Ernest Ward and collective investigations

R. M. S. McCONAGHEY, *O.B.E.*, M.D., F.R.C.G.P.
Dartmouth, Devon.

Do you know, by the way, anything of a proposed Association of General Practitioners for Collective Research, started at Stockton-on-Tees? I have papers about it that Osler sent me.

—From a letter to Sir James Mackenzie from Sir Walter Fletcher of the Medical Research Council. (Mair, 1973).

The only information about this venture is in a small book entitled *Medical Adventure* written by Ernest Ward in 1929. My interest in him is personal and arose when I returned to my practice from the Army after the war. Many of the patients were, or had been, suffering from pulmonary tuberculosis. They would often tell me of the visits made to them by Dr Ward who, after holding the post of tuberculosis officer to Devon County Council for the South Devon area since 1915, had recently died. His popularity with his patients was undoubted.

When in 1948 I became representative of the Torquay Division of the British Medical Association I learned that Dr Ward had been one of my predecessors and that he had been a member of the Council of the Association. He had been popular with his colleagues as well as with his patients, a position not always achieved by local government employees in the profession. When he retired in 1943 through ill health 90 of his colleagues contributed to his testimonial.

To me his name had become a by-word; a figure from the past whose influence continued to shed a light on medical practice; there are men like this whose personalities continue to glow long after they have departed.

One day, I found in a second-hand book shop, *Medical Adventure.* The book consists for the most part of articles reprinted from various journals, but they are replete with medical lore of the time. Here indeed was a picture of practice in the era of *The Citadel* and Dr Finlay's Case-book. Dr Ward's interests were, as was proper in a general practitioner, wide and his ability in reporting his cases and in portraying his experiences were of the first order.

From hints dropped in this and his subsequent book on *General Practice* (1930) and from a few notes kindly provided by his son some indication of his life work may be gathered. The comprehensive obituary notices in the *British Medical Journal* and *The Lancet*, reveal so many inconsistences that no reliance can be placed on them. It is not that they fail to give praise where praise is due; they laud his kindness, gentleness, his rough Yorkshire exterior and forthright habit of speech, but they err in dates, and in one of them there are gross inaccuracies.

Medical career

Ernest Ward was born in Leeds the son of Sir John Ward, twice Lord Mayor of that city. He was educated privately, and at Cambridge University and the London Hospital. In 1906 he gained the fellowship of the Royal College of Surgeons and in 1907 the M.D. of his university. In 1906 he entered partnership in Llanelly where he was surgeon to the steel works and the local hospital. In 1910 he became the surgical partner in a practice in Stockton-on-Tees. Thus far the *Lancet*; the *British Medical Journal* would have him practising from the time he qualified in Paignton in Devon. Ward himself stated in *General Practice*: " Fate has ordained for me a wide and varied experience of general practice: many locums, four partnerships, one of these as a six months' locum, the other three real negotiated and signed partnerships. I have had practices with clubs and without, practices on foot, push-bike and car, medicolegal work, operations, and other side-activities, and since leaving practice I have had a more or less intimate acquaintance with some hundreds of practitioners and many partnerships.

" Today I am often consulted by younger members of the profession about partnerships and other matters connected with general practice, and the more this happens the more I am impressed with the advantages of a wider knowledge of the subject to those about to join our ranks" (Ward, 1930).

One of his last remarks to a colleague who asked him how he employed his time was " Learning—always learning." (Ward, G, 1967).

Undesirable practices

In his manual on *General Practice*, which is directed towards the final year student, he drew attention to three types of undesirable practitioner.

These sketches give an insight into conditions between the wars. There was the ' collector ' who selected from each household members with alleged defects which he treated. If there was no one else to collect he would discover fresh defects in the first patient. Perhaps the border line between the collector and the practitioner of preventive medicine is thin. The financial incentive to collect in this way is now gone, but the duty to give whole family care when appropriate still remains. The second type was the ' brigand ', the man who was apparently careless about fees and treated many grateful patients for nothing, but when a well-to-do victim of suitable disposition came along he plied him with attention and special treatments and "sent in bills for £60, £70, or even £120." As Ward commented, the victim may be irretrievably lost but the free list soon brought another; he had met quite a few of this type.

