# GENEESKUNDE IN DRIE WÊRELDDELE*

E. C. A. NOYONS, *Germiston*

As gevolg van 'n reismanie en 'n posseël-stokperdjie het ek die afgelope 28 jaar in drie kontinente—naamlik Europa, Asië en Afrika—gewerk. Om reiskoste te bespaar, het ek besluit om as 'n geneesheer vir die owerhede te gaan werk. Die volgende is dus 'n paar gedagtes van 'n vroeëre militêre dokter, skoolarts, trope-arts, distrikgeneesheer, stadsgesondheidsbeampte en 'n direkteur of superintendent van nospitale in Nederland, Nederlands-Oos-Indië en in Suid-Afrika.

Deur my talle reise het ek geleer dat toestande nie net op verskillende kontinente verskil nie, maar dat toestande op dieselfde kontinent, ook nie oral *dieselfde* is nie. Noodhulp in Mosambiek is bv. onvergelyklik met noodhulp in Suid-Afrika. Hoewel die *doel* van ons medici oral ter wêreld dieselfde is, nl. die bestryding van siektes, was dit vir my baie interessant om te sien dat daar in *verskillende* lande so baie verskillende paaie na *dieselfde* doel (gesondheid) is. Een en dieselfde siekte, bv. 'n maagseer, word in die een land meestal eers langdurig en konserwatief behandel deur 'n internis met 'n dieetkundige of deur 'n psigiater met 'n maatskaplike werkster, en dan—soms eers na jare—aktief chirurgies. In 'n ander land, nie te ver hiervandaan nie, word die maagseer byna onmiddellik aktief en radikaal snykundig behandel, soms deur die algemene praktisyn self.

*Gesondheid* is volgens die Wêreld-Gesondheidsorganisasie 'n toestand van optimum psigosomatiese en sosiale welsyn. Deurdat fondse en ander middele nie oral dieselfde is nie, kan die *verwagtingspatroon* van die pasiënte, ten opsigte van die geneesheer, ook nie oral dieselfde wees nie.

Ek is baie bewus daarvan dat wat in Wes-Europa in 2 000 jare tot stand gekom het, nie in 'n ander klimaat en op 'n ander bodem in slegs 6 geslagte tot dieselfde peil van ontwikkeling kan kom nie. Baie kollegas van sendingstasies en van die Wêreld-Gesondheidsorganisasie het dit al ondervind. Tog het Nederlandse trope-dokters reeds voor 1940, in rubberplantasies op Sumatra met Javaanse arbeiders in ideale omstandighede dieselfde gunstige gesondheidstatistieke gekry as Nederlandse dokters in dieselfde jare in Nederland.

Suid-Afrika is in die gelukkige posisie om ook op mediese en higiëniese gebied te kan leer van die foute wat vroeër in Europa en Amerika gemaak is, bv. wat woningbou, hospitaalbeplanning en verkeer betref. Ek wil graag met nadruk daarop wys dat ek as 'n *private* persoon en lid van die Mediese Vereniging my *eie* reiservarings bespreek en nie die sienswyse van een of ander departement verkondig nie. Ek wil egter ook nie my eie sienswyse opdring nie.

## DIE OPLEIDING VAN DIE GENEESHEER

Graag wil ek in hierdie gees eers die opleiding van die geneesheer in die verskillende lande vergelyk.

Die historiese *Baccalaureus* en *Magister* grade van die S.A. universiteite is oorblyfsels van die Middeleeuse Gildestelsel van Europa, waarby 'n onderskeid gemaak is tussen leerlinge of geselle en meesters. (In Brussel kan 'n mens nog die pragtige Gildehuise bewonder.) Nederland ken nou geen geselle en meesters in geneeskunde meer nie, maar mediese kandidate (ná 3 jaar studie), *mediese doctorandi* (ná 5 jaar studie), *semi-artsen* en *artsen* (laasgenoemde ná 7 jaar studie). Sodra die arts 'n proefskrif of thesis geskryf het, mag hy hom *doctor medicinae* noem—spesialisasie begin eers ná die arts-eksamen. Eksamens in Nederland is skriftelik en mondelings.

Baie Suid-Afrikaanse dokters het al aan die Nederlands universiteite in Amsterdam (2), Utrecht en Groningen gestudeer en (of) gepromoveer. Hulle het my verseker, dat hulle in *Nederland* veral die deeglike opleiding in interne geneeskunde, die konserwatiewe kindergeneeskunde en verloskunde, en die sosiale psigiatrie geniet het.

Daar is al jare lank 'n ooreenkoms tussen die Suid-Afrikaanse regering en dié van Nederland, waarvolgens jaarliks 50 dokters toegelaat word om sonder eksamens in die ander stamland te gaan werk. Dit beteken dus 'n wederkerige waardering vir mekaar se opleiding.

