REMINISCENCES OF A GENERAL PRACTITIONER

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I arrived in Sterkstroom in 1924 with a recently acquired M.B. diploma; unlimited confidence in my ability to deal with all major medical, surgical and obstetric problems; a Dublin-made and equipped midwifery bag and a second-hand Ford bought on credit for £150. This car had no self-starter, no detachable wheels and no lights unless the engine was running. I sat on the car, not in it.

The midwifery bag contained a combined douche-can and sterilizer (Rotunda model), axis-traction forceps, a perforater, an assortment of clamps, needles and catgut, and also a pubiotomy needle with Gigli's saw (I actually used this implement with great success). I also owned a variety of scalpels, a second-hand amputation saw, a chisel and mallet for emergency mastoid surgery and, of course, some anaesthetic masks and a choloroformdrop-bottle. I had also been given a Clover's ether inhaler. In addition I had an assortment of second-hand instruments which had been given to me by various friends—the most useful instruments being a set of dental forceps and a set of metal urethral dilators. I had had considerable practice in using these implements as a hospital resident and this experience proved to be very useful.

My Mobile Dispensary

I bought a set of syringes in a genuine spirit-proof case. The price was reasonable and the quality first class—both quality and price are now only a memory of days long passed. I had an assortment of hypodermic tablets as well as ampoules of camphor in oil with ether, ampoules of pituitrin and ampoules of electrargol—a non-specific cure for all specific infections. There were metal-covered bottles for chloroform, lysol, tincture of iodine, and liquid extract of ergot and also a bottle containing biniodide tablets.

A firm of wholesale chemists had, on credit, supplied me with an assortment of drugs, pills, powders, bottles, bandages, dressings, and splints. I also owned a beautiful wooden box divided into numerous compartments containing bottles of various sizes. This was my mobile dispensary and it fitted into my Ford. The smaller bottles contained standard tinctures, the medium-sized bottles concentrated stock mixtures, and the larger bottles labelled *Aqua Tapi* and *Aqua Tanki* respectively contained the necessary diluent for the contents of the smaller bottles. When visiting a farm, dispensing had to be done in public. The relatives all wanted to see what went into the bottle and the potency of the mixture dispensed was considered directly proportional to the number of preparations used in its make-up. Great care had always to be taken in measuring the exact quantity of *aqua* required. I found, after a time, that a mould would grow in the *aqua* and, to prevent this, I added a small amount of chloroform water. Had I not done this I might perhaps, quite accidentally, have anticipated the discovery of penicillin.

Conditions of Practice

I arranged accommodation at a local hotel at an inclusive charge of £5 per month. I hired rooms for use as a surgery and dispensary for £2 10s. per month and engaged a Native boy for approximately £1 10s. a month. There was no tele-

phone, I required no receptionist and I doubted if I would ever need a bookkeeper. The only telephone in the village was at the local post-office.

My first call was on the well-established local practitioner, who received me in a very friendly manner and offered to give me all assistance possible. He certainly helped me to establish a practice because he persuaded all the poor of the village to send for me, particularly at night. Those farmers who never paid their accounts were also referred to me. He informed me of his usual tariff of fees and I agreed to charge exactly the same. The fees were 7s. 6d. a visit, 5s. a consultation and 3s. 6d per mile each way for travelling. This fee was traditional and based on the average speed of the horse which travelled 6 miles an hour. In this way the doctor earned a fee of 21s. per hour. The charges for medicines ranged from 2s. 6d. to 7s. 6d. a bottle depending not on the contents but on the size of the bottle. The fee for a confinement was £5 5s., which included antenatal care.

The first person who walked into my surgery was a farmer, who was considered a wealthy man, but this was not known to me at the time. He wanted to know if I was the new doctor and if I could pull teeth. When I had satisfied him as to my identity and qualifications he wanted to know 'how much?'. I quoted him the standard fee which was 7s. 6d. with an injection and 5s. without an injection. When he asked what it would cost to pull 2 teeth I quoted 15s. with and 10s. without an injection. After he had convinced me of his poverty he persuaded me to pull 4 teeth for the price of 2 and then called his wife, who had been waiting outside in the family Cape-cart, and asked me to pull 4 of her teeth without an injection.

