# THE FAITH OF A GENERAL PRACTITIONER*

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Jerome Carden lived in the 16th century and he wrote: 'The doctor's calling is completely servile and so full of toil that I do not marvel that it used to be peculiar to slaves'. The substance of that plaintive cry finds an echo with many of us today. Tonight I shall allow my mind to roam over the nearly 40 years that I have been in general practice. I shall present you with a *pot-pourri* of facts and impressions and, in the process, shall seek a personal answer to Carden's dark and gloomy assessment of our calling.

Dr. Klein

UNDERGRADUATE DAYS

In 1921, having first completed a medical B.A. degree in Cape Town, I transferred to the newly-formed Medical School in Johannesburg, then no further advanced than its fourth-year class. I joined that class of 30 students and qualified three years later, to be one of the first four students to graduate from the new Medical School. A plaque was placed in the School's common room to commemorate this historic event, and to perpetuate our four names. To our dismay, before this little bit of history had even begun to run its course, we were presented with an account for the cost of that plaque!

I remember clearly the antagonism first felt towards the new Medical School. The training would for a long time be inadequate, it was said. The existing hospitals could not possibly absorb a fresh flow of graduates and, above all, the profession would be overcrowded—and by men lacking the impact of the scholarship and culture of the older universities, men who for that reason might not be sensitive to the exacting ethical code of an ancient profession. The immediate answer to all this criticism was to let loose on the public, timidly, not more than four of its products.

I am satisfied that from the very beginning graduates from the University of the Witwatersrand measured up to the highest standards of our profession. From time to time a cry goes forth that entrance to medical school should be selective. It is not strange that no adequate formula for such selection has yet been arrived at. How can we measure academic ability for the study of medicine, which requires such a complex intelligence pattern. The only yardstick applied thus far is a first-class matriculation pass, and that measures intelligence in one dimension only. It reminds me of the time in East Africa during the war when the resources of a hospital serving our brigade were severely strained, and in order to control admissions an instruction went forth that until further notice only patients with a temperature over 102°F. should be admitted.

Judging a student's moral worth is even more difficult. Milton, in referring to the priesthood, spoke of "such as for their bellies' sake creep and intrude and climb into the fold". In medicine, as in the priesthood, there will always be the outsider, creeping into the profession for his belly's sake; but in the main the aspiring candidate seeks a way of living, not a way of earning. It is the dignity of the calling that decides the choice—and stamps the man.

My new medical school, because of inevitable teething troubles, did not have its fourth-year class ready for hospital work when the professor of medicine arrived from England. I was the only student available to him, and for a full year I was his only student and also the only clinical clerk in the Johannesburg General Hospital. It was a case of the professor and I, and established a personal relationship which could not have harmed me much at examination time.

HOUSEMANSHIP

I assumed my housemanship on New Year's Day 1925, and that night was due to share casualty duties with a senior houseman. He arrived in a dress-suit and said he felt that it was going to be a very quiet night and that I could manage on my own; he departed before his opinion could become a subject of debate. Soon the cases started pouring in, and I was in sole charge of the hospital on that New Year's night. A feeling of inadequacy overwhelmed me, a feeling I was to experience time and again in my early years of practice. I do believe that the only diagnosis I made that night, with any conviction, was that of a woman brought in unconscious who had round her neck and beneath her blouse a placard which read: 'I am an epileptic. Don't pump my stomach. Give me brandy'.

* Valedictory address, Pretoria, 14 February 1963.

*Drugs*

A housemanship differed then in two important aspects from today. The range of effective therapeutic drugs was narrowly circumscribed, and specialization had not yet attained its present proportions. The drugs we had at our disposal were morphine and related alkaloids, digitalis, sodium salicylate, mercury, bismuth, thyroid, adrenaline and, by 1924, insulin. These we were taught to use skilfully. The manufacturing chemist, too, helped us to add range and variety to our medicating. The art of the hypodermic tablet, the pill and the soloid, had already reached a high pitch of perfection. A well-known British drug firm, in its equally well-known yearly diary, tabulated, in the year of my graduation, 40 different combinations of iron pills; 33 different combinations and strengths of morphine hypodermic tablets; 37 varieties of ophthalmic tablets; 32 different quinine formulae; and so on. Nevertheless, therapeutics had reached a state of nihilism, and for a time it was thought that the future of therapeutics lay in the field of biology. We used numerous sera and vaccines, but only anti-diphtheria and anti-tetanus serum proved of any value, and of course anti-typhoid vaccine.

