

## FORTY YEARS IN GENERAL PRACTICE\*

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I HAVE been asked to talk on a subject related to a long period of practice. I have not found it easy to plan this or to make a nice tidy job of it. I have no particular words of wisdom to offer or any story of spectacular achievement. Your careers, I suspect, will be little different from mine.

When I qualified, the daily round seemed to be set in its pattern and I didn't imagine the pattern changing. The medical world appeared to be in a stable state of equilibrium and I imagined my life progressing through a normal and familiar routine until in the fullness of time old age arrived. One is always taken by surprise when upheavals come. However, after all the great events and changes that have taken place, the situations we have to face now are the same as those that confronted us 40 years ago. The hardest thing has been the constant effort of self-discipline. In youth this meant overcoming the natural impatience and intolerance of that age. Now it is in overcoming the lethargy that comes with weariness. But the challenge is always there. It becomes no easier with age to be patient with the thoughtless, the stupid, the feckless, the malicious.

Science gallops on in every branch at breakneck speed and each advance brings a host of problems. And who is to say what will happen to medicine. Modern science is big business—it can't exist without vast sums of money. The days of brilliant discoveries in sheds at the bottom of the garden are over. Modern medicine is modern science and state medicine is an extremely expensive luxury. We are in the grip of high finance and there is no escape. Who pays the piper calls the tune. From the marriage of Finance and Medicine

\*An address by Dr Elder to the South London Faculty on 4 June 1963.<sup>1</sup>

there can be no divorce and the union must be made to work without either party becoming too dominant.

I was born in 1900—which makes it easy for me to calculate my age, but the importance of this date is in no way concerned with me. By the end of the first quarter of the century I had grown up, served in a major war, and qualified in medicine. And in this time I had learned not really a great deal more than my grandfather had. The next quarter of a century saw what Julian Huxley has called a ‘knowledge explosion’. Nearly everything important in modern medicine has been discovered since I qualified and this also applies to the other sciences. I will try not to bore you with homilies on what we thought we knew and what we did nearly half a century ago but I would like to contrast life in the medical field then with conditions now and perhaps set you thinking about your own future.

Only those who lived through it can realize the loss the nation sustained in the first war. Nearly a whole generation disappeared. Of the boys who were a year or more older than me at school hardly any were left. The undergraduates of my time were even more peculiar than usual. The older ones were unfit practically to a man, except for the ex-servicemen and they were prematurely experienced and years older than their age. I qualified at 22—an unthinkable situation nowadays. In my first term none of us had civilian clothes. I had outgrown mine and they wouldn’t go on. We attended lectures in uniform and I frequently sat in inorganic chemistry lectures in my kilt and one stripe, next to a brigadier of 25.

The economics of these undergraduate years were a nightmare. Ex-servicemen had an educational grant which kept them in board and lodging and I had scholarships which paid my university expenses. All was well until the inevitable economic crisis. Some of you may remember the Geddes Axe somewhere about 1921. It cut out my grant altogether and I was immediately in big trouble. This meant finding jobs in vacation time. The Scottish universities, unlike the English medical schools, have a three month long summer vacation and a month at Easter. So one could earn enough to see one through the next term. Compare the present arrangement where once accepted the student has no financial worries or at least no desperate ones.

The matter of student health is of interest. In my time the undergraduate years took their toll mainly with tubercle and septicaemia. A pricked finger was a cause of real fear. Many surgeons and pathologists died in a few days from this. My old professor of

medicine told me that in his undergraduate days, I suppose in the 70's and 80's, the bogy was typhus. Nowadays, from what I read, the main danger to the undergraduate is psychoneurosis and suicide. There should be a lesson to be learned here if one could see it.