Die Nederlandse artsopleiding word nou egter hersien met 'n eksamen ná elke jaar. Ná 6 jaar is die toekomstige Nederlandse mediese student dan *Assistent-arts*. 'n Assistent-arts kan dan in die toekoms kies tussen spesialisasie as 'n huisarts (AP) in een jaar, spesialisasie as 'n *sosiaal geneeskundige* in 2 jaar, of spesialisasie in 'n *klinies spesialisme* in 4 of 6 jaar. Die nuwe prosedure sal dus beteken, dat die toekomstige Nederlandse dokter nie vroeër tot die praktyk kan toetree nie, en dat die toekomstige kliniese spesialis geen enkele ervaring meer van huisarts-probleme sal hê nie. Laasgenoemde is volgens my 'n groot beswaar. Ons moet egter besef dat elke besluit in die huidige Nederland 'n kompromis is. Dáár sal in die toekoms dus maar min volledig gekwalifiseerde dokters wees.

In the future there will only be a few Dutch doctors, who will be able and approved to exercise the whole field of medicine, surgery and obstetrics. Until now every Dutch colleague was allowed to do this by law, but not paid for by the Sick Funds to which roughly 80% of the population belongs.

In the Dutch East Indies the training of doctors started as early as 1851 in Batavia. This was the first important, European based, medical school in the whole of Asia. This medical school was affiliated to the University of Utrecht in the Netherlands and Professors Boeke, Bylsma and de Langen went from time to time to Java as visiting professors. In 1913 a second medical school was opened in Soerabaya. Since 1950 there are more Universities in Indonesia, but unfortunately less facilities for real academic study.

In bygone years the Dutch specialist was registered with his own medical association, which was also responsible for his proper training. In recent years, however, the training and registration has been placed on a legal footing, as in South Africa. The old Dutch training system for specialists without examinations which depended on

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the goodwill and the time of the professor, appears to have been insufficient, but in fact provided the world with famous men like Snellen, v.d. Bergh, Boerema, Weve, Kloosterman, de Langen and Jongkees. I think the best export products nowadays are the Dutch specialists for rehabilitation, paediatrics and psychiatry. A new opportunity to specialize and register in the Netherlands has now been created in *social medicine* with branches in industrial medicine, *insurance medicine,* general health and management and youth health.

Coming from a small country with highly specialized medicine to a large country such as South Africa, the Dutch doctor is surprised to see so many cases of coronary thrombosis, congestive cardiac failure, hypertension, pneumoconiosis and rheuma and no private doctors *specialized and registered* in these frequent national diseases.

The newcomer from Europe admires the really wonderful round-the-clock *outpatient service in South African hospitals* even for private patients (and this is also of great interest for the private practitioner), but wonders that South African doctors do not have the opportunity to specialize and register in accident surgery and rehabilitation—not even in the large cities with their wealth of material. Would it perhaps be possible in order to attract more immigrant doctors, to advertise overseas the abundant latent opportunities in South Africa for specializing in pulmo-cardio- and vascular diseases, accident surgery and even in pathology? The world is becoming smaller and smaller, Dutch medical students are trained nowadays in special recognized hospitals in East Africa and Groote Schuur Hospital is training surgeons from all over the world in internal heart surgery.

After a while the immigrant doctor realizes again that the world is not built in one day and that super specialization in South Africa is irrelevant as there is a serious shortage of doctors—in 1965 already estimated at 2 000. He gradually becomes aware of the disadvantages of too much specialization and concentration of doctors in medical centres in a few big towns of a young and vast country with communication and transport problems and he remembers the old English idiom—a specialist knows more and more about less and less. There is another idiom that states: a nation gets the politicians it deserves, one could apply the same to doctors. Apparently the Dutch nowadays want or need lots of psychiatrists and doctors for social medicine, and for the control of their numerous social laws. This seems to be a waste of manpower in a world with a shortage of doctors.

England employs many doctors from India and recently established African Black States where the standard of living is such that their own people cannot afford a doctor's fee and certainly not a health service. Is it not a pity? And what about the right of all men to health? South Africans apparently want or need all-round general practitioners with a forte for surgery, even for obstetrics and medicine and there is apparently still a limited call for specialists (and male nurses).

It is strange for the newcomer to see that nursing in South Africa is still mainly a female vocation even in casualties, urology, orthopaedics—except in the mine hospitals.

The first European doctors in the Far East, were ship's surgeons. In the 19th century army doctors not only treated soldiers and their families, but also other European and Asian civilians. At last the Dutch East Indian Government appointed their own civilian doctors for preventive and curative medicine. After the revolution European mission doctors continued mainly with curative and individual medicine as an introduction to their main aim. Since the last world war Indonesia has become a corrupt and poor country with an enormous shortage of medical officers—so the 'doekoens' or witch-doctors have come into their own again.

