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Presidential Opening Address
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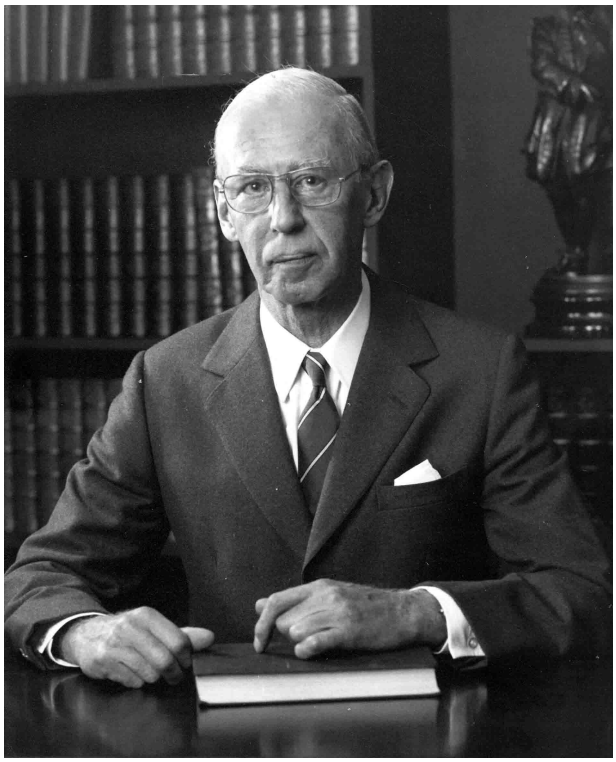
FORTY YEARS ON

FORTY YEARS AGO, this month, I started in practice, I confess without the benefit of vocational training; that came two months later when my chief had his first coronary. I was extremely fortunate in becoming assistant, and later partner, to John Taggart of the Antrim Road, one of the most distinguished practitioners of his day.

Taggart was a County Antrim man, with all the bluntness and sagacity characteristic of County Antrim men, yet full of compassion. He was respected and loved by his patients and held in the most friendly esteem by his colleagues and such men as R. J. Johnston, James Craig, Tommy Houston, Sam Irwin, W. W. D. Thomson, R. J. McConnell and many others. To many of you here tonight they are just names from the past, but I can assure you they were all eminent and distinguished doctors. As I worked with Taggart I soon found how these men admired him as a man and as a very competent physician. I am ever grateful for the four years during which I had the privilege of working with him, before his early death. What he taught me, in a very quiet way, more by example than precept, not only of medicine but also the right relationship with patients and the conduct of practice, has been of inestimable value to me during my professional life. I may say that all his colleagues continued to be most kind and helpful to me after his death.

I have been very lucky that during my time in practice, the rate of advance and progress in medicine, scientific, socialogical and organisational, has been much more rapid than ever before. The vast amount of new knowledge and methods which has come in the last 30 or 40 years is quite staggering.

In the ten years before I started in practice two great life saving discoveries had been made - insulin and the liver treatment of pernicious anaemia; and yet at that time, I suppose we had only two drugs which might be termed chemotherapeutic agents – quinine for malaria, which I did not find to be prevalent in north Belfast, and arsenic for syphilis. Then in 1936



Prontosil was produced and rapidly followed by the other sulphonamides, including the famous M. & B. 693, which not only cured Winston Churchill of pneumonia, but also made a great many other people very sick during the therapeutic process. Today sulphonamides are not really very interesting or exciting drugs, except the new combination with trimethoprim, but at the time of which I speak they were quite revolutionary. To have means of actually curing infections due to streptococci, pneumococci and *B. coli* was unheard of. To be able to reassure the patient with pneumonia that he would be convalescent in a week or so, was very different from waiting for the famous crisis which usually came between the 7th and 9th day, if the patient was fortunate. To students and young doctors of today the anxious care which pneumonia used to require is unimaginable. We were literally helpless and could only hope that good nursing with supportive treatment and the patient's resistance would keep the pulse rate below the systolic pressure. Otherwise, we were taught, the prognosis was bad. Incidentally it is rather interesting that the incidence of typical lobar pneumonia today is very much lower than it was then.

This may be due to the early exhibition of antibiotics in chest infection, where we still see many cases with a patch of consolidation, without much general upset.