I look back on those years with the feeling that at least two years were wasted in the laborious memorizing of quite useless knowledge. I never grasped the elements of physics and to this day the carbon ring is a complete mystery to me. I have never noticed the want of this information nor has it been a handicap to me. I am quite convinced that those in whose interest it is to teach these subjects have an undue influence on the planning of medical education. To load undergraduates with two years of this sort of thing and in the end turn them out as doctors almost ignorant of paediatrics, geriatrics, dermatology, and psychiatry is pure folly. I can see small difference in the medical syllabus at present from its make-up 40 years ago.

We were given very little guidance as to careers and how to fit ourselves for them. Each had to fend for himself and plan his moves as seemed best to him. I had elected to enter general practice for several reasons. First, I knew I hadn't the means to support myself during further training (pay as a house man was one pound a week) or to wait for the years to bring a lucrative income. Second, like most young men I wanted to marry, and third, general practice appealed to me. I have always been more interested in people than in academic erudition. I felt that the most important house-job with general practice in mind was casualty, and in my school it was combined with house surgeon to surgical outpatients. One had two chiefs, junior surgeons, who came on alternate days and who saw and advised on anything the casualty officer cared to show them. I was taught every minor surgical procedure in the book and had ample practice in these. So, even today, I find myself highly critical of the standard of work in nearly every casualty department known to me. The widespread ignorance of proper treatment in minor medicine is due to the fact that it is not those who practise it who teach it.

The next house-job I did was house physician to the professor of medicine. These two jobs really laid the foundation and later were supplemented by a paediatric job in the Hospital for Sick Children in Hackney.

Now, much more interest is taken in advising the young graduate, and the pre-registration year has put a stop to insufficiently trained young doctors going straight into practice. Everyone has his own

ideas as to what house-jobs are important for the entrant into general practice. Probably most would agree that the most useless is the house surgeoncy. I am convinced that all doctors who intend to make their career in hospital work should have some experience of general practice. The lack of this experience is the reason for much bad work in hospital practice.

I first went out into the world as an assistant to an elderly doctor in Kirriemuir—J. M. Barrie's 'Thrums'. This is a small town at the base of the Cairngorm mountains at the foot of Glen Clova, which is the site of Cortachy Castle, the home of Mr Angus Ogilvie who was then a baby with whooping-cough. Here I felt myself very much the unfeathered fledgling. I still get goose pimples when I think of the things I had to handle at the tender age of 24. The old principal decided I was reliable and went off for two months holiday leaving me the practice. My knowledge of midwifery was confined to what little I had learned on the district and as few attendances as was decent in the maternity department. Coping with a post-partum haemorrhage in a cottage 20 miles up Glen Clova in a February blizzard was an experience which is deeply bitten in. It ended with a bimanual compression and a precarious 40 mile journey to hospital. I can't think why she recovered. I well remember going to a croft in the wilds to see a boy who was in coma. The smell of acetone was overpowering. We bundled him into the back of the car and took him, again 40 miles, to hospital because I had heard that there was some stuff called insulin and there was a chance that they might have some. They did. Just enough to cure him. He was their first case of diabetic coma treated with insulin. He also recovered.

We knew so little then and understood so little. We had no appreciation of fluid balance. No intravenous fluids were used. Blood transfusion was a last rite in cases of pernicious anaemia and leukaemia. Tubercle was nowhere near under control. In 1926 the splodge of blood coughed on to a handkerchief produced a shock of fear and horror. Even 'M & B' was still 12 years away. Many of you have never seen a pneumonia run its course and the temperature come down by crisis. But it was common to stand by helpless and watch a strapping young man die in six days without being able to influence the disease in the slightest. Septicaemia also left us helpless. I often recall the frightful infections of the hands and fingers we tried to cope with. I saw an old patient the other day who had had an infected thumb, 35 years ago, which went on for at least two

