Francis Alexander MacLaughlin (1899–1984)

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THE OTHER SIDE OF MEDICINE

This address is an endeavour to deal with a vast, intriguing, and mainly abstract subject which has interested men, and particularly medical men, for thousands of years, which interests us just as much today, and which will concern those who follow us even more.

In the course of the progress of civilisation man has been creating sets of circumstances which produce hitherto unknown factors influencing our minds and bodies, many of them unforeseen and very real, and often harmful in their effects as producing immediate, or remote pathological effects. This fact demands that we must discover means to prevent these effects being harmful, and also to find means to cure them when they have actually harmed us.

While we have vanquished many diseases at an increasing speed, it would appear that we are discovering new ones to take their place at an even greater rate. So it seems that in the foreseeable future mankind will still have many diseases to afflict him, and ample opportunity to study their cure, if he has not by some slight mistake caused mass suicide, or slow genetic extinction, in the name of scientific progress. However, we hope that wisdom and good sense will make us stop short of this rather gloomy prognostication.

This address concerns us as individuals and our reactions upon one another, more particularly as doctors. It is that side of medicine which is not so much taught as acquired by precept, observation, and experience.

If we dip into the dicta and writings of the ancient fathers of medicine we find that these are just as true now as when they were first spoken, and written thousands of years ago, and I hope they will continue to be true into the far future – their statements usually had to do with their fellow-men and women, particularly those who suffered from some disability of mind or body, and much of what follows will be on the same theme.

It was Tennyson who wrote “Knowledge comes and wisdom lingers.” One knows so well how much knowledge comes, but also unfortunately goes, and as one grows older one wonders just how much of all the knowledge we have acquired does stay with us. We can only hope that the effect of the absorption of so much knowledge results in the acquisition of wisdom. In the case of the doctor this should result in knowledge of disease, and wisdom in dealing with our fellows, who in this particular case are our patients.

The success of a doctor depends on several factors, and all who get the necessary knowledge in the course of their progress to a medical degree do not necessarily have the inherent wisdom, or acquired wisdom to match the knowledge, and so do not become successful as practising doctors; but I think the vast majority of those who feel the call to medicine have their share of that inherent wisdom, and are capable of acquiring more with

experience.

The qualities for a physician are outlined by Osler, and perhaps I might quote passages from him – "In the first place, in the Physician or Surgeon, no quality takes rank with imperturbability." . . . "Imperturbability means coolness and presence of mind under all circumstances, calmness amid storm, clearness of judgment in moments of grave peril, immobility, impassiveness, or to use an old expressive word, 'phlegm.' It is a quality which is most appreciated by the laity though often misunderstood by them; and the physician who has the misfortune to be without it, who betrays indecision and worry, and who shows that he is flustered and flurried in ordinary emergencies loses rapidly the confidence of his patients." "In a true and perfect form, imperturbability is indissolubly associated with wide experience and an intimate knowledge of the varied aspects of disease."

I think this can be summed up as suggesting a well-educated individual, generally, as well as medically, with the confidence produced by knowledge, and with mental poise, combined with the wisdom of knowing the type of patient with whom he is dealing and how best to adjust his approach to that patient's particular needs, both physically and mentally. Sympathy without sentimentality is also a desirable ingredient to include. It all adds up to "Aequanimitas" such as has been possessed by many of our teachers, and is possessed by many of our colleagues.

Osler says: "One of the first essentials in securing a good-natured equanimity is not to expect too much of the people among whom you dwell." If this advice is followed then we will not adopt an air of superiority toward those with whom we work, and who may be less experienced and knowledgeable – and also it will enable us to live and think more on a level with those we treat, and try to help. This I think presupposes that we must try to adjust ourselves mentally to the level of the education and understanding of the patients with whom we are dealing, and to try and give our explanations and instructions in language and amount, readily understandable by the individual to whom we wish to convey them.

It is often a fault of youth in medicine to use technical words and expressions to describe methods of treatment to individuals who do not even understand the words in which the instructions are couched, and it is also a common fault when describing the disease from which the patient suffers, and its course, to do so at too great length, and in too much detail. Because many of the patients show a very low level of mental absorbability of any facts to do with their bodies, and their maladies.

Frequently one takes it for granted that highly educated and cultured individuals have a high degree of knowledge of themselves, and it is with somewhat of a shock to discover that they are in fact profoundly ignorant of the structure and workings of their most precious possession; the same condition is found in those who have always been very healthy and have little contact with our profession – another characteristic of people like this is that they have relatively little sympathy with those who have suffered often, or long from illness, and are apt to regard them as inferior, and something to be disdained, rather than those to whom sympathy and consideration should be shown.