In 1939 the War came and for a while life went on much as usual. A.R.P., later known as Civil Defence, was gradually organised with static and mobile First Aid Posts. The Emergency Medical Service deployed the hospitals for the many casualties which were expected. The Blood Transfusion Service intensified its work and built up its reserves. Very many doctors served with the Forces.

It was, as you know, not until 1941 that Belfast experienced its quite heavy, but few, air raids. As a consequence of these many people left the city and the work in the practice became very light. Thus I was able to undertake a part-time appointment with the mellifluous title of Liaison Medical Officer to the Belfast Civil Defence Authority.

Soon we began to hear of the wonders of penicillin, but of course all supplies were devoted to the Services. When the war was over supplies slowly increased, at very high prices, and again we were joyful that we could treat effectively many infections. Then came streptomycin and the attack on the tubercle bacillus was on. Soon, however, very severe side effects, notable intractable vertigo and deafness, appeared.

Perhaps the most agonising consultation which I can remember was with Fred Kane and the late Fred Allen. The patient, a little girl, the daughter of personal friends, presented with the symptoms and signs of meningitis. A lumbar puncture was done in the Clark Clinic. The pathologist reported that although tubercle had not been found, the fluid was otherwise consistent with tuberculous meningitis. The question was to give or not to give streptomycin; remember this was in its fairly early days. Its value in what had previously been a fatal disease was pointed out. The possible side effects were considered and all this was put to the parents. Ultimately it was decided to wait till the next morning. Happily by then the child had developed a parotid swelling, so the question of treatment was resolved.

We soon had the tetracyclines which had the great advantage in practice that they were active when taken orally. They were called the wonder drugs and indeed they seemed to be so. Please do not think that I am dramatising the point when I emphasise what the chemotherapeutic and antibiotic drugs meant to general practice. Before we had them in so many cases we could only exhibit masterly inactivity and simple supportive measures. Nevertheless we should remember today that many simple and minor infections are self-limiting. During the fifties many valuable drugs were added to our therapeutic armamentarium. The various ganglion blocking drugs gave hope for the treatment of hypertension, although in most cases the aetiology remained obscure. The early drugs in this group had unfortunate and uncomfortable side effects, and had to be administered with caution. However, as time went on and other hypotensive compounds were formulated, it was soon seen that the treatment of hypertension was well worth while.

Later the first oral diuretics – the thiazides – were introduced, and they, with the more recent diuretics, revolutionised the treatment of cardiac failure, and particularly the treatment of what might be termed chronic failure. Before this we had to rely on digitalis and injections of mersalyl. Today it is astonishing the number of cardiac cases who can lead comfortable and reasonably active lives due to the combination of digitalis and oral diuretics. One knows of many patients who have suffered severe attacks of congestive failure and are now easily maintained with these drugs. In the old days many would not have survived a year. One of the interesting by-products of the oral diuretics in practice has been a noticeable drop in night calls for cardiac asthma.

Corticosteroids were produced and, with a great flourish of trumpets, cortisone and its derivatives were presented to the profession and the public. At that time they appeared to be a panacea for many ills. But the bogey of side effects and the limitations of treatment with these drugs soon became apparent. In time their place in therapeutics was properly evaluated. The corticosteroids can be life saving drugs in many serious and some uncommon conditions, and at the same time, provided they are used judiciously, bring relief and comfort in such common and disabling conditions as rheumatoid disease and asthma. They have, of course, been a godsend to the dermatologists and their patients. One wonders sometimes what has happened to the surplus supplies of tar, which used to be prescribed in vast quantities and under many guises.

In psychiatry E.C.T. was being used more and more. In suitable cases of endogenous depression it gave results little short of the miraculous. I have seen patients whose lives were quite literally transformed after a few treatments. When we got the anti-depressant drugs, E.C.T. was not so much required. As time went on one became more confident in diagnosing depression and treating it with the tricyclic drugs. To me the response, in the truly depressed patient, gave a great sense of

satisfaction. To see these poor unhappy people returned to a bright and enjoyable life brought me great pleasure. Of course, the treatment was not always effective, due I am inclined to think to inaccurate diagnosis. I have often thought how useful a biochemical test for depression would be. Who knows, it may yet come.