months and which only healed after the terminal phalanx sloughed out of the incision. My first experience of 'M & B' was with a drug called prontosil. I had booked a primipara who was a, not very close, friend of the family. All went well until she was about a week from her expected day of delivery when she developed a fierce follicular tonsillitis, the swab from which grew haemolytic streptococci. This frightened me to death because if she went into labour before the throat infection cleared up she might well infect herself and die of puerperal septicaemia. So my first patient got her prontosil. Now prontosil was a very toxic drug indeed—far more toxic than its successor sulphapyridine. To use sulphapyridine nowadays would be almost malpractice. Prontosil's side-effect was to cause methaemoglobinaemia, a condition where the patient turns blue. This she did and to crown it went into labour. She had a high arrest with a persistent occipito-posterior. This meant an anaesthetic—chloroform, a manual rotation, and high forceps. This was successfully accomplished and the baby delivered. He would have been in white asphyxia if he hadn't also been blue. However, we pulled him round and in the next few days both made a splendid convalescence. I am still convinced that without the prontosil both would have perished. You will probably think that they nearly did because of it.

Tubercle at this time was one of the great killers. The tubercle bacillus was everywhere. One seldom sees in public places now the legend "DO NOT SPIT". But these were everywhere—in the streets, stations, buses, lavatories. And the tubercle bacillus was the reason. One of the common skin diseases seen in outpatients was lupus vulgaris—tubercle of the skin—and the common site was on the buttocks of babies and toddlers. They rubbed the bacillus into their naked bottoms when hitching themselves about the floors. Another killer was diphtheria and this disease was a constant anxiety in general practice. Every sore throat had to be swabbed and one was uneasy until the laboratory telephoned in the morning. Throats which looked like diphtheria weren't, and ones which didn't look like it were. Many, many children died. Venereal disease was extremely common and I am convinced that one reason for the present day sexual indulgence is the absence of the deterrent fear of V.D. Imagine the situation if one in every six young people who now indulge, came up with gonorrhoea. Tertiary syphilis came into almost every differential diagnosis in chronic conditions. Rickets was a commonplace and it is interesting to see in the journals at present reports of rickets in coloured children.

The situation in obstetrics is difficult now to envisage. By far the majority of deliveries took place at home or in nursing homes. At one time, my senior partner did about 200 a year, usually with only a handywoman present. There were very few midwives doing private midwifery in working class practice. All sorts of procedures were carried out in the home and only desperate conditions like failed forceps and haemorrhage were sent to hospital. The other day a patient brought her baby to the surgery and I recalled my first meeting with her. I was called to her mother in labour to find a small hand protruding. I gave her chloroform, stuffed the hand back into the uterus, got hold of a foot and pulled it down, anchored it with a clove hitch to the foot of the bed and then waited. Labour eventually restarted and the half-breech made an excellent dilator and all was well. Adherent placentas were removed under chloroform on the open mask. Eclampsia was smartly diagnosed on the first convulsion. There was practically no antenatal care. Many general practitioners were highly skilled obstetricians because they got plenty of practice in dealing with conditions they should never have allowed to occur.

Having made many of my early mistakes in the assistantship I began to search for an opening in which to settle. At this time there were plenty of young doctors but very few openings. Partnerships were not nearly so common then as now and the great majority of practitioners worked single handed usually in bitter competition. I also kept a lookout for death vacancies. They were more of a problem because whereas a junior partner's share cost about £1,200 or so, a death vacancy price would be higher and the cost of the house would have to be met as well. The other means of entry was squatting. An enormous element of luck was involved in this. One had to guess whether the area in mind was going to expand rapidly or whether there was enough to provide another doctor with a living. Squatters were very unpopular with the established practitioners who foresaw losing patients. Many squatters set about it by first finding what fees were in operation in the area and then undercutting. I suffered very seriously from this in my early years. The routine was to get into a house by undercharging a non-insurance patient and then saying "Well, we might as well make it all the one doctor" and collect four or five panel cards. In two or three years a list of 400 or so patients could be built up and with some fiddling of the private cash book the practice could be advertised as a "rapidly growing nucleus". The squatter would find a buyer and move on having cleared some £1,500-£2,000.

