Medical Education

McMaster revisited

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Introduction

The Medical School of the McMaster University at Hamilton, Ontario, and in particular the novel three-year curriculum for the MD degree, caused stir and excitement in medical education unparalleled since new methods were introduced at Western Reserve, Cleveland, Ohio. The McMaster approach has been described several times, perhaps best by John Hamilton,¹ who gives useful further references, and Ali *et al* give further interesting insights.²

Summarised to the point of caricature, the essentials (see table)

Year I 1 September	Year II	Year III
<i>Phase I</i> (10 weeks) Medical community and resources Structure and function of the body <i>Phase II</i> (10 weeks) Reaction to stimuli, inflammation, neoplasia, homeostasis, ischaemia Behaviour Elective <i>Phase III</i> (4 × 10 weeks) (A) Blood and gastrointestinal systems	<i>(Phase III continued)</i> (B) Cardiorespiratory system (C) Neurological and locomotor systems Psychiatry (D) Renal, reproductive, and endocrine systems <i>Phase IV</i> (3 × 16 weeks) Clerkships	<i>(Phase IV continued)</i> (A) Medicine and surgery (B) Family medicine Psychiatry Obstetrics and gynaecology Paediatrics (C) Elective experience Revision 30 April

Outline of phases. Holiday breaks, some electives and revision periods, and much other detail omitted.

are: selection of students from varied backgrounds by personality as well as academic achievement; self-learning in small tutorial groups by problem solving based on "clinical situations," and no lectures, no examinations or grades, but assessment by the student himself, his group, and tutors as "satisfactory" or "unsatisfactory"; a course of two years and eight months containing two phases of ten weeks each, a third phase of four system-based ten-week units, and a fourth phase of three 16-week blocks of clerkship, as well as several electives and other elements.

In Canada the licence to practise is based on an examination of the Medical Council of Canada and completion of one year's

acceptable postgraduate hospital experience: it is not conferred by a degree.

I visited McMaster briefly in 1972, when the first class had taken the licensing examination, again in 1975, and for some months in 1978, when I asked: Why is it that McMaster has successfully resisted all pressures, external and especially internal, which must be operating to shift its radical educational attitudes and methods towards the conservative and traditional mean?

There are assumptions and value judgments in this simple question. My own impression is that the basic educational attitudes have been maintained from the start of the school in 1965. Many people make the point that adherence to the tenets of 1965 may constitute a new orthodoxy, while the founders might have wished for continuing revolutionary and evolutionary change. They seem to have set up a system designed to perpetuate their principles: the changes, refinements, and improvements introduced in the last ten years have been minor.

This might be due to the power of the dean to demand certain types of performance; the pervasion of committees by specialists in educational process exerting powerful influences on decisions; an unusual efficiency in the staff selection processes; staff promotion and review giving special regard to approved educational performance; initial and continuing training in educational methods; or student expectations and demands. Students may generate powerful pressures in tutorials and elsewhere. No single explanation seemed adequate, and in discussion the powerful evangelism of the founders was always emphasised.

Historical

Dr John Evans was appointed dean on a half-time basis to start planning in 1965 and by the time Mr R C Walker had been similarly appointed as executive director of McMaster University Medical Centre in 1967 about a dozen people such as Dr Spaulding, Dr Anderson, and Dr Mustard had already written a definition of the programme.

I believe that the architecture in every sense of the McMaster Health Sciences Centre³ represents important aspects of the founders' intentions and policies, and that it continues to influence profoundly all those who work there. The building belongs to the university. The hospital portion (60%) is leased to the trustees of the McMaster University Medical Centre.

The first class of students started work in temporary accommodation at Chedoke Hospital in 1969 after at least four years' intensive planning of their education. Arrangements were made and staff appointed at the other teaching hospitals to start clinical teaching. Inpatients were first admitted to McMaster University Medical Centre in September 1972. Today 302 beds are available for use.

