MEDICINE TO-DAY AND YESTERDAY A RETROSPECT

BY

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I joined the staff of the London Hospital early in 1900 and am therefore in a fair position, so far as memory serves, to compare the state of medical practice—especially of course hospital and consulting practice—half a century ago with what it is to-day.

Contrasting the medical scene in the year 1900 with the present, and remembering the tendency for distance to lend enchantment, for age to be a praiser of the past, and the rosy mist through which a man is apt to view his early professional life, I still think that medicine was a more interesting, exciting, and adventurous business in the early years of this century than it is now. And that for several reasons.

In the first place, the doctor, whatever his branch of work, was much more engaged in single combat with disease and less one of a team. He went into action for the most part armed only with his own senses and a stethoscope, with a few simple urinary tests, blood films, and an old-fashioned ophthalmoscope as auxiliaries. Bio-chemical tests had not yet been invented (happy days!), nor were the sphygmomanometer, the electrocardiograph, and other mechanical aids to diagnosis available. Even *x* rays were only in their infancy. Still, it was more exciting to find out things for oneself and to try to come to a correct conclusion on insufficient data than simply to collate the "reports"—often conflicting—of a number of technical experts. Nor was diagnosis so bad at that time after all. It is true that its main object was to try to foretell the findings in the dead-house, but this limited object was achieved with astonishing accuracy by the physicians of those days as a result of careful history-taking, thorough physical examination, and the exercise of their "clinical intuition"—a faculty with which I think they were better endowed than their modern successors. Disorders of function they hardly aspired to determine, for functional tests were mostly still in the future.

In the second place, when one looks back disease seems to have been more varied and, if one may use the word, *florid* than it is now. The advance of preventive medicine alone has robbed the clinical field of some choice specimens. Typhoid fever—once a hardy annual in medical wards—is one. Where, too, are the "beautiful" examples of rickets and infantile scurvy, or the cases of acute rheumatism with enormous nodules which I remember so well at Great Ormond Street? Soon diphtheria will also be a thing of the past. Surgery, too, has taken its toll. What young physician has seen an advanced case of pyloric stenosis with gastric fermentation in which the patient belched marsh gas so that sometimes when lighting his pipe the gas took fire and he seemed like a dragon breathing flame? Yet I have witnessed this interesting and exciting occurrence two or three times before the surgeons intervened. Again, when does one now see an old-fashioned case of lobar pneumonia ending dramatically by crisis in seven or nine days? Most cases of pneumonia in these degenerate times end not with a bang but a whimper.

Other interesting clinical specimens have vanished of themselves and for unknown reasons. Chlorosis, well named the "green sickness," for instance, of which the modern "hypochromic anaemia" is but a pale simula-

crum, and, simultaneously with it, its frequent accompaniment acute gastric erosions with gastrostaxis, which latter has so bedevilled the statistics of gastric ulcer and haematemesis compiled by moderns who have never seen a case of what was once one of the commonest objects in a female ward. Gone, too, is muco-membranous colitis, the typical casts of which I could demonstrate to my clinical clerks almost any day in the early years of the century. Interstitial nephritis ("chronic Bright's," as we called it) occurring in men of middle age and often showing itself first by uraemia and proving fatal within a year is now, I understand, become a rarity.

Further, modern treatment has made it impossible to follow the natural course of many diseases. How many students to-day realize that pernicious anaemia is a disease which, left to itself, shows two or three complete remissions before finally proving fatal? Or that exophthalmic goitre is a self-limited disease ending in recovery in about three-quarters of the cases, though the patient may be left rather pop-eyed?

On the other hand, the present generation may console itself with the greater commonness of some of the old diseases and with the emergence of some that may be new. Among the former peptic ulcer, coronary occlusion, cancer of the lung, and infective hepatitis at once suggest themselves. Why they have become commoner I have not space to discuss, but I would only say quite emphatically that it is not a question of better diagnosis. Odd though it may seem, we were not altogether fools fifty years ago, and could diagnose these conditions quite well, though we may have called some of them by different names. Besides, we always had necropsies to correct our errors or oversights. As regards the appearance of new diseases in the last half-century, it is well to bear in mind the warning of Gee, that it is more likely that they have previously been "overlooked or confounded." However, encephalitis and atypical pneumonia are for practical purposes new, and of course a large number of new "syndromes" have, for good or ill, been differentiated in recent decades.

Another thing that made for greater interest in hospital work in the old days was that every physician was supposed to be a *general* physician, even though he often had a particular interest in some special branch. Patients were not segregated according to their disease, and every ward afforded a varied assortment of cases.

It is probable, of course, that disease has become less "picturesque" with each generation, and 1850 no doubt showed many more graphic types than 1900. Should medicine ever become an exact science—which Heaven forbid—it would probably be so dull that no one would want to practise it. But we are a long way from that yet.

It is in treatment, however—we never used the word "therapy"—that the present scores. Looking back, the advances are almost unbelievable. At the beginning of the century there was prevalent a good deal of therapeutic scepticism. Bacteriology, from which much had been hoped, was proving disappointing, and it was widely believed—how falsely!—that drugs were at the end of their tether. A medical ward full of advanced cases of organic disease was rather depressing; one felt so helpless to do anything.

On the new remedies and methods which have been introduced in the last fifty years it is unnecessary to dwell in detail, but they have changed the whole picture, and as regards ability to cure, which, after all, is the main purpose of medicine, the latter days are incomparably better than the former.

