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PRESIDENTIAL ADDRESS AT THE ANNUAL GENERAL MEETING (M.A.S.A.), PRETORIA

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This is the first occasion on which the Chairman of Federal Council, the Vice-Chairman of Federal Council and the President of the Association are general practitioners. We also have the honour to welcome a very distinguished guest in the person of the President of the British College of General Practitioners. It is, therefore, fitting that I should say something of the place of the general practitioner in our profession and of his important role in our society. But, before doing so, I must place on record that in our Association there is no distinction between general practitioner and specialist. We are all members of the same Association, we all accept the same code of ethics and we all agree that the interests of the Association, as a whole, are more important than the interests of a group.

My predecessor in office is a distinguished specialist anaesthetist, no doubt the more distinguished because he has had the benefit of general practice experience before entering the ranks of the specialists. We are grateful to him for what he has done for our Association. He was preceded in office by an ophthalmologist—a man of the highest repute, a man who made service to our Association his life's work, and whose passing has been a personal loss to all who have known him and to all who were honoured by his friendship. Dr. du Toit well deserved the highest honours which the Association could bestow on one of its members. No-one has given longer or more faithful service to our Association. He will long be remembered. On your behalf I would like to assure Mrs. du Toit and the members of her family of our sincere sympathy and of our genuine sense of personal loss.

Dr. R. Schaffer

We are living in an age of science. At the beginning of this century it was possible for one man to have knowledge of all branches of science. It is now impossible for a single human brain to comprehend more than a fraction of the knowledge that has been gained in even a limited field. This applies to all the sciences, including medical science. It is, therefore, no longer possible for one individual to be competent to diagnose and treat all the disorders that may affect the human being. There must, therefore, be men and

women with special training, with special knowledge and with special skills in the ranks of the profession.

We cannot do without the specialist. He has become an essential cog in the wheel of medical practice and medical progress. There should be no antagonism between general practitioner and specialist. Their functions are complementary and cooperation between them is essential. The one is certainly not inferior to the other in status and he should also not be held inferior in public esteem. Both are essential, but it is right to state that the health and well-being of society depends primarily on the well-trained, conscientious and competent general practitioner. The general practitioner remains the backbone of the medical profession. Fortunately for this country the standards are very high, both as regards general and specialist practice. I do not know of any country where the standards are higher.

A great deal has been said and written about the declining status of the general practitioner and the urgent need for his rehabilitation. I have personally never had occasion to complain of loss of status and I am, as yet, not in need of rehabilitation. There is, however, a very urgent need to readjust the general practitioner to the changing needs of society and to train him so that he will be better fitted to fulfil his many responsibilities.

THE NATURE OF GENERAL PRACTICE

In order to discuss how the future general practitioner is to be trained and how the present general practitioner is to adjust himself to the changing needs of society, let us enquire into the nature of general practice.

No-one can tell what a general practitioner will or will not have to do. This will depend largely on where he is to exercise his profession and on the changing demands made upon him by the population; but he must be capable of dealing with changing situations. He cannot possibly have a complete and detailed knowledge of every medical discipline and cannot be expected to treat each and every disorder that may affect the human being. He should also not be a 'screener' who determines to which specialist a patient is to be referred. He must be able to give advice, and in many cases treatment, in all forms of illness and in most cases he may be on his own. The general practitioner does not practice in the sheltered environment of the teaching hospital where responsibility for diagnosis and treatment is shared. He also cannot rely on the radiologist or on the pathologist to make up his mind for him. The responsibility for the patient is his and his alone. It is true that he can, at times, refer the patient to a hospital and it is also true that he should have the opportunity of treating his patient in hospital, or, at any rate, participating in the treatment of his own patient. But hospital beds are few, distances often great, and patients unwilling. He can, of course, when circumstances permit, refer a patient to a specialist or to a senior colleague, but this is not always possible.

