demand for specialists has also been an important factor. So far specialism has been in the main beneficial, but I fear it may lead to the passing of the general physicians in hospitals, where their value in teaching, and especially in giving a right perspective and in recognizing the importance of considering the patient as a whole and not parts of him, is of the greatest value. I am also afraid that the general practitioner may be deposed from his present position as the guide and trusted friend of his patients, and that not only in medical matters. I would hazard a guess that some of my audience have been influenced in their choice of our profession by the example or the advice of the family doctor.

Clinical Instinct

In the light of this description of the conditions of teaching in my student days and the limitations from which my teachers suffered in comparison with the plethora of assistance of the present time, what is my reaction to their memory? I may say at once, it is that of abiding admiration and gratitude. They used their five senses methodically and remarkably acutely. They insisted on the definite sequence of inspection, palpation, percussion, and auscultation. They seemed to develop what it was the custom to describe as a sixth sense, or clinical instinct—a mind's eye, as I should prefer to call it—which was in fact the summation of the information provided by systematic observation and the recalling of stored memories of other cases. I am convinced that they were, subject to the limitations of knowledge in their day, as often right as the clinicians of the present day. Of course, it is dangerous to rely on clinical instinct only. I feel, and have always felt, that we should use every means to arrive at our diagnosis and to determine the best means of helping the patient, but I hope I shall not be regarded as reactionary when I say that nowadays many patients are over-investigated and over-treated.

In conclusion, though the face of medicine is ever-changing, I trust and believe that the soul or ideal of medicine will remain as it has since Hippocratic days—the patient, the whole patient, and nothing but the patient's interests.

GENERAL PRACTICE FIFTY YEARS AGO

SOME REMINISCENCES

BY

ALFRED COX, O.B.E., LL.D., M.B.

There can be only a handful of men left who entered general practice the way I did—as an apprentice and dispenser-assistant. In the year in which I qualified, 1891, the G.M.C. forbade the employment of unqualified assistants—a wise move, because there were hundreds of dispenser-assistants all over the country in those days, many of whom were grossly exploited, and fewer of whom ever qualified.

In the early nineteen hundreds the habits of the G.P. were being transformed by the advent of the motor-car. Up to that time, unless you were an old-established and therefore privileged practitioner, the top hat and frock-coat were almost *de rigueur*. I have even seen doctors cycling in this uniform. The older and more prosperous men had their smart dogcart or brougham. The younger ones walked or cycled and hired a cab in specially busy times. What we went through in the days when cars were mechanical mysteries, tyres very treacherous, and

roads were not macadamed can be imagined. But we persevered under the belief that the car was going to save much precious time. I wonder what we did with all the time saved.

Nearly all doctors dispensed their own medicines, and there is no doubt we had a more intimate knowledge of the drugs we prescribed than is the case now, and we were much less at the mercy of the manufacturing chemist than are the doctors of to-day. I suppose the red lamp which at one time adorned the entrance of most town doctors' houses has quite disappeared. It was even in my time beginning to be regarded as rather bad form. But it had its uses in streets which were poorly lighted when a stranger was looking for a doctor in emergency.

Our practices were largely built up on a reputation for midwifery. My clientele was composed as to 90% of working-class people with large families and small incomes, and our fees were regulated accordingly. It was not unusual for a G.P. to do as many as 150 to 200 cases in a year. This entailed much weary night work, and men grumbled about it. The 1914–18 war saw the transference of much of this work to midwives of an increasingly competent kind. There was more grumbling about that, but there can be no doubt that the change has made the work of the G.P. easier.

I practised in Gateshead from 1891 until 1908, when I joined the staff of the B.M.A. Most of the doctors in Gateshead had family clubs for their poorer patients. A subscription of 3d. a week was collected at their homes by a collector, who was paid a commission but who was not supposed to do any canvassing. But unfortunately canvassing was prevalent in my day and caused a lot of friction between doctors. There were also a good many friendly society appointments in which members could get their doctors' services for 2s. 6d. or 3s. a year. There was quite keen competition for these jobs, as they gave the practitioner an introduction to the family.

It was no secret at the time that many of these friendly society appointments were obtained by bribery and corruption. I put it to some of my colleagues that we ought to get together to find a remedy for this sordid business. Reform, I was convinced, must come from ourselves.