Then there was the ' stunt ' practitioner who discovered special defects for which he gave long treatments, such as polyglandular therapy—the therapeutic crank is still with us today.

Tuberculosis

General practice was not to be Ward's life work. Like many another in those days he contracted pulmonary tuberculosis. Fortunately it was a comparatively mild attack, and he went to Davos as an assistant medical officer to the sanatorium. When he returned he devoted the rest of his life to the duties of a whole-time tuberculosis officer. How well he did these is attested by his patients. He became president of the Tuberculosis Society of Great Britain, was honorary secretary to the tuberculosis group of the Society of Medical Officers of Health, and was the first officer to be president of the Society. In 1924 he was instrumental in founding the Joint Tuberculosis Council.

Encephalitis lethargica

In the mid-1920s Ward suffered from an attack of encephalitis lethargica. His description of the illness is the final chapter of *Medical Adventure*, and is a classic portrayal of a disease syndrome by a medical sufferer. It must have required great courage and an unusual dedication to duty even to attempt: he expresses this in the opening words of the paper: " Of all the chapters in this book this was the most difficult and painful for me to write. It was written, and to be of any value had to be written, during the illness—every sentence, every word an effort. Sometimes only a few words could be put down at a sitting, yet in the end the work was done."

Encephalitis lethargica is seldom seen today. In the 1920s the disease was relatively common and victims of its ravages still linger amongst us. The diagnosis of the acute attack is difficult and in the absence of an epidemic may easily be overlooked.

For this reason Ward's account is most valuable. True to the best tradition he writes impersonally in the third person: " A medical man, aged 47, was attacked in the evening of January 17 with acute coryza. . . . He remained in bed for four days with pyrexia. . . . On the 21st and 22nd there was effortless morning vomiting, with hardly any nausea; a type which he considered cerebral. . . ."

And so, unemotionally, he recounts the whole sad story—the increasing weariness, visual difficulty when backing his car, the onset of diplopia, his realisation that he was suffering from encephalitis and his hope that the attack would be abortive. This was on 4 February and he retired to bed " rather uncertain of the morrow, and awoke at 8 a.m. after a heavy dreamless sleep, feeling better and without the diplopia for central vision." But the disease progressed. Drowsiness became more marked, with intervening restlessness; tremors, myoclonic movements, muscular inco-ordination and facial weakness supervened. There follows an analysis of the symptoms with an account of the progress of the complaint and a dispassionate consideration of the prognosis. " One is inclined to advise this patient not to face the situation too squarely, and to envisage, not the shadowy future, but rather the busy present, or even the well-filled past. Prudence and foresight are useful and estimable virtues, but those who exercise them to the utmost do not always escape disaster. Life is a game, and its chief art is to turn adversity to good account." There spoke a brave man. He continued in active work until the ravages of Parkinsonism forced retirement on him in 1943.

The Association of General Practitioners for Collective Research

While Ward was at Stockton-on-Tees the National Health Insurance Act (1911) became law and he must have been in the thick of the discussions which preceded its implementation. The attitude of the profession was violently against the Act and the British Medical Association recommended that no one should join the ' panel ' of doctors willing to take part.

The Government threatened to engage young doctors at a salary of £500 a year to practise in places where no general practitioner would join. In the event, at the final show-down the divisions of the Association voted overwhelmingly in favour of joining. In Stockton the vote was unanimous. Doubtless those who were still against the Act kept away from these meetings, and Dr Ward's partnership remained a non-panel practice and when later the National Health Service Act came the partners remained outside it (Rowlands, 1972). Ill-feeling and distrust lingered on for a long time after 1913, and the discontent was such that many feared that general practice would cease to be a worthwhile calling. In the words of Dr Ward: " A number of practitioners, depressed by the prolonged Insurance Act negotiations and by the partial, if inevitable, defeat which the profession suffered, were inclined to give up hope of anything except the earning of daily bread and provision for their progeny." It was in this atmosphere that in the late summer of 1913 Ward and another doctor of Stockton discussed forming an Association of General Practitioners for Collective Research. They were joined by two others from West Hartlepool to form the committee.

Collective investigations were not new. The British Medical Association had since its foundation sponsored many. During the 1880s there had been so much activity in these researches that reports were issued by the Association in special volumes for the years 1883, 1884, 1887 and 1888 (McConaghey, 1956).