Eventually in 1925 I settled as a junior partner in the practice where I have remained ever since. My senior partner seemed to me to be a very elderly gentleman indeed although I now know that he was about eight years younger than I am now. He was a slow-moving, slow-working, and very methodical man and was the best obstetrician bar none I have ever seen. He taught me practice organization and how to work. He was the personification of integrity and quite incapable of anything remotely suggestive of the unethical. For two years I went round the practice on a bicycle. Nowadays young assistants and junior partners arrive with a car, a wife, and two children. But, of course, they are older.

In 1925 the N.H.I. Act was in force. All who worked for a wage, paid insurance stamps and were entitled to attention on the 'panel'. Dependants were private patients. Private fees in lower class practice were from 2/6 in the surgery and from 3/6 a visit, both including medicine. Confinements were from 1½ guineas but practically no antenatal care was given. Most practices did their own dispensing. We have all heard the stories about coloured water. These, I think, were mostly libellous. Certainly in our practice proper prescriptions were dispensed. We kept to a limited range and half a dozen mixtures served most needs. For expectorants we used Mist. Ammon. Carb. and Ipecac.; for sedative cough mixtures, a syrup bought in bulk from the wholesaler; for alkali, Mist. Bism. Carb. and Mag. Carb. Pond.; for sedation, Mist. Pot. Brom. or Tab. Phenobarb.; and as a tonic, Nux Vom., and Gentian. Drugs for dispensing, such as sodium salicylate, ammonium carbonate, potassium bromide, sodium bicarbonate, were kept in solution 1 in 4, 1 in 6, and so on. Using a six-ounce bottle with tablespoon graduations, two graduations of a 1 in 4 solution gave a 10 gr. dose per tablespoon. So to make up a bottle took about 1-2 minutes. The dispensary, with a little planning, could be accommodated in an average sized cupboard which also contained the hand basin with a special bottle tap. Corks were bought by the 12 gross and all medicines were wrapped and sealed with sealing wax. The name and address were written on the wrapping and the medicine could be put out to be called for (medicine is an article no one steals). We employed a boy who came after school with a large satchel and delivered the medicine. We provided a bicycle and paid him half a crown a week. We would come in at the end of a morning and make up 15 bottles each in about 20 minutes.

Dispensing meant that patients requiring 'repeats' came to the

surgery and paid another half-crown. It was this that really produced the income. There was no living to be got by making your diagnosis and giving a prescription. You never saw the patient again and it was the chemist who made the profit. I well remember the private records which were meticulous in noting the 'rep. mists' owing, if a little short on clinical data, which were inclined to be a bit terse. To keep a patient's medicine going while one was on holiday could be a problem. Giving a prescription was simply losing the patient to the chemist. The solution was to mark the prescription firmly "Repeat Twice". At the end of each quarter the accounts had to be got out. This was a job the whole family was liable to be press-ganged into, addressing envelopes and licking stamps.

Once a month the traveller from the wholesaler came for the drug order. Many doctors found this man a useful agent for all sorts of things and he was absolutely reliable in the matter of locums. He knew all the bad ones and never recommended a dud. The drug bill was about £10 a quarter and to this day I am more aware of the cost of each drug than most, and I still use a limited range—my partners can usually tell by the patient's description exactly what I have given without looking it up.

Our practice never sent out large bills. We learned how much one could allow a patient—it was a bad thing to have a patient owing large bills. They were not paid and as we hated pressing for money it meant that it got around that they needn't worry about owing us money and the bad debts soared. If we wanted to get rid of a patient we just sent an exorbitant bill. We held the parish appointment and so were in a fairly good position in that we could, when a bill was owing, suggest that the patient get an 'order' from the Relieving Officer. Looking back I am quite sure that the story that patients suffered from not being able to afford attention is untrue. They probably suffered because we could do very little effective in treatment. Certain it is that they did not swallow the mass of drugs that they do now. It is also certain that if some payment had to be made at the time of service there would be a great drop in attendances. Those who were in practice at the appointed day will remember the immediate floods of patients in the surgeries.