The doctor who assumes the responsibilities of general practice must be prepared to cope with each and every emergency. His knowledge must be such that he is able to diagnose and treat the common or ordinary ailments. He may treat more serious conditions and undertake major procedures when he has had the necessary training and experience in the particular field. But he must have the honesty, the common sense and the judgment to realize his limitations and to refer his patient to a specialist or to a more experienced colleague when this is necessary.

The general practitioner does not only require the basic medical skills in diagnosis and treatment, he must understand the main ways in which hereditary factors, living conditions and social forces affect the human being favourably or otherwise, and, above all, he must recognize that each patient who calls on him for advice is not just a patient, but also a person. He will know after a few months in general practice that diseases in patients are not quite the same as diseases in text-books. His knowledge cannot be limited to the pure scientific knowledge of the aetiology, the signs and symptoms, and the pathology of organic disease, but he must have a wide understanding of human nature and appreciate how anxieties and stresses are not only responsible for functional diseases, but also influence the course, the symptoms and the prognosis in organic disease.

The health situation in all countries has changed rapidly during the past quarter of a century and much of this change is due to advances in medical science. Thanks to the introduction of antibiotics, diseases which were once common are now extremely rare; but diseases which were extremely rare or almost unknown a quarter of a century ago are now becoming much more common. Modern methods of anaesthesia have made almost every part of the human body accessible to surgical assault and modern methods of diagnosis have made accurate diagnosis possible in conditions which were previously only diagnosed on the post-mortem table.

Some of the demands made on medical practitioners have also been determined by such information as the public has gained about advances in medical science. Sensational news items in the lay press about marathon operations, performed not only in America, but also in Cape Town, about artificial kidneys available in Pretoria and about surgical advances and surgical miracles in Johannesburg, have created a public demand for new and sensational treatments, particularly when publications such as the *Reader's Digest*, confirm the sensational reports. It is, therefore, essential that the general practitioner be well informed regarding all recent developments so that he can not only give sound advice, but also safeguard his patient's purse. There would not be so many overseas journeys if members of the public realized that the same advice and treatment can be given nearer home. Much unnecessary expenditure and much unhappiness would also be avoided if the patient accepted the family doctor's advice about the suitability of the well-advertised treatment in the particular case.

Unfortunately, there has been insufficient change in the medical curriculum to fit the new graduate into general practice, and the opportunities open to the established practitioner for acquiring the new knowledge and the new outlook are also few and far between. Students are today not trained to be general practitioners and, unfortunately, are also not always encouraged to be general practitioners.

There was a time when a physician was a general practitioner who limited his practice, as far as possible, to internal medicine. He reached eminence and, therefore, consultant status, after years of experience in practice. Today the medical teacher reaches the highest status, not because he has been in practice, but because he has been careful since

graduation not to lose his place in the queue. Professorial status is often conferred on the research worker who has gained eminence in a particular field. Such research worker is not necessarily an authority on the problems of general practice and is also not necessarily a competent teacher. Very fortunately South Africa has produced outstanding research workers who are also excellent and inspiring clinical teachers. We have every reason to be proud of the achievements of our young medical schools and universities, but it is necessary to point out that teachers with general practice experience would perhaps be of greater value to the students who are to be the future general practitioners.

It has become necessary in all countries, but particularly in this country, to decide what is to be the objective of undergraduate medical education. If it is the intention to give men and women the basic training of a doctor who will be fit, after serving an internship and working as a hospital resident, to assume the responsibilities of general practice, then we should so arrange our medical curriculum and so organize our intern and residency training programme as to fit the graduate for the duties and responsibilities he will have to assume. The quality of our future specialists will not be lowered if, before embarking on specialist training, the doctor is first taught the rudiments of general practice. The knowledge and training required of a general practitioner will not later on hinder a specialist, but will rather be an asset to him, giving him a wider sense of proportion and perspective in the exercise of his specialty.