Particularly in hospital work it is advisable to give our patients some simple explanation or fact to which they can cling, rather than give a long and complicated explanation which they are unable to understand. The manner in which they can distort what has been told to them is often very surprising and disconcerting, as one often finds at a subsequent consultation, when the story is recounted back, it is unrecognisable.

This leads one to the fact that when our patients come to us they are often frightened – and here the causes of fear are often threefold. Firstly, when they visit a consultant they have probably not seen him before, and as this is one of life's milestones they are apt to let imagination run away, and to remember all the dreadful things they have been told by other patients who have gone to consultants, and who often exaggerate their experiences in a somewhat twisted attempt to magnify their own importance, in the reflected glory of the experience. Secondly, they have the usual human attitude towards the unknown and so feel frightened by something nameless, which they cannot put into words. Frequently patients from the country who live relatively isolated lives show this more than town-dwellers. Thirdly, and this may be present in those who are not worried by the first two causes – and indeed might well occur in you and me – the fear of what will be found, and what the future will hold.

When the patient goes to his general practitioner he probably knows the doctor as an individual and does not fear a visit to him, and also

the experience is not so terrifying because it probably has happened before – but still the third factor remains – what will he be told? So it behoves us each time we see a patient to remember the three main causes of fear, and by our own efforts to do the best we can to remove them, and this is where wisdom rather than knowledge is so helpful.

Many doctors either have, or have developed an ease of manner when dealing with patients which makes it easy for themselves, and for their patients. Along with this is that indefinable characteristic of inspiring confidence in our patients, who will go to one man and say they would trust their lives to him, and to another and then say they would not let him touch them at any price.

This fact, of inspiring confidence, is one of the most valuable possessions of a doctor, and seems to be a compound of personality, ease of manner, confidence in himself, which usually comes from knowledge, and the reputation he has acquired in the eyes of his medical colleagues and former patients, along with his education generally, and last but far from least a sense of humour, and the fitness of things. Appearance, race, colour, and sartorial distinction have very little to do with this, as it seems the patient, when ill and anxious, has a perspicacity which sees beyond these things.

In relation to the amount that patients will absorb of what is told to them, a nervous patient does not take in much of what is said, and it is always wise to have a relative, to whom nothing is happening, in the room so that they may remember those facts, or some of them, that the patient may forget. Also frequently older patients are deaf, and more are mentally dull from their malady, and so unable to hear, or understand intelligently, what has been told to them.

In this connection a patient who is ill and anxious, by virtue of being placed in an unusual set of circumstances, may say, and do, things which normally he would not, and so a considerable modicum of tolerance and forbearance is demanded from the doctor, who can very easily let pass something which could not be disregarded in other circumstances.

It is always wise to remember that a great deal of the good we do to our patients depends on what we say; indeed, often it is more important than what we do.

Another interesting point is that often we can do a great deal of harm to our patients by what we do not say – in not giving some explanation of the condition from which they are suffering, and how we propose to deal with it – the overanxious patient is inclined to think that either we do not know, or else that it is so terrible we are afraid to tell him. Can we afford to say we do not know? We can give a qualified "I do not know," as is often the truth, and explain that we cannot give a definite opinion until we have carried out certain tests or until the patient has been seen by a specialist, or, if in the case of a consultant, by a specialist in another branch who has more knowledge, experience, and technical skill in the particular condition in question. An unqualified "I do not know" is dangerous, and one feels should only be given to someone who is intelligent and knowledgeable, and who is relatively well known to us, when they will respect us for being able to say it, and not misconstrue it for just plain incompetence and ignorance.

It often happens when one is not sure that we feel we would like to bring a colleague who may know more or have a different approach, or be more senior, and who will help to share the burden of difficult decisions, or actually assist in carrying out some difficult procedure. This approach, when made known to the patient or his friends, will often improve the mutual trust and confidence between doctor and patient. Patients are usually well aware that no doctor knows everything, and they soon bowl out the "know-all" and the "bluffer" – these are often those who have neither knowledge nor wisdom, and will eventually fall by the wayside.

It is always well to be completely honest with our patients, and if this is undesirable for any reason, say so much as may be true and refrain from saying any more. It is better to tell a half-truth than to tell a lie, and a half-truth is only permissible if it is to spare our patients' mental anguish, or a severe mental shock which could have serious consequences, but always make sure in these circumstances that the whole truth is given to a near, and preferably dear, relative, who will understand your motive.