Under the system at the time no one who required attention was unable to get it. Latterly the method of having one parish doctor was abolished and a panel of doctors undertook the work. When I stood on a doorstep no one knew whether I was about to pay a private, a panel, or a parish visit. Moreover, if the case required



admission to hospital a telephone call secured immediate admission with no queries. *Admission could not be refused.* I am daily filled with horror and shame at the present situation and resent bitterly the slanderous statements of politicians who talk of the bad old days when the poor could not get the treatment they needed. The present difficulty in the hospitalization of the acute and chronic sickness in the old is a blot on our culture.

What sort of clinical medicine did we do? I have the feeling that at bedside diagnosis we were very good. When there is little in the way of clinical aids one has to be good on physical signs. On diagnosis on clinical examination I am sure I am no better now than I was 30 years ago. That is not to say that I don't rely as much as anyone on x-rays, the laboratory, and all the accessory services. Did we miss all the coronary infarcts and bronchial carcinomas? No! These conditions simply were not seen. At least coronary infarct as we see it in the previously healthy, young-middle aged just did not occur. We saw it very infrequently associated with atheroma and arteriosclerosis. In fact, as the incidence increased, I continued for long to be puzzled by seeing it in the absence of obvious arterial disease. Carcinoma of bronchus was extremely rare. I never saw one as a house physician. We did not miss it—there is no mistaking a death from carcinoma of the bronchus. On the other hand, diphtheria and whooping-cough were the bane of our lives. Full blown pertussis is a very distressing disease both for the patient and the relatives. Under a year, it was lethal, and even although most recovered it was a damaging disease leaving a trail of collapse of lung and bronchiectasis. Children after a severe pertussis often looked like something out of Belsen. There was not one of us that was not caught out, not once but many times, by tubercle. In the early days radiology was not very reliable and later many patients would present with symptoms which seemed in no way related to the respiratory system and which were very apt to be regarded as functional. When the diagnosis was eventually made the doctor appeared in a very poor light. None of us was guiltless in this respect.

During the thirties one was gaining experience and confidence. I had become under my partner's tuition pretty expert in obstetrics and having added to my paediatric training, experience on my own children (which is how most of us learn paediatrics), it became obvious to me that success in general practice has its basis in these two subjects. If one handles a pregnancy and confinement efficiently and shows interest and ability in neonatal paediatrics a bond is formed between the doctor and the family that is not easily broken.

Most young mothers quickly see when they find a doctor who really knows what he is doing with her and her baby. It was this work that gave me the greatest satisfaction and I have many very happy memories of it.

However, it seems now, on looking back that I worked in isolation. It is true that I served on many committees with my colleagues and gained valuable knowledge and experience in this, but in my daily work I was very much alone. In 1937 my senior partner retired after a serious illness and I was on my own. It meant a colossal financial burden for there was not really enough for two partners and one needed time to build up and consolidate. But after a year came Munich and the certainty of war. No one then wanted to buy a partnership and later in the fullness of time came the war and in due course I went into the Army once again.

It was then that I realized how much I had learned. In clinical judgment and acumen, the elicitation of physical signs and in confidence in assessing situations, men of my age were at an advantage. Provided we had kept reasonably abreast of the times we felt fairly equal to the affairs. The great good that came out of it was the daily association with colleagues, sharpening our minds and clarifying our ideas. This period convinced me that to separate the practitioner from his colleagues in hospital is disastrous. Somehow the practice of medicine must be unified and ways must be found for the family doctor to work for periods in hospital.

With the end of the war came an avalanche of problems. Ruined practices had to be rebuilt. Financial crises had to be met and resolved. The imminence of a National Health Service had to be faced. And on top of all this there was being released a mass of new knowledge which had to be mastered. We returned to the familiar state of isolation with every man for himself in a general atmosphere of cynicism. There was a horrible and demoralizing sense of disillusion, and relationships between doctors were worse than they had ever been. Those who had remained in their practices felt that those who had been on service had had an interesting time at the nation's expense with pay and allowances as well as income from their practices. Those who served were resentful that the protection of practices scheme had been a failure and that their practices had disintegrated. Strongly held and diametrically opposed opinions caused rather bitter arguments about the coming health service. It was an unhappy time. I found myself without any premises from which to practise and it was three months before I could get going.