EQUIPMENT OF THE MEDICAL STUDENT

I have already referred to what the general practitioner should know and what he may have to do. I would now like to refer to the basic qualities required in the medical student which will equip him for training as a general practitioner. I am definitely of the opinion that no student should enter a medical school until he is an adult, both as regards behaviour and conduct. He must be adult, not only in years, but also in his general education. He requires integrity, intelligence and capacity for work. He does not require an ability to memorize unrelated and often unimportant facts for a limited period so that he can satisfy the examiners and so obtain a first class matriculation certificate. We do not want medical students and doctors who can remember a great deal but understand very little. Students can, unfortunately, not be given a general education after entering the medical school. No time is permitted for such luxury. The student should, therefore, have received a basic education before entering university.

It is essential that the doctor, in order to command respect and maintain a position of influence and importance in society, should be an educated man or woman. The future doctor must have the ability to understand. He must be able to integrate his knowledge and experience, since only in this way can judgment, which is the most essential of all the qualities required of a practitioner, be developed. Unfortunately, the matriculation certificate is not necessarily evidence of satisfactory or sufficient education to qualify for admission to a university, and our educational standards must be revised and improved. A year spent in post-matriculation studies is, I think, essential in many cases.

Basic general education must introduce the student to the worlds of science and of man, must train his powers of reason, of observation and of imagination and, above all, teach him to express himself clearly and with logic. According to John Morley, an educated man knows when a thing is proved while an uneducated man does not. According to Sir Richard Livingstone, an educated man knows and an uneducated man does not know what is first-rate, and the best educated man is he who knows the first-rate in the most important human activities. I think it is essential that a doctor should know what is first-rate and should also know when a thing is not proved.

It is essential that both the student and the doctor should know that education is a continuous process, that there is very little value in memorizing facts which are out of date almost before they appear in print. Knowledge of a particular vintage no doubt has historical significance, but the doctor must know how to evaluate, and how to evaluate critically, the knowledge of the present, always remembering that what is accepted as valid theory today may be proved wrong tomorrow. I think it will be generally accepted that our present generation has learned far too much, but has understood far too little. The future general practitioner must both learn and understand a great deal.

Our medical student, starting with a wide general education and having mastered the basic principles of the medical sciences, must be taught that the patient is more important than his disease, and he must be given the opportunity of learning something about his patient. An elementary knowledge of sociology is more important to the family doctor than a detailed knowledge of laboratory technique. A basic knowledge of the science and art of dietetics is also more useful than a detailed knowledge of the more unusual neurological lesions. Above all, the future general practitioner must be given the opportunity of studying the patient in his normal environment, not in the artificial environment of the teaching hospital. He must know how to diagnose and treat minor ailments, how to give advice on matters of health and hygiene and how to keep his patients well rather than send them to hospital to be 'patched' once they are ill. It is also becoming very necessary that general practitioners should have a special knowledge of the problems of aging. Improvements in public health and in medical care, as well as advances in medical knowledge, have so increased the life expectancy of the population that each year a larger percentage of the population will be old. This has already created problems both in sociology and medicine. Each year more of our patients will be suffering from the degenerative conditions associated with old age.

It cannot be emphasized too often that the acquisition of a degree in medicine and a licence to practice the ancient art is not the end of medical education; it is merely evidence of fitness to go out into the world and learn how to become a doctor.

It is necessary that every graduate should serve a compulsory apprenticeship in a suitable hospital, but it is wrong that the future general practitioner should serve his entire apprenticeship in specialist departments in teaching hospitals. He will obtain wider and more useful experience in smaller hospitals and he can only learn the practice and principles of general practice from those skilled and experienced in the art. Positions on the resident staffs of teaching hospitals should be reserved for those who, having qualified as general practitioners, wish to acquire more specialized knowledge so that they can become more useful

to their patients, or for those who after general practice training wish to become specialists.

EDUCATION OF THE PRACTITIONER

How is the established general practitioner to improve himself professionally and make himself more useful to society? It is, of course, essential that he be given the opportunity of continuing his education so that he can become more expert in those particular fields in which he has shown aptitude and ability. The action of the authorities in making expenditure on postgraduate studies deductable from taxable income, has been a step in the right direction. This concession is much appreciated by the profession, and will, no doubt, pay handsome dividends in improved professional standards. But income tax concessions are not enough. The general practitioner needs sufficient leisure to rest, to read and to think, and he needs a secure income so that he can afford to have the necessary leisure. Otherwise he cannot possibly continue his education.

