him study the report of the cardiologist and not bother about the promptings of his own "heart."

Another remark of Latham is not obsolete; it is this:

"But, in our day, there is little fear that students will be spoiled by the recommendation of their instructors to be content with a scanty knowledge, and trust to their sagacity for the rest. They are not likely to suffer harm by having Sydenham held up as an example for imitation: the fear is of another kind (and it is well grounded), namely, that many men of the best abilities and good education will be deterred from prosecuting physic as a profession, in consequence of the necessity indiscriminately laid upon all for impossible attainments, of which no example is or can be held forth for their imitation."

THE RURAL PRACTITIONER AND MATERNITY.

BY

MAURICE MOTTRAM, M.R.C.S., L.R.C.P.

In a leading article in the *BRITISH MEDICAL JOURNAL* of November 15th, 1924, surprise was expressed that no general practitioner had taken up the cudgels in the recent conference and correspondence on puerperal sepsis. Doubtless many felt that much might be said, but perhaps thought that we were inclined to be too touchy, and that the remarks made did not bear the meaning that they seemed to do. The leading article, however, seems to confirm the impression that a very definite attack has been made on the general practitioner.

Why were these remarks allowed to pass in silence? Two reasons, at any rate, can be offered. In the first place, it is quite useless to argue when the other side is ignorant. No one would question the right of the various speakers to speak with authority on all matters gynaecological, but I think it is no exaggeration to say that most of them showed a regrettable ignorance of the conditions under which midwifery is practised by a large proportion of the profession. Until they have at least a working knowledge of the various types of practice the advice they give us must of necessity be robbed of much of its value.

There is another possible reason for our silence. Just as the eels in the story got used to being skinned, so we have become used to being criticized. Each Annual Meeting brings its crop of criticism of the general practitioner—some of it just and fair, some pitying and patronizing, and some unfair and in very bad taste. Unfortunately the last is generally copied into the lay press, and the prestige of the profession is lowered accordingly. Such articles as "How to conduct a confinement in a private house" are common, and seem to be written by those who never do it, or, at any rate, not in the country. For example, one enthusiast wants the matter treated as a major operation—the pictures down and the carpet up; the surplus furniture removed. Where to? Presumably into the street, for the husband and rest of the family are sleeping in the only other room, which is already overfull. Another writer seems to depend on a gas stove for his routine. The nearest gas stove is eight miles away. And so on *ad infinitum*. After reading a few lines of these gentlemen's advice one is driven to the conclusion that, however perfect their technique may be, it is useless to the rural practitioner.

This brings me to the root of the matter—the total lack of understanding of the work and conditions of the rural practitioner. To make the matter quite clear I will define the type of man and practice that may fairly be looked upon as rural. He works single-handed in a radius of five miles, he lives eight miles from his nearest town and hospital and five miles from his nearest medical neighbour, he dispenses all his own medicines, he would probably have from 750 to 1,000 insured persons on his list. There are, of course, the mountainous practices, where the conditions are accentuated, and the semi-rural, where they are better. I venture to say that a man running such a practice is generally a good type, and to-day he is threatened with extinction—in fact, the process is well started. I hope to show the relation such a man has to maternity work in the country, and to raise the question whether the maternal welfare will be best served by scrapping him and replacing him with something else, or by trying to improve the conditions under which he works, and so making him a still better type.

In the recent discussion the word "practitioner" was used. It is a bad word, for the work of a rural and urban practice is so different that the question of maternity work in either must be discussed separately. I have had twenty years' experience of rural conditions, and my suggestions apply *solely* to rural practices. I have no advice to offer in connexion with

town practices, of which I know nothing. I would that those who know nothing of the country would be equally reticent.

Most of the points raised by the various speakers and writers are, I think, covered by the following headings, and I propose to discuss them in so far as they have a bearing on the rural practitioner and his work.

Maternal Mortality.

This, we are told, does not fall, and apparently it is the fault of the person attending the confinement. I find no suggestion as to where the incidence is most common, town or country. We are constantly told that child-bearing is a natural process. But is it? The production of young by the female is natural, but to say that child-bearing by a woman of to-day, with her curved pelvis and various diseases to complicate matters, is a normal process is untrue. In view of the splendid opportunities for trouble to arise it is surprising that things are not worse, though that, of course, should not deter us from trying to make them better. If our knowledge has increased tenfold, the difficulties to be overcome have increased a hundredfold.

