Portraits from Memory

20—Dr Hugh Morton (1883-1941)

JAMES HOWIE

In 1934 Hugh Morton succeeded James Carslaw as chief in charge of wards at the Western Infirmary of Glasgow; but not without some argument. He and Carslaw were not compatible; and when Carslaw

Hugh Morton as a young man. (Greater Glasgow Health Board Archives.)

became chief he made it clear that Morton's presence as an assistant in the wards was not welcome to him. Morton therefore devoted himself to developing his very successful consulting practice and did not trouble Carslaw. As a result, when Carslaw retired the board of managers considered breaking with precedent by not automatically appointing his non-functioning assistant Morton to succeed Carslaw as chief. When news of this possibility reached Morton he let it be known that if the board of managers failed to appoint him as chief they

would be required to "show cause" for thus breaking with clearly established precedents.

"Showing cause"—an ominously legal sounding phrase—would not prove easy. Indeed, it would be extremely difficult. Morton had two higher qualifications, one of them the MD with honours, and a gold medal for the best thesis of the year 1911. His success as a consultant was not in doubt. He was in great demand and this was not because his fees were low. Indeed he drove to the hospital in a Rolls Royce saloon car and maintained an open tourer of the same make for use when the weather was good. Moreover, his fame was not only local for he spent his Saturdays and Sundays consulting in Harley Street and he had published articles on his subject—gastroenterology—in the right places. Not everyone agreed that his interpretations of test meal results were scientifically sound; but that was a matter of controversy wide open to inconclusive argument.

Good listening

I met Hugh in the summer of 1936 when my senior in charge of the clinical laboratory was on vacation and Hugh was a frequent visitor to our place near the back door of the hospital. He was always

a welcome visitor. He did not hesitate to ask for help and advice on how to use the latest developments in bacteriology and haematology, and he was always completely frank in saying that he needed help on these matters and would be glad if we kept him right. He was certainly quick to learn the possibilities of our discipline and to apply them to diagnosis and treatment. New sulphonamides were appearing, and different types of anaemia were being identified. Hugh wanted to be told all about them.

For my part I realised that Hugh had a lot to teach me about clinical medicine. Without much scientific medicine he had built up an enormously successful consulting practice in gastroenterology. How had he done it?

"Well," said Hugh, "I obey Osler's dictum. I listen to the patient telling me the diagnosis. I never interrupt a patient. I take down all that she tells me [the 'she' is significant]. I read it back to her and I say if she remembers anything I have left out she must tell me. So the patient feels I really know her case. That ensures her confidence in me. I examine her and may prescribe treatment there and then. Or I may admit her to a nursing home for an x ray and a test meal. In any case, I exclude cancer and assure her that I can tell her not to worry about cancer. That is often the therapy that really matters. Or I turn her over to the surgeons if cancer is still a real possibility. In any case the patient is satisfied that I understand her problem. If it comes to treatment constipation is almost always a big part of any gastroenterological complaint. So I teach her how to infuse senna tea. I don't prescribe it as a made up medicine. I want to give her an involvement in her own treatment that is direct and simple. I ask her to come back and see me in a month if she is not better. I have very few returns. I keep happy and fully informed both the patient and her doctor."

There it was. It was not for nothing that in his Berlin and Paris days—which were de rigueur for young aspiring physicians before the first world war—Hugh had studied psychology and psychiatry. He understood their limitations but he had learnt what they had to tell him about patients and their problems. And he applied his understanding with common sense and good effect.

Nice yellow guineas for me

One day he told me that I had to go with him that afternoon to see a patient in Kilmacolm, 26 miles from Glasgow. The patient had a friend who had been correctly diagnosed as having pernicious anaemia. The patient seemed to have symptoms like those of her friend and thought that she too had pernicious anaemia. She didn't have it. Her good family doctor told her so; but she was not satisfied. So Hugh was called as a consultant. He needed to be accompanied by an expert in haematology—me. I told him it was nonsense, I'd give him tubes, diluting fluids, and slides and I'd give an answer on the specimens he brought back. No use. The expert in haematology must set up his microscope in her bathroom, take and examine her blood, and let her and Hugh look down his microscope at a film of her blood and see how different it was from that of a patient with

Edinburgh EH13 0BU
SIR JAMES HOWIE, MD, FRCP

Correspondence to: 34 Redford Avenue, Edinburgh EH13 0BU.

pernicious anaemia. That was what was necessary. And the reward to the haematologist was a guinea a mile. Twenty six guineas to a young, recently married apprentice pathologist—I went. And the results were completely satisfactory. Could any different procedure have been equally effective?

