, but also a muscle that knows how to maximise performance."

James is putting this theory into practice with Team Sky. "A new form of training that we're getting interested in is depleting carbohydrate and glycogen through an evening session, and then waking up the next morning and exercising straight away in a fasted or protein-fed state"

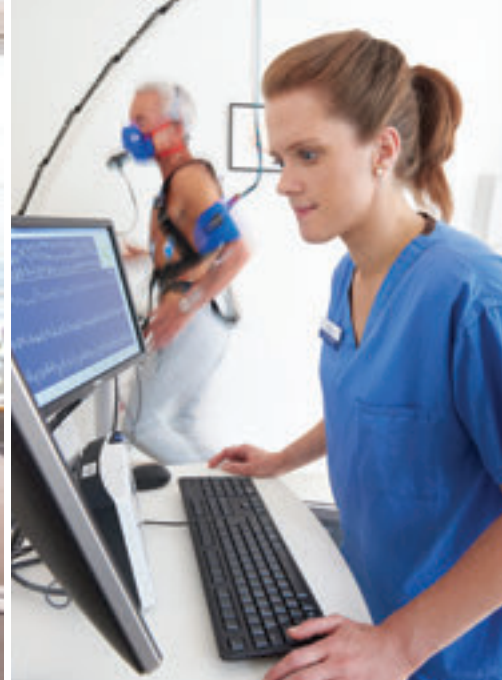
This may be a case of science catching up with practice: "Look at how the best athletes in the world fuel and structure their training programmes: they do this anyway. Triathletes train three times a day and there's no way they can replenish muscle glycogen to the full before every session. Kenyan runners have been training fasted for years."

conversation to tell an athlete that they need to actively change their body composition. We have to give them a reason: okay, by doing that, we think you'll be able to better your speed, and your coaches say that your speed is your limiting factor..."

One specific moment at the RSM helps to contextualise all of the talk of nicotinic acid, mitochondrial biogenesis and fuel efficiency. In the afternoon Dr Steve Ingham, director of science and technical development at the English Institute of Sport, lectures on the science of training techniques. Behind him, a video plays of Mo Farah on a treadmill, shirtless and wired to monitors, running at 24km/h. It is unreasonably fast, staggeringly so, a full-on sprint for a half-decent amateur runner. But this is a world class athlete, properly fuelled thanks to the hard work of some serious scientists. As Steve talks, Mo keeps on running. And running. And running. And running...

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Q+A

Sean Curry, orthopaedic surgeon at the London Orthopaedic Clinic, on fractures, frustrations and 3D printing

Interview: Viel Richardson
Portraits: Joseph Fox

How would you describe orthopaedics?

Orthopaedics is a part of surgery dealing with bones, joints and muscle injuries—essentially, anything to do with what we call the locomotor system: those parts of the body that allow us to move around. You can get orthopaedic spinal surgeons, shoulder surgeons, elbow and hand surgeons, knee surgeons, foot and ankle surgeons, and so on.

What is a fracture?

The easiest way to define a fracture is a broken bone. At one end of the spectrum you can have someone who walks into the surgery with a small stress fracture, at the other end is a bone broken into several pieces with extensive soft tissue damage around the injury.

Are some people more prone to fractures than others?

Yes, they can be. At the extreme end of the spectrum there are inherited diseases which cause osteogenesis imperfecta, better known as brittle bone syndrome. For some people with this condition, they only need to cough to break a bone.

Osteoporosis—a condition in which the bones become brittle and fragile—can be the result of poor diet; smoking doesn't help your bone health, and the same for not getting enough exercise. So there are lifestyle choices involved, but there is also a genetic aspect. Osteoporosis is something that is affected by aging, especially affecting post-menopausal females. If they are seriously osteoporotic they can be treated with medication. The great thing is that your bone density is not set in stone—it is variable throughout your life, so you can do something about it if you choose to.

How has fracture treatment changed in your time?

It has changed significantly through our increased knowledge of the science of bone repair. We now know much more about the biology involved in bone healing, and we have been able to develop ways of influencing that healing process. We are also much more pro-active in our approach—we used to treat fractures by carrying out an open operation to fix the bone, then encasing the area in plaster and waiting. Now we can manage fractures non-operatively, using removable splints or boots. These allow patients to move their muscles a bit, which keeps them healthier. While such equipment was in existence in the past, it was not particularly widely available. That may have been partly due to unit costs, but also a lack of general acceptance of these devices by clinicians.

What was behind that caution?

You have to maintain the stability of the fracture during the healing process. If something shifts and the fracture heals in a poor position the repair won't be as strong as it could be and—depending on where it is—can end up increasing the



risk of things like arthritis. Understanding how these devices worked under different circumstances took time.

What are the biggest problems you encounter?

Some particularly complex fractures can be difficult to fix, but we usually find a solution. Others appear simple, but then fail to heal. That can be because they haven't had the right stability, or for some reason the biology has not been right. Fractures heal naturally as long as certain conditions are met, but sometimes this does not happen. Then we have to investigate why.

Can you explain what you mean by the 'biology' of fracture repair?

There are certain nutrients and minerals that the bone needs in order for it to heal. There are also certain messenger proteins produced in bone marrow that are required for healing. This is what we call the biology of the fracture.

Say you have a fracture that is caused by repeated small injuries, like a stress fracture; all you need to do is protect it and it will heal. It already has stability, so if you take the load off the fracture and rest it, the fracture will heal. It already has the right biology.

But if you have multiple fragments of bone, where the soft tissue around the injury is badly damaged, it is a very different situation. The blood supply—and therefore nutrient supply—to the injury could be completely shot. Where the biology is significantly damaged, it will need to be improved for you to get the best result. As well as getting the stabilising structures right, getting the biology right is absolutely vital.

How would you go about getting the biology right?

We have to influence the chemical environment within which the bone sits, which is where bone grafts would usually come into play. Taking a piece of bone from another part of the body and grafting it in place in the location of the fracture brings some of these proteins into the region of the damaged bone. What is exciting now is that, instead of a bone graft, we can instead draw bone marrow from the donor site, mix it with some specialised paste and inject it into the wound to introduce these beneficial proteins into the area.

What areas are you struggling with?