Puerperal Sepsis.

I do not intend to try to define this, but there seemed to be very little agreement at the conference on the subject. All varieties of treatment seem to have their advocates. Suffice it to say that any case that runs a temperature after confinement is a source of worry to the conscientious practitioner, and has to be dealt with. It seems that the person attending is apparently to blame. Dr. Stevenson blames the doctor and absolves the midwife. This is a very serious charge, and appears to be based solely on his interpretation of certain figures. But which, in point of fact, are the cases which run a temperature in the country? Ask any experienced rural practitioner, and he will probably say that it is not the difficult forceps case, which has had no end of handling (with intervals while the operator has to stop to give more anaesthetic), which shows a rise of temperature, but more often the case that has, perhaps, never been examined during labour. In a case of this sort the chances of the doctor being directly responsible are greatly reduced. The fact that just outside the window pigs are wandering about knee-deep in filth may have something to do with the matter, and this is a job for the Ministry of Health.

Notification of Sepsis.

I am relieved to find that some speakers seem to be losing their faith in this fetish. To some minds a notification to an official is all that is needed to cure every ill. It may be some use to notify an infectious disease in a town; I believe it is. But, speaking of the district in which I live, I have no hesitation in saying that up to a year ago it was useless. There being no hospital to which a case could be removed, the medical officer of health was powerless. It is true that in present circumstances it is possible to get a case into the town infectious hospital *sometimes*. But I remember notifying a case of diphtheria in a two-roomed cottage with five inmates. Medical officer of health, district nurses, health visitors—all were useless. When the child was moribund I felt that it might be justifiable to try my hand at a tracheotomy. A neighbour was found who "durst" hold a candle for me. The child revived and lived two days, succumbing when the membrane spread below the tube. He was nursed by his father, who had once looked after a tubed horse. And yet, with this case in my mind, I am asked to enthuse over the advantages of notifying puerperal sepsis! A tin of disinfectant from the sanitary inspector, and a visit in due course from the medical officer of health, who lives thirty miles away, is all that can be expected here.

Professor McIlroy suggests that notification is apt to get the doctor into trouble. In this instance I agree with her. The notification that something is wrong, and the coming of an official who may or may not be tactful, is quite enough to set the husband thinking that the doctor is to blame. What more natural, in the present state of affairs, than that he should bring an action? Recent cases have shown that the fact that the doctor is, from the medical point of view, not to blame has very little bearing on the matter. The judge will make his usual platitudes and the jury find against the doctor.

I would suggest that before we are asked to make further notifications those responsible should set their house in order, and see to it that there is a chance that the notification will bear some useful result. As I said before, I am concerned with the country districts only.

Specialists.

Regret was expressed recently that a midwife had done her duty in calling in a registered practitioner, the suggestion

apparently being that she should send for a specialist or, though it seems incredible, the medical officer of health himself. The fatuousness of such a suggestion can only be appreciated by those who live in the country. In this district the medical officer of health lives nearly thirty miles away and the nearest specialist gynaecologist forty. Dr. Fitzgibbon appreciates the difficulty, and estimates that over 700 specialists would be wanted. I admit I have not worked it out, but should think that this number might go some way towards supplying the larger towns. To give a really efficient service in the country areas I suggest that nearer 7,000 specialists would be wanted. It would, of course, be possible to appoint a certain number of men as "specialists." Sillier things have obtained official sanction before now. But I fail to see that the parturient woman will be one iota better off, and it will have appalling results in other directions. If there is one man fitted to deal with an emergency (other than the obstetrician, the genuine ones), surely it is the rural practitioner. A bad case in a cottage a mile off the road, two candles for light, a limited supply of hot water and utensils, an ignorant woman to assist, and no medical help nearer than five miles. And yet these cases live and do well. Could our critics do better in such circumstances, or as well?

Hospitals.