Although McMaster University Medical Centre is built and equipped for 439 beds, government fiscal policies and estimates of need preclude opening more beds. The additional patients and staff required to educate classes of 100 students a year were secured by affiliating Hamilton's hospitals (Hamilton

General, Henderson, St Josephs, and Chedoke) to the university. Each as well as the McMaster University Medical Centre contains clinical teaching units charged with the core undergraduate education.

An enormous reserve of intellectual and numerical strength lies in the massive commitment to excellence and volume in medical research which has been fostered successfully from the beginning of the school. Without this, the sort of staff who make the McMaster approach of small group tutorial learning possible would not have been attracted or retained. Their intellectual vigour and rigorous scientific criteria are major factors towards the success of any policy supported by the staff.

Administration

The fact that the dean and the "deanery" are personally concerned in undergraduate education carries great weight, especially since they use their strong personalities to ensure full weighting of educational performance in appointments, re-appointments, and promotions. The dean and several other senior figures are phase I tutors in considerable demand and are subject to the usual disciplines. This both keeps them fully aware of what is going on and underlines the importance attached to the tutorial functions.

At all staff promotion or review committees the educational contribution of the staff member under consideration is reviewed by the associate dean (education) or his representative and carries real weight. The information is based on self-assessments by the staff member and reports on his performance by the students and the co-ordinators and other people concerned with the particular programme. It is expected that members of the faculty will devote at least 20% of their time to education, the MD programme having priority. Norms have been laid down for the time usually spent in being a tutor, unit planner, discipline consultant, phase chairman, clinical skills preceptor, student adviser, electives' supervisor, or in some other way contributing to the programme. Such reports are communicated to the staff member and frequently result in improved performance. If the reports indicate inadequacies, he may be advised to take part in workshops and other events designed to improve his educational methods.

The part-time tutors in clinical education in the other hospitals teach for nothing. To my surprise it is not thought appropriate to keep full assessment files on them as is done with the full-time salaried university staff. Nevertheless, their performance is evaluated by the students and they are told of these findings to a variable degree. Other forms of assessment are also applied.

The dean of the faculty of health sciences, Dr Fraser Mustard (who is actively engaged in research and teaching), exerts most of his influence through appointments, promotions, and staff reviews, and the chairmanship of the faculty council and in particular the faculty executive. The educational aspect at these levels is reinforced by the associate dean (education), Dr W J Walsh, who chairs the health sciences education committee and is also active as a general physician. The MD education committee, chaired by Dr R G McAuley (who is also heavily concerned in the family medicine unit at the Henderson Hospital), reviews the entire programme, especially the reports from the admissions, phase planning, and electives committees, carries out investigations, and makes recommendations. At the same time the dean and particularly Dr Walsh and Dr McAuley take care of the "political" implications of educational suggestions and decisions put up by the planners, phase chairmen, and others, so that these do not have to look over their shoulders at such aspects.

It seems that this role was taken in the very early days by John Evans, who "kept the gate" or "defended the bridge, like Horatius" and dealt with the formidable mass of important matters to do with getting the medical school established, financed, and the buildings designed. This allowed the designers of the original educational policies, particularly Jim Anderson,

Bill Spaulding, Fraser Mustard, Bill Walsh, and then David Sackett, Luis Branda, and Nathan Epstein, to follow their inspirations without getting over-involved in the battle for worldly necessities.

The phase planning committees become increasingly complex. In phase III the four organ system units each have their own unit planning group with many discipline consultants and resource persons. Administrative arrangements become voluminous and may be difficult to handle, as exemplified by the phase III review of April 1978. This contained a relevant statement suggesting strongly that any group carrying out a review of the overall objectives (which had been recommended) should include some of those who were party to the original definition of the McMaster philosophy—for example, Dave Sackett, Jim Anderson, and Moran Campbell.

In phase IV many different subjects have to be accommodated in at least four hospitals, so that the administrative load involved becomes still heavier. The collection, verification, and recording of all the staff and student evaluations and assessments under the supervision of the associate dean (education) are formidable tasks.