In 1909 Ehrlich's discovery of 'salvarsan' had offered the profession its first antiparasitic sterilizing agent. It was a breakthrough for synthetic chemotherapy. Domagk followed Ehrlich's visionary example many years later. I was in London doing postgraduate study when Prof. L. Colebrook and his co-workers were testing out the newly-discovered drug 'prontosil' under a cloak of secrecy. Excitement in London was great when news filtered through about how favourably they were impressed with the drug. I wrote to my brother, who was running our practice in the Free State, to tell him all about prontosil, and what was thought of it. He wrote back to say that he had been using prontosil for some time and that he also liked it! Once more a drug firm had beaten the pistol.

*Senior Doctors*

As I have mentioned, a most notable change in the pattern of medicine since my qualification is the rise of specialization. At the Johannesburg General Hospital the majority of the senior physicians at that time were general practitioners. Young specialist physicians were just beginning to infiltrate, and filled the junior posts. Johannesburg had one genito-urinary surgeon, and one orthopaedic surgeon, and dermatology and venereal diseases constituted one specialty. ENT and eyes were often also linked together. The Superintendent of the General Hospital ran the skin department. A professor of surgery practised as a general practitioner until a short time before his appointment. One of the junior surgeons was the district surgeon of Johannesburg, and was also lecturer in forensic medicine.

Interesting social commentary is the fact that the housemen's quarters used to receive an over-liberal weekly ration of beer, and that the operating theatre had its private liquor cupboard.

## COUNTRY PRACTICE

I hankered for the country, where a man was a landmark on the horizon, and bought what was but the shell of a practice from a senior man. He was a very fine man, but had been in bad health for some time. He was a large man—I looked younger than my immature years, and when I stood beneath the shade of his spreading moustaches I wished that the 14-day agreed-upon introduction would pass more quickly. I paid £250 for the practice—gross earnings in my first year of practice were £900—and my Dodge five-seater car cost me £350. I did well to be free of debt by the end of my second year.

I was now established as a country doctor, who practised medicine, surgery and midwifery, and prescribed and dispensed medicine; who often substituted for the vet, and sometimes for the undertaker; and I must not forget my dental services either. Before I had even arrived in the country town where I practised, I had been primed about the importance of teeth extractions. I bought a set of dental forceps (second-hand) even before I bought my axis-traction forceps (also second-hand), and the order of precedence was the correct one. One graduated from the dental forceps to the obstetric forceps. My predecessors had had to contend with a local blacksmith who was no mean puller of teeth—since then a dentist had arrived and his sterling services were later to be fully appreciated, but in the beginning many still favoured the swift assault, with no finesse, and for a time I had to continue pulling teeth. They said they found me so very much like the blacksmith!

One is apt to look at one's early years through the rosy mists of time. I look back with love to those wonderful country folk who so eagerly befriended the young doctor. When a patient died they often sympathized as fervently with the doctor as they did with the next-of-kin. The doctor shared his status with a minister of religion. He also shared the fruit, the flowers and the konfyt. It is the function of the doctor and the priest to comfort the afflicted. That is the consummation of the doctor's calling—to relieve pain, be it physical or mental. But for the priest it is not enough that he comfort the afflicted. If he wishes to keep his community on its toes, he often has to afflict the comfortable. It is not strange, therefore, that the community often found the doctor the more satisfactory benefactor of the two.

The district surgeoncy is a distinctive feature of South African country life. It demands expert knowledge of public health and medico-legal medicine. It gives an unrivalled opportunity by way of autopsies, of viewing the body.

*Typhoid and Typhus*

When I first arrived in Clocolan I found typhoid fever endemic among the Bantu population, and I saw literally hundreds of cases each year. Then came the great drought and the great depression that started in 1932. At the end of a very severe winter I began seeing a different type of case. The fever mounted more quickly, and lung congestion and cough were a frequent sign, with death occurring by the second week. One afternoon I received a message to say that there were two very ill Natives on a farm, and soon after another message that they had died. I decided to do a postmortem examination. It was a bitterly cold morning and my Native assistant and I settled down to do the autopsy in the shelter of a barn where we had found the bodies. As my assistant removed a belt from one of the bodies he said: 'These dirty Natives are full of lice'. An inspiration alerted me: we pulled the bodies out into the open and found them swarming with lice by the thousand. Typhus fever had come to the Eastern Free State. Other areas were contacted and typhus was found scattered among the typhoids, and in some gaols it was masquerading as influenza. On a district surgeon's salary of £15 per month I had battled since the very beginning with hundreds of enteric cases as only part of my duties. I now asked for aid to combat this greater menace. It came in the form of numerous pamphlets and some gallons of paraffin oil, but I was allowed the part-time help of a retired policeman. He went on his first assignment and reported as follows: 'Proceeded to farm Witputs as directed. There I scrubbed, oiled and boiled six Native women and burnt their clothes'.