As for Harley Street and its big fees Hugh was going to give up all that nonsense. Overnight sleepers: out on Friday night and back on Sunday night—it was not worth so much labour and stress for all that was left in his pocket after expenses and taxation. What was left? Well—about £100 for two exhausting days. [That, in 1936, would be the equivalent of £2000 today. Not really worth it for two days' work!]

Hugh's fees for consultations were arrived at empirically—often

reasonable or even generous; at other times what the market would bear. He quoted one remarkable example.

"I was making out my bills and my wife was looking over my shoulder. 'Hughie,' she said, 'what's this £20 to that woman? You saved her life!' 'Maybe I did,' I replied, 'she was perhaps suicidal till I got her case cleared up. But that's nothing.' 'Nothing,' said my wife. 'Put on the nothing then!'"

Said Hugh, "I hesitated, but I put it in just to see what would happen. She had plenty of money. Back came my bill with the cheque for £200, a warm letter of thanks, and an invitation to take my wife with me on a Mediterranean cruise and send the bill to her."

I never underestimated Hugh Morton. I read of his death in office with sadness; but I never thought of following in his footsteps.

Lesson of the Week

Low back pain and testicular cancer

R P COLE

Testicular cancer accounts for only about 1% of cancers in male patients but is the commonest solid tumour in men aged 20-34; its incidence is increasing. It is potentially curable because of recent advances in chemotherapy.¹ With combination chemotherapy a three year survival of 75% can be achieved in metastatic non-seminomatous germ cell testicular tumours.² There is a significant association between an initial delay by the patient in seeking advice or by the doctor in making a diagnosis, or both, and the occurrence of advanced testicular cancer.³ Delay between the first symptom and the start of treatment is a determinant of long term survival.² I report two cases in which delays of several months occurred in the diagnosis.

Case 1

A 17 year old youth presented to his general practitioner with low back pain, which had been gradually increasing in severity and had stopped him working for one month. The pain was exacerbated by coughing and sneezing but did not radiate. He was told that he had a slipped disc that would settle. After a further month off work the pain became worse and radiated into the thighs. He developed weakness and numbness in the left thigh and was admitted for a two week course of traction. The symptoms worsened and signs of L2-3 compression became more pronounced. He was referred for a neurosurgical opinion and underwent myelography. This showed extradural compression of the cord at L2-4.

Low back pain may be the presenting complaint of young men with testicular cancer

At this point his scrotum was examined; there was a hard mass at the lower pole of the left testis. The right testis was atrophic with an associated inguinal scar after orchidopexy at the age of 8 for an undescended testis. Blood was taken for assay of tumour marker concentrations, and a left orchidectomy was performed. Histological examination showed a non-seminomatous germ cell tumour. Because of small pulmonary metastases it was graded as stage IV.

Cyclical chemotherapy resulted in resolution of his symptoms and the return of the tumour marker concentrations to normal. Computed tomography showed only a residual nodule in the right lung, which was removed at thoracotomy and histologically was a necrotic, non-viable tumour. He was subsequently disease free.

Case 2

A 15 year old boy presented to his general practitioner with dragging low back pain, which had gradually become more severe. There were no neurological signs. The symptoms worsened over several weeks, and he developed lethargy and malaise. He was referred to an orthopaedic clinic. Radiographs of the lumbar spine did not show any abnormality. A non-steroidal anti-inflammatory drug was prescribed. The symptoms persisted, and at a follow up visit the erythrocyte sedimentation rate was noted to be raised. He was then referred to a rheumatologist, who diagnosed ankylosing spondylitis and prescribed a different non-steroidal anti-inflammatory drug.

The symptoms persisted and he began to lose weight, so he was admitted for bed rest, analgesia, and physiotherapy. At this point his scrotum was examined and a hard irregular mass in the left testicle found. Blood was taken for assay of tumour marker concentrations. Orchidectomy was performed, and histological examination confirmed a non-seminomatous germ cell tumour. Abdominal ultrasonography showed retroperitoneal lymphadenopathy and metastases in the liver. Chest radiography showed multiple cannon ball metastases; the tumour was therefore graded as stage IV. Despite intensive cyclical chemotherapy the patient died.

Wessex Cardiothoracic Centre, Southampton General Hospital, Southampton SO9 4XY

R P COLE, MB, FRCS, registrar in surgery

Correspondence to: 4 The Gazings, Gazing Lane, West Wellow, Hampshire SO51 6BS.