Contrary to general belief, the average doctor does not earn a very high income. While some doctors are, of course, super-taxpayers, others have difficulty in making adequate provision for their families. While medical fees have almost doubled, the cost of providing the service has more than trebled. The car which used to cost £300 now costs £1,200. Rents are higher. Receptionists' salaries are higher, and taxation has made it almost impossible to save. I know many wealthy doctors, but most have either inherited farms or inherited money which has been wisely invested. They have not become wealthy from the proceeds of general practice.

It is necessary that general practitioners so organize their affairs that they will be financially secure so that they may have sufficient time for postgraduate education. This can only be done if two or more practitioners are associated in practice so that each can take leave at regular intervals. If each member of a medical firm makes a particular field his special study, it becomes possible, not only to give expert general practitioner service, but also to give competent advice and treatment in the more specialized fields. This may not be necessary, advisable, or even possible in the larger cities, but it is of great advantage to the inhabitants of the smaller towns. Group practice of this kind is the most satisfactory arrangement both to the doctor and to the patient.

There are younger specialists who may, perhaps, find it professionally satisfying and also economically advantageous to leave the medically overpopulated cities and join general practitioner groups in smaller centres. It will, of course, be necessary for such specialists to become expert general practitioners.

REWARDS FOR EXPERIENCE

It is difficult to understand why a competent and experienced physician or surgeon, who is also a competent general practitioner, should be compelled to charge less for his services than is charged by the specialist who may have the same qualifications, but who may not necessarily have equal competence or experience. It is also unreasonable to expect the senior and better-trained practitioner to charge the same fee as is paid to his most junior and least experienced colleague.

It is right and necessary that the charging of excessive and extortionate fees should be condemned and prevented. Unethical conduct of this kind deserves both censure and punishment. But it is also right that there should be additional rewards for additional experience, training and competence. If the fees paid to the general practitioner are too low, he is compelled to see too many patients. The doctor who, as a result of his economic circumstances, or as the result of the nature of his practice, is compelled to see too many patients, cannot possibly give those patients the service he would give had an increased fee made it possible to devote more time to each case.

It is the accepted policy of the Medical Association of South Africa that, as far as possible, each patient should have free choice of doctor and that each doctor should have free choice of patient. I am satisfied that this is the right policy. Unfortunately, it is not always possible to apply this policy to patients in the lower-income group. Some form of panel system, giving either limited choice of doctor, or no choice of doctor, has been unavoidable for these patients. Irrespective of the nature of his practice, whether the general practitioner is engaged in private practice or is in full-time employment, he must be adequately remunerated and he must have adequate periods of rest and leisure so that he can give good service and keep himself up-to-date.

This country has undergone an industrial revolution. A major portion of our population, both White and non-White, has migrated to the cities and has become industrialized. It is inevitable that in an industrialized society the employers of labour must become interested in the health and welfare of their employees. It is in the interests of organized industry that there should be adequate medical services for all employed in such industry. There is no reason why organized industry and organized medicine should not agree on the best method of providing such services.

The specialist register introduced in 1938 has served one very useful purpose, in that it has restricted specialist practice to those who have been adequately trained. As the expert general practitioner should be as well trained as the competent specialist, he should enjoy equal status and be entitled to equal remuneration. Only the consultant, who sees patients only when referred to him by another practitioner, should have a higher status. Any doctor who is suitably qualified and who enjoys the confidence and respect of his colleagues, should be entitled to become a consultant. There can be consultants in all the specialties and the experienced general practitioner who becomes a consultant may in some cases render the most useful service.

