MEDICAL MEMORIES OF BANGKOK AT THE TURN OF THE CENTURY

MALCOLM SMITH, M.D.

EDITORIAL NOTE

Dr. Malcolm Smith was born in 1875 and qualified as a doctor in London. He went to Bangkok in 1901 where he remained in practice until 1924. After some years as an unofficial medical advisor, he was appointed as official medical practitioner to the Queen Mother Saowapa in 1914. He also treated many others at the Court. On retirement he returned to England and devoted the rest of his life (he died in 1958) to research into reptiles, on which subject he published two textbooks and a large number of scientific articles. This account of his experiences in Siam has not been previously published.

The Editor wishes to express his appreciation to Professor Michael Smithies for referring this text to the JSS and to Mr. A. G. Smith of Queensland and to Dr. M.G. Smith of Newryham, N.S.W., sons of the author, for permission to publish this note.

Malcolm Smith's book, *A Physician at the Court of Siam*, was first published in 1957 in London, and was reissued in 1982 (Kuala Lumpur: Oxford University Press).

Most of my life has been spent in the daily round of work that is the lot of most of us, but when I went abroad to the East, events of unusual interest happened to me and it is of these that I write.

I was born in November 1875 and was educated at a small private school, for my father was not a wealthy man, and we were a large family. By the standards of today I had a poor education, yet throughout my life I have not found that it handicapped me.

When I was sixteen I entered the office of a civil engineer since my father wanted me to follow his own profession. I soon discovered that it was not the one for me as my love then was and still is anatomy. So I persuaded my father to let me become a doctor and I returned to school, took the examinations necessary to allow me to "walk the hospitals," and at the age of seventeen entered Charing Cross Hospital Medical School where I spent five years and emerged in 1898 as a qualified general practitioner.

After a year "in house" I went on a voyage to Singapore to see what the East was like and liked it, so I entered the London School of Tropical Medicine which had just been founded as a teaching centre. Whilst there I accepted an offer to join a group in Singapore while one of the partners came home on leave and there I stayed for eighteen months.

In those days when most Europeans went to the East they did not do so because they wanted to experience the countries, but because the pay was good and the life pleasant. They seldom got to know the people of the country and were not particularly interested in them.

They did not trouble to learn the local language except for the smattering that was required to get them through their occupation and in many places it was the locals who learned English and not the Englishman who learned the local tongue.

The white man spent his day at the office and, his work done, went off to the Club to play games and to drink. The Club was the sanctuary when the day's work was done and wherever more than half a dozen Europeans were living in the same area they managed to form a Club of some sort; a good deal more drinking went on there than in Europe.

It was the local way of life that interested me, and in all my spare time I tried to see as much of it as possible. Singapore offered a wonderful variety of nationalities. It was a Malay country but the main population of the island were Chinese and Indians. I attended the men frequently as patients but seldom the women, for both the Moslems and the Hindus kept their wives strictly to themselves. They were seldom seen in the streets and when they did go out were so heavily veiled that nothing could be seen but their eyes.

I was occasionally called in to see women when they were sick but often no form of examination was allowed. The patient was smothered in clothes and the only part that was presented to me was three inches of wrist so that I could take the pulse. It was not surprising that often a diagnosis could not be made.

As my time in Singapore was coming to an end an advertisement appeared in *The British Medical Journal* asking for an assistant to go to Bangkok to help a medical missionary in his practice there. The pay was not great and I was not particularly interested in missions, but I had heard a great deal about the fascinating life in Bangkok with its colourful Court and its people from all over the world and it appealed to me. I was surprised when I heard later that I was the only applicant for the post; for me it turned out to be a gold mine both financially and in the rich experience [it provided].

So in 1901 I arrived in Bangkok where my employer was Dr. Heyward Hays, an American who had been sent there by one of the missionary societies.

As a missionary doctor he did not accept fees but his practice grew so large and so rapidly that he finally decided to leave the mission and open his own practice. He was a first class businessman and a generous employer. Soon after I joined him he offered me half the fees of all new patients that I brought into the practice. Some three years later, finding himself so deeply and remuneratively engaged in business that he had no time for medicine, he gave what practice he had left to me.

It was hard work on my own and I had practically no leisure. Except for my meals I generally worked from the time that I got up until I went to bed. However, I earned a lot, and for many years my takings were between six and eight thousand pounds a year, with ten thousand in one memorable year. In Siam at that time there was no income tax but living was two or three times as expensive as England. I enjoyed the work and was never ill.

The conditions of practice in Bangkok were very different from what they are today. There were no consultants, so if we wanted a second opinion we called in one of the other doctors. There was no dispenser [pharmacist] and this work was done by the doctors, who were given a room over the dispensary to see their patients.