It has been suggested that all abnormal cases should be sent to hospital. No one is such a fool as to want to tackle eclampsia or a placenta praevia in a cottage. But, as a rule, by the time the doctor sees the case the time for removal is gone.

Midwives.

Professor McLroy refers to these as a "highly trained body of specialists." On what does she base this statement? I should describe them in the country as a hard-working class, but to refer to them in bulk as highly trained specialists is absurd. How did they become so? Was their training superior to that of the average doctor? Is their knowledge of anatomy and physiology greater, or are they by nature our intellectual superiors? It is such random statements as this which make the rural practitioner feel that argument is useless. Doubtless Professor McLroy's experience of midwives is vastly greater than mine, but I have yet to meet a single one of these highly trained specialists. On the other hand, I have met several who have been positively dangerous. She suggests, further, that the midwives are cutting out the doctors, and appears to derive some satisfaction from this. But is it a matter for congratulation? As a matter of fact it is true, but it is not due to the superiority of the midwives; the reason is largely financial.

Finance.

This is a subject that is seldom mentioned, partly because those who speak most at conferences, etc., appear to be enjoying fixed salaries. The last clause in the leading article that I have already referred to is typical: "Provided discussion is carried on from the wide viewpoint of the public good and not from the narrow one of professional interest," etc. Surely the public good is intimately combined with the best interests of the profession. The utter ignoring of the financial side of the doctor's business, so far from having done good, is going to do the public in the rural areas an incalculable amount of harm. It is an unfortunate fact that practically every innovation which is alleged to be for the public good leads to a diminution of the doctor's income. The worst of us probably rarely spends a day without giving something away, frequently of necessity rather than as a virtue. But it is one thing to give individually among the people that we live with and know, and quite another matter to be called upon to give our services generally and at the demand of public bodies. If we received preferential treatment in the matter of taxation there might be some excuse for it, but no profession is treated more shabbily than ours. All our small privileges have been swept away—for example, reduction on car tax and petrol.

It is absolutely certain that when a district nurse is introduced into a practice the doctor can say good-bye to a slice of his income. The habit arises of calling in the nurse to decide if the doctor is wanted. If he is not wanted the doctor loses the fee he should have had. Often the nurse tries her hand at treatment for a few days. This, when the case is of an infectious nature, may have disastrous results, and I am quite sure that this practising by unqualified practitioners—for it is nothing else—is not for the public good. In the case of the very poor there may be some excuse, but the habit spreads to those who can and should pay fees. The well-to-do farmer's wife has the nurse to attend to the boil on her leg and the child's cut hand. There is an idea that the doctor does not

want to be "bothered" with trivialities. This may be true, and I blame the members of the profession to a certain extent for this idea. Looked at broadly, the doctor has to do a certain amount of work to make a certain income. The simpler the case the greater the profit. The acute abdomen and the difficult confinement are not profitable; the fee is insignificant compared with the amount of work and worry involved.

But it is when we come to the maternity work of the midwives that we find the most crying scandal in the matter of fees. Let us assume fifty confinements per annum in a country practice such as I have in mind. In this district the minimum fee is £2. Among the working classes it is also nearly the maximum, for however bad the case it is no use asking a man for a fee that he cannot possibly pay. The easy cases must pay for the difficult. Of the fifty cases about thirty will be normal—I quote Dr. Fitzgibbon. The doctor gets £60, and it is admittedly fairly easily earned. Let us assume ten cases will be abnormal, and a few of these will be really bad, causing no end of work, and, what is much worse, anxiety. In a poor district it is probable that he will not get more than an average of £3 per case. He has earned every penny of this £30, and it is probable that a little has had to go in anaesthetists and help. The remaining ten cases would probably be better-class cases which would not have the midwife. Thus he gets £90 for forty cases, and, taking the rough with the smooth, it is not too bad. What happens when a nurse is imported? She manages the thirty normal cases without help, and the doctor is £60 out of pocket. And this brings us to the most scandalous part of the business. The nurse, remember, is "cutting the doctor out." Professor McLroy has said it. She is his professional opponent. She meets with one of the abnormal cases. She is in a difficulty, and this difficulty may have been increased by her failure to diagnose the abnormality early. The general practitioner—for whom, apparently, Professor McLroy has no use—is sent for. The matter is urgent—the well-being, perhaps the life, of a woman is involved. Human nature prompts the doctor to tell the nurse to get herself out of the difficulty. Ordinary humanity compels him to go, and not only to go, but to abandon whatever else he may be doing. A call of this sort cannot be put off. Now, one would have thought that even a soulless organization like a county council would have had a sufficient sense of honour to pay the man that they are ousting a really good fee when he helps one of their agents in her extremity. A certain speaker (I am not positive of her name, so will not mention it) stated recently that in the circumstances "a fee is paid." She did well not to mention the amount; perhaps a sense of shame stopped her. The fact is as follows. A doctor may be called upon to turn out at any hour of the day or night to help an organization which is admittedly opposed to him, to tackle single-handed any and every sort of obstetrical catastrophe in a patient living at a distance up to two miles from his house (a small mileage fee is paid for longer distances), and to put in all necessary attendance for ten days, and the fee is £2—the same fee that he can get for a normal "B.B.A." Surely, seething the kid in its mother's milk is by comparison a humane and decent proceeding. I feel that I may end my indictment and defence on this note. If those who have read as far look upon this as a fair and just deal, then I have failed indeed.

