Diet.

A diet suitable for a boy of 5 or 6 who tends to have liverish or gastric attacks at intervals should be along these lines. On waking he should have a glass of orange, grapefruit, or grape juice, sweetened with four lumps of sugar. Breakfast, half an hour to an hour later, should consist of some cereal, such as porridge, groats, cream of wheat, puffed rice, or shredded wheat, with a very little milk but well sweetened with sugar. As a second course, on two days in the week he may have an egg, and on four days, crisply done, very thin rashers of bacon, which should be fried until the fat has been mainly removed and allowed to drip, so that a minimum of grease or fat remains. Fish should be given on one or two mornings. Crisp toast and butter with freshly brewed tea or Horlick's malted milk, or well skimmed milk and water, equal parts, one cupful only, complete the meal. Nothing should be given all the morning. For dinner—and it is best to have early dinner with these children, say at 12.30—fresh mince or stew, underdone beef or steak or cutlet, should be given on four days in the week, with chicken or fish or brains on three days. A small portion is sufficient. Potato and green vegetables, a tablespoonful of each, should also be given. Milk pudding or stewed fruit, but not suet pudding, should follow, and the child should have water to drink. At tea—4.30 to 5 p.m.—thin bread-and-butter or crisp toast, with stewed fruit, jam, treacle, honey, golden syrup, or a little milk pudding, may be given. The drinks should be the same as at breakfast. In winter a bowl of soup may be taken at this meal.

The child should not have an excess of eggs or cream, much creamy milk, pastry, or suet pudding, chocolate, or cocoa.

GENERAL MEDICAL PRACTICE AND THE MEDICAL CURRICULUM.*

BY

J. M. MUNRO KERR, M.D.,

REGIUS PROFESSOR OF MIDWIFERY IN GLASGOW UNIVERSITY.

You can readily understand that my return to this classroom as Regius Professor awakens many memories—memories of undergraduate days of almost unalloyed happiness, and later memories of early essays as a teacher during the years when I was assistant to Professor Murdoch Cameron, who had succeeded to the chair in 1894. The decade immediately preceding this year was most eventful, not only in surgery but also in obstetrics and gynaecology. It witnessed the birth of surgical obstetrics and gynaecology. Quick to recognize this development, more especially as it affected obstetrics, Professor Cameron introduced into the Glasgow Maternity Hospital the modern operation of Caesarean section which Säger of Leipzig had evolved in the early eighties. The successes he secured and reported focused the eyes of the obstetric world on the school of Glasgow. I feel sure you desire to be associated with me in wishing Professor Murdoch Cameron many years of enjoyable leisure.

In selecting a subject for the inaugural address which use and wont prescribe, my chief difficulty was in deciding whether to review the past or forecast the future. I have chosen the latter, for to forecast the future is one of the few adventures left to the middle-aged. Besides, there is a certain fitness in the choice, because to you the future is everything. It occurred to me, therefore, that as most of you will ultimately embrace the arduous but very honourable calling of general practice it might be of interest if I placed before you the future of general practice as I see it, and the manner in which the medical curriculum might be modified to suit the changing conditions which are slowly but steadily occurring in general medical practice.

* Inaugural address (abbreviated) delivered on January 10th, 1927, on appointment to the Regius Chair of Midwifery in Glasgow University.

We have reached a very important stage in the evolution of medical education. For many years the general trend of medical education has been along certain simple lines—namely, as knowledge in a department has advanced the policy followed has been increased instruction in the subject or subjects of that department, with the result that the student of the present day finds it impossible to digest the mental food provided. As a remedy it has been suggested to lengthen the curriculum; and when we consider the length of the medical curriculum in other countries as compared with ours—take Sweden as an extreme example with its eight to nine years—this policy might appear justifiable. But before adopting such a policy—which to those responsible for medical education is the easiest way out of the difficulty but to the student a most serious one—it will be advisable to consider whether some rearrangement or modification of the curriculum is possible.

It is conceivable that with the altered conditions as regards medical practice modifications in the curriculum might in great part get over the difficulty. This implies a correct forecast of the trend of general medical practice. Until this is determined it is impossible to decide how the curriculum should be altered to suit the requirements of the young graduate of to-day who is ultimately going to practise his profession as a general practitioner.