Despite our best efforts, sometimes fractures don't heal. That can be very frustrating. You do your best, you think you have done a good job and yet they don't heal—and we simply don't know why. Whether it is an unknown infection or some aspect of the biology we don't yet understand, the healing does not happen.

What is the end stage if a fracture does not heal?

The worst case scenario could be an amputation, and that is what happened in the past. But now there are more advanced bone regeneration techniques. It is possible to cut out a section of bone that is infected or dead, shorten the limb, put an external scaffold in the limb and very slowly lengthen the scaffold as bone forms in that gap. This can be quite involved for the patient and they could have to wear the scaffold for 12-18 months, but that is infinitely better than an amputation. There are degrees of interventions we have available before we get to that horrible end point, which hopefully we avoid.

When would you use this technique?

If a year down the line a fracture has failed to heal we would call that a non-union, and be asking questions about why.

Has there been movement within the repair, or is there an issue with the biology? If we have feel it is the biology, we would look at a bone graft, or one of these chemical solutions.

Does technology have a big influence on the field?

Advances in imaging and the software that goes with it have been huge. For example, a CT scan can be translated into a 3D image that we can manipulate on screen for an incredibly detailed view of the damage to the bone and the surrounding tissue. More recently, 3D printing allows us to take these scans and make a model of your fracture. Even with the most complex fractures, you can plan your operation before laying hands on a patient—that has been a great leap forward.

Has this changed the way you conceptualise an operation?

That's an interesting question. I think the ability to conceptualise in three dimensions is very necessary in the type of operation where you are fixing several pieces of bone, and you need the fixing tools to interact with the bone at precisely the right angles. Previously, I was trying to think in three dimensions anyway, but this technology has certainly aided in that.

What would you say has been the biggest advance in your field?

With regard to fractures, I would say the biggest advance has actually been a change of mind-set. When I started, the paradigm was that you carried out an open operation to repair the fracture. The thinking has moved on from there. Now, we have developed techniques where, for example, if you want to put a stabilising plate on a patient's tibia you make a small hole above the fracture, slide the plate down along the bone and then use targeting devices to screw it in place. Instead of one big cut you have multiple small ones. It is all about preserving that envelope of tissue around the wound, which is vital for bone healing. That is probably one of the biggest advances, but it has been a stepwise improvement as opposed to a great leap.

If you had a silver bullet, where would you aim it?

I was looking at an orthopaedic journal from 1949 where they talked about what the great leaps forward in the field would be, and one was an injectable paste. There would be no open operation. You would set the fracture, and then inject a paste around it, which would then set and hold everything in place while the fracture healed. That would still be my magic bullet: if you could inject an internal plaster, hold the repair rigid and then give it the right environment to heal.

Is there anything like that in the horizon?

Alas, no. There are injectable pastes available which are aimed at improving the biology. What is really exciting is that we now have genetically engineered substances that we can inject into and around the fracture which mimic those proteins.

What do you like most about your job?

It suits my personality, I like problem-solving and finding solutions. A patient arrives with an issue that is impacting on some aspect of their life, be it work, sport or general mobility. I analyse it, identify the problem and devise a treatment plan. The vast majority of the time it works and they go away happy. That really appeals to me, hearing that they are back to running again, or have taken up a sport they love, or are just living pain free. That gives me real satisfaction. ■



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12mm



Patient experience

How David Kelly discovered a 12mm-wide stone in his throat—and how having it removed changed his life for the better, despite forcing him to miss one of the biggest days of his career

Interview: Clare Finney

When I did initially see Mark McGurk at King Edward VII's Hospital he told me that in 96% of cases he could feel the stones in the neck, so could get at them easily. My stone, however, was so deep he couldn't feel it at all. I was in that unlucky 4%

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Up until a year ago I didn't even know salivary stones existed, although I'd had a bit of an issue with my glands swelling at meal times since I was about 12 years old. By the time my parents ever got me to the GP, the swelling had gone down. The GP checked for mumps, and told them to just keep an eye on it; there wasn't much they could do, they said, and it only happened about once or twice a year.

Then, about a year ago, it started happening more frequently. I'd be eating, then my jaw would swell up painfully until eating became uncomfortable. One day it happened when I was having lunch at work.

I work at Manchester United Football Club, where I'm the first team's sports scientist, so I went to see the club doctor. He alerted me to this condition called salivary stones, in which one of the tiny calcium balls that are produced by salivary cells all the time and are normally just washed out in the saliva gets stuck on a duct wall or bend. There, it acts as a nidus for calcium dissolved in saliva to precipitate out, causing the ball to grow in size at about 1mm a year.

Eventually this 'stone' ends up partly blocking the duct, so at meal times, when saliva is stimulated, it can't flow into the mouth. The gland inflates with obstructed saliva—hence the swelling in the lower jaw and cheeks—until the dammed saliva slowly finds a way around the stone into the mouth and the swelling recedes again. It's called mealtime syndrome apparently. It's the major symptom of salivary stones—and

when I went to my local hospital in Barnsley as the doctor at Man U recommended, the x-ray revealed a large stone, about 12mm wide, deep inside my neck.

I have to say, I was surprised to see it. A week before, I didn't know salivary stones existed: now I was looking at a large calcified mass inside my submandibular gland. They told me the only way I could have it removed was to take out the whole gland, through my neck—a big operation, which comes with a big risk. The submandibular gland sits very close to a major facial nerve, and trying to dissect the gland without affecting this nerve is difficult—like a needle in a haystack, apparently. If it was damaged, it could create a paralysis—like I'd had a stroke.

I was adamant I wasn't going to have that done. It would leave a big, visible scar on my neck, and if the nerve controlling the face was affected, my face would droop. This makes me sound vain, and I'm not, but the last thing you want is a drooping face. I did some research on the internet to see if there was an alternative way to remove the stone, and came across this leading expert in salivary gland surgery, Professor McGurk.

I went back to Barnsley, told the doctor there that I'd discovered this surgeon who had pioneered the use of minimally invasive surgery for salivary stones—known as the Endoscope Assisted Submandibular Gland procedure—and he said immediately, “You must mean Mark McGurk? I worked under him, years

ago. However, looking at the scan of the x-ray, I think you'll find this salivary stone is so deep even his surgery won't work.”