Conclusion.

The matter seems to boil down to this. The maternity service is unsatisfactory, and it is suggested that the general practitioner is to blame. There are three ways in which the matter may be tackled. The general practitioner may be abolished or superseded by a superior service—it is the same thing. He can be left to continue as he is, or his work and general conditions may be improved.

Do those who criticize us really wish to do away with the rural practitioner? Can they offer anything that will take his place?—I mean in actual fact, not in theory. And have they considered what very far-reaching results such a step must have, and whether it will be for the public good, of which we hear so much? I think most of us would be willing to withdraw to fresh fields of activity if a better service can be provided. But can it? The midwives will have to increase vastly in numbers and skill before they can be trusted with all and every confinement. And what of the people of limited means? The *nouveaux riches*, who now inhabit most of the large houses, can easily get their doctor from the nearest town; but there is an enormous majority of people living in the country who cannot afford to pay a doctor to come eight miles to see them, and even if they manage to pay him they are not in a position to get medicines, etc., from a chemist who lives equally far away. I am perfectly sure that if nothing is done to encourage the better class of men to practise in the country, the rural practices, where they still exist, will within twenty

years be in the hands of the very lazy and the very incompetent. I cannot think that this will tend to reduce the maternal death rate in the country.

The Cure.

Destructive criticism is useless in itself. I honestly believe there is a means of putting the country practices on a sound footing, a means that will benefit the medical profession—I am quite unashamed of putting ourselves first—the general public in the country, and incidentally in the towns as well. Salvation lies in the erection of numerous cottage hospitals. Every year large numbers of potential good surgeons are turned out from the medical schools. A liking for a country life leads some of these into the country. They get the life they want, but so far as professional advancement goes they might as well have tied the proverbial millstone round their necks. At first they find little scope for surgery. If they undertake it they find that the obstacles to success are innumerable—the best surgeon in the world is useless unless the case can be nursed. Gradually the inclination wears off, and the capacity soon follows. A vicious circle is set up—the less a man attempts the less he feels inclined to attempt, and he gets into the habit of passing his cases on to the nearest hospital; whereas, given the opportunity, he could perfectly well have treated them himself. Now, with a cottage hospital to about every three practices things would be different. Neighbouring practitioners should or would work together,

more partnerships would probably be formed, and team work, with all its advantages, undertaken. As at present, surgeons from larger hospitals would probably be willing to do major operations, but the necessity for such help, now generously given, would diminish with time; there would soon be plenty of capable surgeons in the country districts if opportunity for surgery was offered. The present congestion of the existing hospitals would be relieved. The existing organizations of district nurses and midwives might be incorporated with the hospital nursing staffs, and maternity wards could be arranged for those cases whose houses are utterly unsuitable. Though I love the country, I should strongly advise any young man straight from hospital to give it a wide berth. But with a cottage hospital a country practice would be a very attractive proposition.