### PRACTICE IN HOLLAND

And now, how do our colleagues practice?

The modern Dutch doctor has learnt to co-operate in a *team* specifically in mental hospitals, rehabilitation centres and children hospitals with i.a. psychologists, rehabilitation doctors and assistants, social workers, pedagogues, physiotherapists, occupational therapists, etc., that is to say, with experts from different disciplines, for psychosomatic disease need a multi-conditional approach.

In the Netherlands it is stated that every patient has the option of his own doctor, but in a small village with only 2 000 patients and in a small hospital with only one physician and one surgeon—this is fictional, especially in emergencies.

As a result of a whole number of social laws, a certain *control* of the patient, even by doctors is obvious. In the Netherlands this is not done by the private general practitioner but by a second type of doctor—the 'kontrolerend geneesheer' (KG).

Daar is dus 'n prinsipiële skeiding tussen die behandeling en die kontrole van die pasiënt deur die KG. Die meeste Nederlandse doktors vind dit baie belangrik vir die noodsaaklike vertroue van die pasiënt in sy eie geneesheer. Daar is bv. die KG vir skattings van arbeidsongeskiktheid (disability) in gevolge die wet op arbeidsongeskiktheid wat geen onskeid meer maak tussen die ongeskiktheid as gevolg van 'n ongeval of 'n siekte nie.

Die Nederlandse algemene praktisyn werk baie mooi saam met die distriks- of wykverpleegster van sy wyk; nie net met die algemene verpleegster nie maar ook met die wykkraamverpleegster of *kraamversorgster* veral in die buitestedelike gebiede. Die huisverpleging spaar ook kosbare hospitaalbeddens wat nou in Nederland reeds R20 000 per bed kos net om te bou.

Wykverpleegsters, kraamversorgsters en ook gesinsversorgsters is meestal in diens van kerklike maatskaplike verenigings, wat deur die owerhede gesubsideer word, maar die pasiënt moet self ook 'n betalende lid van die Kruisvereniging wees.

Ek moet hier nog meld dat die onvermoënde en minvermoënde pasiënte in Nederland deur die welsynsorganisasie verseker is by 'n siekefonds. Hulle kan dan na enige AP gaan. Daar is in Nederland dus *geen hospitaal- of vrypasiënte* soos in Suid-Afrika nie. Daar is dus ook geen behoefte aan groot 'ongevalle'-afdelings by die hospitale of distriksgeneeshere nie.

Die Nederlandse algemene praktisyn woon of bly meestal tussen sy pasiënte en hou spreekure by die huis wat

vir hom belastingvoordele bied, maar ook nadele het, veral oor naweke.

Die Nederlandse Mediese Vereniging is om mediesetiese redes nie ten gunste van *mediese sentra,* en *verpleeginrigtings* nie, veral nie as die dokters self eienaars is nie.

Die Siekefondse betaal algemene praktisyns nie vir spesialistiese werk nie, die gevolg is dat die Nederlandse algemene praktisyn meer hulle eie werk doen, soos die behandeling van psigo-somatiese siektes (50% van sy gevalle!).

Daar was vroeër in Nederland minder dokters met vennote soos in Suid-Afrika, met die gevolg dat daar veral onder die ginekoloë 'n groot sterftesyfer is. Groepspraktyke word nou bevorder. By die groep kan dan ook 'n vroedvrou, sosiale werkster en wykverpleegster ingeskakel word —'n goeie idee vir Suid-Afrika! Daar is ook opgeleide doktersassistente en verpleegsters vir hom beskikbaar.

### IN THE DUTCH EAST INDIES

And now the way we worked in the Dutch East Indies. Government doctors did a lot of preventive medicine and mass therapy concerning yaws, malaria and dermatosis. The missionary doctors preferred to do *individual* curative medicine. Long before the first World War the Dutch Reformed Churches introduced in the self-governed part of Java '*Djokjakarta*' a very good system of *integral* medical, social and pastoral health for the underdeveloped Javanese people consisting of a central situated hospital with all facilities and peripheral radial clinics round this hospital, at distances of 15 - 30 miles. In the central hospital, daily clinics were held. The peripheral clinics were visited by a doctor and male nurses once a week.

The underdeveloped people were attracted to these clinics by the then spectacular result of our Neosalvarsan injections against yaws. Gradually they gained confidence in our European medicine and in the end they were prepared to come to the central hospital and gradually they brought us their more desperately ill people.

It was a great pleasure for me to work along these sensible lines in 1945 - 50 as District Surgeon with an own hospital for the Government in Borneo as well.

In these hospitals natives had to pay a nominal fee for educational reasons and communication between doctor and patient was in the patient's language—Maleis or Javanese.