Some of the reasons put forward by Ward for the formation of his Association were closely paralleled by the College of General Practitioners' research committee in 1953: " The specialist has difficulty in following up cases or observing them for long enough, and he does not usually see the beginnings of disease. . . . The general practitioner is in the best position to advance our knowledge of the minor diseases and discomforts of daily life . . ., of the commencement of epidemics, and of the value of certain drugs and other forms of treatment. . . . Apart from the purely scientific value of such an association, its members will keep alive interest in their profession for its own sake, and prevent, to some extent, that unavoidable waning of enthusiasm as years increase. . . . Finally it was hoped that the level of scientific attainment and therefore the value of the daily work done by the rank and file of the profession would be raised " (Ward, 1929, chapter 6).

Profiting by the relative failure of past attempts, the committee drew up a circular letter which was distributed amongst practitioners inviting them to participate. Twelve subjects were selected for investigation and these ranged over a wide field. The treatment of and the after-results of treatment of gastric ulcer and gall-stones and of nasal sinusitis; the occurrence of urticaria; the beginning of epidemics; cardiac irregularity and the causation of the ' dyspeptic extra-systole ' and its significance; the minor diseases and discomforts of pregnancy; the value of certain prescriptions or drugs; ' curious cases '; the infectivity of pulmonary tuberculosis— ' this may seem obvious enough, but has not yet been carefully worked out '; the value of different treatments in pulmonary tuberculosis—these were fresh air, cod-liver oil, drugs, and tuberculin by mouth or hypodermically.

This list was sent to doctors personally known to the committee, with a request for the names of others who might be interested. The deans of all the medical schools were asked to father the scheme in their areas. In this way the support of Osler at Oxford, Harvey Littlejohn at Edinburgh, and Sims-Woodhead at Cambridge was achieved. The greatest help came from the Dreadnought School at Greenwich, now forgotten as a medical school. " The Association pinned its faith on the younger generation. Men were to continue, when in practice, their hospital habit of recording and observing accurately, and if they joined the Association on leaving hospital would not have to start afresh."

The reception of the scheme was more favourable than had been anticipated. Though the majority of those circulated did not reply, before it had been in existence three months the number of participants had reached 200. Alas, the Great War and the secretary's illness suspended the Association's activities. " Practitioners enthusiastic enough to join us were also the most

eager to join up when war was declared." According to Ward, the Mackenzie Institute at St. Andrews considered, after it was founded in 1921, whether it could use the membership of the Association but decided that it would be more useful to limit its work to St. Andrews. In 1929 Ward wrote that resurrection was still possible.

If the Association had continued, with enthusiastic guidance, its effect on the standards of general practice might have been greatly beneficial. In the period between the wars young doctors were beginning to realise the need to train themselves for the work although it was still possible to start in practice immediately on qualifying and many did so. Would there have been a need for the formation of a college of general practice? Would it have been founded earlier? Who knows? All that we can say is that the acceptance by so many of the ideals behind the venture indicates that many doctors were practising in the first quarter of the century who were scientifically minded and keen to maintain and improve their standards.

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MEDICAL AND SOCIAL SCREENING OF PATIENTS AGED 70 TO 72 BY AN URBAN GENERAL-PRACTICE HEALTH TEAM

A medicosocial survey of 259 elderly patients aged 70–72 was carried out by three doctors, a health visitor and a nurse in an urban general practice. Seven hundred and ninety diseases or disabilities were identified—an average of 3·2 per patient—of which 20·5 per cent were unknown to the doctors. Using a simple checklist for symptom inquiry, the health visitor or nurse missed very little of the physical or psychological disease. In some respects their symptom inquiry was more revealing than that of the doctors but they had difficulty in eliciting evidence of malnutrition, masked depression, and incipient dementia. Initial health screening of the elderly for unreported disease in general practice can easily be done by a health visitor with training in geriatric problems and the recognition of psychiatric illness.

Initial health screening can also be done by a nurse with community-nursing experience, but she will require additional training in the techniques of social assessment. The doctor must examine those patients found to be suffering from alerting symptoms. A general practice of three or four doctors requires one health visitor for routine work and one additional health visitor or nurse for screening of the elderly. Unreported disease in the elderly indicates failure to make contact and failure to ask the right questions. Unknown disease may be due to inadequate records.

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