

# HISTORICAL RURAL PRACTITIONERS

## *Role models for the future*

### ALBERT SCHWEITZER

A pioneer rural doctor, who was also a philosopher, theologian, musician, and Nobel Prize Winner, Dr Schweitzer distinguished himself by the medical work which he and his wife, a trained nurse, undertook in the early 20th century in Gabon, West Equatorial Africa. He crystallised his philosophy in the phrase "Reverence for Life". This included animal life, which, in an era of game hunting and apparent plenty, was far ahead of its time.

He worked at Lambarene as a rural doctor, a hospital administrator and planner, an architect, builder and engineer. He wrote extensively on music, philosophy and theology and was an inspiration to many generations of doctors. He was, and is, still considered one of the greatest men of this century.

Schweitzer has been criticised for his authoritarian and paternalistic manner, but his hospital was one in which his African patients could feel at home. Friends and relatives could cook food for patients in hospital, as their culture then would not let them accept food from a central kitchen, lest it be poisoned or bewitched. In his view, kindness and compassion were integral to healing.

He said on radio in 1959:

"It is not merely enough to exist. It is not enough to say 'I'm earning enough to live and support my family. I do my work well. I'm a good father, I'm a good husband. I'm a good churchgoer.' That's all very well, but you must do something more. Seek always to do some good somewhere. Every man has to seek in his own way to make himself more noble. You must give something to your fellow man. Even if it's a little thing, do something for those who have need of man's help, something for which you get no pay but the privilege of doing it."

— Dr Edward Bowen Jones

### SIDNEY AND EMILY KARK

The work which Sidney Kark did, both in South Africa and in America, made a significant contribution to the 1978 decision by the World Health Organisation and the United Nations Children's Fund to endorse as policy community-oriented primary health care.

Kark had a comprehensive view of health. With Emily Jasan (later his wife and lifelong collaborator), he founded the Society for the Study of Medical Conditions amongst the Bantu, as Black Africans were described at the time.

In 1940, after graduation, the Karks established a health centre at Pholela in rural Natal. This centre began with primary care as the substrate from which preventive medicine and the care of the community developed. Ethnographic, sociological and psychological knowledge was seen as important to an understanding of the nature of community and its strengths and ills.

As director of the Institute of Family and Community Health in Durban, Kark recruited and trained health teams who would care for families as a whole, in demarcated service areas. Between 1946 and 1948, some 40 of the envisioned 400 health care centres were founded, but the Nationalist Party Government was not supportive of his plan. Later, appointed as Professor of Social, Preventive and Family Medicine at the University of Natal Medical School, Kark's ideas on social medicine attracted supporters who established community health facilities in other township areas, particularly in Alexandra.

As Dean of the University of Natal Medical School, Kark was investigated by the Department of Health for so-called communist activities, because he advocated the free distribution of food (particularly skimmed milk, the standard treatment for malnutrition), to rural Blacks, by the health centres under his direction.

The Karks were forced to leave South Africa and worked initially at the University of North Carolina. Later the World Health Organisation assisted Kark in the founding of the Department of Social Medicine at the Hebrew University and Hadassah Medical

School (which evolved into the School of Public Health).

Principles tested in South Africa were disseminated through an international teaching programme and in published works.

— Dr Irwin Friedman

### DR WILLIAM VICTOR JOHNSTON

*"Mr General Practitioner of Canada"*

The founding father of the College of General Practice of Canada, William Victor Johnston was born in Lucknow, Ontario, Canada. He trained as a doctor at the University of Ontario, graduating in 1923. From 1924-1954 he practised as a country doctor in Lucknow, Ontario.

Known as "Mr General Practitioner of Canada", Dr Johnston was the driving force behind the establishment of the College of General Practice of Canada in 1954. He served as Executive Director of the College (later called the College of Family Physicians of Canada) from 1954-1965.

Like so many people ahead of their time, he was a visionary. Many of his ideas were based on his own practice and experience. Fellow physicians remember him as "a tireless worker ... who expected no less effort from his colleagues". Dr Mel Corrin stated, "Because of his long association with the district, because of his compassion and curiosity and interest in people, he was indeed able to provide 'continuing and comprehensive care within the family and community', a job description for the ideal family physician."

Rural medicine in Canada in the 20s, 30s and 40s reflected the situation in many countries. In his book, *Before the Age of Miracles*, published in 1972, Johnston described emergencies and operations he handled. He said, "A perforated appendix was often fatal. Pernicious anaemia was a death sentence. One in four pneumonia patients died. Tuberculosis often resulted in death, frequently after long periods in sanatoria."