It turned out the Barnsley doctor was right not to be too hopeful—because when I did initially see Mark McGurk at King Edward VII's Hospital he told me that in 96% of cases he could feel the stones in the neck, so he could get at them easily. My stone, however, was so deep he couldn't feel it at all. I was in that unlucky 4%.

The stone had been there for 12 years at least, and probably much longer. If I cut the stone open, he said, I'd see rings of calcium like the rings of a tree. I remember asking him at that moment what would happen if I just left it, and didn't proceed with any treatment. He said it would almost certainly get bigger, until eventually bacteria found it and started causing infections. The more infections there were, the more damage would occur to the gland—and it would ultimately make me very sick. Although it would be tricky, we decided to go ahead with the Endoscope Assisted Submandibular Gland procedure.

I still think I'd have lived with it had there not been the possibility of having



Nidus The central point of focus around which a structure such as a salivary stone or an infection can develop.

Submandibular glands The major salivary glands located beneath the floor of the mouth.

Micro endoscope A piece of equipment which allows a tiny tube with a camera at the end to be guided to an internal organ, where a still or moving image can then be taken.



- 1— Accessory parotid gland
2— Parotid duct
3— Sublingual gland
4— Submandibular gland
5— Salivary gland stone
6— Parotid gland

He's an interesting guy. He's done a lot of work around mouth and neck cancers too, and works for a charity called Project Harar, treating facial deformities in Ethiopia. I'm going to get Wayne Rooney and the lads to sign a shirt for him, so he can auction it

”

it removed via this procedure. As it was, I decided to work until the end of the football season at the end of May, then have my op. The club were happy for me to have it earlier, but I wasn't in agony and I was happy to wait until it was best for the team. The surgery was booked for the evening of Thursday 19th May: the FA Cup Final was that Saturday at Wembley, and the plan was to stay with my nephew, who lives in London, and then take him to the game.

Of course there was some discomfort when I came round after surgery on Thursday night: after all, they had cut through the floor of my mouth to reach the gland via the duct using a micro endoscope to find the stone before releasing it. Also, in order to ensure the important lingual nerve was not affected by surgery they had had to isolate it, which leaves a tingling sensation in your tongue. Come Friday afternoon, however, it seemed everything was back to normal besides the tingling sensation, which was similar to that you get after a visit to the dentist. There was no swelling, no pain, and they allowed me to go home to my nephew's. I was really overjoyed, if a little tired—so as soon as I got in I went to sleep.

I woke up Saturday morning to find one side of my face had swollen up quite badly. I realised I was having difficulty swallowing—then, difficulty breathing. It felt like a ball was trapped inside my windpipe. So far, my sports science background meant that I'd found the stone quite intriguing: I'd read journals and papers, and really got very

interested—but this experience of being infected and feeling so ill was entirely new. I'd never really been ill before, because of my job. I have to stay fit and eat healthily to keep up with the team. The most I'd had was the flu; now it felt like my neck was closing in. It wasn't very nice really—so I rang Mark McGurk, who told me to come straight to the hospital.

My nephew lives in east London, so it's a 45-minute tube journey to King Edward VII's Hospital—and it felt like the longest 45 minutes of my life. I was really struggling to swallow by then, so I had to take an empty water bottle with me and spit in it during the journey. I don't know if you've ever tried not to swallow, but it is very unnerving—and I was pretty embarrassed, spitting in this bottle—but I thought people on the tube had probably seen worse.

As soon as I got in, Mark McGurk put me on antibiotics and a bit of pain relief. I'd got an infection, he said, which can happen in a few cases because when you disturb the stone bacteria can get in. I had to stay in the hospital for 24 hours so they could keep an eye on me, and I continued with antibiotics for the rest of the week.

It was terrible. I ended up watching the FA Cup Final, where Manchester United beat Crystal Palace, alone in my hospital bed with my IV drip. But the way I was feeling at that moment, I just wanted to be safe—and I felt safe where I was. I sorted my nephew out with some workmates so he got to see it, which was good—and I'm happy with the outcome. Now when

you look at me, you'd not know I'd had an operation. Within a few weeks the stitches dissolved and disappeared, I didn't feel sore and while my tongue was still a bit tingling the swelling had gone and I could eat normally—even sour foods, which used to be the worst because they stimulate your glands the most.

I'll see Mark McGurk in three months, just for peace of mind, but he said the chances are he will take one look at me, ask me how I am and I'll tell him I'm perfectly fine. I'm so glad I went to see him. After reading so much about this condition, I don't think many surgeons could have got that stone. He's an interesting guy. We had good rapport. He's done a lot of work around mouth and neck cancers too, and works for a charity called Project Harar, treating facial deformities in Ethiopia. I'm going to get Wayne Rooney and the lads to sign a shirt for him, so he can auction it. I'd like to help in some way.

I'm devastated I missed the FA Cup win, but at the end of the day it's out and it's done, and that's the main thing. Besides, there's the new season, and training starts soon. I've already told the lads they have to do the same again, because I missed it—and I've taken in the stone to show them. It's pretty gruesome-looking, and really hard, like marble. I can't believe it was inside of me for so long. ■

King Edward VII's Hospital
5-10 Beaumont Street
London W1G 6AA
020 7486 4411
kingedwardvii.co.uk





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THE ELEPHANT IN THE ROOM

Of all Marylebone's doctors, none has had quite the same cultural impact as **Frederick Treves**, the subject of books, Hollywood films and a Broadway play, best remembered for the compassion he showed to Joseph Merrick, the Elephant Man

Words: Glyn Brown

Sir Frederick Treves, seated, and fellow physician Sir Francis Laking in a painting by Harry Herman Salomon

Frederick Treves was born in Dorset in 1853, at 8 Cornhill, Dorchester—

the Costa coffee shop on the site now proudly flaunts a blue plaque. Son of an upholsterer, as a small boy he was deeply influenced by attending the local school run by Dorset dialect poet William Barnes. In one of his many later books, Treves remembers Barnes absently pacing the floor of a classroom, lost in thought and possibly poetic composition, when Treves dropped a piece of fruit—food was forbidden in class. He scrabbled after it, Barnes (*“the gentlest and kindest of men”*) fell over him, but it was Barnes who apologised, still concentrating on his poem. When he was 14, Treves’ father died, and his mother sold the family business and moved to London, where at 25 Treves became a member of the Royal College of Surgeons. He found a position at the London Hospital, Whitechapel, and began to establish himself, specialising in abdominal surgery.