Thirty years ago we had not heard of tranquillisers and anti-depressants, and had to rely on barbiturates and bromides. Bromide was quite a helpful drug. I remember my senior partner describing it as specific for menopausal symptoms; that of course was in the days before the oestrogens were used. Today it never seems to be used, although it was effective in short courses. I can only remember one case of bromism. The phenothiazines were the first generation of this group of new drugs. I remember when Largactil was first marketed being assured by a pharmaceutical representative that it would replace E.C.T. It did not, however, work quite like that. It is not a true anti-depressant, but most useful in some psychosis and in the disturbed elderly. Then the benzo-diazapines came along. Librium, then Valium and now Nobrium, etc., all valuable for the anxious and agitated, but it is much easier to start their use with a patient than to discontinue it. The quantity of these and similar drugs ingested throughout the population is colossal. Why, I do not know. Some blame must be put on ourselves, who find it easier to prescribe them than to spend much time trying to help the patient sort out his or her problems. It may be partly addiction or drug dependance, whichever term you like to use; but why do people have so much more anxiety and depression than they did 30 to 40 years ago? Is it due to what is termed the pace of modern life, or is it due to discontent and fear of not being able to keep up with the Jones's? Or is it due to our change of values both material and spiritual in our supposedly highly civilised society? There seems to be a great amount of insecurity in present day life which must contribute to all this. Of course the appalling situation in our country in the last few years has accentuated this, but there is a world-wide restlessness and loss of confidence.

However, I have digressed. During the past thirty years practically all the so-called infectious fevers have been eliminated or brought under control. I cannot remember when I last saw a case of diphtheria. It is strange how scarlet fever has spontaneously changed its form. Once it was a potential killer and damager of the kidneys. Now it seems to be practically always a benign and insignificant illness. Tuberculosis is controlled to a great extent and is treatable. Poliomyelitis is, we hope, practically eliminated due to the vigorous immunisation schemes sponsored by our public health colleagues.

Surgery has advanced quite unimaginably and its horizons seem to know no bounds. What is probably most noticed by the family doctor, who rarely nowadays has the opportunity of being present at his patients' operations, is that surgery has become so much less traumatic to the patients. They seem to take their operations in their stride, as indeed does the modern young mother take her confinements, and convalescence is much shorter. In the old days an abdominal operation meant months of infirmity and apprehensive familial sympathy. I am certain that early post-operative ambulation has been a great factor in this, both physically and psychologically. Having said all this, I think that it should be remembered that surgery could not have made the strides that it has without the wonderful advances in anaesthesia. The anaesthetists appear to be able to give the surgeons practically carte blanche in their procedures, and they have undoubtedly contributed immensely to the patients' comfort and post-operative progress. When I first started in practice I had to give the anaesthetics, while my partner assisted. It was really a very crude business for the patient, the surgeon and myself. When I was a surgical pupil in the Royal, I recall Cecil Calvert coming up one night to do an appendicectomy. I was deputed to give the anaesthetic. When he had finished he came to me and with his quite unforgettable quiet smile remarked, "That was rather an in and out anaesthetic, wasn't it?" I could but agree.

This has been, I am afraid, a rather sketchy and superficial resume of the advances in treatment during this period. There are many other matters which I could and should have mentioned, but looking back, perhaps these are the things which probably impressed me most, and made the greatest impact on our work.

I have not dared to mention the permissive society and all its implications. A whole paper could be devoted to that. But, I would like to say, that from what I have seen, the young people of today are on the whole a very good lot, and much better informed and more socially conscious than my generation at their age.

As medicine becomes more and more specialised there are more and more sophisticated techniques of diagnosis and treatment which the family doctor

should know of, but has little opportunity of using.

With all the discoveries and advances in treatment we are perhaps apt to be a little self-satisfied. What is on the other side of the coin?