There is one bar to this scheme. It will be said that the country cannot afford it. This is untrue. Unlike an individual, a nation can afford anything it wishes for. We had to afford a war, and a very small part of the money spent on this—about three millions a day, I believe—would have gone far to providing a considerable proportion of the necessary hospitals. We can afford vast sums for doles, old age pensions, and education. But the public health makes little appeal to the general public, and as a vote-catching stunt is useless.

Finally, I beg those who criticize the general practitioner as a whole to try to learn something of his conditions, and to consider what the state of the country is likely to be in the future without him or with something worse.

PULMONARY TUBERCULOSIS TREATED BY SPAHLINGER'S SERUM.

We have been asked to publish the following reports, by two medical observers, of a case of pulmonary tuberculosis treated by Spahlinger's serum at Geneva.

Dr. TH. STEPHANI (Montana) writes:

The following case—Mr. R. G., aged 29, an old patient of mine who has again recently come under my observation—is so remarkable that its details might interest your readers. He arrived at Geneva at the end of July in a most critical condition, with advanced cachexia; an evening temperature ranging between 102° and 104° for eight months previously; pulse 110 to 136; extremely weak; severe coughing—5 to 6 oz. of purulent sputum, containing tubercle bacilli in large numbers; cyanosis and distressing dyspnoea necessitating the administration of large doses of oxygen for fifteen minutes hourly; profuse sweating; considerable emaciation; anorexia; prostration; breath foul. Moist râles were present over the whole of the left lung, which was completely involved. There was widely scattered disease in the right lung with a cavity in process of formation at the apex. It appeared as if the end would be only a question of a few days. It was decided that Spahlinger's serum should be given daily in as large quantities as possible. This treatment was started on August 1st, 1924, by injections, by rectum, and by mouth, together with oxygen, digitalin, camphor oil, and cryogenin. The temperature, pulse, and appetite improved rapidly, and the progress of the reduction of the toxæmia was most remarkable. Ten weeks later the disease seemed to be completely arrested. The temperature and pulse were normal; the cough and sputum were almost absent; tubercle bacilli were occasionally present in expectoration, but only in small numbers; he had gained over 1 st. 5 lb. in weight; the lowest weight had not been ascertained. The patient is now allowed to take mild exercise. Chest examination indicates a complete clearing up of the physical signs, the improvement being confirmed by radioscapy.

FIG. 1.—Radiogram taken May, 1924.

FIG. 2.—Radiogram taken September, 1924.

Of the two radiograms reproduced the first was taken at Mentone in May, 1924. The second, taken recently, shows a striking disappearance of the shadows in the former. Unfortunately the patient's condition was such that no x-ray photograph was possible on his arrival at Geneva.

The large doses of partial serum have rapidly arrested an extensive and severe evolution of the disease where there was practically no hope of a recovery.

I have treated this case in conjunction with Dr. E. Trechsel and Dr. A. Mermod of Geneva, and send you enclosed a report by Dr. B. Hudson of Montana, with whom I saw the patient in consultation.

Dr. BERNARD HUDSON (Montana) writes:

I was asked to see, in consultation, a young man, aged 29, suffering from pulmonary tuberculosis, who was on his way from the South of France to Montana. He unfortunately became so ill in Geneva that he was unable to move. I saw him with his doctor on August 1st, 1924, and we were both in agreement that the condition of this patient was well-nigh hopeless. The temperature was running up from 102° to 104° every night, and had been doing so, without intermission, for many months; there were signs of extensive softening in both lungs; he was thin, emaciated,

hectic-looking, and coughing up a large amount of offensive purulent sputum. To put it shortly, the patient had all the signs of active and severe pulmonary tuberculosis. Taking into consideration his condition, and the steady downhill course which the disease had been taking during the past year, I considered the case to be quite hopeless, and informed his friends accordingly. The patient himself was very anxious to try the Spahlinger serum; I discouraged this, as I did not think it would have the slightest effect in such a case. However, it was tried, with very beneficial results. I saw the patient again ten weeks later. The signs in the chest had cleared up, the temperature had become normal; he is gaining weight, the sputum is decreasing—in other words, the disease is becoming inactive. I have been asked to report this case, and am pleased to do so, for there can be no doubt that the recovery in this instance is a very striking one.