He practised alone until 1936, when he engaged a recently-qualified assistant doctor. This association was so successful that he employed an assistant annually. During the 1940s he visited the University of Western Ontario, 130km away, in an annual search for "promising interns set on becoming general practitioners". He felt that it made little difference whether a doctor originally came from a rural or urban background.

In his book he stated that "GPs like myself in rural communities everywhere made do with what was available to us. By necessity we could not treat our patients for specific complaints alone. We knew them and their problems too intimately. We had to see them whole."

One of his many comments on general practice still applies today: "About 85% of human ills are common in nature and respond to direct measures. Then as now, I considered general practice one of the most difficult fields of medicine, because a competent GP must be one of the most expert diagnosticians. He not only must know when he can help, but what is just as important, he must be quick to recognise a situation that is beyond him and refer such a seriously ill patient to more expert care than he can give."

The image of the GP declined steadily through the 30s to the 50s until the point was reached where the respected and beloved family doctor of old was becoming, in the eyes of the public, a professional incompetent concerned first with personal gain and only secondarily with the welfare of the sick.

It was believed that the only sure way for general practice to survive was through better education which could put the family physician on a firm academic and clinical basis with his specialist colleagues. The College became the only professional body in Canada with regulations to keep its members abreast of progress. The extensive programme had three main aims:

1. A more realistic training in medical school for general practice;
2. Two or three years' internship training for general practice

after finishing medical school;

3. The prevention of professional obsolescence of practising physicians through a continuing upgrading programme of study.

In recognition of Dr Johnston's service to his profession, in 1965 the College of Family Physicians struck the William Victor Johnston Medal of Honour, to be awarded annually to an outstanding member of the College, as well as the William Victor Johnston Oration, to be given by a speaker on invitation at its annual assembly.

— Dr Jim Rourke

### WILLIAM PICKLES

William Pickles, country practitioner and epidemiologist, had a fifty-year association with the valley of Wensleydale, Yorkshire, UK. With his partner, Dean Dunbar, he established a practice based almost solely on home visiting (1919). He realised the value of his practice as a place for original research, and began keeping epidemiological charts, recording the onset of symptoms and case notes on each patient.

The closed society of Wensleydale and his encyclopaedic knowledge of the local people made efficient tracing of the "short and only possible contact" possible. He was thus able to establish periods of incubation and infectivity.

He published papers on Sonne dysentery, Bornholm disease and epidemic catarrhal jaundice before publication of his major work, *Epidemiology in Country Practice* in 1939. After his retirement his papers and lecture tours took him to five continents, and he received an honorary Doctorate of Science from Leeds University. He became the first President of the Royal College of General Practitioners and was awarded the Commander of the British Empire.

— Dr Martin Green

### MAX KAMIEN

*An early exploration of the concept of a doctor as an agent of social change in an Australian Aboriginal community*

Early in 1970 I went to work in the remote town of Bourke in the far west of New South Wales. I was the resident doctor for what was known as the Ecology of the Arid Zone, a project of the University of New South Wales.

Bourke and the surrounding districts has a population of 6 500, of which 25% were Aborigines. They were historically gravely disadvantaged, dispossessed and discriminated against. In 1970 they lived a separate life to the non-Aborigines, excluded from most things except rugby and the front bar of the hotel. Attitudes towards them were extremely racist and they had never had representation on any local government, hospital or school boards. They lived as fringe people on the edge of town and the local economy.

Their health was poor and life expectancy was 22 years less than local non-Aborigines. Underlying reasons for poor health were exclusion from the mainstream economy, poor education, poor nutrition, inadequate housing and waste disposal and the anomie which results from the loss of the usual social and ethical standards, following dispossession, deculturation and the resultant refuge in alcohol.

#### The doctor's role in change

Research before I went to Bourke showed that previous research was repetitive, lacked action to improve the lot of Aborigines and was narrowly ethnocentric. Nowhere did the authors suggest that doctors or other health workers could improve the existence of Aborigines by influencing medical and social factors which determine people's health.

My first action was to use my status as a doctor to provide better cultural and physical accessibility to health care than previously existed. This meant consulting outside the normal surgery and at hours to suit the patients. I also recorded an epidemiology of the physical, psychological and social disorders of every Aborigine in the area.

My first aim was to detect disorders amenable to therapy.

Secondly, I wanted to support my arguments for change and improvement in health care with scientific data rather than opinion and anecdote. I also made good use of papers in refereed journals, where the data was deemed credible by those with power.

Improvements in health services followed, including preventive measures such as immunisation and a focus on diseases such as ear, skin and other infections and a 30% rate of enuresis. I started the first family planning clinic for Aborigines, not to control the population, but to give them control over their own lives.