The administration and committees have their own momentum, which tends to preserve the direction in which they have been set. Some aspects of the "McMaster philosophy" have become rigid to the point of caricature. For instance, it was never intended that "lecture" should become a dirty word and an illegal event to the extent that it has. In fact, some phase chairmen think so great a deliberate effort would be required to bring about any radical change in educational method, that, even if it were decided on educational grounds that this should occur, it might be impossible to implement it. This argument is based on the investment in money and faculty time in the existing machinery, set up in more optimistic times, and the difficulty of starting again with much tighter resources. This investment is in the very structure of the building (flexible though it is); the composition of tenured faculty; and the provision of library resources, problems and problem boxes, simulated patients, computer-aided programmes (such as McPee and McPuff), and expensive audiovisual machinery and staff.

Programme for educational development

The Programme for Educational Development was added to the faculty structure after the school had admitted at least three classes. Dr Victor Neufeld joined the faculty with the intention of practising internal medicine with an interest in medical education along the McMaster ideals, which caused him to spend the first year in East Lansing at Michigan State University with Hilliard Jason. There he got much caught up in the theory and practice of medical education and in the integration of the teaching of internal medicine. He joined a planning group at McMaster to work out the form that educational development should take. All agreed that there should be no one working full time in educational development. He was persuaded to take a leadership role as director of the programme to the extent of about 60% of his time, the other 40% being devoted to internal medicine.

Since the early days of heady enthusiasm, increasing importance has attached to the role of faculty workshops and similar activities, focusing especially on problem-based learning and the dynamics of tutorial groups. More formalised processes have replaced the early spontaneous self-directed activities. The people in these new groups and programmes are the conscience of the educational philosophy and also a resource of educational method. Howard Barrows, a neurologist, whose special subject is the project for problem-based learning systems, devises new methods and resources. Jackie Wakefield of the department of family medicine deals with evaluation methods. Chris Woodward, attached to the department of clinical epidemiology and biostatistics, is concerned with programme evaluation.

It is the declared principle that no one on the health sciences

faculty staff should be working wholly in educational method. Research associates and fellows are employed whole time in developing and running various methods sections. Dr Geoff Norman (originally an atomic physicist, now assistant professor, family medicine) certainly has no clinical role. The increasing contribution of the programme for educational development may be based largely on their participation in education research, which enables them to pose highly intelligent, pertinent, and fresh questions of real academic merit, concerning usually the process but sometimes also the content of medical education.

Student selection

I doubt whether the laborious and lengthy student selection procedures do what they are stated to do. Important members of staff are convinced that they are effective. To substantiate their view they have to prove that students so selected "pass" the McMaster "course" more readily than a group selected on other grounds (for example, marks), or make "better doctors," or both. This needs instruments to measure "good doctoring" in the various specialties and follow-up data on the graduates to which to apply these instruments. Several classes have now graduated, but the measuring instruments are still being developed and not many data on graduates have become available, so that we must suspend judgment on the effectiveness of the student selection process.

I have no doubt, however, that it is a powerful preserver of the McMaster approach, and a splendid public relations exercise. The very participation and expenditure of time by many of the best members of the faculty, the student body, the community, and practising doctors in this highly organised and congenial annual ritual are powerful commitments to and reinforcements of the system. This makes the procedures well worthwhile, even if the validity of the methods employed has not been scientifically established.

It is also argued that the present student selection process could militate against admission of exceptionally brilliant students. Such a student might have a clearly defined goal, as, for instance, in neurological surgery or in a corner of medical research, and might not be willing to couch his application, letter, and interview in the "community and people-oriented" terms most likely to be acceptable to at least half of the interviewing team. While it has been claimed that such students might not fit into the McMaster educational scheme (although I do not believe that such an assumption is justified), and therefore rejection by the interviewing committee might be correct, they nevertheless are people whom most medical schools rightly would like to have.

Student influence

Not all students are devoted to the McMaster approach when they apply for a place. A powerful process of raising definite expectations and making positive and negative commitments is started in the minds of the applicants as they begin to read the application material, or indeed when they first hear of the "McMaster approach." Such expectations and commitments are reinforced during selection not only in the future students, but also in the members of the community, the profession, and especially the staff and students. The intention to preserve the detail of the McMaster approach is further reinforced in all participants of the orientation programme for new students.