Having learned to pull the teeth of Dublin Metropolitan policemen, I had no difficulty in extracting 4 of the lady's teeth and, to show my sympathy for suffering humanity I gave her an injection of cocaine even though this had not been included in the contract. The operation was so successfully performed that my reputation as a general practitioner was made

The nearest hospital was at Queenstown—36 miles distant and just over 2 hours by fast car and about the same time by train. I can now travel the distance in 35 minutes, but the train has adhered to the old time-table, with this difference, however, that it is not always as punctual as it used to be. Farm roads were very bad and even main roads were impassable in rainy weather, and many visits to farms had to be completed on horseback. When my services were required on a farm, a messenger was usually sent for me.

Farm visits were the major source of income and as there was no telephone there could, fortunately, be no telephone consultations. Surgical cases were taken to Queenstown where they were very skilfully operated on by my friend, the late Dr. Harry Lewis. Occasionally, patients were too ill or too obstinate to be moved. Sometimes weather conditions and road conditions made it quite impossible to move a seriously ill patient, and during the next 2 years I performed several appendicectomies and one mastoid operation on a kitchen table without a nurse, without an assistant and without an anaesthetist. I used spinal anaesthesia for the appendicectomies, and a child with a very acute mastoid was put to sleep with chloroform and the mastoid was then opened before the child woke up. The child fortunately recovered from both the anaesthetic and operation.

The only patients who paid cash were the few Native patients I saw. The fee was 2s. 6d. for a child including medicine and 5s. for an adult. The inhabitants of the village paid their accounts occasionally, perhaps, and it was customary that farmers only received their account once a year during the shearing season. If the wool cheque was sufficient the doctor also received a small share.

It did not take me very long to establish a very extensive practice and to build up a very substantial overdraft. I was frequently called to see patients in the surrounding districts and was often asked to see patients at the request of other doctors. After I had been in Sterkstroom for about a year I was persuaded to open a nursing home. The Church promised to assist, the farmers offered their support, and a very attractive young nurse agreed to work for me. The venture was not very profitable but provided me with ample experience, particularly in economics. I was also appointed railway medical officer at a salary of £108 per year.

Sterkstroom is a railway junction and, as such, it was necessary for an engine to be permanently stationed there. As the engine required a driver, the driver and his family had to live at Sterkstroom. The driver has long since died but the engine is, I believe, still in use. Three times a week this particular driver went on duty at 2 o'clock in the morning and at least twice a week used to wake me on his way to the station because he had a headache. At first he was treated with sympathy and given the necessary pills, but after numerous nocturnal disturbances I was no longer the sympathetic railway doctor. Instead of an aspirin or similar tablet I gave him a 5-grain calomel tablet and assured him that the cure would now be permanent. It was!

One Saturday afternoon while I was playing tennis, I was urgently sent for by the youngest daughter of a railway employee with the urgent request that her mother required raw linseed oil and Condy's crystals (potassium permanganate). I suggested that this prescription could wait until the Monday and I continued with my game. A little later another child of the same family arrived and repeated the request for Condy's crystals and linseed oil. This request was also refused. A little later the eldest child of this family came along and asked me please to let her mother have the linseed oil and the crystals because they were required urgently. When I refused to agree to this request the child burst into tears and informed me that the visitors would be gone by Monday and they had to get the floors polished before they arrived the next day.

A young fireman, who possessed a second-hand motor cycle, developed an enormous appetite for castor oil—almost every day he sent for castor oil until I discovered that he thought Castrol and castor oil were the same and that both could therefore be used for motor cycles.

In 1926 I was able to persuade a colleague to take over my practice with all its responsibilities and I joined Dr. Lewis, of Queenstown, as an assistant.

Queenstown

In 1926 Queenstown was already a progressive town and the educational and inland commercial centre of the Border and Eastern Cape. There was a good hospital and also a well-run private nursing home. The part-time medical superintendent of the hospital, Dr. W. Paisley, had practised in Queenstown since the Boer War and his many friends are very pleased that he is still actively interested in the medical

profession and the Medical Association. He was a model superintendent who never interfered with the smooth running of the institution under his control.

The district surgeon was Dr. Cranke, a wise old general practitioner of the old school who taught me a great deal about the diagnosis of infectious diseases. He was expert in the diagnosis of typhus, typhoid and smallpox.

I learned a great deal in these early days, not only from my chief, Harry Lewis, and from other practitioners, but also from some of the wise old nursing sisters who knew more about treatment than had ever been taught in medical schools.