An event which was of great importance to me was the publication

of the Collings' report. This caused a sensation and the presentation of a factual description of the state of general practice produced in some quarters resentment and in others heart searching. When the Dankwaerts award was paid up I found I had a considerable amount of back pay—about £1,000. I spent the lot on modernizing my surgery premises. The planning of this and the execution of the work meant a pretty thorough re-think of the purposes and organization of general practice.

I was also stimulated at this time by an association with a teaching hospital when I was asked to show students general practice. At this time I was full of ideas about organization, premises, rotas, ancillary help, research, and so on. I engaged a very experienced ex-sister from a teaching hospital as a full-time nurse-secretary. She was with me for eleven years.

Then came the founding of the College and the pleasure of emerging from isolation to meet others imbued with the same sort of ideas, hopes, and ambitions. The College has been a tremendous stimulus and you have all shared in this—otherwise you would not be here tonight. Now with the acquisition of partners one no longer works in a vacuum, one gets some free time, and the old anxieties about illness and holidays has gone.

Now I come to the present time. The future concerns you more than it does me, and I may be forgiven if I give my ideas as how to it should be shaped.

The members of the College must hold on to the leadership of the general practitioners and in doing this will have to continue to strive to put and keep the house of general practice in order. They will have to preach to the unconverted and continually hold up the picture of good and proper methods. They are already becoming regarded as examples of what good general practitioners should be. They will have to keep pressing their hospital colleagues in proper attitudes and in establishing good and fruitful relationships. Medical officers of health also require cultivating. A great deal more could be done here, for example by lending midwives to practitioners who conduct their own antenatal clinics. In many areas the obstetricians are far behind in proper liaison with general-practitioner obstetricians. There should be no feeling of inferiority here. The practitioner's postnatal work is usually, and could always be, streets ahead of the hospital, where much important detail in the postnatal examination is completely neglected. There is a very important experiment going on in the South-west Metropolitan area where health visitors

are being used in the general practices.

One of my great regrets is that I didn't have a proper recording system. Details of patients who have been attended and then moved away have been completely lost. In your lifetime in practice you can amass a tremendous amount of data which can be used for all sorts of purposes, not the least being the means of providing ammunition to shoot down foolish suggestions of people in high places. For instance, those who say general practice should be transferred to hospital. For those who may one day wish to do and publish a piece of research, an age and sex register is essential. But it is no use putting off instituting this until you suddenly find you need it. I most strongly advise you to think again about record keeping. There is now within the College a considerable literature on the subject, and the *Journal* of the College (1963, 6, 195-232) has a large part devoted to it.

When people talk about what they have learned in a long career they are usually simply expressing the opinions they have formed. What they have learned, others also have learned and there is nothing new in it. It is so easy to make the same mistakes for 40 years and call it experience. So what follows is simply opinion—some of it probably prejudiced. None of it, I hope, has been formed without reason and certainly all of it could be challenged. A lot of it is scepticism about currently accepted ideas, but this is the privilege of the elderly.

Let me take paediatrics first. When I started in practice child deaths were common. How often do you see a child die now? Babies died frequently from the complications of measles, pertussis, and diphtheria. They died from iatrogenic disease—marasmus. Marasmus was starvation and dehydration and the wrong approach to feeding problems caused it. It no longer exists because we know now that you cannot overfeed a young baby, that no food is 'better' than another, that a crying baby is nearly always a hungry baby, and that demand feeding takes care of most troubles. Everyone who deals with obstetrics and infant feeding should be able to rewrite from memory Waller's paper on breast feeding.