It is natural for anyone with long experience of our profession to reflect on the changes in pathological theory as the years go on. In the early part of the century "auto-intoxication" and "uric acid poisoning" were all the vogue, with resulting abuse of "intestinal antiseptics" (does anyone ever prescribe them now?) and "uric acid solvents." Now it is the turn of "allergy," "avitaminosis," and "endocrine imbalance," with the consequent indiscriminate use of antihistamine preparations, vitamins, and hormones. The conception of psychosomatic medicine was not formulated in 1900, and the psychologist was a rare bird outside the asylum.

If the practice of our profession was more interesting and adventurous fifty years ago it was not less arduous. I am always inclined to be sceptical when people talk of the "strain of modern life" as explaining the increase of certain diseases—coronary occlusion, for example. As a matter of fact, the doctor of 1900 had in many ways a more exhausting life than his successor of to-day. The motor-car had hardly come in. A surgeon would dash up to the hospital in a barouche and pair, having perhaps lunched off a few sandwiches on his way from the West End; a physician would alight from a one-horse brougham, whilst the assistant staff came by foot, bus, Underground (there were as yet no "tubes"), or—on rare occasions—by hansom.

Few kept a secretary. Letters were written by hand, mostly in the evening, and eminent members of the profession could often be seen taking them out to post at midnight, for in those days letters were collected late. All this was rather wearing, especially as week-ends had hardly begun; but, on the other hand, most consultants lived "over the shop" and were spared the strain of the double life of St. John's Wood and Wimpole Street. The Cavendish Square district was then really residential, each house, even in the Square itself, containing its family and retinue of servants. It was rare to find more than one brass plate on a door. Certainly the sight, now so common, of a covey of plates, a quarter of them bearing foreign names, was then unknown. In keeping with this more dignified living there was more seemliness of dress. The silk hat and frock-coat were *de rigueur*. And a very comfortable uniform it was. I remember in the hot summer of 1911 going so attired to a consultation at Greenwich when the temperature reached a record of 100° in the shade. Nor did I feel much incommoded.

Whether consultants were better paid on the whole than they are now it is difficult to say, especially since the muddle introduced by the N.H.S. Juniors certainly were much exploited. House-men usually got no pay at all, and registrars had to work very long hours for a mere pittance. In established consulting work the fee for a first consultation was two guineas (it was not long since it had been only one), and for a "domiciliary" consultation, within four miles of Charing Cross, three guineas. These figures went up after the first war to three and five respectively. "Country journeys," however, were probably over-paid (two-thirds of the mileage in guineas)—a relic of the days when one travelled by coach. They were also much more frequent than they are to-day, for fifty years ago there were few recognized consultants outside London except in the really large cities.

It must also be remembered that in those days there were no devalued pound notes. The sovereign was supreme and worth fully twenty shillings. Living also was extraordinarily cheap and taxation light. Take it all in all, the Edwardian era was certainly the Golden Age of consulting practice. It is improbable that anything like it will ever return.

SURGERY IN 1900

BY

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Surgery as I saw it fifty years ago mostly concerned the practice of the old Newcastle-upon-Tyne Royal Infirmary, a large, active provincial hospital.* In 1900 that institution had a normal complement of about 250 beds, but then and for many years overcrowding was a very serious problem. This was especially so on the surgical side, and I have seen a double row of beds all up the middle of a female ward, with one or two patients lying on mattresses on the floor, and two patients in one bed, an adult at one end and a child at the other. Reception for each of the firms went on for a week and recurred every four weeks. By the end of that time the wards were often in an appalling state of congestion, with nurses distracted and house staff worn out.

Nature of the Admissions

The surgical wards took many more than half the admissions, and during that year 2,642 major operations were carried out. The nature of the cases was very different from what it is to-day. For instance, there were no fewer than 129 major amputations with 14 deaths, whereas only 62 cases of appendicitis were operated upon with 12 deaths, and 7 ruptured gastric ulcers with 4 deaths. Stomach surgery of the cold type was just beginning and there were only 11 such operations that year. Strangulated hernia seemed much more frequent, and among 192 hernias of all varieties there were 39 presenting that complication, with 11 deaths. Stricture of the urethra was not only a much more common condition than it is to-day, but was more serious. There were 43 cases admitted to the wards, and many of these were complicated by periurethral abscess or extravasation of urine. Every year two or three cases of tetanus were admitted, and it sometimes arose in cases operated upon in hospital. The mortality was appalling, for antitetanus serum was not yet a practical proposition.

The industrial occupations of the district were reflected in the nature of many of the admissions, and coal-miners accounted for nearly all the 34 cases of injury to the semi-lunar cartilages, while from the lead works on the Tyne came 36 cases of poisoning. I cannot help remarking on the frequency of thoracic aneurysm, for no fewer than 26 cases were admitted that year, and many were quite obvious externally. Alcoholic diseases were also very common, and there were 14 cases of liver cirrhosis: some cases with ascites were being treated by the omentopexy of Drummond and Morison with encouraging success.

At that time gynaecology was done by the general surgeons, and there were 53 cases of ovariectomy with 2 deaths. An x-ray department had just been started, but only 157 cases were examined. Genito-urinary cases had to be investigated without the help of accessory methods, for the cystoscope was still a curiosity, catheterization of the ureters was not employed, and the urine separator had not yet arrived. Bacteriology as a clinical instrument was in its earliest infancy.

A Time of Adventure

At that time practically all the operations were done in the one theatre. It is true that there was another small operating-room on the top floor of the institution, known as the "ovarian room," but it had lost its special status and was used as an occasional general theatre. It was

*The present Infirmary was not opened until 1906.