One facility that we did not have and was badly needed was a pathology laboratory. Malaria and dysentery could be easily diagnosed under a microscope but with typhoid and paratyphoid, which were both common in Bangkok, we had to send blood to Singapore for a positive diagnosis. For most of the illnesses drugs were little more than palliatives and nature did the rest. In fact, if one were quite honest with oneself, it had to be admitted that nature did most of it.

I was always more fond of surgery than medicine or orthopaedics and although I had no special qualifications as a surgeon I managed to do quite a lot of it—mostly on the Siamese, but it gave me the practice that I needed.

One of Dr. Hays's appointments was the charge of the Bangkok hospital, which was a small institution of about sixteen beds. It was really no more than several converted local houses, and each ward or room contained four beds. In charge of the place from a medical point of view was a Chinaman who was unqualified but quite capable of the work that he did. The general care and feeding of the patients was done by their own relatives, who could come and go as they pleased.

One room was set aside for operations. One could hardly honour it by calling it an operating theatre. Except that it had a table on which one operated—a plain one made of wood—there was nothing else in it to justify the name. Nevertheless quite a lot of operations were performed there and many of them could be classed as major ones. Accidents from various causes sometimes necessitating the amputation of a limb accounted for much of the work. Fractures, both simple and compound, were common. Fighting between men using knives was frequent and some of the gashes inflicted were large and involved a lot of stitching.

Cancer was rare, and as the patients usually did not come until the disease was well advanced and inoperable, nothing much could be done about it. After many years in practice I came to the conclusion that cancer among the Asiatic people was very much less common than among Europeans. I do not attempt any explanation of this fact.

When operating, chloroform was the usual anaesthetic given. Gas and ether were not used owing to the fact that the rubber of the bag that was required for their administration deteriorated rapidly in the tropics and became useless. This trouble was later overcome.

One handicap that I had to work under in the hospital was that the relatives of the patient were always coming into the room to watch the operation. When I started work there I attempted to clear them out, but working with open doors to keep the room cool and let in as much light as possible meant that they would always come creeping back when I was busy with other matters. Moreover I had been told that if I did not allow some of them to come in and see what was being done they would probably not come at all. So finally I compromised and agreed that if not more than two or three came I would allow it.

It would have been thought that working under such conditions many cases would go septic, but it was not so. Slight sepsis was not uncommon but severe sepsis was rare. The only explanation that I can offer for this—and I believe it to be the right one—is that the Asiatic has a greater resistance to inflammatory conditions than the European. In using the term "Asiatic" I refer mainly to the Chinese who formed the majority of my patients.

The ability of the Chinese to recover from injuries and septic conditions is indeed remarkable. On two occasions I was called in to see men whose legs had been so badly crushed that

amputation seemed the only thing to be done. I told them this and offered to do it, but was politely declined. Some months later they came to see me, not for further treatment, but to show what their Chinese doctors had accomplished. The wounds were healed and the limbs were stiff, but they were able to hobble about just as efficiently as they could have done if I had provided them with a wooden stump.

The Asiatics did not always come for European treatment when it was available. Many of those who came to see me still had great faith in their own doctors. Quick cures, or at any rate a quick improvement in the condition of the patient, was always expected, and if it was not forthcoming another doctor was called in. In a long illness sometimes as many as ten or twelve doctors would be consulted and when, finally, the patient recovered, it was the doctor in charge at that time who got the credit.

Sepsis to them meant nothing and any attempt to prevent it was generally thwarted. Many times I disinfected a wound and covered it with a dressing only to find when I went back two days later that my dressing had been removed and replaced by a large poultice of herbs and horse or cow dung. I can't say that it appeared to do any harm.

Payment was by results. No cure, or at any rate no improvement, meant no pay. In a long illness when many doctors had been in attendance it was the last one who got the fees. This was the general custom and was accepted by the doctors.

The treatment of disease by the Chinese doctors was entirely medical. Surgical interference was never attempted even to open a simple abscess, and as the doctors were completely ignorant of the anatomy of the body it was just as well. There was no physical examination of the patient, the pulse was never taken and the clinical thermometer unknown. Diagnosis of the complaint was made by inquiry and as their conception of the causes of disease was very simple, it did not present any particular difficulty.

A mysterious agency called "the wind" governed all functions of the body. It caused the blood to flow—you could feel it in the beating of the pulse—the digestion to act, the bowels to move, and the skin to perspire. Any disturbance of its balance resulted in disease. *Pen Lom* was a disease that I was constantly called on to treat. Such was the state of local medicine when I began to practice in Bangkok.

Each European community had its own doctor, but it happened that I was the first to introduce successful treatment of two diseases that were prevalent in the country and as a result I gained many new patients.

The two diseases were cholera and dysentery, both of which could be very serious. To take cholera first, the water supply for the city was the river, which at Bangkok is tidal. During the rainy season it [water] was collected from the roof tops and stored in jars by those who were particular about what they drank; but by most of the people—and the majority lived on houseboats—no care was taken. They drank it straight from the river. During the rains there was a good volume of water and it was comparatively fresh. But from October to May no rain fell and the river slowly sank in volume and increased in turbidity. By April it was brackish and cholera then became a regular epidemic.