Staff in phase I and phase II make sure that students are conditioned to problem-solving. By the time they reach phase IV they can withstand the contrary pressures applied by some clinicians. This is a declared and explicit major objective of phase I. The tutors for phase I are selected with the greatest care and they include the dean and Ron McAuley. Much hard work has gone into making phase I tutoring so attractive and exciting for the staff that many are anxious to get this accolade.

These phase I tutorial groups are further strengthened by containing a specially selected 2nd-year (phase III) student ("senior mentor"), who is intended to be and is a great influence towards maintaining the party line. Phase III students with their many pressing commitments put much time and effort into this, extending beyond the actual tutorials into social and other activities.

In the early years there was a special course for students without a biological science background, but this was discontinued. Now the capabilities of such students are investigated during phase I and an individual educational prescription written for each one. The course is sufficiently short and concentrated for students not to lose enthusiasm and to become bored and disenchanted in the middle of their curriculum (as usually occurs in longer courses) before the final spurt at the end. If towards the end of phase IV they develop doubts about the adequacy of their experience of patients as a preparation for the responsibilities of internship elsewhere, they are unlikely at that late and busy stage to challenge the establishment they are so soon to leave.

Phase IV

The section on learning methods in the MD programme publication begins: "To achieve the objectives of the MD Programme students are introduced to patients and their problems within the first phase." The intention of this phrase apparently has been much debated. The "patients" referred to are seldom real patients, but simulated, taped, recorded, or synthetic in problem boxes. The clinical skills programme starts here. Compared with more conventional schools, real contact with patients and real life medicine is scarce before phase IV. This may have a bearing on the fact that phase IV, the clerkship, is widely thought to be the least satisfactory and most unstable part of the curriculum. This is not a necessary consequence of the McMaster approach. Nevertheless, the fact that the medical centre has never had more than 302 of its 439 potential beds occupied, and cannot be considered an active well-rounded general hospital, in my opinion has weakened the McMaster approach in the clinical areas where the founders considered problem solving most relevant. The excellent staff at the affiliated hospitals could not be expected wholeheartedly to convert to this novel approach and the university influence cannot run so strongly in them.

The shortage of "ordinary" patients at the medical centre suitable for introduction to clinical practice and the consequential shortage of clinical teaching staff there in my opinion are the prime causes of the continuing dissatisfaction with phase IV. Much is being done to improve this phase, since any weakness here must directly affect performance of the graduates in practice. There is a Canada-wide problem about the relative places of the undergraduate clerkship and the graduate internship. An authority⁴ recently stated: "the intern is a graduate of a well designed clinical clerkship that has brought him close to the point that his counterpart used to achieve a year later, after a rotating internship." I do not believe that this objective can be achieved at the end of phase IV without more clinical contacts than most students get at present. In my opinion the most serious single threat to the successful continuation of the "McMaster approach" lies in phase IV, and this does appear to be a reasonable explanation of some points discussed below.

Assessment and unsatisfactory performance

Performance at all stages is evaluated in various ways against the stated goals and objectives of that phase or unit. These, especially in the early phases, include the educational process approved in the McMaster approach. The threat of an evaluation of "unsatisfactory" is likely to be based on process rather than content in the early phases, although in phase IV the

question of clinical competence may arise. Similar criteria apply to the evaluation of faculty members, especially tutors, and this whole system is a most powerful preserver of the approved McMaster educational approach.

This is further strengthened by the events which follow an evaluation of "unsatisfactory." In spite of the troubles experienced by tutors recording such an evaluation, there have been several such instances in phase IV. It has been suggested by the chairman of the students' assistance group (which prescribes remedial programmes for such students in defined circumstances) that the most valuable remedial resource in phase IV may be residents who are McMaster graduates continuing to work at McMaster institutions and are thus most likely to perpetuate the status quo in a potentially more open clinical environment. I have found that some of these young men have narrow attitudes based on limited experience.