Many doctors are born naturally courteous, others acquire courtesy later by experience, and it is always easy to be courteous to patients, particularly in hospital where, no matter how uncouth they may be, a courteous, sympathetic, and interested approach will tend to bring out the better side in the patients and so make the interview much more easy and pleasant – and also helpful to the patients, who will be put more at

ease.

Sarcasm and cynicism should have no place in our dealings with patients, and indeed, if used, are boomerangs, as the patient who is already rather on edge is liable to hit back in the same manner, and so the doctor has spoiled what is really rather a delicately-poised relationship, and is unable to help his patient as adequately and efficiently as he otherwise might have done.

At times we encounter the abusive patient or relative, who perhaps, when we know all the facts, has some justification for indignation – it is well to listen to the story first and get at as much of the facts and truth of the matter as possible before judging, and very often the quiet and understanding response will quench the flames, whereas a quick or intolerant reply will only fan them, and indeed could produce a conflagration that might end in the courts.

If the doctor has been kindly and sympathetic and explained what is going on to the patient, and his anxious relatives, where things have not gone according to plan, or have gone badly, they will be more inclined to forgive; whereas if ignored or not treated courteously they will be more inclined to push the matter to any length in a spirit of revenge, and again the matter might well end in a charge of negligence, or incompetence against the doctor.

When receiving a patient, and during the time the patient is with you, always be sure to give your full attention and discourage any unnecessary interruptions, because the patient usually believes that he is the only one who matters, and you must behave as if you believed it also. Many consultants carry this so far that it is well-nigh impossible to get a word with them during their consulting hours, no matter how urgent it may be – but one usually finds that when an interruption does occur a few words of apology and explanation to the patient will set matters right.

In consulting practice it is often difficult to keep absolutely to time; an emergency may come in and require attention, and even a minor one requires time, and one seldom knows the exact nature of a case before it arrives. It may take only a few minutes to deal with, or may be a difficult problem requiring a considerable time for its solution. Here again a timely apology, accompanied by a broad explanation, will smooth any ruffled feathers.

It is always, useful when discussing patients anywhere never to mention the name and the disease; one can be mentioned without giving a clue to the other, and this wise dictum is not only confined to other doctors, or to hospitals. It is wonderful the curiosity people have about other people's business, particularly their illness and defects, and wonderful to what lengths many will go to try and find out these facts, and often will try to use them against the sufferer. When asked by one of these busybodies about some mutual friend who happens to be one's patient, the problem can be passed over by being obviously obtuse, or perhaps irrelevantly flippant on some other subject. When one discovers some defect in a patient which is not obvious, or likely to be a handicap, or is a sequel of some cured condition, it is well to tell them not to mention it at all, and indeed if it is not brought out at intervals into the open, the possessor may forget about it, and permit others to do so.

There is always the temptation to patients to discuss their operation, and patients seem to feel some form of self-aggrandizement by so doing, and by perhaps adding just a little to it all – a kind of martyrdom complex.

This leads on to thinking of patients as falling into different types, and here at once we think of the two broad divisions of mental and physical types. All down the ages men have tried to divide people into various arbitrary divisions, and as mentioned early in this address most of it deals with the abstract, so are the divisions abstract in part, particularly the mental, but we are on more concrete ground where the physical divisions are concerned. The hard matter-of-fact statisticians and those who wish to measure everything scientifically have found the various classifications far from easy to make satisfactorily.

In the mental sphere the psychologists and psychiatrists have tried to correlate mental types with mental diseases and also mental diseases with physical types, with some measure of success, and in the physical sphere many well-known names from Hippocrates, down through the years to Sheldon in 1942, have tried to classify humanity into various physical types, and then to try and see if these physical types are predisposed to various groups of diseases and conditions.

Hippocrates divided men into two types – habitus apoplecticus and habitus phthisicus, and Sheldon, 1942, into three types – endomorphy, mesomorphy, and ectomorphy. Gillilan, 1955, reiterated in more detail – sympathotonia and vagotonia, with which we have long been familiar,

and added amphotonia as well. This is something which we all do, and years of experience have led us to various conclusions as to the different types of individuals who come to us as patients, and this experience helps us in our diagnosis, and also in having opinions as to how to deal with the different types, and adjusting our treatment to their special requirements.