I do not believe that geriatrics is a specialist field. A properly trained and experienced general practitioner should be the person to care for old people and only when certain acute conditions are superimposed on chronic is there need for specialist help. But I also consider that every one of us has more to learn in general medicine, physical medicine, orthopaedics, and pharmacology before we are

good geriatricians. If I wanted to make a really big improvement in my geriatrics I would not go to a geriatrician. I would go and learn more about physical medicine, orthopaedics, and manipulative techniques and injection techniques. More about aiding the handicapped, and more about pharmacology. I would want more self-discipline to enable me to use what ingenuity, knowledge and experience I have to alleviate every detail which can be alleviated in the burdens of the old. The increase in well-being that even a small relief can bring, is surprising. I believe that only the experienced family doctor has the broad spectrum of knowledge that is required to do this. When we were young junior partners and were seeing one of the old man's patients we had the desire to produce even a small improvement that the old boy hadn't managed, by any means possible. And with a bit of ingenuity we usually did it. It is a good thing when seeing a geriatric case to remind ourselves of this. A little means a lot to the old.

I come now to psychiatry, which I have left to the end. This part I find very difficult because it is bound up with my own vague and groping philosophy of life. The science of psychiatry for practical purposes did not exist when I was a student, and I have found it very difficult to absorb. The psychiatrists have a language of their own and use words which I do not understand and cannot memorize, and to learn it, is to me like trying to learn trigonometry in German. This naturally builds up the mystique and tends to make me feel inferior, with the result that I become aggressive in order to assert my equality. When I succeed in taking it to pieces I find I have got something I already knew, and this blinding with science I find irritating. I resent all these special terms and words that get applied to perfectly familiar problems with the inference that having christened them, they have been solved.

We in medicine, and particularly in general practice, are closer to the lives of people than probably any other section of the community. Many come to us with their fears, hopes and weaknesses. Before many, we stand in humble admiration. In others our training and experience enable us to see the personality variations, the infantile attitudes, the compensating for inferiorities, the withdrawal from contact with a too harsh reality. In other days men and women went for comfort to their spiritual advisers and often the fear of hell and damnation kept untold millions to their duties and the path of rectitude. Sin and shortcoming could be expunged by confession and the plea for forgiveness. In modern times our deficiencies, our

sins of commission and omission are now explained by the psychiatrist, who labels neatly the reasons why we committed them. But whoever heard a psychiatrist say that this or that is wrong, and whoever heard a psychiatrist admit that something was a sin?

Is it possible that the great knowledge and understanding which the psychiatrist has of the working of the mind is being used in the wrong place? I have had many patients who have been cured at least for long periods and sometimes completely, by psychiatrists. But these have all been cured in one of two ways, neither of which has anything to do with psychiatry—electric convulsion therapy and drug therapy. I can think of no patient who has been cured by any other means and many who have been made much worse. Think of another picture. The abnormal behaviours and attitudes that the psychiatrist finds are the results of conflicts and failures of adjustment, failures of acceptance, and resulting guilt-feelings. These adjustments should have been made, acceptances and disciplines learned, by the child whose personality is moulded in small degree by his heredity and in overwhelming degree by his environment. Those who were dealt a poor hand will have great difficulties and may not have the ability to come to terms with their natures at all. But those who had normal childhoods with intelligent understanding parents have been helped by personality training and precept. They were dealt a fair hand and were shown how to play it. Not all young parents are gormless and feckless. Even if not of high intelligence they are capable of some understanding. As far as I can see only the glossy magazine gives them any help. We seem to be patching up a product which keeps rolling off the production line at a rate that is too much for the repair squad. The Church used to have the opportunity to train us in youth. Perhaps it did not do it very well but it made a better showing than the means used by our present culture. If the insight, knowledge, and understanding of the psychiatrist could at least in part be used at the other end of the production line, would it be better?

Finally, I would like to say how much I have enjoyed working in the College's affairs with you, meeting you repeatedly, and being stimulated by you. I wish you well in your careers, and in your work for the College. It has been said that every man owes a debt to his profession. You members of the College are repaying that debt.

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