George Dock, M.D.: Innovation and Tradition in the Teaching of Medicine at the University of Michigan in 1900

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Introduction

The Medical School has long been at the forefront of innovation in medical care and the teaching of medicine, and that was as true at the turn of the last century as it is today. Yet older habits of thought and practice continued alongside the new. George Dock, one of the premier instructors of internal medicine in 1900, was quick to implement new discoveries—he brought the Tallquist hemoglobin scale to the attention of his students soon after it was published—he also clung to old ideas of medical practice, such as cupping.

Excerpts below are drawn from an extraordinary document of late 19th–early 20th century medical education, George Dock Notebooks, the 16-volume transcript of his 4th year medical clinics from 1899-1900.

Hospital and Medical School

By the time George Dock arrived at Michigan in 1891, the hospital and the medical school had changed dramatically. First established in 1869 in a former faculty house, the Catherine Street Hospital, was the 16-volume transcript of his 4th year medical clinics from 1899-1900.

George Dock

A graduate of the University of Pennsylvania in 1884, George Dock had already taken steps to place himself at the forefront of scientific medicine. He interned at a hospital (unusual at the time), sought out the eminent internist William Osler, and spent three years in Austria and Germany, studying in laboratories and clinics.

In 1891, Dr. Dock emphasized clinical instruction as the basic form of teaching in Germany, studying in laboratories and clinics.

In clinic, Dr. Dock often exhorted his students to keep up with the medical literature; he brought up current articles for discussion. In a case presented 13 January 1900, an article from the latest edition of the Medical News (10 January 1900) was read as part of the differential diagnosis of a child brought in with an adenoid condition on pharynx and other "conditions which are very interesting from a pediatric standpoint."

If you remember in infantile scurvy the child, as you approach it, feels and acts afraid—evidently has some tender points about it which it attempts to keep from you. If you touch the limbs, the child will cry out as if with pain. If you remember, the Author says if you leave the child alone and do not touch it, it will probably remain quiet. At first the limbs are drawn up and kept still. On examination the limbs in case of scurvy show enlargement of epiphysis, and along the bone, along the shafts of the tibia and femur. Here there is nothing of that nature. You can handle these limbs without causing pain…

In infantile scurvy, besides the condition of the limbs, you remember the teeth come in very slowly, and after that there is spongy condition of the gums. In this child you do not find spongy condition of the gums, and the teeth have come out very well as you may see. . . . In this case the child is able to draw limbs up, but there is a spasmotic condition of the arms. [Dr. Amnell reads an extract]. The facts to keep in mind in infantile scurvy are that neuritis and also sepsis (I might follow, and it is necessary to exclude these. In this case, however, we will exclude the infantile scurvy. (1899–1900, pp. 407–8).

As elsewhere, the use of X-rays was adopted eagerly at Michigan. In Dr. Dock’s practice, they were used often to diagnose aneurisms and kidney stones, but physical examination was of paramount importance. In the case of a patient with vocal paralysis and pain in the chest, X-rays are mentioned only after 2 pages of careful physical examination.

In 1900, Dr. dock's clinic was held twice weekly in the amphitheater of the hospital, the 16-volume transcript of his 4th year medical clinics from 1899-1900.

Evidence

Innovations in Medical Practice

Tradition

The first thing to do with a patient of that kind if you see it early is to give it a dose of vitamin P. If you get into the habit of wiping the first drop of blood with a towel or filter paper you will notice that not all bloods color the towel or filter paper in the same way. . . . We will pass this around in a minute and along with them a scale we have here. You will notice a great difference in the color of the two drops. Recently a Finlander named Tallquist has devised this scale which can be used in connection with this. . . . Tallquist made a series of dyes, matching the haemoglobin, say from 10 on the ordinary color scales, running up to 100. He had an artist copy these colors, and then had them reproduced as accurately as he could. . . . You can see from the specimen I send around how evident the thing is. In the first place you get a striking difference that can occur in the blood drop, and you can easily realize that one can match those colors within a comparatively close margin. . . . The idea is to read the colors as soon as the blood has stopped running. (1900–01, pp. 224–25)

The most important thing is to produce sweating of patient; to do this by a hot pack or wet pack also at the same time that the bowels are made active. . . . You might use drugs, but this is better than drugs. You might use hot applications to the lumbar region, or even blister the lumbar region to have a counter irritating effect on the kidneys . . . counter with plaster slow painful method. What you probably had in mind was cupping. (1899–1900, p. 767–68).

On 21 January 1901, a baby with suspected pneumonia was brought to the clinic and calomel was prescribed as the first part of treatment. The first thing to do with a patient of that kind if you see it early is to give it a dose of vitamin P. If you get into the habit of wiping the first drop of blood with a towel or filter paper you will notice that not all bloods color the towel or filter paper in the same way. . . . We will pass this around in a minute and along with them a scale we have here. You will notice a great difference in the color of the two drops. Recently a Finlander named Tallquist has devised this scale which can be used in connection with this. . . . Tallquist made a series of dyes, matching the haemoglobin, say from 10 on the ordinary color scales, running up to 100. He had an artist copy these colors, and then had them reproduced as accurately as he could. . . . You can see from the specimen I send around how evident the thing is. In the first place you get a striking difference that can occur in the blood drop, and you can easily realize that one can match those colors within a comparatively close margin. . . . The idea is to read the colors as soon as the blood has stopped running. (1900–01, pp. 224–25)