The hospital possessed a very elaborate X-ray unit with rotating rectifier and gas tubes. The controls had been manipulated by so many inexpert hands that the machine no longer worked, and it was replaced by a low-powered semi-portable unit which could show 'bone outline' and occasionally demonstrate a fracture. There was no pathological laboratory and specimens were sent to the South African Institute for Medical Research. The service given was very satisfactory and reports were received more quickly in 1926 than in 1960. There was no doubt less work both for the pathologists and the postal officials.

The operating theatre was small and extremely hot in summer. The table was old-fashioned even in 1926 and the theatre light was designed by Harry Lewis and had been manufactured by the local plumber, but it was very much better than some more expensive lights. The standard of work was better than it was in most centres, and some of the medical practitioners, particularly Harry Lewis and Jimmy Ritchie, were extremely competent operators. My first appearance in the operating theatre was in the role of anaesthetist and I arrived with a bottle of anaesthetic ether even though I was told that ether could not be used at a high altitude and in a hot climate and that, in any case, chloroform was a safer and better anaesthetic agent. I introduced this dangerous substance most successfully and, before long, it was used by most practitioners.

Fees in Queenstown were very much the same as they had been in Sterkstroom, but the greater part of our income was derived from surgical practice. The fee for an appendicectomy was 25 guineas and for a cholecystectomy or hysterectomy 30 - 45 guineas. There were, of course, no medical aid societies and surgical fees were usually arranged with the patient according to his ability to pay. Patients were treated as free patients whenever this was considered necessary, and we all did free work at the hospital in our capacity as honorary medical officers. The Medical Committee, of which we were all members, had a great deal to say in the administration of the hospital and our recommendations were almost invariably accepted.

Methods of Treatment

In 1929 I went overseas for purposes of postgraduate study and on my return Dr. Lewis left Queenstown. In Queenstown at that time all practices were dispensing practices. Doctors did not require receptionists and patients were not required to make appointments. Consulting hours were between 11 and 12 midday and 2 and 4 p.m., and patients waited until they were attended to. Many of the farmers had telephones, but roads were bad and country trips were still a major source of income. I engaged a receptionist towards the end of 1930 at a salary, considered excellent at that time, of £5 per month. The price of my expensive car was about £400 and a more useful car, such as a Ford or Chev. could have been bought for under £300. There were no expensive drugs and stock mixtures were adequate for most conditions. There were always cases of pneumonia and enteric fever in hospital and if they survived it was due to the expert nursing and not to the drugs used. Camphor-in-oil with ether was the most commonly used injection and had the great advantage of never doing harm. About this time two quinine preparations were introduced for the treatment of the pneumonias. These were solvochin and transpulmin and both remained in popular use until 1946.

There were many cases of syphilis, and neosalvarsan, mercury, and intramuscular bismuth were used extensively. I saw 2 fatal cases of exfoliative dermatitis following treatment with neosalvarsan. Two of my patients died of agranulocytosis, caused by arsenic in one and by veramon—a popular amidopyrine-containing analgesic tablet—in the other.

Gonorrhoea was treated according to the methods used during World War I—and not cured. The first real advance in the treatment of this prevalent condition was the introduction of short-wave diathermy.

I well remember my introduction to the first of the sulpha drugs. I had a case of severe puerperal septicaemia and a trade representative gave me samples of red prontosil for intravenous use. The result was dramatic. Streptococci, gonococci and meningococci had great respect for prontosil Other sulphonamides such as sulphanilamide and soluseptasine soon displaced prontosil but were not superior. It was only in 1939 when sulphapyridine (M & B 693) was introduced that effective chemotherapy against the pneumococcus became possible. Therapeutic failure of sulphapyridine was usually due to insufficient dosage, because of fear of crystalluria. This could be prevented by the use of alkalis and by adequate fluid intake, given intravenously if necessary.

In 1924 I did not diagnose coronary occlusion, but patients nevertheless died of the disease. I am satisfied that the incidence of ischaemic heart disease has more than doubled in the past three decades. Carcinoma of the lung was also not diagnosed and many a family history of tuberculosis was, in fact, a history of carcinoma.

In 1930 amoebiasis was not very prevalent in the Eastern Cape. The disease was usually contracted in Natal and the Eastern Transvaal. In 1931 Dr. Ramsay, of Molteno, described cases of hepatomegaly successfully treated with emetine (report to meeting of Queenstown Division, M.A.S.A.). I had seen some of these cases and proved them to be amoebiasis. The patients had never been outside the Molteno and Dordrecht districts. I have since seen many cases of amoebiasis contracted in this area.