At this point another form of assessment begins to loom large in the mind of most students—namely, the Medical Council of Canada licensing examinations (LMCC), which have to be passed before a licence to practise can be obtained. While being of questionable validity with respect to the explicit objectives of the programme, it is an implicit objective that the graduates must pass the LMCC and thus the LMCC represents an objective outcome measure. Preparation for this—the unofficial "phase V"—commands an interesting variety of support or opposition from the staff. Many students and staff perceive a necessity to conduct phase V in a traditional manner to pass a traditional examination, although a student who has met the McMaster goals satisfactorily should encounter no difficulties with the examination.

Certainly the first class in 1972 distinguished itself by an exemplary performance in the licensing examination, but this standard was not maintained. In the next year McMaster dropped to about the average grades of Canadian medical schools and correspondingly in rank order, five out of 39 students failing. Performance was good in psychiatry, preventive medicine, and public health, but weakest in surgery, medicine, and obstetrics and gynaecology. Since then there has been improvement. To me it is astonishing that internal pressures toward reverting to tried and proved methods did not become overwhelming at that time, and this surprise and admiration generated the present inquiry.

Staff selection

In some ways the selection of staff is even more important than that of students. Thus the university rule that department chairmen must retire after six years assumes great importance: all but one of the original chairmen have now been replaced. This raises several questions, especially when new chairmen come from outside the school.

The continual introduction of new thoughts and attitudes with new chairmen is valuable, but can their clinical and research activities be accommodated in facilities or departments of limited area, budgets, and beds without restricting or extruding other members of staff, which may prove impracticable or undesirable?

Can the newcomer understand the complex and interlocking systems and matrices sufficiently well to keep on course where desirable or, making use of his own fresh concepts, change course effectively when it seems to be indicated? Can retired chairmen with their wealth of experience continue to develop and advance their contributions, or are they bound to become dissatisfied, resentful, and disillusioned and either leave—or worse employ their undoubted talents and manipulative skills in counterproductive or destructive ways?

Accreditation

Medical schools in Canada have to be accredited so that their graduates may be allowed to sit for the LMCC and the National

Board Examinations in the United States. This accreditation was carried out by a liaison committee for medical education from the Associations of Canadian and of American Medical Colleges, also representing the Canadian and American Medical Associations. After much information had been submitted, the committee visited McMaster on 10-14 February 1975.

So that clinical programmes may be approved, it is necessary for the teaching hospital to be fully approved by the joint commission on accreditation of hospitals. McMaster University Medical Centre was so approved in November 1976, possibly in the expectation that its services would continue to expand.

On general grounds I would expect that the process of accreditation could generate powerful pressures towards conforming with standard practices of medical education and hospital administration in North America. Apparently no such pressures were generated, no doubt because of the eloquence with which the new methods were described and supported by their protagonists and the enlightened attitudes of the visiting committee.

The possibility remains, although it is probably remote, that pressure might be generated at the next visit in 1980 if the committee were to find areas of dissatisfaction.

Conclusions

"power resides in various elites"

McMaster University Medical School has maintained most of the unusual educational approaches designed for it by the founding fathers, such as admission of students with a varied background; emphasis on selection by personality characteristics as well as academic achievement; self-learning based on clinical problems, small group tutorials, without lectures or examinations; and evaluation by self, group, and tutors based on skills in problem solving and self-study.

These features were established over ten years ago. There are four likely reasons for their relative stability so far.

Firstly, the high enthusiasm of the original staff persists undimmed and has been encouraged by success. It is supported by an increasing volume of educational analysis and research tending to prove the value of the methods, at least to the satisfaction of those there. This reinforces the genuine ideals and enthusiasm for methods arrived at intuitively. At least one of the original people of major influence after temporary withdrawal has re-entered the fray to refurbish some of the original methods, and a call has gone out for others to help.

Secondly, the international fame of the school—brought home daily by an ever-increasing flood of visitors, and by its capacity to attract first-class staff, students, grants, and invitations to many parts of the world to help other schools—are dependent largely on the maintenance and success of the "McMaster approach." Thus idealism in the staff élite is reinforced by adding enlightened self-interest to the efforts involved to maintain the approach and its success.