And then, one day in 1884, Treves passed a vacant greengrocer’s in the Mile End Road, just opposite the hospital. The front of the shop was obscured by a canvas sheet, on which it was announced that the Elephant Man could be viewed within, for an admission price of tuppence. A daubed illustration showed roughly what you’d see. The exhibition was closed, but Treves located the proprietor in a local pub, and was granted private admission. He was shown into the shop—empty, dusty, and littered with old tins and bits of shrivelled vegetables. It was November, and cold.

In his book, he explained the next moments thus. *“The showman pulled*

back the curtain and revealed a bent figure crouching on a stool, covered by a brown blanket. In front of it, on a tripod, was a large brick heated by a Bunsen burner. Over this, the creature was huddled to warm itself... The showman, speaking as if to a dog, called out harshly: ‘Stand up!’ The thing arose and let the blanket fall to the ground. There stood revealed the most disgusting specimen of humanity I have ever seen. In the course of my profession I had come upon lamentable deformities... but at no time had I met with such a human being as this lone figure displayed. He was naked to the waist, his feet bare, and wore a pair of threadbare trousers...” A sign hung by the curtain proclaimed: *“The Deadly Fruit of Original Sin.”*

This, of course, was Joseph Merrick, then a young man of 21. Treves would later discover that he had been born in Leicester, abandoned by his mother, brought up in a workhouse and run away to make an income as a freak on display. It wasn’t an unusual line of work: during the 1880s the British public could see Jo-Jo the Dog-Faced Boy, Krao the Missing Link and any number of giants, dwarves and bearded ladies. In the David Lynch film made in 1980 from Treves’ book, Anthony Hopkins, as the surgeon, weeps silently as he takes in the man’s appearance and condition.

Whether or not that happened, Treves does seem to have been very moved. He had Merrick, in a long black cloak and cap with a length of material attached to hide his entire face and body, conveyed to the hospital to be examined, astonished by the enormous, misshapen head (*“from the brow, there projected a huge, bony mass like a loaf”*),

It would be reasonable to surmise that his brutish life would have a great effect upon a sensitive, intelligent man. He might be spiteful and malignant, swollen with venom, or a despairing melancholic. But Merrick’s troubles had ennobled him

”

the fungal, cauliflower-like growths on the skin, the gnarled, slab-like face, from the jaw of which a bony mass projected, turning the lip inside out (and exaggerated, in the illustration, into a tusk or trunk), and the fact that although one arm was perfect, the other was a bloated fin or paddle. Merrick appeared cowed and shy and, due to his multiple deformities, seemed unable to speak. Treves assumed, and hoped for Merrick’s own sake, that he was *“an imbecile”* with no emotions or real understanding of his situation. We know now, of course, that the ‘creature’ was a hopeful, imaginative man who suffered from neurofibromatosis, a rare disorder characterised by tumours under the skin, around nerves and in the bones.

Merrick left, and the following day



Sir Frederick Treves

Surgeon

1853 Born in Dorchester, Dorset

1871 Began studying medicine at University College London, then at the Medical School of the London Hospital

1874 Became a licentiate of the Society of Apothecaries

1875 Passed the membership examinations for the Royal College of Surgeons

1878 Gained Fellowship of the Royal College of Surgeons

1879 Began 20-year stint as a surgeon at the London Hospital

1884 Began association with Joseph Merrick

1899 Called up to serve as consulting surgeon to the field forces in the Crimean War

1901 named Knight Commander of the Royal Victorian Order

1902 Operated on King Edward VII's appendix just days before his scheduled coronation

1908 Retired

1923 Died from peritonitis

Lithograph of Frederick Treves, 1884



Treves found that the show had been shut down by police, and the shop was empty.

In 1886, Treves moved with his wife and children to a new home at 6 Wimpole Street, which would see his most flourishing years. Occasionally he thought about the man he had met, *“exhibited as a monstrosity, housed like a wild beast, his only view of the world from a peephole in a showman’s cart”*. During these years, it later transpired, that showman, Tom Norman, and his charge travelled to Europe, the exhibition having been banned as degrading everywhere in England. When they couldn’t work abroad, Norman pocketed the paltry savings of his cumbersome liability and put him on a train back to London. At a loss at Liverpool Street, hounded by a jeering crowd, Merrick gave police Treves’s card, which he’d kept. And his life was changed.

Many years later, what followed would be hotly debated, and in some quarters Treves’ name was dragged through the mud. It’s conjecture now, I suppose, but it’s interesting to read modern takes on the case that say Treves exploited Merrick as badly as Norman did, using him for notoriety in a similar way. Yes, it’s possible, as American academic Nadja Durbach insisted in 2013, that Merrick was happiest as a free agent ‘entrepreneur’, marketing himself as a sideshow. But independent to what extent? And always having to capitalise on his ‘horror’ value. For me, this argument feels a bit strained.

Treves took Merrick back to the London Hospital and installed him in a

“

The showman pulled back the curtain and revealed a bent figure crouching on a stool, covered by a brown blanket. In front of it, on a tripod, was a large brick heated by a Bunsen burner. Over this, the creature was huddled to warm itself. The showman, speaking as if to a dog, called out harshly: ‘Stand up!’ The thing arose and let the blanket fall to the ground. There stood revealed the most disgusting specimen of humanity I have ever seen

A drawing of Joseph Merrick
by Frederick Treves



WELLCOME LIBRARY, LONDON

small, private apartment he converted for him on the ground floor. He sat with Merrick every day and saw that he could indeed speak and with concentration be understood. Soon, Merrick began to lose his shyness. From Treves' book:

"It would be reasonable to surmise that his brutish life would have a great effect upon a sensitive, intelligent man... he might be spiteful and malignant, swollen with venom, or a despairing melancholic. But Merrick's troubles had ennobled him. He showed himself to be a gentle, affectionate and lovable creature, without an unkind word for anyone." Treves brought him books, and soon the young man had a library of his own. He introduced visitors, who brought ornaments and pictures. He took Merrick, in disguise, to the theatre. He arranged for him to holiday in a remote country cottage, where Merrick, transported, collected wildflowers. He bought him the "dressing bag" he begged for, the sort of thing a young gallant might have, and Merrick spent hours lovingly arranging the silver-backed brushes and comb, the razor and silver shoe-horn, none of which he could use. Countesses, duchesses, Queen Victoria herself came to sit with him. The only thing Merrick didn't have was romance. *"His bodily deformity had left unmarred the instincts of his years. He would like to have been a lover."*

And then, in April 1890, Merrick was found dead in bed. Though Durbach maintains that he killed himself in misery, it's more likely that, as Treves writes, Merrick had simply tried, for once, to be "like other people" and sleep lying down—the great weight of his head meant that he had to doze in a sitting

position, head propped on his knees. His pillow was soft, he had died *"without a struggle"*, his head fallen backward and his neck dislocated. He was 27.

Treves had already performed the very first appendectomy, in 1888. In 1899 he took himself off to volunteer at a field hospital in South Africa during the Second Boer War and, on his return in 1901, was appointed one of several Royal Surgeons to Edward VII. The new king's coronation was scheduled for 26 June but on the 24th, Edward was diagnosed with appendicitis. Treves decided to operate. *"But I have a Coronation on hand,"* roared Edward. Treves shrugged, *"If I don't operate, it will be a funeral."* London was full of dignitaries and heads of state, who had travelled here for the occasion; they had to go home. Treves performed a then-radical operation, draining the infected abscess and leaving the appendix intact. The following day, Edward was sitting up in bed, smoking a cigar.

Treves had learned the hard way to follow through on his medical hunches. In 1900 his 18-year-old daughter Hetty developed severe abdominal pain. Treves wasn't sure it was appendicitis, but he was wrong; Hetty developed peritonitis and died. He never hesitated again. The delighted Edward insisted the entire British Empire drink a toast to the new baronet, Sir Frederick Treves. Appendix surgery entered the medical mainstream.

Still happily based in Marylebone, where he had run a private practise since he was 45, Treves retired at 50 and turned his attention to the writing he loved. He wrote melodramatically

but with care about Joseph Merrick (in *The Elephant Man and Other Reminiscences*, a book which would much later become a play, starring at various times David Bowie and Mark Hamill, before it was a film with Merrick played by John Hurt). He penned the Dorset edition of Macmillan's *Highways and Byways* series, cycling over 2,000 miles around the county for research (it's still the most popular book on Dorset). He wrote a book about his experiences of Edward VII's illnesses, including the time the king fell down a rabbit hole, strained his Achilles tendon and had to be fitted with an iron splint. He travelled widely, detailing his travels. He wrote surgical books, and he also wrote about the influence of clothing on health, insisting, far ahead of his time, that women were dangerously deformed by corsets and that tightly swaddling a baby, which was habitually done at the time, was *"unintelligible"* and dangerous, too.

But the place Treves adored was Dorset. He rented a cottage in West Lulworth and moored his yacht *Vagabond* in the cove, where he taught a number of medical colleagues to sail.

Frederick Treves died at the age of 70 in Lausanne, Switzerland—ironically of peritonitis, caused by a ruptured appendix. His wife arranged for his ashes to be brought home to England, to be buried in Dorchester cemetery. The funeral took place on 2 January 1924, and was arranged by Sir Newman Flower, Treves' friend and publisher. The service was organised by Thomas Hardy. Hardy, 84 and very frail, was implored by Flower not to attend: it was bitterly cold and raining hard. The poet insisted, and stood beside the open grave, without an umbrella, for the entire ceremony. He wrote a poem for the occasion, published in *The Times*, which began, *"In the evening, when the world knew he was dead..."* Treves and Hardy had been fast friends, often meeting to reminisce about old Dorset, dining on Dorset Knobs with Blue Vinny cheese, washed down with a fine Burgundy.

We all know about Thomas Hardy. Many know about Joseph Merrick. But no one really knows much now about Frederick Treves—in his time, an extremely famous man. And, if the deep friendship Hardy had for him says anything, it indicates that he was a good and compassionate one, too, who had helped someone very much in need of help, and certainly not used him. ■



B.D.S. London, L.D.S. R.C.S. (Eng),
Diploma in Orthodontics, R.C.S. (Eng)



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OUT AND ABOUT

The Harley Street Medical Area is situated right in the heart of Marylebone. Surrounding its medical buildings are shops, restaurants, cultural institutions, and parks. In this section, we explore some of the elements that make this such a unique location for a medical area



MY MARYLEBONE

Mike Davison, managing director of sports injury clinic Isokinetic London, on what he loves most about Marylebone



Wigmore Hall

I'm 40 now, but I feel that in 20 years' time I'll be spending my days watching the cricket then going to concerts at Wigmore Hall

Atmosphere

Someone once taught me that the difference between service and hospitality is that service is something that happens to you, hospitality is something that happens for you. So if I go to La Fromagerie (and I go fairly often) they know I always have the French artisan cheese board—but they might also occasionally say, "Do you think it's time for something new?" So last week we had the Italian, which was very good—and that's the thing with Marylebone: you get a better lifestyle experience. In terms of relative value, you'll get some of the nicest experiences you could have in London. You are not in Shoreditch, you are not in Mayfair, you are among normal people, who work hard and are looking for the best pockets of leisure time available. And they are here.

Community spirit

Marylebone is one of the most accessible areas in

London, yet it never feels busy. Our staff and patients really appreciate that village-like feel in one of the most cosmopolitan, busy cities in the world. All the niceties of life are celebrated here.

I decided that, as a business, we would be the best neighbour possible. If I was going to have a cup of coffee, I would go and have an artisanal flat white from Monocle Cafe, with one of their cinnamon buns. If I was going to buy Christmas presents, I would shop in Marylebone. Over the course of the year I like to take every one of my team out to lunch, and as long as it's in Marylebone they get to choose where. The boys like the Le Relais de Venise L'Entrecôte or the Golden Hinde; the more health conscious like Sourced Market or Daylesford. The ones who are testing my pocket will ask for Fischer's, with its air of aristocratic Viennese culture!