The grouping of types according to their mental make-up is used by many as a guide in the approach to the patient; some are highly strung and some phlegmatic. A good example of this is how we are all impressed by the varying degrees of tolerance of pain, or often indeed the intolerance, and also in some cases the quick or slow reaction of various individuals to remedies directed towards relief of their pain. The same thing we often see in the reactions of different types to anaesthetics, and particularly to premedication.

Many of the more sensitive patients are terrified at the thought of an operation under a local anaesthetic, others are terrified at the thought of having a general anaesthetic, and it is our duty, where we can, to try and allay the often unreasoning fears of these patients by adequate verbal premedication beforehand, much of their fear being reactions to the unknown.

The examination of a patient is not only a matter of the simple inspection, palpation, percussion, and auscultation of the individual lying unclothed on the couch: it should begin as the patient walks into the room – and indeed often before that, as one may have received a letter from the patient which can provide various clues about him, or a telephone message – and then as soon as they enter all the senses should be used – vision, hearing, smell, and later touch. Such things as colour, gait, voice, accent, manner, and manners, along with the clothing and accessories, will give one clues as to type, temperament, intelligence, status, occupation, location of home, country of origin, race, etc., all of which are of great assistance in enabling the doctor to adjust himself and his treatment to the particular requirements of that patient – the patients' friends also unwittingly often provide clues as to the family environment, and may often be a help or a hindrance at the interview – as they may be to the patient elsewhere.

We do not often think of the sense of smell as a help at a consultation but if we pause to think, it is very intriguing to consider just how much we can learn about other people by its aid, and particularly about our patients, and their diseases – for example, perfume will tell quite a lot, either as an allure, a façade, a self-satisfaction, or a camouflage. Many diseases have a distinctive odour, such as acute rheumatism, acidosis, diphtheria, incontinence, atrophic rhinitis and many more, not excluding death itself.

A patient's hands will tell a great deal about their possessor, temperament, character, occupation, interests, and may show signs of certain diseases very clearly. Indeed, by looking at a person's hands a very good idea can often be obtained as to subjects of conversation which may interest them, and frequently an intelligent use of this fact may be the means of initiating an opening conversation at the beginning of a medical interview designed to put a nervous patient at ease, before starting the purely medical business of the consultation.

Another interesting clue to the patients' personality is to enquire into their hobbies and interests; some are gregarious in their recreations and others are solitary, and often those who have solitary hobbies are more sensitive and artistic, and appear to require more time alone to enable them to recover from the rush and tumble of every-day life. They are more sensitive to, and fatigued by, the impacts of our lives, and the reasons for their hobbies are often not understood, or are completely misunderstood even by those who think they know them well and who may be of a different and less understanding type.

Hence the greater understanding the doctor has of the mental and physical type of his patient the better is he able to advise according to the particular needs of the individual with whom he is dealing, and the closer will he get to his patient in the mutual confidence so necessary for the successful treatment of mind and body.

Many doctors have an instinctive and finely adjusted sense which tells them how to deal with a complete stranger who comes as a patient, and may conduct some trivial or totally irrelevant conversation in order to give the nervous patient time to take in the surroundings of a consulting room, which in its turn may give them some idea of the manner of man they are meeting for the first time, as well as letting the patient have a mental look at the doctor before getting down to the real reason of the visit. This enables the patient to regain poise and equanimity.

The rooms in which we practise can be full of medical furniture and white enamel, and to many

this is rather terrifying, or they can be more like a library or study and play down the medical side. This is particularly important where children are concerned, as they tend to be frightened of white coats, and medical equipment and instruments which are best kept at a minimum, or out of sight.

Very early in a consultation it is often possible to sense a fear and, as it proceeds, to get a more precise idea of what the fear really is, and it will often fall to the doctor to pin-point that fear by questioning, as the patient may not put it in words, or possibly will mention it when one is showing him, or more often her, out of the door. A patient at ease will give a more complete and accurate story than a flustered one, and the time spent in preparing them will often shorten the whole interview, and make it more satisfactory to both parties.

In the course of examination one should always give some short explanation of any procedure which could be unfamiliar to the patient, and not become irritated if he does not appear to be co-operating as intelligently as we might expect.

Most patients tend to ask: "Will it hurt, doctor?" – and to this it is wise to give a truthful answer, as far as possible, or they will not trust you the next time, and in this connection it is well to remember that what is a mere touch to one is acute pain to another. So the gentle hand always pays – and is something which, if not naturally present, should be carefully cultivated, as its use will get information not otherwise possible to acquire, owing to the resistance of the patient from fear of being hurt.