Digitalis is still the sheet anchor in cardiology. No better analgesic than morphine or its derivatives has appeared. Ergot and pituitary extract have not been superseded in obstetrics. Glyceryl trinitrate gives the most rapid and predictable relief in angina, and, dare I say it, aspirin is still probably the best day to day analgesic, in spite of the fashionable paracetamol, which is less effective and may be nephrotoxic. A poultice is still very comforting in superficial sepsis while the antibiotics get to work. We have lost, unfortunately, the art of the use of the placebo in what we used to call functional conditions, because we think we have really potent drugs for so many disorders. Many of these used to respond to a placebo and continuing reassurance in complete safety. Do we really know much more of the aetiology and treatment of peptic ulcer than we did forty years ago? Vitamin B_{12} is still recommended in the treatment of multiple sclerosis, although its effects, if any, are dubious. The treatment of rheumatoid arthritis is little changed except for the suitable exhibition of steroids and the most recent analgesics in the pharmaceutical mail. Osteoarthritis and all the other degenerative diseases are still with us. Coronary artery disease has increased enormously and although the treatment now provided has saved many lives, there is no agreement on the many theories of prevention. Common viral diseases are untreatable, although vaccination is a help in some.

Malignant disease is as common as ever and although cure can take place if by good fortune the patient presents early, the aetiology is as obscure as ever, except in lung cancer. So far as I can see the best regime for treatment of cancer of the breast is not agreed. In 1954 I was called to see a lady in the terminal stages of this disease – a fungating mass, multiple secondaries, ascites and so on. She only survived for a week. I asked her when she had first noticed the lump. She replied, "About the time of the air-raids, but I didn't see you because of the way my mother was." The poor old mother was then demented. That was a thirteen year survival, without treatment, in a series of one. Not, I realise, statistically significant, but rather interesting. Some day, we trust soon, the breakthrough in the treatment of cancer will come.

The pattern of morbidity has changed as so many of the acute conditions can be controlled and treated, so we find that more and more time is being spent on the degenerative diseases, and, as I have mentioned, on psychiatric conditions.

While all these therapeutic advances were becoming available in the post-war years, there was, of course, great activity on the medico-political front. With Government plans going ahead for the introduction of the Beveridge Welfare State, the profession was soon suffering from an acute anxiety neurosis. It was inevitable that the National Health Service would come into being, but we, having in the past conducted our profession in a rather individualistic fashion, were apprehensive of government control and direction. There were many acrimonious and some near hysterical meetings as the discussions went on. Ultimately the 4th July, 1948, arrived and we were in it for better or for worse. Personally I felt that, with increasing costs and rapidly expanding, and usually expensive, facilities for treatment, the Health Service was quite inevitable, as well as being basically truly humanitarian. I still believe that when history comes to be written the courageous experiment of the Welfare State will rank very high amongst social reforms.

In the early days of the Health Service, general practice was in the doldrums and general practitioners appeared to develop an inferiority complex. The reasons for this were difficult to pin-point, but I think it was partly due to the greater publicity given to the rapid expansion of the hospital service, partly to the differential in remuneration between consultants and general practitioners and perhaps largely to fear of the possible consequences of the new regime. There was great talk of abuse of the service by patients, the unnecessary work demanded by trivial complaints and of course economic considerations. The last was remedied to some extent by the Dankwerts Award and over the years has continued to be improved. I never found abuse of the service by patients to a noticeable extent. People did not come to sit in the waiting room for an hour or an hour and a half, unless they had a problem and wanted help. The complaints that appear trivial to the doctor may be very big to the layman, and surely it is the primary duty of every doctor to answer any call for help. And, of course, the trivial symptom can be the pointer to something sinister. What I did frequently notice was the consideration of the patients – "Johnny has been ill for four days, but I didn't want to trouble you; we know how busy you are now." I heard that time and again, and often wished I had been called earlier.

With the development of the Health Service the work and scope of the hospitals became greater and

greater. Expert consultant advice became available all through the country, as well as in the larger more specialised centres. The assistance and advice available to family doctors has been most helpful and has contributed greatly to the standards of general practice. The care and comfort of patients in hospital is vastly improved, but with all the modern techniques, humanity has not been lost. Almost without exception patients who have been in hospital extole the kindness, skill and thoughtfulness of the nursing and medical staff.

One aspect of the hospital service, which if I dare suggest, could I believe be improved in some units is communications. To this day a visit to out-patients or admission to the wards is a frightening experience to most people. But to go to hospital and to be given little information about your condition or treatment, and then to have to wait usually for some weeks before the family doctor gets the report, causes much anxiety and distress to the patient, and is a source of frustration to the doctor. I am sure this could be greatly improved.