A doctor some 300km away was starting human relations workshops for Aborigines at about that time, so four Aborigines and I took part in them and brought them back to Bourke. They were the beginning of true acceptance by the previously, and not unexpectedly, suspicious Aborigines and the catalyst for the establishment of the Aboriginal Advancement Association.

From this came specific programmes such as literacy education, sporting and social activities, a housing co-operative, as well as the first training for Aboriginal health workers. Another important role was to act as advocate and cross-cultural interpreter for the Aborigine people in their dealings with various administrative, political and charitable bodies. A further important role was support for emerging leaders, who were uncertain and open to attack by white authority figures, their peers and sometimes each other.

A doctor acting as change agent needs a strategy and tactics to fulfil short and long term aims. He or she has to empower the Aborigines and encourage health professionals to embrace the concept of social change.

This approach did result in an improvement in the health of children and Aborigines became more demanding consumers of health care. They developed some hope for the future and learnt how to have a say in local, state and national politics.

There were also some failures. There was a lack of development of an economic base for Aborigines in the area. Intervention for Aborigines had little effect on non-Aboriginal society and in some ways entrenched racism became worse.

#### The five-star doctor and three key principles

Twenty-five years later, in 1995, WHO produced a global strategy for the doctor as care-provider, decision-maker, communicator, community-leader and manager of the individuals and organisations that provide local health care needs. Such a doctor would indeed be an agent of change.

Three key principles underpin the concept of doctor as agent for social change:

- blacks are not all white and whites are not all black;
- any social intervention is also subject to Newton's third law of motion, which states that for every action you can expect an equal (or greater) opposite reaction;
- be congruent with one's own beliefs and personality, because anything else would be transparently false.

It is not an easy role, but, for those who see medicine as a social science, a necessary one. If doctors and nurses will not accept responsibility for trying to influence those factors which perpetuate the sickness and maladaptation of their less fortunate patients, is it then unreasonable to ask who will?

— Professor Max Kamien

### THE LIFE OF DR HORACE COOPER WRINCH: PHYSICIAN, PIONEER, LEADER & ROLE MODEL

#### The Setting

Dr Horace Cooper Wrinch came to Ontario, Canada, as a boy in the late 1880s. His first vocation was agriculture and he graduated from the Faculty of Agriculture receiving the Governor General's Gold Medal. He established himself as a successful farmer, but felt called to undertake further service and eventually graduated from Trinity Medical College in Toronto.

While Wrinch was receiving his medical education, a pioneering physician, Edward Bolton, responded to the medical needs of the people of the Northern British Columbia Coast where the salmon canning industry had been established. Several thousand First Nations people, Japanese and Chinese, had been attracted to the area to crew fishing boats and work in the canneries. There

was no physician available to this large community within a distance of several hundred miles. Health conditions were deplorable, leading to excessive illness and disease.

### The Route

Before 1858, British Columbia was entirely "virgin" territory, almost inaccessible from Eastern Canada, the only route to the province being by way of New York. With the discovery of gold in California in 1858, people gradually worked their way up the coast and in the 1860s missionary activity started around Port Simpson.

In 1890 Dr Bolton brought the first trained medical aid to the area. Soon a small hospital had been built in Port Simpson, managed by a local board. In the remaining decade branch hospitals were established to serve the fishing, canning and logging communities in Port Essington, Bella Bella, Rivers Inlet and the Nass River. Bolton appealed for assistance to cover this vast territory and, among the physicians who responded, was Horace Wrinch.

In 1899, Wrinch and his wife travelled the long distance, mainly up river by canoe, to the village of Kispiox, in the Hazelton area. The community received only two mail deliveries during each winter. All supplies came in by paddle steamer during the summer and were distributed by pack trains of horses or mules and by dog teams and toboggan trains in the winter.

The territory covered by Wrinch's practice extended over many hundreds of square miles. The nearest medical aid was at Port Simpson, some 200 miles away to the west on the coast, at Ashcroft to the south, a distance of 600 miles, at Atlin to the north, 400 miles, and at Edmonton to the east, some 600 miles away. In summer the chief form of travel was by saddle horse, and by snow shoe and dog teams in the winter.

### The First Establishment

In Kispiox their first home consisted of two rented rooms in a small log home, one of the rooms having been turned into an office and dispensary. A lean-to was eventually built for the accommodation of patients who had come long distances in need of treatment. Mrs Wrinch, a qualified nurse, assumed the role of "community public health nurse", visiting the native women in their homes. Dr Wrinch was often called to travel long distances into places where roads were merely trails through the forest. His St Bernard dog, Rover, was his constant companion on these difficult and dangerous journeys, and carried the medicine kit.