My colleagues were more interested in surgical conditions than in medical problems. The most important advance in surgery was the introduction of the modern treatment for paralytic ileus. It took many years to persuade doctors and ward sisters not to irritate the post-operative bowel with purgatives and enemata. It also took many year to persuade colleagues and nurses not to use 'donkeys' (bolsters) and to recognize the importance of the prevention of deep-vein thrombosis.

The War Years

When war was declared I volunteered for service and in May 1940 was at the Zonderwater training camp. When my assistant also joined the army the practice had to be closed for the duration of the war.

Work in military hospitals provided useful experience as well as excellent teaching from some very eminent senior colleagues. It also confirmed that no individual doctor can give adequate service without the cooperation of colleagues trained and experienced in different fields, and that highly specialized knowledge was most useful when based on wide practical experience.

It is impossible to give up a practice without very considerable loss, and war is never entirely pleasant, but the friendships made and the comradeship enjoyed amply compensated for the sacrifices made. While I was on military service the South African Medical and Dental Council saw fit to place me on the register of specialist physicians, but on demobilization I voluntarily reverted to the status of a general practitioner.

My practice was soon re-established and after a year a colleague, who had worked with me in military hospitals joined me as assistant and later became a partner. Soon another assistant joined the firm which has grown over the years, so that now we are 5. Each is a general practitioner able to do all routine general practice work, but each has his special interests and has had special training in his particular field. Group practice is, in my opinion, the ideal practice for the smaller hospital town. It is pleasant for the doctor and also for the patient.

Changing Patterns of Living

The past 20 years have been years of industrial revolution and it was inevitable that there should have been a shift of population from the platteland to the town and from the village to the city. There has also been a change in the pattern of living. The good road and the closed car make it possible to move a patient to the nearest hospital. It is safer to move the patient 100 miles to a well-equipped and well-staffed hospital than to leave him in a village nursing home where equipment and staff cannot be adequate. Should hospitalization not be necessary it is usually possible to take the patient to the nearest doctor. It is cheaper than asking the doctor to visit the farm. A telephone call to the doctor may also make a visit unnecessary.

Babies are no longer born on the farms and it is cheaper and better for the patients to go to the nearest town where there is a well-equipped maternity home or hospital. It was inevitable, therefore, that the doctor should leave the village and migrate to the big city.

One village which supported 4 doctors in 1924 now has 2. Villages which had 1 doctor only, now have none. The doctor in the town no longer dispenses medicines, but the country doctor is compelled by circumstance to dispense. He not only dispenses stock mixtures but also supplies his patients with expensive antibiotics and corticosteroids. He is not always paid for the drugs he dispenses. His car, which used to cost £300, now costs £1,200. He needs more equipment than was necessary in 1924 and he also requires a receptionist.

The increase in medical fees has been very moderate when compared to the increased cost of providing the service. When the country doctor needs a holiday he also needs a *locum tenens*. The 1926 *locum tenens* was pleased to receive £1 11s. 6d. a day all found. In 1960 'locums' are almost unobtainable and the fee is from £5 5s. to £7 7s. a day all found.

The general practitioner in the large city may see more patients than his country colleague, but his income is derived almost entirely from domiciliary visits and consultations. In addition he has the expensive privilege of driving many miles through dense traffic.

The post-war years have been most interesting. Society, both White and non-White, has largely become an urbanized, industrial society and contract practice has, in many cases, replaced traditional private practice.

Rapid progress in medical science has increased the citizen's expectation of life, and has also increased the need for and the cost of investigations and treatment. The high cost of modern drugs, essential in many cases, has made the drug bill a greater burden than the doctor's fee.

While the general practitioner is gradually adapting himself to the changing world, micro-organisms are rapidly adapting themselves to an antibiotic-saturated environment. While drug manufacturers are producing antibiotics of ever increasing variety and price, their indiscriminate use is generating numerous strains of antibiotic-fast organisms.

When I was a young man I did not intend to become a general practitioner, but economic circumstances forced me to become one. There were no well-paid hospital posts in 1924 and a junior medical officer in a teaching hospital was fortunate to earn £10 a month. The young doctor who had to earn a living had to become a general practitioner.

I had many regrets in 1924, but have had no regrets since. There has never been a more interesting era in recorded medical history. General practice has always been a rewarding experience. I have certainly enjoyed my first 36 years.