Just about this time Dr. A. Pijper reported on pellagra in the Pretoria gaol. In my student years no case had ever been demonstrated to me, but from an illustrated article I realized that pellagra was rife in my area, and I collected a series of cases for a clinical meeting of our Division. The P.M.O. of Basutoland was our chairman at the time. He came to me very glumly—they were also recognizing pellagra in Basutoland and he had planned to make it the subject of his annual address!

It is difficult to describe the intimacy of country practice as I knew it; how intimately one was identified with the drama of life; with birth and with death. More clearly than anything else I remember the long vigils. Waiting for a birth and waiting for a death. One's presence was as important at the end of a life as at its beginning. There was the long vigil with the acute pneumonia and in the end one moved in and spent whole nights with the patient. Patients with typhoid fever, pelvic cellulitis, gonococcal salpingitis, osteomyelitis, rheumatic fever—all demanded constant care day in and day out, for months on end.

*Obstetrical Anecdotes*

A few anecdotes will best convey the rich flavour of a

country doctor's life some 30 years ago; maybe little has altered even now. Maternity work on lonely farms with no expert help and relatives everywhere, was often a sore trial, but even this work often had a lighter side to it. I remember the case where the husband asked me whether he could perhaps do something to help. I said that he had already done all that could be expected of him. Yes, but what about the afterbirth? Mustn't that be buried? I said he could go and dig a hole for the afterbirth. When I eventually presented him with the afterbirth, he uttered an exclamation! He had asked for work and then, like a true South African, had told the Native to do it, and he had forgotten all about it in the excitement of the occasion. I went with him to the garden. It had rained a lot and the ground was very wet. The Native was still digging but had long ceased to be visible. We dropped the afterbirth into the depths of the earth in the presence of a very bewildered Native.

There was the occasion when I was completely alone with a patient in labour. I couldn't leave her, but couldn't keep awake either; there was only one bed in the house, the labour was very long, and the night very cold. I looked longingly at the bed and in the end crawled into it with her. She woke me when her pains got too bad, and I delivered her. Afterwards I bathed and dressed the child and served a pot of tea for two—and of course buried the afterbirth!

One more anecdote will suffice. A patient had booked me from a neighbouring town and arrived with her pains on her, but it just so happened that she could not be taken into the local hospital, nor could she be accommodated anywhere else. My bachelor quarters, part of the surgery, was the only solution, and she was confined in my bed. I left her to a pretty nurse and took up my quarters at the local hotel. It was the custom for people who came to call the doctor at night to walk in through the ever-open door and shake him awake. I had forgotten about such an eventuality. On the very first night someone did come to call me and was confronted by a pretty girl in a negligée. Taken aback, he stuttered that he wanted the doctor, but that it didn't matter now! All blushes, she replied that the doctor didn't sleep there; he said he knew that the doctor slept there, but that it still didn't matter.

While I am on the subject of labour, I think back on Basuto deliveries I have witnessed. The woman in labour sits in a semi-squatting position, supported by an immobile attendant on either side. The midwife hovers around at a respectable distance—all is quiet except for the soft groans of the patient. I cannot help comparing this non-touch technique and the silence in the huts on those distant hills, with the laying-on-of-hands and the salvo of disturbing instructions that accompany each bearing down pain, which is so often the pattern of behaviour in sophisticated institutions nearer home.

*Dispensing*

Dispensing by the country doctor was traditional. Faith in the bottle of medicine credited the cure to the one that dispensed it, and so we continued to dispense our own medicines even after the chemists had begun to reach the country areas. We were in no way better qualified to do so than is the doctor of today; it added but one more anxiety to an already anxiety-laden existence.

I remember the occasion when I threw together what was meant to be a particularly stimulating tonic for a patient and friend. At a sundowner party soon after, she succeeded in pouring down my throat, playfully, what purported to be an interesting cocktail, but was in fact a measured dose of my own medicine. It was the only way I could learn what an extraordinarily revolting brew I had concocted.