Culture

I like to imagine travelling the world in the downstairs travel section of Daunt bookshop, or go to the Everyman cinema on Baker Street if we're staying in town for the evening. One of favourite things to do in Marylebone is to take a box of salads and deli bits from the Natural Kitchen and head to the Open Air Theatre—or just sit in the rose gardens in Regent's Park. One place I have never been but would love to go to is the Wigmore Hall. I'm 40 now, but I feel that in 20 years' time I'll be spending my days watching the cricket then going to concerts there. Walking along Wigmore Street, I regularly see people falling out of Wigmore Hall at lunchtime, humming away.

Food

Another of my top five things to do in Marylebone is a late lunch at Fischer's, with a friend or colleague. I'd have

the smoked fish and rye bread starter, followed by the wiener holstein topped with a fried egg and buttered French beans, with a velvety cappuccino to finish, served with a glass of water on a silver tray.

I like to go to Daylesford with my daughter, who is at school in Marylebone, and have breakfast—just to introduce her to the fact that sometimes you should spend a little bit more money on good food. She's 12, but she has their avocado on toast with two poached eggs. Sometimes I like to pretend I am shopping there, when I am actually just trying their cheeses and biscuits—it's like going to a cocktail party and having the canapés. But the staff are so friendly—they know you'll have lunch there at some point.

Isokinetic London

11 Harley Street,
W1G 9PF
isokinetic.com/en



THE STORY OF...

Sourced Market

Ben O'Brien, the founder of Sourced Market, explains how his stunning Marylebone store came to be

I have always loved food, but that love largely manifested itself in eating it. I ended up living above Borough Market in 2002 and I was working in the music business, which took me to a lot of festivals. If you go back to that time, the food offering at festivals was pretty dire—white vans knocking out burgers of dubious origin—and I was spoiled. I lived above Neal's Yard Dairy and Monmouth coffee, and my appreciation of the finer things in life, in terms of food at least, increased accordingly.

One day I was moaning about the food at a festival and I thought, surely there are people like me who would appreciate food of the same standard as the music? I had got to know a couple of traders quite well by that point and I managed to persuade a bunch of them to come to a festival: The Innocent Village Fete in Regent's Park, in 2007.

Back then, there wasn't the street food offering you get these days—in fact, 'street food' wasn't even really a term. That festival was more like an actual market: cheese, bread, olives. We had one of the farmers knocking out bacon and sausage sandwiches, but otherwise it was very much a picnic in a field. Most traders sold out on

the first day, so had to spend all night prepping.

The shift in the business from festivals to bricks and mortar was prompted by my own move to Hackney. The change was terrible. In those days, Hackney didn't have anything like the food offering it has today. I moved from Borough Market, to somewhere where my options were either a convenience store or Tesco Express. It dawned on me that while lots of people want the quality produce and the experience of a farmers' market, the reality is that at half seven on a Tuesday evening, convenience wins out.

So I thought, what if I take the quality, the sourcing and the atmosphere of a market, and put it in a convenient location, with opening hours that work? I heard that the people behind St Pancras station were looking for a new food offering, so I rang them up and pitched them the idea of Sourced Market.

Looking back, I was quite naïve; I just had an idea, I thought it would work and loved the architecture of the station. A couple of things worked in our favour, though. For a start, it was such an awkward space: 40 metres long and four metres deep. It didn't suit a normal retail

operation, but it suited our set up. And the offering at stations at that time was pretty shoddy. The received wisdom was that in a captive market, people would just buy anything. Now there's an understanding that if you have an attractive enough offer, people will come in because of it.

When I started looking for a second site, initially I was trying to find another station, but when I realised we weren't going to find another place like St Pancras, I broadened the net. What struck me about St Pancras was its ability to showcase our produce in such a broad



JOSEPH FOX

display. You can't do that in a rectangular box with a window at the front, which is the design of most shop units. What drew me to the Marylebone site is its flat-iron shape: three long windows, great ceiling height and lots of sunlight. It's very visible.

So what makes a Sourced Market product? Well, on a basic level we ask, does it taste great? Then there's the price. It could taste amazing and be at a price point most people simply won't consider. It's not rocket science—that said, you have to make sure you don't get too caught up in your bubble. When Mallow and Marsh, who supply our marshmallows, first got in touch I told them no one would buy marshmallows at £2.50. Then she was on Dragons' Den, in Sainsbury's—and of course, they are phenomenal. So you do have to make sure you don't drift away from the mainstream.

Our attitude to food as a nation is changing. Six years ago, the street food 'scene' didn't really exist. Getting good coffee was tricky and many of the craft breweries hadn't started. If we hadn't been at the forefront, in some cases we'd no longer be relevant. We were one of the first stockists for a lot of the producers—many of whom were, when we found them, making their products at home or in a rented kitchen. Now they're big names: Kernel, Doisy & Dam, Beaver town, to name a few.

I am constantly inspired by the producers we work with. What is great is that they are, almost without exception, really nice people—and I think this is because they are fortunate enough to be doing something they are really passionate about. There is nothing more inspiring than meeting someone with a passion.

Sourced Market
68-72 Wigmore Street
W1U 2SD
sourcedmarket.com

5

Places in Marylebone to find a great coffee

If you're not drawn to Nordic Bakery purely by its famed cinnamon buns (and you definitely should be), the heavenly smell of fresh, ground-to-order coffee should clinch it



THE PROVIDORES AND TAPA ROOM

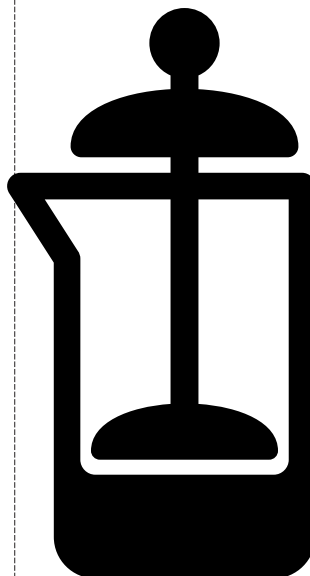
109 Marylebone High Street,
W1U 4RX
theproviders.co.uk

Upscale restaurant downstairs, relaxed cafe and Tapa Room (tapa, not tapas, though the plates are small and numerous) upstairs, Peter Gordon's much-loved restaurant is well-known for its high quality fusion food, and, as you would expect of a place owned by New Zealanders, its coffee promises to be equally good. Drop in for brunch on a weekend or, if you can beat the crowds, grab an al fresco spot for a leisurely flat white.