Thirdly, the students derive pride and advantage from being part of such an admired system and from being certified as having both the intellectual and personal characteristics required for good doctoring. They are assured that the system produces doctors best equipped for the future.

Lastly, the sheer intricacy and interlocking nature of the administrative systems militate against change.

The constantly increasing financial stringency forbids expensive modifications requiring new or different resources. Paradoxically, increasing economy drives may present a serious threat to systems requiring unusual devotion of time by many dedicated, highly educated members of staff paid from various sources and unusual resources difficult to justify on patient need when full bed occupancy at the heart of the school is indefinitely postponed.

With the change in the financial background for new medical schools in all relevant parts of the world, it seems likely that McMaster can maintain for some time without a serious rival its position as the Mecca of study and experiment in medical

education. Nothing succeeds like success, and it would be foolish to abandon an approach which appears to be so successful. People at McMaster are not foolish.

I thank the dean and faculty for generous hospitality and a great deal of help. The emphasis, judgments, and opinions in this paper, and any errors, are entirely my own.

MATERIA NON MEDICA

Fun run

It would never have entered my head to join in the *Sunday Times* fun run for joggers, even though—sometimes—I do jog (if I'm feeling strong) or walk (if I'm not) round the Serpentine, but for a telephone call from my brother. He farms in Herefordshire and, every morning before the rest of the farm is stirring, jogs a mile and a half in a waspish yellow and black track suit—it's wise to be visible on a misty, twisting, country road. At any rate, his enthusiasm was infectious and we found ourselves at the Hyde Park car park threading our way out of those concrete corridors and caverns that make you feel as if you are escaping from Alcatraz (it's not surprising that someone has chalked over the archways "You, the condemned"). Hyde Park, the air sharp, and the grass and trees beginning to turn yellow in the early Autumn, was full of people—families picnicking on the grass, dogs running, and everyone moving briskly with that special look that comes from having a mission in life.

The men in our party had entered for a specific age group, the women, not in such good training, had decided that the fun run at the end of the afternoon was enough. We zigzagged backwards and forwards across Hyde Park—to the starting gate, to the numbers tent, to the finishing post, to the track itself, caught a glimpse of small boys running—very business-like, very rhythmical—and then went back to the starting gate, under orders to hold pullovers and track suits for our stripped-off enthusiasts. We found ourselves speculating about the other competitors and viewing them not as people but simply as machines for running—"He'll do well: he won't"—and I was reminded of Lea, Colette's *grand horizontale*, and her friends, who—admittedly for other purposes—eyed men up and down as if they were prize cattle. The age group in which we were interested, far from being horizontal, got off from the count down to a very good start, individual runners lost in a thicket of bodies.

Once more we slowly trekked across the park to the finishing post, just in time to see a 60-year-old, running out of his age group, come in first and in remarkably good shape. The wind was getting up, a few spots of rain were falling, and we'd all, in our different ways, done enough. In no time at all we had decided to forget about the fun run and continue our post mortem at home over brandy and tea, and later still at a Greek family restaurant. The whole afternoon had been a country point-to-point, Glyndebourne, and the count down at Cape Canaveral all rolled into one. Fun we certainly had, though run we didn't—not all of us at any rate.—GRACE WILLIAMS (London).

Ganseys

In the north-east of England there has been recently a revival of interest in the fisher gansey. A well-attended exhibition in a Gateshead museum bears witness to this. The fisher gansey is a woollen knitted outer garment which was the uniform of the inshore fishermen of the north-east coast between the Humber and the Tweed and perhaps a little further north in the last century and the early part of the present century until the almost universal acceptance of the shirt and jacket. Unlike the well-known knitwear of the Irish, Channel Island, or Fair Isle fishermen these unusual garments had been almost forgotten until a local man decided to bring them to the public eye—hence the exhibition.