There is one more story that must be told. Mr. X, a bachelor from a distant territory, was an ex-heavyweight boxer, an ex-policeman, a suspected burglar and a man whose path no man should cross. Along with everyone else I feared having anything to do with him. He, on the other hand, trusted no one, but he picked on me for his doctor and we thus had a doctor-patient relationship based on mutual distrust and fear. In the event, that mutual distrust and fear were fully justified, for X was eventually found guilty of a quite extraordinary variety of crimes, and sentenced to a long term of imprisonment; but not before I had poured sulphuric acid into his bladder. I had treated X for the full range of specific diseases, but he was a perfectionist and worried about a tiny drop of gleet that still presented itself. That was a difficult condition to clear, and we used to pass a catheter up to the membranous urethra and instil a 'protargol' solution. To the uninitiated, it must be explained that protargol, to dissolve smoothly, must be floated on to distilled water, and that takes time. I therefore weighed out the silver salt and left my Native dispenser to do the rest; when it was ready I injected the prepared solution into X's urethra. Within half an hour he was back. He looked bigger than ever, and said his stomach was on fire. I thought his eyes were. What he was passing looked to him mighty like pieces of bladder, and pieces of bladder they were! It did not take me long to realize what had gone wrong. I examined the bottle said to contain the distilled water and found it contained pure sulphuric acid. My dispenser had discovered that we were out of distilled water, and very intelligently went to a garage which he knew kept distilled water for battery use. However, they also kept sulphuric acid for the same purpose in identical bottles, and nothing was labelled. That is how I had injected sulphuric acid into my 'friend's' bladder. I came back and told him what I had done—that I had injected sulphuric acid into him. He gave me a dreadful look and said (and some of you may think this is the reason why I am telling this story): 'Doctor, it is your good luck that you happen to be so honest!'

X eventually recovered from his experience and a specialist friend of mine declared him completely healed. The financial aspect of this mishap was also comfortably disposed of—the firm that supplied the sulphuric acid went insolvent; and not because they were selling sulphuric acid at the price of distilled water, but because of incompetence in other directions as well. A claim for damages was met without demur by the executors in the insolvent estate when they learnt who the claimant was!

When X landed up at the Central Prison in Pretoria, he turned his mishap to good account. The silver lining to a cloud had nothing on the silver lining to his bladder! He asked for a certificate detailing his case history, and the horrible story must have had a terrific impact on the prison authorities because, when he wasn't lying snugly in a bed in the prison hospital, he was acting as a hospital orderly; and so he quite enjoyed his extended stay in this garden city of ours.

At this point I wish to refer to present-day dispensing procedure. It is surprising that our profession still tolerates the mumbo-jumbo nonsense and obscurity that goes with the issuing of a prescription. Much of what we prescribe today is either frankly poisonous or potentially dangerous. The fact that the pharmacist keeps his drugs under lock and key and that the doctor's prescription must be retained for 5 years, in no way protects the patient if, despite the elaborate ritual, he is at the end presented with an anonymous article in a nondescript container—a 25 mg. pethidine tablet looks exactly like a ¼ gr. tablet of phenobarbitone, but the difference would immediately become apparent if given in error to a baby a few weeks old. The time has come for our profession to require a *nomen propium* for every drug it issues, and Association policy should be directed to that end.

After some 11 years in the country I decided to transfer to a city, firmly convinced that the finest entry to medicine is country practice; but I was equally convinced that the standard of education supplied is inadequate and that one's early years are fraught with too many doubts and fears because of inadequate training for that stupendous specialty that is general practice. One more year in hospital in addition to the already stipulated year, doing work well planned and well directed, would, I feel, make all the difference. A sound foundation, and thereafter unremitting postgraduate study, is all-important. That extra clinical year would solve many administrative problems and would deserve an adequate remuneration; but above all, it would bring us nearer to the ideal we set for the general practitioner.

## POSTGRADUATE STUDY

I wish to enlarge somewhat on the subject of postgraduate study. Osler, writing of the general practitioner, said: 'Self-

centred, self-taught, he leads a solitary life and unless his everyday experience is controlled by proper study, he soon ceases to be of the slightest value and becomes a mere accrete of isolated facts'. He added: 'It is astonishing with how little reading a doctor can practise medicine, but it is not astonishing how badly he may do it'.

To my mind mere reading in our day, no matter how assiduously performed, is not enough. In the hurly-burly of a busy practice one tends to skim past what takes time to understand and absorb; and scientific work with its ever-changing nomenclature eludes one soonest. Physiology, pathology, pharmacology, bacteriology; the wheels that drive the clinical chariot forward, move on and leave one far behind. There is but one answer to the general practitioner's universally felt problem of how to keep up with the advances in his profession, and that is that he periodically absent himself from his work in order that he may resume, untrammelled and in an academic atmosphere, those studies that will enable him to speak again in the scientific language of his day. I wish to stress quite forcibly that the patch-quilt type of refresher course which covers a subject in an hour and the whole field of medicine in a week, is but an *apéritif* — a whetting of the palate for a true understanding of the subject.