There are several items one should remember particularly in older people – never remove hope, always leave a loophole; be perhaps on the optimistic side, but never obviously unreasonably so. Do not be afraid to remark on some good point such as a strong heart, good hearing, a good colour, a fine head of hair, or good vision for their age, a very normal blood pressure, etc.; it is not suggested that all these points should be emphasised, but an occasional one does help the morale of the elderly, and often pointing out to them how many talents they still possess to counterbalance all the complaints they have brought to tell you gives moral uplift.

It always seems cruel to examine a patient and then tell them nothing at all, but that you will report it all to their doctor and he will in turn tell them what to do. This destroys a great deal of the value of a visit to a consultant; always tell them something, but just enough that you do not embarrass their own doctor in any way when they return to see him.

The background, education, interests, and mental make-up are useful in deciding on the treatment. One who is artistic and sensitive is often upset disproportionately by what seems to be a small deviation from the normal – for example, a miniature painter with a very small refractive error, a singer with a comparatively slight deviation of the nasal septum – conditions which would not even be noticed by one of coarser fibre.

The relationship between intelligence, artistic capability, and allergy is one which is very real, and many cases of atypical migraine hitherto undiagnosed can be brought to light by starting with an assessment of the patient's personality, intelligence, interests, and hobbies, and when this has been done we are in a much better position to explain the condition to the patient, and suggest measures which may be helpful, and which may be more of the nature of advice as to the general hygiene and ordering of the patient's life than purely medical in nature.

When interviewing a patient try and create the atmosphere that one has all the time in the world. Do not hurry or fluster, but try and produce the impression that they are the only person in the world who is ill, and that the doctor is not interested in anything but their condition – a somewhat difficult thing to do when he knows that several others who are perhaps in much more urgent need of attention are waiting next door. Also when dealing with the discursive and circumstantial patients one so often meets it is always possible to bring them back from their beloved side avenues to the main road of the problem on hand by a well-timed question or remark.

You will possibly have noticed on a recent circular the quotation by Payn in 1884 that the "Busiest men have most leisure, idle folk have least," and as we look around our colleagues we see how true this is, as many of them who live busy lives have plenty of time to talk to all sorts of people, to share in administration, act on committees, and often have many hobbies and interests outside their work. This faculty is also shown in their professional lives by the characteristic of never seeming to be in a hurry, and yet never wasting time in idle or irrelevant conversation, and these are the ones who, while

not spending long with any one patient, never create the impression of hurrying them in any way, and in being thoroughly interested.

Dealing with children as patients is partly a matter of temperament and partly acquired. Some of us have been fortunate in having younger relations early in life, some have children of their own, and some have had the good fortune of working in children's hospitals. All these give an ease of manner in dealing with children, and there are various factors which lead to success in this field. Children are extremely quick to size up adults, and seem to know, as dogs do, those who like them, and those who are not afraid of them, afraid in the sense of being ill at ease in their presence.

Always speak to a child as if you had known it all its life. Some children appreciate being spoken to first and being asked to take mummy into the consulting-room and get her a seat. It gives them something to do and also seems to raise their sense of importance in their own eyes, and generates a feeling of responsibility. This does not always work with the rather timorous "apron-string," and somewhat spoiled small child, and then it is wise to let them come in relatively unnoticed and have time to look around, and form their own opinion of the doctor and his room – and this they will soon do. Usually the child who starts to cry straight off is one of these, or has been to a doctor before, and remembers an injection, or some other uncomfortable procedure – and then it is one's duty to try and erase this bad impression as far as possible for the next man, and frequently a considerable measure of success can be achieved.

When getting details of name, age, etc., about a child, start by asking the child, and let it go as far as possible before bringing the parent to the rescue. This enables the child to sum you up and feel that it is getting to know you, and at the same time enables you to assess the child's intelligence and reactions, for your own guidance in examining it. It is often difficult to get the parent to keep quiet, as many mothers will persist in answering questions which the child could answer quite as well, a "smothering" process, and often one has to ask the parent to stop, and it is well to explain later that this is the best way to let the child know the doctor, and vice versa. During this process one can study the child and parents, and how often one notices that the boys resemble mothers and the girls resemble fathers in appearance; and often this goes for nature as well, but not by any means always, and indeed one sees the whole process reversed. One supposes that only a small segment of the Mendelian law is seen in one family, as there are seldom enough children in any one human family to make it more obvious! Often the heredity of some condition can be traced back to one or other side of the family, like red hair, squints, etc., and help in diagnosis and lines of treatment.