The future of general medical practice lies more and more in the direction of pure medicine, and the general practitioner must be raised in pure medicine to a very high level. He, associated more intimately with the consulting physician, clinical pathologist, and officer of health, is the individual whose assistance will be of inestimable value in advancing medicine. For, as the late Sir James Mackenzie pointed out repeatedly, on the general practitioner must we depend for the early recognition of disease—the field of medicine which at the present moment offers the most promising harvest. Though this will ultimately be the vocation for the general practitioner, it does not mean that he will occupy a less important place in the community, nor that he will be less beloved than the old-time family doctor. The general practitioner as I see him will occupy a more important place, and incidentally he will have an infinitely more interesting professional life. He will be brought into closer relationship with the consulting physician, the clinical pathologist, and the medical officer of health, who also will benefit, for hospital, laboratory, and office work has a tendency to produce a mentality too academic and bureaucratic.

Looked at from yet another standpoint, this co-operation between these different departments is becoming necessary to the teacher of clinical medicine and his students, for, as you are well aware, a number of diseases have been relegated to special hospitals which the medical student only occasionally visits, and in which, therefore, he has few opportunities for clinical study.

Some months ago, in the pages of the *BRITISH MEDICAL JOURNAL*, I had the temerity to refer to this question of the trend of general practice. Let me quote a few lines from the editorial¹ on the subject:

“General medical practice is not, as a fact, developing on lines such as those which Professor Kerr indicates as, in his opinion, desirable. So far from restricting himself to pure medicine, afraid to use a knife or any other surgical instrument, shrinking from responsibility for a maternity case in any of its stages, ante-natal, natal, or post-natal, the general practitioner, in partnership or association with his fellows, is finding it useful to his patients and advantageous to himself to undertake an even wider range of service than was at one time customary; and the results justify the method.”

I am quite prepared to admit that individual practitioners and firms of practitioners find this policy advantageous to themselves. But general surgery and the surgical specialties, including obstetrics, are crafts, and craftsmanship only reaches its highest level when individuals in addition to having a natural aptitude for craftsmanship have continuous practice in their craft. This is not possible in general practice, no matter how large the practice may be. Further, the development of general practice on the lines above indicated introduces an

atmosphere of commercialism into medicine which we must ever strive to avoid if our profession is to retain the respect and confidence of the public. Fortunately, it is doomed to ultimate failure, for the wealthier community will continue to employ specialists; while those of moderate means and the artisan class will also insist on the services of specialists. Interesting in this connexion is the following sentence from the Hippocratic oath: "I will not cut for stone, even for patients in whom the disease is manifest; I will leave this operation to be performed by practitioners (specialists in this art)."

It is obvious that sooner or later some arrangement must be made to supply insured persons with advice and treatment in the various special departments of medicine and surgery. As a matter of fact, this has been done in dentistry and ophthalmology. Many of us remember the introduction of the National Health Insurance Act and the opposition it aroused. I have no hesitation in stating that this opposition and the behaviour of a certain number of the profession did great harm to the status of the profession in the eyes of the general public. Would these critics wish to see the Act repealed? There is no necessity for a similar controversy when the question of special treatment to insured persons is under consideration.

Having attempted to indicate the trend of general medical practice, let me now consider the medical curriculum. It is obvious that I cannot discuss this matter of the curriculum in detail. It is giving many of us much thought. Its importance is fully recognized by the General Medical Council, as evidenced by the fact that quite recently it asked for supplementary information and suggestions to the reports formulated by the different subcommittees of 1922.

The General Medical Council, if one reads the discussions and reports on the curriculum published, is far in advance of the times. It sees that radical alterations in the curriculum are necessary. But the conservatism of teachers generally, the vested interests of certain teaching bodies, and the jealousy of individuals regarding their particular subject are barriers to innovations which are very difficult to overcome.