NORDIC BAKERY

37b New Cavendish Street,
W1G 8JR
or
48 Dorset Street,
W1U 7NE
nordicbakery.com

If you're not drawn to Nordic Bakery purely by its famed cinnamon buns (and you definitely should be), the heavenly smell of fresh, ground-to-order coffee should clinch it, served in traditional Skandi 1950s-style Teema cups. Possibly the coolest cafe (in fact there are two in Marylebone) in town,



the characteristically uncluttered, stylish aesthetic makes for a uniquely cultural culinary experience.

LA FROMAGERIE

2-6 Moxon Street,
W1U 4EW
lafromagerie.co.uk

As with everything at La Fromagerie, the focus here is on quality and provenance. La Fromagerie sources, stocks and serves coffee from Carlalberto Relli—made from beans grown on company-owned plantations across Africa, Asia and South America and roasted on site in Florence—and the smooth, sweet blends of Parisian company Belleville Brulerie Coffee. Oh, and there's a pretty phenomenal walk-in cheese room, too.

ROMO COFFEE CART

17 Marylebone Road,
NW1 5LT
romocoffee.com

Peter Fernie's coffee cart has been parked on the steps of St Marylebone Parish Church come rain or shine since 2013, serving ethically-sourced, speciality single-origin and blend espressos and homemade cakes, not to mention top-notch conversation, should you fancy passing the time of day. Perfect for a pick me up on the fly, or a lazy sup in the church grounds.

THE IVY CAFÉ

96 Marylebone Lane,
W1U 2QA
theivycafemarylebone.com

The Ivy? Isn't it that a seriously posh restaurant, favoured by the rich and famous? Well, yes. The Ivy Café in Marylebone, however, prides itself on being a relaxed, neighbourhood restaurant with all day dining: from business breakfasts to an afternoon coffee and cake, with a number of tables dedicated to drop-ins.



RECIPE

Roast chicken, kumquats, black garlic, kale and avocado

By Peter Gordon of The Providores and Tapa Room

Serves 6 as a main course

Black garlic is a delicious fermented garlic that adds a lovely treacle-caramel flavour and depth to dishes without a strong raw-garlic aftertaste. It is becoming easier to find, but if you have no luck, you can use regular garlic. Kumquats are great here, too, adding a slight bitterness because you use them unpeeled; if unavailable, substitute thinly sliced lemon, mandarins or oranges. Avocado oil works well in any dish that contains avocado. It has a high burning point, which means it is terrific for roasting and pan-frying. Olive oil or sunflower oil are fine to use instead if you can't get hold of it.

Ingredients

- 8 boneless chicken thighs
- 8 black garlic cloves, sliced
- 8 kumquats, unpeeled, thinly sliced
- 2 tsp fresh rosemary (or fresh thyme or oregano or a mixture)
- 4 tbsp sunflower seeds
- 2 tbsp avocado oil
- 1 small red onion, thinly sliced into rings
- 200g kale, thick stem removed and discarded
- 2 avocados
- 2 tbsp lemon juice
- 1 cucumber, ends discarded, thinly sliced

Method

— Preheat the oven to 180C. Place the chicken thighs, garlic, kumquats, rosemary and sunflower seeds in a roasting dish. Pour on the avocado oil and 2 tbsp water and season with salt and pepper. Toss everything together. Roast, turning the chicken several times while cooking, until the chicken is cooked through and the skin is golden and crispy, about 30–40 minutes. Remove from the oven and leave until cool enough to handle, then cut each thigh into four or five slices.

— While the chicken is cooking, soak the onion in cold water for 10 minutes, then drain. Meanwhile, blanch or steam the kale for 3 minutes. Tip it into a colander and, when it is cool enough to handle, squeeze out as much water as you can, then coarsely shred it.

— Remove the flesh from the avocados and cut into chunks. Mix with the lemon juice to prevent it going brown.

— To serve, toss the kale, onion, cucumber and avocado together and lay it on the bottom of a serving dish. Lay the chicken on top then spoon over the contents of the roasting dish.

Savour: Salads for all Seasons by Peter Gordon. The Providores and Tapa Room, is this year celebrating its 15th anniversary.

WHAT'S ON

PRIDE AND PREJUDICE 2nd–17th September

Regent's Park Open Air Theatre
Inner Circle
Regent's Park,
NW1 4NU
openairtheatre.com

Simon Read's adaptation of Jane Austen's beloved classic returns to the Open Air Theatre following a sell-out run in 2013, this time led by Felicity Montagu (Alan Partridge, Bridget Jones' Diary) as the frivolous Mrs Bennett—matriarch of a family of five unmarried daughters—in a familiar tale of the hapless pursuit of love.

THE MIDDLE: TOM ELLIS 15th September –27th November

The Wallace Collection
Hertford House
Manchester Square,
W1U 3BN
wallacecollection.org

Tom Ellis—the figurative painter, not the Eastenders actor—is the man behind the Wallace Collection's most ambitious exhibition since the landmark Joshua Reynolds Experiments in Paint last year.

This might seem an odd juxtaposition, but though he is very much alive, in his early forties, and known for being anything but derivative in his

approach, Tom Ellis's subject matter is inspired in part by Old Master catalogues and art history books—so when it comes to inspiration, Joshua Reynolds' portraits, and indeed the entire Wallace Collection, are a source from which Tom frequently sups.

This newly commissioned series of works pairs Tom's enigmatic figurative paintings with self-made furniture, reflecting the unique and eclectic profile of Hertford House.

JEREMY DENK 17th September

Wigmore Hall
36 Wigmore Street,
W1U 2BP
wigmore-hall.org.uk

From indebted Juilliard graduate to 2014 Musical America Instrumentalist of the Year, American classical pianist Jeremy Denk rapid progress into the upper echelons of classical performers has driven by an imaginative, lively, interpretative style. In this performance, covering six centuries of repertoire, he charts the history of western music from medievalism to modernism.

