Kaapstad, 9 Oktober 1965 Deel 39 No. 36 Volume 39 Cape Town, 9 October 1965

VAN DIE REDAKSIE : EDITORIAL

ALBERT SCHWEITZER, 1875 - 1965

Toe Oskar Kraus[1] in 1922 die eerste maal met die filosofiese werke van Albert Schweitzer kennis maak, was sy gevoel: ‚hier is 'n man bedeel met uitgesproke kritiese vermoëns en die moed van opregtheid'. Op daardie stadium was hy nie bewus daarvan dat dieselfde man reeds 'n wêreld-beroemde biografie van Johann Sebastian Bach geskryf het nie. Vir hom was hy tot op daardie dag slegs vermaarde teoloog en filosoof, hoofsaaklik bekend vir sy studies *Geschichte der Leben-Jesu-Forschung*. Dit was ook met ontnugtering dat hy mettertyd besef het dat dié man deur die hele Europa bekend was as 'n meesterorrelis. Wat hom egter die meeste getref het, was die verskyning van 'n boekie deur Albert Schweitzer, D.D., D.Phil., M.D.: *On the Edge of the Primeval Forest: Experiences and Observations of a Doctor In Equatorial Africa*. Dit het hom laat besef dat: , . . . Schweitzer's case is totally different. A man who was doing outstanding work as a pastor, scholar and musician, one who had become an international celebrity, whose sphere of activity had always been in the chief centres of European culture, feels himself, to quote his own words, "driven from his scientific and musical studies into the primeval forest" by the force of reflections and convictions which may have been entertained by man, but which have not induced anyone in similar circumstances to take a similar step.' En dan weer 'n entjie verder: ‚Schweitzers' mysticism, built up on a rationalistic foundation, does not include any of those blissful states of consciousness and impulses by which saints, visionaries, prophets, and ascetics have been raised to the Beatific Vision, by which they believe to have achieved union with God . . .'[2]

Aan hierdie man, ook genoem ‚die grootste etiese en geestelike denker van ons tyd', wil ons hulde bring, nie net omdat hy ook geneesheer was nie, maar juis omdat hy geneesheer was ter uitlewing van sy *Lebensanschauung* wat 'n deel was van sy Christelik-georienteerde *Weltanschauung*. Tot aan sy dood het hy die besluit, op 30-jarige leeftyd geneem, uitgevoer te Lambarene, en daar is nie twyfel dat sy sendinghospitaal lig en genesing aan duisende gebring het nie. As ons dit egter nie sien in die lig van sy filosofiese en moreel-etiese oortuiging nie, is hy slegs een van vele toegewyde sendingdokters. Vanaf Lambarene het die stem nie geswyg nie, maar sy *Verval en Herstel van die Beskawing* en sy *Beskawing en Etiek* het vandaar die lig gesien, sprekende tot 'n wêreld waarvan hy sê: ‚Once every man of science was also a thinker who counted for something in the general spiritual life of his generation. Our age has discovered how to divorce knowledge from thought, with the result that we have, indeed, a science which is free, but hardly any science left which reflects.'

Hy sou, glo ons, nie verlang dat enige huldeblyk bloot die katalogisering van sy vele prestasies moet wees nie. Daar was van die begin van die eeu af immers vele daarvan, insluitende die Goll-beurs, die Goethe-prys, die Nobelprys, en so meer. Veel eerder glo ons dat die tyd nou gepas is om 'n paar van sy gedagtes weer in herinnering te roep.

Sy eerste boek handel oor sy voormalige orrelmeester, Eugène Munch, en hy was ten tyde van die aanvang van sy teologiese studies in 1893 student in die orrel onder Widor van Parys. Van die orrel sê hy: , . . . for the organ represents the *rapprochement* of the human spirit to the eternal, imperishable Spirit, and it is estranged from its nature and its place as soon as it becomes the expression of the subjective spirit'.

In 1905 verskyn sy boek: *J. S. Bach, le Musicien-poète*. Van Bach sê hy: ‚The great point is that Bach, like every lofty religious mind, belongs not to the church but to religious humanity, and that any room becomes a church in which his sacred works are performed and listened to with devotion.'

Van vroeg in sy lewe ontwikkel sy eie siening van die Etiek: ‚Ethics is the activity of man directed to secure the inner perfection of his own personality', of andersom ‚Whatever is reasonable is good . . . To be truly rational is to become ethical.' Maar ook hier blyk dit dat sy agting vir die lewe gebaseer is op die Christelike liefde: ‚However much it struggles against it, ethics arrives at the religion of Jesus. It must recognize that it can discover no other relationship to other beings as full of sense as the relationship of love.'

Met hierdie etiese grondslag blyk dit: ‚The terrible truth that with the progress of history and the economic development of the world it is becoming not easier, but harder, to develop true civilization, has never found utterance', en ‚only those who respect the personality of others can be of real use to them'. Geleidelik vind sy ‚reverance for life' uitdrukking, en hierop is sy werk gebaseer; dit was ook die spoorslag vir sy geneeskundige loopbaan van sestig jaar onder die inboorlinge van tropiese Afrika:

‚The first spiritual act in man's experience is reverence for life. The consequence of it is that he comes to realize his dependence upon things quite beyond his control. Therefore he becomes resigned. And this is the second spiritual act: resignation,' en ook: ‚ultimately, the issue is not whether we do or do not fear death. The real issue is that of reverence for life.' Die betekenis van hierdie idee vir ons tyd kan as volg opgesom word in sy eie woorde: ‚When my will-to-live begins to think, it sees life as a mystery in which I remain by thought. I cling to life because of my reverence for life. For, when it begins to think, the will-to-live realizes that it is free. It is free to choose whether or not to live. This fact is of particular significance for us in this modern age, when there are abundant possibilities for abandoning life, painlessly and without agony.'