They were knitted in navy blue yarn as a single piece without any seams by using five needles. The sleeves were cunningly provided with a gusset to allow free movement of the arms and a shoulder strap allowed room round the neck. The most curious feature was that the pattern was started half way up the body and continued half way down the sleeves. This was to allow reworking of the welt and lower half of the body and sleeves when they became worn with work (these were working dress) without disrupting the pattern. Each village had its own pattern, which was knitted into the gansey—usually a com-

References

- ¹ Hamilton, E J, *British Medical Journal*, 1976, **1**, 1191.
- ² Ali, M A M, *et al*, *Canadian Medical Association Journal*, 1977, **116**, 59.
- ³ Zeidler, D H, *Healing the Hospital*, McMaster Health Sciences Centre: *Its Conception and Evolution*. Toronto, The Zeidler Partnership, 1974.
- ⁴ Wilson, D L, *Canadian Medical Association Journal*, 1978, **118**, 879.
- ⁵ Newman, P C, *The Canadian Establishment*, Toronto, McClelland, 1975.

bination of cables, ladders, flags, diamonds, and crow's feet. A special design known as Betty Martin was used on the sleeves.

For high days and holidays there was a special gansey, the pattern of which continued right to the bottom of body and sleeves. These were often knitted in silver-grey yarn. Some of the finest of these were the "rocket ganseys" worn by members of the local lifeboat crews (who were summoned to their task by a maroon or rocket).

Although knitting was a practice traditional to the sailors themselves these ganseys were knitted by the wives, mothers, and sweethearts of the fishermen as they waited at home or sitting by the harbour wall for their menfolk to bring home their catch, which they would then clean and sell. A skilled knitter could finish a piece in about 60 hours.

It is to be hoped that thanks to one man's interest we will continue to see some of our traditional dress worn in the north-east. A blue gansey may not be as eye-catching as a Scotsman's kilt, but it is just as worthy of preservation in this age of uniformity and mass-produced high street goods.—WHELDON T HOULSBY (SHO, London).

Sir Thomas More

Dunedin has seen Sir Thomas More recently and was able to recognise him for that fine chap which history records. I confess I had never realised what an inspiration he is to such a rich following of admiring savants. With a character list of 54, the world's first full-length production of "*Sir Thomas More* by William Shakespeare and others" was a major undertaking for a group of Dunedin enthusiasts—the Thomas More Quincentenary Celebrations Committee.

Entombed in the recesses of the department of English in the University of Otago, Alistair Fox edited from copies of manuscript sheets, among which are the only original samples of Shakespeare's hand the world has, a producible stage version of the full-length play by Shakespeare and a small posse of contemporaries. More was born in 1478 (the object of the exercise was the celebration of the quincentenary of his birth) and died under the headsman's axe at Henry's behest in 1535, being canonised 400 years later. The play was never produced at its time of writing, being much too near the event it portrays to be politically tolerable.

The success of the five-night run in a 300-seat theatre in Dunedin is to be gauged by the winnowing of a modest profit. On reading, the play is an unremarkable series of tableaux of More's life. In the hands of Miss Oakshott, daughter of a medical practitioner in Thorne, in the West Riding, it came to life. There is little of the drama of *Hamlet* or *Macbeth*, little of the frivolous comedy of *Twelfth Night* or *Midsummer Night's Dream*. In common with the latter, however, there is a play within a play and a party of buffoons, the leader portrayed by a professor of economics known for his views on the economics of medical services. There is recognisable Shakespearian humour, somewhat protracted perhaps, around More's attitude towards his own decapitation, typified, during his approach to the scaffold, by:

"... lend me thy hand
To help me up: as for coming down
Let me alone, I'll look after that myself."

The cast was studded with academy, from quite senior professors to aspiring classics scholars at Oxford (England). I wondered at the (conjured?) irony of the role of a man hanged on stage being played by a local magistrate. The irony was completed by the need for the professional advice of a fellow player, the coroner's pathologist, on how to act hanged. Of the remaining 53 characters, many were doubled up and most were "bit" parts; indeed some of us were forced to adjure our admiring loved ones not to blink at a given time or our performance would be missed.

It is not every day that a Shakespearian world première is presented; Dunedin was proud to do it, and satisfied to do it well.—A G HOCKEN (senior lecturer in medicine, Dunedin, New Zealand).