The large number and frequency of review appointments which some departments use, seem to me to be unnecessary. The patients are called back at frequent intervals and usually are seen by a different registrar each time. In most cases these follow-ups could be done quite effectively by the general practitioner, and with less inconvenience and worry to the patient, and avoidance of hospital neurosis.

It seems a pity that the day of the old fashioned domiciliary consultation between consultant and family doctor at the patient's bedside is declining. Nearly always now it appears to be too difficult to arrange a mutually suitable time for this. I believe that all parties concerned are thereby losers. Over the years I learned a great deal from my senior colleagues chatting after the consultation. Of course frequently on the visit to the patient next day, one was asked, "But what do YOU really think, doctor?" – a small example of the sometimes frightening trust people put in their family doctor.

In 1952 the College of General Practitioners was launched through the farsightedness and enthusiasm of a comparatively small number of men in London and throughout the country. I think the object of the College can best be summed up by its noble motto, "Scientia cum Caritas"–Science with compassion. It is purely an academic body with no political intent, formed with the improvement of the quality and status of general practice as its aim. This it is achieving over the years. Many useful research projects have been carried out by the College, the concept of continuing post-graduate education and the introduction of undergraduates to practice were inaugurated. These things are taken for granted now, but it is well to remember that the College had so much to do with the propagation of the ideas. More and more universities have now introduced departments of general practice, many with professorial chairs. Here again the stimulus of the College has been a notable factor. The College is consulted at the highest levels on all things pertaining to the academic side of general practice, and I am sure that it has brought a new dignity and confidence to its members. It must be a great source of satisfaction to its founders that the College has achieved so much in twenty years.

As time went on more and more partnerships were formed, group practices came into being in converted or purpose-built premises. A few experimental health centres appeared. With more financial help from the government and with the liberalisation of official policies, these tendencies accelerated. Health centres and group practices are common place - the single handed practice is disappearing in all but the remote areas.

All these changes have been of great advantage to doctors. They are working under better conditions, with improved equipment and facilities, and often with the assistance of nurses, social and welfare workers. They are no longer in isolation, but can work in cohesive teams, with all the help of discussion and sharing of duties.

With these advantages in the organisation of our work, we must not lose sight of the raison d'etre of our job – the patient. I believe very strongly that general practice to fulfil its highest aims, must be a personal service between the doctor and the patient. It has always been maintained that the continuance of personal and family care is perhaps the greatest asset of general practice. I have had some misgivings that in these days and in the future this principle may become eroded. With multiple partnerships it is easy for the patient to have less continuing care from his doctor of choice. I feel that if this tendency should go on it will be a disadvantage to the patient: and the doctor will lose a great deal of satisfaction in his work if patients become depersonalised, rather than friends who depend on his help through difficult periods in their lives. In the recent report on the Organisation of Group Practice, it is stated "the primary object of all medical care is to meet the health needs of the individual and the society in which he or she lives." This must not be lost sight of.

General practice has always been an exacting way

of life, both physically and mentally, with the responsibility of being prepared at all times to make the right decision in matters of little importance, or literally in matters of life and death. But today with the changes which I have mentioned, it is much less arduous and practitioners are better trained and equipped to deal with their work. Nevertheless, I feel strongly that the needs of individual patients must be the doctor's first consideration. In all organisation of practices this must be given priority. In other words the doctor must still have the same dedication and unselfishness in his professional work which so many of his forbears had.

I fear that this has been rather a meandering address and perhaps too autobiographical. However, I have tried to show you some of the thoughts of an ageing general practitioner, looking back over his time in practice. Many things have changed, but we should not accept change without proof, purely for the sake of change. I have seen many theories advanced which appeared wonderful, but were found to be of little value. Vitamins were hailed as a cure for all ills. Fifteen years ago we were told we should not eat fat. Today sugar has been labelled the great enemy of our health. I have sympathy with the old adage "a little of what you fancy does you good", the operative word of course being "little" If you think about it, the human digestion and metabolism are extraordinarily flexible and tolerant processes.

Various remarks have been made of "the cottage industry" but it should be remembered that in the past many workers in cottage industries were superbly skilled craftsmen.

Let us go forward and maintain the standards and integrity in the art of our profession which our predecessors laid down, aided by all the continuing wonderful advances in the science of medicine.

I thank you all for coming here tonight and listening so patiently.

Scientia cum Caritas – do not let us forget the Caritas!