This evening event follows an open house day at Wigmore Hall, which includes tours of the historic concert hall and performances from

Though he is very much alive, in his early forties, and known for being anything but derivative in his approach, Tom Ellis is inspired in part by Old Master catalogues and art history books

Wigmore Hall Learning's outreach ensemble, Ignite.

KOHN FOUNDATION BACH CANTATAS 2nd October

Royal Academy of Music
Marylebone Road,
NW1 5HT
ram.ac.uk

In the October performance of an ongoing series of monthly events in celebration of the great Baroque composer's finest works, the Royal Academy's Iain Ledingham and Margaret Faultless, director and leader respectively, bring us performances of Allein zu dir, Herr Jesu Christ; Wohl dem, der sich auf seinen Gott and Warum betrübst du dich, mein Herz, performed on historical instruments.



Pride and Prejudice



GLOBAL HEALTH FILM INITIATIVE: THE TRUE COST 19th September

Royal Society of Medicine
1 Wimpole Street,
W1G 0AE
rsm.ac.uk

The True Cost is a documentary that pulls back the curtain on the fashion industry and asks us to consider, who really pays the price for our clothing? Andrew Morgan travelled to 13 countries including India, Cambodia and China to shine a light on some of the less enlightened industrial practices and some of the medical issues these populations have to cope with as a result.



Ala Bashir

GALLERY PROFILE

Hay Hill Gallery

There tends to be a different exhibition on each of its two floors, and the space is curated according to what looks good aesthetically, rather than being strictly thematic. The space changes every month or so, and there is usually a summer show around August and a winter show around January, in which several artists are exhibited.

Art

Hay Hill Gallery is perhaps better known for its sculptures than its paintings. Most paintings are oil on canvas or board, not paper, and there is no restriction on the style of art: everything from hyperrealism to impressionism. We look for quality of work—a good understanding of composition and consistent high standards. The paintings have to already look like master works.

Artists

Hay Hill Gallery has a roster of more than 100 contemporary artists from around the world. Most are already established, but emerging artist are also judged on their merits. The gallery looks to promote them long-term, with agreements for at least six years.

More recently, it has also started presenting works from Old Masters such as Michelangelo Cerquozzi, Jan Philip van Thielden and Gerard van Spaendonck.

Sculptors

At the moment the gallery has sculptures from Edgar Degas, August Rodin, who is recognised as one of the most important sculptors of the 19th century, and Eleanor Cardozo, whose bronzes were exhibited all over London during the Olympics—to name but a few.

Hay Hill Gallery
35 Baker Street
London, W1U 8EN
hayhillgallery.com

History

The gallery was established by Mikhail Zaitsev on Hay Hill in Mayfair in 2002. Originally it showed purely Russian art gallery, until 2007 when it relocated to Cork Street and started to bring in other international artists and sculptors. In 2013, Hay Gallery moved to a far bigger space on Baker Street.

Space

Bright, open plan and blessed with sizeable windows, the gallery space is unusually large for central London, and is particularly conducive to the presentation of sizeable sculptures.



Paddington Street Gardens

THE GUIDE

The best spots in Marylebone for relaxing outdoors

PADDINGTON STREET GARDENS

This attractive park has long been a haven of quiet, enjoyed by locals and visitors alike. The larger south side has formal open grass areas, traditional bedding displays, mature London plane trees, a children's playground and plenty of benches—the latter being a particular draw for local workers, who head here on their lunchbreaks at the first sign of sunshine. Landmarks include an unusual 18th century mausoleum and the Street Orderly Boy statue by the Milanese sculptor Donato Barcaglia (1849-1930). The statue has twice been

The garden has formal grass areas, traditional bedding displays, mature plane trees and plenty of benches—the latter being a particular draw for local workers, who head here on their lunchbreaks

stolen, the last time turning up in a shop in west London, but has now been very securely anchored to prevent any further adventures. The north side of the park is less developed—you will often see people sitting on the ground with a book and a drink on summer afternoons.

THE REGENT'S PARK GARDENS

Designed by John Nash, Regent's Park covers 395 acres, including some of the most beautiful parkland in London. It also offers a number of different gardens, each of them beautifully designed and maintained. Queen Mary's Gardens, a rose garden named after the wife of King George V, has London's largest collection of roses, with approximately 12,000 flowers, set out in 85 single variety beds. The Victorian-style Avenue Gardens is famed for its formal displays, tiered fountains, evergreen hedges and vast ornamental bowls filled with flowers, while the Wildlife Garden has been designed to allow native wildlife to thrive in the centre of the city.

ORRERY TERRACE

Orrery has long been one of Marylebone's dining treasures, and the addition of its outdoor dining terrace has added another jewel to the area's

culinary crown. Lined with lavender and olive trees to recreate the sights and scents of southern France, this is one of the best places in London to enjoy sophisticated cuisine in the open air. Its rooftop location, looking out over the high street and the parish church, raises you above the hurly burly of everyday life while the elegant design creates a peaceful atmosphere to enjoy dishes such as chilled tomato, summer truffle risotto, or a selection of cheeses from Orrery's legendary cheese trolley.

MANCHESTER SQUARE GARDENS

One of the many private garden squares in Marylebone, this beautiful Georgian square regularly opens its doors to the public. It is named after the Duke of Manchester, who was attracted here by the area's excellent prospects for duck-shooting. The layout has changed very little since the square was first laid out between 1776 and 1788. Black metal railings surround mixed shrubbery, a circular path encloses the central lawn, and shade for the garden is provided by mature plane and lime trees. A major replanting of the garden took place between 2006 and 2008, ensuring that Manchester Square continues to exude that sense of 18th century splendour.

ST MARYLEBONE PARISH CHURCH GROUNDS

The present monumental parish church, which opened in February 1817, is the fourth known church building to serve the parish of St Marylebone. Sitting at the north end of Marylebone High Street, its attractive grounds host the popular Cabbages and Frocks market every Saturday. For the rest of the week this courtyard, with its series of benches surrounding a central grassed area, is a favourite place for denizens of the area to meet and relax beneath a canopy of shady trees.

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