We are told that the disease was brought to Siam from India in 1819 and that in the following year it took a heavy toll in deaths. So many died that the temples could not dispose of the bodies fast enough and the corpses lay stacked in heaps in the grounds. It was something that the people had never known before and they fled in panic from the city, bringing it to a standstill.

The next great epidemic was in 1849 when in one month between fifteen and twenty thousand people are said to have died. As in 1819 the living could not dispose of the dead fast enough. There was no wood left to burn the corpses and they were again piled in heaps in the temple grounds and left for days. Many were thrown in the river to drift slowly out to sea.

Disposal of bodies normally took place in the temples, either by cremation or burial, although at times when there were no relatives or friends at hand to attend to them they were left to the vultures and the pariah dogs to devour. It is from the records kept at the temples listing the numbers of bodies disposed of within their precincts that we learn something of the history of these terrible epidemics.

When I went to Bangkok the disease was still prevalent and it was not until a water supply drawn from the river some forty miles upstream was built that real control over it [cholera] was achieved.

That the disease was waterborne was pretty clear but that did not explain everything, for the discharges from the sick were loaded with bacilli, and one would have expected that the flies settling on excrement and then on food would have conveyed them from one to the other. That the disease could be fly borne was generally accepted. Yet in the Bangkok hospital, where cholera was prevalent and flies abounded, no case that I ever heard of ever developed.

The early cases of cholera that I saw were severe and usually ended fatally. Then as the virulence of the bacillus lessened—as it does in all epidemics—the disease became milder and when the epidemic was coming to an end most of those who were attacked by it recovered.

The main cause of death in the early stages was the intense diarrhoea and vomiting with the resulting depletion of the body fluids and the consequent heart failure. This appeared to me to be the main cause of death rather than the toxemia produced by the virus, and the introduction by Dr. L. Rogers in Calcutta of overcoming this by the injection of several pints of saline solution into the system through one of the veins led to spectacular results. To save a patient from what appeared to be almost certain death was a great achievement and to my delight I was the first doctor in Bangkok to introduce this treatment. It told the people that an effective cure, at any rate in the early stages of the disease, had at last been discovered, and provided that the kidneys escaped damage, they recovered.

Amoebic dysentery was the other serious disease that was common. The locals had acquired an immunity to the microorganism from long years of living with it, but the white man had no such immunity and in the course of time invariably developed

the disease. Every European in the country, no matter what care was taken in the handling of his food, would almost certainly develop it.

The specific treatment was ipecac, and this was given in the form of a large pill. It was about half the size of a golf ball and was called a bolus. The drawback to ipecac as a drug was its strong emetic properties and to keep it down long enough for it to have any effect was one of the battles that had to be fought out by the patient.

The extraction of the alkaloid in ipecac, namely emetine, by which it could be given as an injection, revolutionised treatment. I remember well when I first used it on a European. I had used it with success on two of my Siamese patients and was then called in by the German doctor to see one of his patients whom he had been treating unsuccessfully for some time but he had not heard of the new drug. One dose did not cure the disease but it stopped the diarrhoea and made the patient comfortable. The news of the spectacular result of that one injection was all over Bangkok in forty–eight hours.

I was not called on to do much surgery among the European community except for the occasional accident. It must be remembered that the men who came to the East were a picked lot, picked in the sense that they had had a thorough medical examination before they were sent abroad and had been passed as in first class condition. Life in the tropics, even under the best conditions, is a strain upon the European and if a man were not thoroughly fit in every way he was not allowed to go.

Most of them when they first arrived were young men in their early twenties, and their wives when they came out were young and healthy too. Surgical operations among such a group were seldom needed but on rare occasions they had to be done.

There was one case of mine that I remember well. A man in Government service had gone home on leave and returned with a wife. A few days after his return he came to tell me that she had had two slight attacks of appendicitis recently and that they were going up country where there was no surgeon. He therefore asked me to remove her appendix, but under the circumstances I could not immediately agree. I could not let the girl go away with an appendix that might flare up at any moment, but at the same time I did not feel it necessary to tell the husband that I had never removed an appendix before, so I told him that I would think about the problem before agreeing.

Appendicitis among Asiatics was almost unknown. I have been told that the reason for this is that people who eat rice instead of bread do not get it. Today an appendicectomy is looked on as a simple operation, but in the days of which I write any operation that involved opening the abdominal cavity was regarded as a major one.

So to gain some experience of what I had to do I went to the Police hospital where I knew that there was always a supply of corpses, and operated on four bodies. Armed with this experience I removed the lady's appendix without difficulty and all went well. When she showed me her scar some ten years later it was hardly noticeable.

Much has changed in Bangkok since my days and they have modern hospitals which offer modern medical skills. But the old Chinese ways are still followed by many, and I feel sure that we still have much to learn from them.