After 10 years in practice I allowed myself a sabbatical year of study and travel overseas, visiting hospitals and teaching institutions in the British Isles and on the Continent. I attended refresher courses in anatomy, surgery and surgical pathology, and I also devoted myself to obstetrics and gynaecology at specialist level.

When I returned years later for a further prolonged course of study, I devoted my time entirely to medicine. All-in-all I have spent more than two years away from my practice on study leave. The war years entailed further absence from my work. Contrary to what many believe, such absence from one's practice does neither oneself nor one's patients any harm. Those who in one's absence have succeeded in getting their health back may well have cause to bless one—they may also go to another doctor, but when one comes back refreshed, and with enthusiasm replenished, these patients will soon be replaced by others. In any case, there is a constant rotation of patients in every practice, and it follows a percentage pattern.

### DIAGNOSIS

I have said that this address will be a hotch-potch of facts and impressions. To few men is it given to discover a new truth, but a man often thinks that he sees a new slant to an old truth, and then he likes to talk about it. That 'the exception proves the rule' is a commonplace saying, but how does it prove the rule? Quite obviously it does nothing of the sort. This saying is not a translation but a transliteration of the Latin *exceptio regulam probat*. The exception probes the rule —it issues a challenge to the rule. This has great meaning to the clinician. The diseased state that appears to be unusual is not necessarily a condition that does not conform to a known disease entity, deserving an aristocratic double- or treble-barrelled name. It challenges us to classify it, if at all possible. We all accept that common diseases occur most commonly, but it should also be known that what occur next in frequency are unusual manifestations of the common diseases. Because it is the exception that has to prove itself, and the rule itself is an accepted fact, let the clinician in general practice assume that the rare condition does not occur at all in his practice. In his lifetime he may miss two or three such oddities, but he will have reduced his clinical mistakes to a minimum.

Since I seem to have started a homily on diagnosis, I wish to repeat a few axioms that have often been stated before: Let your patient talk. He is trying desperately to give you the diagnosis. Our worst mistakes come, not from ignorance, but from being impatient of listening, and casual in examination. The worst that a patient can say of a doctor is: 'He wouldn't listen to what I had to say and he hardly examined me'. Lastly, be wise enough to know that when a patient flatly refuses the treatment you offer him, you may have more to learn from such refusal than he has to lose from not accepting your advice. Above all, accept this advice from Pope:

> 'Be not the first by whom the new is tried,
> Nor yet the last to throw the old aside.'

### CONCLUSION

My address draws to a close. Today we who practise in a city see the pattern of medicine changing before our very eyes and out of all recognition. Each new scientific advance demands an additional clinical approach; each new therapeutic agent an additional watchfulness. Modern prophylaxis brings new problems. The lengthening span of life supplies the doctor with a patient his predecessors never knew, and overriding all else is the health consciousness of present-day society and the great expectation with which the clinical prowess of the modern practising doctor is viewed. The time has long passed when one man can offer a round-the-clock and round-the-year service to his patient. Group practice preferably, but otherwise a partnership practice or a loose liaison between individual practitioners, is the only answer to present-day conditions.

I have faith in the general practitioner to meet every challenge. I have faith in the future of general medicine. Medicine saw its finest hour in the golden age of Greek culture—when there were only general practitioners. It went into a decline in the Dark Ages when pedantry, as exemplified by the philosopher-physician-priest, faced quackery across a void, and there were no general practitioners. Action and reaction is the tempo of history. The 19th century saw once more the rise of the general practitioner. It was a period of great progress on a broad front. In recent times the accentuation of specialization has thrown doubt on the usefulness and worth of the general practitioner. The specialist knows his subject in detail—the general practitioner is distinguished by the width of his knowledge over a wide field. The phenomenal development of the College of General Practitioners is an expression of the belief that knowledge in breadth is all-important to the welfare of medicine; that that knowledge demands a more thorough basic training and subsequent unremitting postgraduate study. It expresses a new faith and sets out to translate that faith into reality.

It must have been some 27 years ago when, as Chairman of the Basutoland and Border Division of the O.F.S. and Basutoland Branch of the Association, I chose for my address 'The History of Medicine'. As a young man then, I was looking backward. Today, after nearly 40 years in general practice, my gaze is on the future, and I know what my answer must be to the spirit of old Jerome Carden. Medical practice is a dedication. It is not a toil. It isn't servile; and though at this point in my life the grazing grounds already beckon the old cart horse—days in the sun, and nights with one's family 'with old books and old friends', another couplet of Pope keeps ringing in my ears:

> 'The graces of age are sure to please
> Folk like their doctors mouldy like their cheese.'

Be that true or false, I believe I shall carry on until that day when a newspaper will tell how 'Local curiosity collapsed at doorstep of patient'.