Despite the arduous original journey to reach Hazelton, it was necessary for Dr Wrinch to pass the Medical Examination of the British Columbia Medical Council in Victoria in the May following his arrival. Had he waited for the opening of the river, he would have been too late to sit the exam, so there was no choice for him but to walk the winter mail route, the only means of communication between Hazelton and the outside world for six months of the year.

In the late winter of 1901 he set out on foot and, after 120 miles, reached the open water of the Nass River. He travelled a further 60 miles downstream by canoe to the community of Aiyansh and from there went by river boat to the mouth of the river at Kinkolith. From there he travelled by coastal steamer, completing the journey to Victoria, having travelled 1000 miles — all this to write a qualifying examination.

### The Hazelton Years

Wrinch had decided that Kispiox would not be the most ideal location for a hospital to serve the area and selected a better site about a mile from Hazelton. It took between two and three years to assemble all of the material to begin to build. In the meantime, he had been using an empty stable for storing his supplies. When the stable was destroyed by fire in 1901, Wrinch decided it was time to build.

By August 1903 the doctor's residence was complete and work on the hospital began. He and his family took in some of the more urgent cases until the hospital was completed by September 1904. Before the hospital was built, Wrinch was forced to perform most of his early operations in his patients' homes. Despite extremely difficult conditions, Wrinch achieved an excellent record and had

no complications due to infection as a result of his surgery.

In addition to providing medical care in these early years, Wrinch began making his own furniture. The sitting room and two bedrooms were often occupied by patients, some of whom had travelled over 200 miles on snowshoes in below zero weather to obtain medical attention. The staff of the early hospital comprised one doctor, two nurses, a house-keeper and a handy-man. During the first year of operation 127 patients were treated for a total of 3 048 days.

This was the start of a boom period for Hazelton, as the building of the Telegraph Trail had begun and brought many people into the area, many of whom stayed as settlers. Prospectors opened up small mines in the area and in 1904 surveys began for the Trans-Continental Railway. Hazelton became a hive of activity and although additions to the hospital had been made, further expansion was needed.

Wrinch kept pace with all the latest advances and bought equipment from the leading supply houses in Toronto and Winnipeg. The operating and sterilising rooms were well furnished with glass and enamelled steel equipment. Instrument cabinets were well filled, X-ray tubes for radiographic and treatment purposes were the best. A several thousand dollar X-ray machine installed in 1914 was identical to machines purchased at the time for the Mayo Clinic in Rochester.

In keeping with his interest in agriculture, a hospital farm was developed. Jersey cows were acquired, fruit trees planted and vegetable and flower seeds were provided. He secured a canning outfit which canned enough fruit and vegetables to provide the hospital with adequate supplies for the long winters. He landscaped the grounds, which he planted, and the crops produced were among the finest found anywhere in the area.

At the World's Hospital Convention in 1931, focusing on small hospitals, Hazelton Hospital was considered to be among the ten best in Canada. Wrinch put forward ideas and recommendations for the development of a provincial hospital commission in order to standardise medical care in the province.

### A New Hospital

In 1930 a new hospital was erected, a reinforced steel and concrete fireproof building close to the original hospital, having proper plumbing and sewage, hot water heating and electric lighting. There was a separate power plant for the new X-ray equipment. In addition, there was an operating suite containing four rooms with rubber tiled floors, a call system for patients' beds, a fire alarm system and an automatic coal feeding system.

It was Wrinch's hope that the hospital would become self-supporting and by the time he retired in 1936, only \$3 500 came from outside — from the Women's Missionary Society and the Board of Home Missions — just sufficient to cover the care of patients who were unable to pay.

Wrinch displayed a vast range of skills. Not only was he an excellent physician and skilled surgeon, he was also elected Liberal member for the District of Skeena in the Provincial House of Commons, a Justice of the Peace and a Methodist missionary, as well as being an agriculturalist, furniture builder and a superb community leader.

As the railroad with its international workforce came into the community, new infectious diseases were brought into the community — malaria, typhoid fever, influenza and syphilis. At the height of the Spanish Influenza epidemic of 1918, the entire interior population of British Columbia was solely dependant for medical aid on Dr Wrinch. In order to care for the people, he set up emergency hospitals in some northern hotels and also used empty railroad cars.

In 1936, after a lifetime of service and with a new hospital well established and almost self-supporting, Wrinch retired at over 70 years of age. He stands to be recognised as a giant of service in medicine, who gave everything he had, in a remote area, when he might easily have achieved great recognition had he stayed in a larger centre. He and other physicians like him call us to renew our efforts, to double our energies, and to re-dedicate ourselves to the service of the people in our care.

— Dr Peter Newbury