Leaving aside for the present the purely scientific subjects and confining myself to the later clinical subjects, and more especially to obstetrics and gynaecology, let me indicate the training which I think suitable. In obstetrics the student should be trained to have a general conception of obstetric and gynaecological problems, and to be able to deal with ordinary deliveries. If he wishes to do more, he must have special post-graduate instruction and practical experience. The duration of this training need not be longer than three months, provided he gives up his whole time to the subjects of obstetrics and gynaecology. This was the recommendation of the Scottish subcommittee which dealt with this part of the curriculum in 1922.[†] And it is greatly to the credit of the Edinburgh school that it immediately adopted the recommendation. Another school which has adopted the principle as regards obstetrics and gynaecology is St. Thomas's Hospital. There Dr. Fairbairn, who directs the department, has followed the recommendation of the English subcommittee and established a six months' course, which includes not only obstetrics and gynaecology but also pediatrics. The reason for this longer course in St. Thomas's is that it, in common with many of the other London hospitals, has difficulty in providing sufficient clinical material for the teaching of obstetrics. Many American schools have arrangements somewhat similar, and in Sweden, which I visited last summer, a four months' course of concentrated teaching has been the arrangement for many years. Owing to the exigencies of obstetric practice it is only by such an arrangement that the student can be satisfactorily trained in obstetrics. Fortunately, in our school here in Glasgow we have abundant material and a large and well appointed hospital. What is necessary is that the clinical teaching should be better organized and that systematic lectures should be cut down by at least half.

This brings me back to the extent or type of the train-

ing in obstetrics and gynaecology, and it is interesting to consider what other countries are aiming at. There may be said to be two opposing camps—one which aims at an extended training and a very thorough experience in obstetrics, so that the young graduate may be able to undertake almost any operation in obstetrics; this is especially advocated in some of the schools of America. The other school views matters quite differently. Its policy is to train the undergraduate only to a moderate extent. This type of training pertains to such countries as France, Sweden, and Denmark. These countries are aiming at an obstetric practice carried on by particularly educated and well trained midwives, assisted in cases of difficulty and supervised by specialists or specially trained accoucheurs distributed over the country—in other words, the establishing of an obstetric service very much on the lines I suggested in the paper already quoted. My reason for supporting this latter arrangement is because it is impossible for the general practitioner to obtain continuous practice in obstetric operations. If we take Glasgow as an example, we find that some 60 per cent. of confinements are attended by midwives.[‡] Further, there is an ever-increasing number of women who elect to go into hospital for their confinements. Thus the experience that practitioners of former generations gained in their private practice is not available to the practitioners of to-day.

The great fault of the present system is that the student is not "steeped" sufficiently in clinical work; and, let me remark, this clinical experience and training should be as thorough in the outdoor department as in the wards, because so many minor ailments and early phases of disease are only seen in the outdoor department. As a matter of fact, the old system of apprenticeship whereby the young candidate of medicine was associated with a practitioner and gained his clinical experience from actual practice was most useful, and nothing in the clinical training since that system was abolished has quite taken its place. We must get back in a different form to the idea of apprenticeship.

I have indicated the training in obstetrics and gynaecology—namely, a whole-time concentrated course of three months as a minimum. As regards medicine and surgery, I speak with less assurance. I am inclined to the opinion, however, that clinical training in medicine should be increased and that possibly clinical training in surgery might be lessened. The clinical training of the undergraduate in medicine is not sufficient for present-day requirements. Further, ophthalmology certainly, and possibly some of the other medical specialties, should be given greater consideration.

Surgery is on a very different footing. No one to-day attempts to practise surgery seriously without some special post-graduate training. The great surgical principles, the possibilities of surgery, surgical pathology—these are the subjects to which the medical undergraduate's attention should be directed. The craft of surgery can only be learnt after graduation. I venture to suggest to my surgical colleagues that the training of the undergraduate in surgery might with advantage be modified to suit the requirements of general practice of to-day. The same applies to the surgical specialties.

Each of us engaged in the training of medical undergraduates must seriously consider medical education, not solely as it affects his own particular department, but with a broad outlook on the position of present-day medical practice. We must not attempt, as some countries are doing, to train experts in medicine, surgery, and the specialties. With the foundation well laid in biology, chemistry, anatomy (modified), physiology, and pathology, exactness in clinical observation is the first essential, and this I maintain can be developed to the fullest extent in medical wards. Again, I maintain that medicine, with the medical specialties, is the ultimate calling of the general practitioner.

REFERENCE.

¹ BRITISH MEDICAL JOURNAL, June 12th, 1926, p. 999.

[†] A subcommittee appointed by the Faculty of Medicine is at present considering the co-ordination of clinical teaching in the final year.

[‡] Some districts of Scotland show 80 to 90 per cent. of confinements attended by midwives.