Then "The Battle of the Clubs" began, and a few of us tried to ginger the B.M.A. into taking a more active part in this. Matters came to a head in 1900, when, in response to a proposal put forward by the secretary of the Manchester Medical Guild, there was a conference in Manchester of representatives of many local medical societies and of some branches of the B.M.A. in England and Wales. The third day of that meeting was devoted to medical organization, and many of the Lancashire representatives were in favour of setting up a new body devoted exclusively to medical politics and ethics. I resisted this and moved that "every attempt should be made to capture the B.M.A." It is of interest to record that Smith Whittaker, of Great Yarmouth, who subsequently became the first Medical Secretary of the B.M.A. and later Deputy Chairman of the Board of Insurance Commissioners, said then that "he could not hope that the Association would ever reform itself."

The committee appointed by the conference was invited to meet the Council of the B.M.A. at its Annual Meeting at Ipswich in 1900, and, largely owing to the influence of Sir Victor Horsley, a member of Council, we had an unexpectedly favourable reception. The result was that a constitution committee was appointed. It drew up a report

which was approved by the Annual Meeting of the B.M.A. at Cheltenham in 1901.

What a helpless, unorganized body we were before 1903, when the B.M.A. came alive to its responsibilities to the general practitioner. Before that time nobody thought of the Association as the natural protector of the men who form the bulk of the profession. But it soon tackled the glaring abuses of contract practices and the miserable salaries paid for such posts as parish doctor, just in time to be ready when National Health Insurance plunged us into a great political struggle, the result of which, *inter alia*, was greatly to improve the lot of the average general practitioner.

Since 1914 the change in the financial position of the general practitioner has been phenomenal. I suppose there are few who remember the inquiry made by the Government in 1912, when an independent firm of accountants was directed to find out what the doctors in six towns (selected by agreement with the B.M.A.) actually earned per head of the local population for every kind of medical service rendered. It emerged that the average income of all the doctors (225) whose books were examined was £493 a year, which worked out at 4s. 3d. a head, including every section of the local population.

One thankfully recognizes that the present-day G.P. is able to do much more for his patients than we were. He has many remedies quite unknown in my time, when every pneumonia case was a gamble, as we could only treat symptoms. And nearly every puerperal septic case was a tragedy—perhaps the most painful of any in the practitioner's daily work.

It may come as a surprise to my younger readers to hear that there was a time when patients did not want to go into hospital. Many thought that being sent there was a sign that their complaints were incurable. The word operation was anathema. I understand that nowadays it is only the paucity of hospital beds that prevents the majority of patients from having their illness there. I fancy the G.P. of my time was readier than his successors to tackle minor surgery. We had the idea that our hospital training was intended to make us equal to opening an abscess or dealing with a simple fracture. I am credibly informed that a large proportion of these cases now find their way to hospital. This may be all right, but it gives one the impression that much of the elaborate training of the student will be wasted. And I need hardly point out that this state of things does not enhance the reputation of the G.P.

We had one advantage denied to the present generation—at any rate to those entering the National Health Service. We lived in a time when it was regarded as a laudable ambition for a doctor to work hard to build up a practice he could call his own—something he *created* and which accumulated a capital of goodwill with which he could look forward to the future when the time came for retirement. Now, private property of almost any kind is coming to be regarded as nearly a crime against the community. The young G.P. now is working in a practice which belongs to the State, and I doubt if he will put into it the same energy and devotion as we did. But of course I am an old and an old-fashioned man.

But there have been many changes for the better—a great increase in the scientific aspects of practice, with fair hopes of even greater triumphs in the near future. I have even a hope that some day that opprobrium of our profession named very properly the “common” cold may be mastered, and I can think of no disease, not fatal, which causes more misery and discomfort.

TRANSPORT AND COMMUNICATIONS

BY

W. J. BISHOP, F.L.A.

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The only outstanding inventions in the field of transport and communications that fall within the twentieth century are the aeroplane and broadcasting. Railways, the telegraph, the telephone, and the motor-car all came in during the Victorian era. But neither the telephone, which dates from 1876, nor the motor-car, which reached England about 1895, came into common use until after the turn of the century.

The first great change in the doctor's means of transport since the invention of the wheeled carriage was brought about by the advent of the motor-car. The *British Medical*

Two well-known models popular in 1907

Journal of May 16, 1896, described an “Exhibition of Horseless Carriages” which showed that “the manufacture of these vehicles is now passing out of the experimental stage.” Particularly commended was “a very workman-like carriage,” costing about £125, which was “easily steered and stopped, and did not give out much smell.”

Doctors were the first large professional group to experiment seriously with the car and to keep records of its cost and performance. For example, Sir Henry Thompson, the celebrated surgeon, was one of the pioneers of motoring in England. In 1902 he contributed a chapter on “Motor-Cars and Health” to the volume on *Motors and Motor-Driving* in the Badminton Library, and recorded