Van sy besluit om geneesheer te word lees ons: ‚I wanted to be a doctor that I might be able to work without having to talk. For years I had been giving myself out in words, and it was with joy that I had followed the calling of theological teacher and of preacher. But this new form of activity I could not represent to myself as talking about the religion of love, but only as an actual putting it into practice.' Dit is welbekend dat hy in sy besluit om tot die sending-geneeskunde toe te tree die

eerste was om Christus se gelykenis van die Ryk man en Lasarus toe te pas, nie slegs op die individu nie, maar op die gemeenskap as 'n geheel.

Albert Schweitzer, leraar en denker, die heler en die sanger, die soeker en die skrywer, is heengegaan, maar die mensheid wat hy liefgehad en gedien het, word verryk agtergelaat. Ons bring hulde aan die man wat ons professie nodig gevind het om uiting te gee aan sy *veneratio vitae*.

1. Kraus, O. (1950): *Albert Schweitzer, His Work and his Philosophy*. Londen: Black.
2. Joy, C. R. (1952): *Albert Schweitzer: An Anthology*. Londen: Black.

ECONOMICS OF MEDICAL PRACTICE IN THE REPUBLIC

There is an increasing and laudable tendency throughout much of the world today to endeavour to subsidize the individual in some way in order to help him meet the ever higher costs of medical care. This subsidy may be provided via the State itself or via organizations within the community. The scope of a medical health service provided by the State is dependent upon the size and economic status of the population. In the Republic of South Africa it does not appear to be economically feasible for the State to provide the White population with a health service based, for example, on the lines of the National Health Service in the United Kingdom. However, if it were possible to extend the present system of prepaid medical care, as exemplified by the medical aid societies, to cover at least the greater part of the White population (perhaps 70%), then a great step forward will have been taken in bringing adequate private medical care to many who would otherwise be hard pressed or unable to afford it. At present it appears that there would be a smaller part of the White population (perhaps 30%) in the low income brackets who will have to depend on free hospitals subsidized by the provinces or the state or on part-paying hospitals, and/or on subsidized care through some form of low-subscription medical care plan on the lines of a medical benefit society.

For several years now the Minister of Health has shown himself anxious to extend the scope of prepaid medical care throughout the White population of the Republic, and as a result the Medical Schemes Bill was gazetted on 26 February 1965. Owing to a number of objections from various interested parties, the Bill was subsequently withdrawn and referred to a Select Committee, which is receiving further evidence. It seems that the Bill may well be re-introduced at the next Parliamentary session, and therefore it behoves the medical profession to ascertain its economic status and requirements accurately before passing final opinion on the Bill.

Valuable information concerning the economics of the profession was gathered by the Schedules Committee, and this has now been supplemented and correlated by the Actuarial Committee, which is due to report to Federal Council in October. The Actuarial Committee is to make recommendations concerning a suitable Tariff of Fees which would be required if prepaid medical care were extended to cover the bulk of the White population. In order to base their recommendations soundly, the Actuarial Committee carried out an economic survey of their own, and also asked the various groups to detail the fees they desired on the basis of a Republic-wide standard tariff of fees, on the premise that benefit societies and hospital patients were to remain as they are at present.

A standard tariff of fees poses a particular problem as regards general practice throughout the Republic, and as a consequence a sample economic survey was carried out by the National General Practitioners Group. The report of this survey was published in full in this *Journal* on 25 September 1965. In this report average figures relating to various items were worked out for the Republic, but were also worked out for 'Metropolitan' and 'Other' areas. It is of interest to refer back to this report and note the economic differences in practice in the large towns, on the one hand, and in the smaller towns, dorps, and rural areas on the other. By and large the practitioner in the large town has significantly greater practice expenses, runs a smaller car, and has a slightly smaller investment in furniture and equipment, than his counterpart in the country. He works for virtually the same number of hours per week, but he does significantly less procedural work. He does, in fact, rely on consultative work (i.e. consultations and visits), for the large bulk of his income, and in contrast to his country colleague he does not charge mileage for the majority of his visits, most of which are within municipal boundaries where mileage charges are not presently recognized by medical aid societies. In an endeavour to compensate for his greater practice expenses, his dwindling procedural work (which is relatively more lucrative than consultative work), and his loss on travelling expenses, the general practitioner in the large town has been forced to charge more for his consultative work than his counterpart in the country. These differences are shown in the survey report.

At present, a standard tariff has certain definite advantages, and in the long run should have more. However, it does appear clear from the survey report that on average, at present, a standard tariff will definitely favour the country practitioner at the expense of the practitioner in the large town. This seems acceptable, since rural practitioners are in short supply and an incentive in their favour can only be to the advantage of patient and doctor alike. However, in fairness to all general practitioners, a standard mileage tariff would seem indicated, irrespective of municipal boundaries. As travelling expenses are usually borne by the patient and not by the medical aid society, the probable end result in the large towns would be that a general practitioner would practise in a well-circumscribed and relatively small area, and if a patient moved to another area in the same town he would probably change his doctor rather than pay the extra for his mileage. This situation appears satisfactory, since it could result in the urban general practitioner spending less time on visits and more on office consulting, increasing his daily work efficiency, and decreasing his personal wear and tear, and thus benefiting both himself and his patients. He would be able to see a larger number of patients per day than his rural counterpart, and thus compensate to some extent for his lack of procedural work and increased practice expenses.

In conclusion, it would appear that this survey report contains data of definite interest and significance, and full cognizance should be taken thereof in future negotiations with the medical schemes and the Minister.