So often the small child cannot help one much and the story of the parent and one's own observations, plus the child's reactions, give the necessary information, and in older children a great deal of information can come from what the child will say itself.

It is a very foolish thing to ask a child to give one anything, such as a toy it has brought. By all means ask the child to let you see it, and then admire it, as the toy brought is usually a very treasured possession, or newly acquired because the child is coming to see the doctor, as a sort of bribe. Small girls will very readily respond to admiration of some article of clothing or jewellery, and, as mothers usually put on the good clothes to go and see the doctor – and these are often new – admiration goes a long way to weld confidence. Small boys may be asked questions about trains, soldiers, playing games, etc.

When actually examining the child some silly joke about feeling for tickles, or such like, distracts its attention, and as children are always suspicious of instruments no attempt should be made to conceal them: the child's natural curiosity is at work and we should explain what they are and what they are for; this makes the unknown familiar in the child's mind and it will often co-operate as a sort of game. Some sideline can be introduced like showing them vessels in their hand with a torch, if one has to examine in the dark, or perhaps doing it on mummy first, as this gives confidence.

If care is taken in this way the child will usually come back quite happily, and it is often a good idea to give some small reward, such as a sweet, at the end of the interview for having been good, and this is often the only thing remembered years after. It is foolish to give a bribe early on; let it always be a reward.

Some parents like to put the child out of the room when discussing its problem, and unless there is some very cogent reason, such as telling the doctor the child is adopted when it has not been told or of some congenital disease which it may have inherited, this is inadvisable because it may arouse suspicion of the parents or the doctor

as to what the future may hold. It is far better to discuss the whole problem and mention any operation which may be desirable and explain the reason for it, and the benefit which the child will obtain from it. Most children will accept this, and if too young to comprehend what it is all about at least are not frightened.

When talking to a child never talk down to the child. Conduct the conversation on a "man-to-man" basis, of course in language which the child can understand; and in the case of older children try to inculcate a feeling of responsibility that it is something they will have to do for themselves in order to help themselves in the future, and that if they do not carry out what is asked they are going behind their own back, and not letting their parents down.

The occasional scrap of humour fitted to their comprehension, or the showing of some object which may interest them in the surgery or consulting-room, will help to make them feel that they are visiting a friend who happens to be a doctor.

For those of us who like children it is a joy to work with them and for those who do not like children, and who are ill at ease with them, it is hard to develop a manner with children which will deceive their quick instinct and perception. With those who are not happy in their company there will always be a curtain between them and the child which keeps them apart, and prevents the doctor doing all he might for the child. These people would be well to leave children's medicine and surgery severely alone.

Generally speaking, small boys are more difficult and large boys more resistant; small girls are less difficult and older ones more timid and fearful. Occasionally one is completely beaten by a small boy, but seldom by a small girl, and often if one ends the interview and brings them back they have got over the initial and rather unreasoning terror, and in the light of the first experience are more amenable on the second visit.

Very small children often resist examination very forcibly and at times it is necessary to have them held, preferably by a parent, and in this connection it is remarkable how much we can learn without the use of any instrument which seems to terrify them more than a human hand.

Small children respond well to voice, touch, and facial expression, and if they are not hurried will often submit happily enough to examination. If a child has been frightened some effort should be made before their departure to try and remove the fear and leave a good impression for the next visit to oneself, or to another doctor.

During the war years it was very interesting to see the way in which many Servicemen responded to the civilian approach rather than the more disciplined service attitude. Of course the majority had been civilians before joining a service, but the regulars were very responsive to this approach, possibly being unaccustomed to it, and, as a rule, they did not take advantage of what to them may have seemed softness or weakness on the part of the medical officer, and this was good also in its effects on the doctor who would have to return to civilian practice in many cases when the war was over.

What has gone before is largely a summary gleaned from observation of methods dealing with patients by our teachers, colleagues, and pupils, and a great deal from experience of what has been found best down the years.

Each must find the method best suited to his own particular temperament and ideas, and as it is impossible to measure and delineate such things accurately, it all must remain decidedly abstract.

An appropriate ending might perhaps be from 1st Corinthians (ninth chapter, twenty-second verse) where St. Paul writes: "To the weak became I as weak, that I might gain the weak: I am made all things to all men, that I might by all means try to save some."