A COLLEGE OF GENERAL PRACTITIONERS

When the South African College of Physicians, Surgeons and Gynaecologists was founded, it was hoped that opportunities would be provided for the professional advancement of the general practitioner. It is hoped that general practitioners will be admitted to the higher examinations of the College on the basis of their general practice experience and on the basis of experience gained in non-teaching hospitals. While, in the opinion of some, experience gained only in the teaching hospital is of value, in the opinion of others experience gained only in the teaching hospital is not enough. It is advisable that the clinical facilities and the clinical

(*Continued at foot of Page 978*)

mag misbruik word. As dit egter oordeelkundig gebruik word, kan dit van onskatbare waarde wees en sal dit nie meer as iets skrikwekkends beskou word nie, maar wel as 'n instrument van verlossing.

1. Jeffcoate, T. N. A. (1953): Brit. Med. J., 2, 951.
2. Lewis, T. L. T. (1956): *Progress in Obstetrics and Gynaecology*. Londen: Churchill.
3. De Lee, J. B. (1920): Amer. J. Obstet. Gynec., 1, 34.
4. Jones, E. P. (1952): *Kielland's Forceps*. Londen: Butterworth.
5. Cox, L. W. (1950): J. Obstet. Gynaec. Brit. Emp., 57, 197.
6. Assali, N. S. en Zacharias, L. F. (1947): Amer. J. Obstet. Gynec., 54, 651.
7. Hamilton, J., Jeffcoate, T. N. A. en Lister, U. M. (1949): J. Obstet. Gynaec. Brit. Emp., 56, 413.

POLYMYOSITIS

In 1863 Wagner used the term polymyositis to describe an acute generalized muscular condition with skin involvement that ended fatally within 6 days of its onset. Subsequently, most reports indicated uncertainty regarding the relationship between muscle diseases and skin lesions, the early authors using the terms polymyositis and dermatomyositis indiscriminately. Today it is recognized that there is a condition of polymyositis without skin involvement.

Recently Walton and Adams[1] have published a monograph, based on their experience with 40 cases in north-eastern America, in which an 'idiopathic' generalized disease of muscle is analysed in detail and compared with other myopathies. This polymyositis does exist in acute, subacute and chronic forms. The acute condition is rare, but the subacute and chronic varieties are more commonly found and are accompanied by little or no constitutional disturbance, pain or muscle tenderness, so that diagnostic errors can readily occur. Distinction from such diseases as progressive muscular dystrophy or myasthenia gravis may be difficult, so that special procedures such as electro-myography and muscle biopsy may have to be utilized.

Many attempts at classification of this pleomorphic syndrome have been made, but since even a single case may vary from time to time and qualify for inclusion in more than one group, and since the aetiological factors are unknown, arbitrary grouping has perforce to be accepted at present. Walton and Adams consider polymyositis (confined to the muscles) in one group, polymyositis with collagen disease (dermatomyositis) in another, severe collagen disease with minor muscle weakness in a third group, and polymyositis or dermatomyositis in association with malignant disease, in a fourth group.

The clinical picture of polymyositis may resemble a number of muscle, nerve or skin disorders and the pathological appearance may be relatively non-specific. Some of the more important points of differentiation from muscular dystrophy mentioned in the monograph of Walton and Adams are: (1) In childhood polymyositis tends to be the more common in females, (2) in many cases the disease progresses more rapidly than in the dystrophy, (3) spontaneous remissions may occur (unknown in dystrophy) and (4) all proximal limb muscles tend to become equally involved, unlike the distribution in dystrophy. The neck muscles, too, are usually severely affected; muscular atrophy is generally not as severe and pseudohypertrophy is uncommon. In polymyositis muscular pain and tenderness are much more likely to occur than in muscular dystrophy, and other changes in skin or collagen tissue may be present; the pathological picture of the muscle, as shown in electromyograms and biochemical tests, will indicate polymyositis as a specific syndrome in the majority of cases. The authors consider the various aspects of the disorder in detail.

There is general agreement that in many cases of this syndrome the disease process is related to the collagen or connective-tissue diseases. In some cases recovery occurs spontaneously, while other cases respond to adrenal steroid or corticotrophin therapy. The characteristic muscular symptoms and signs of polymyositis may precede, coexist with, or follow, collagen diseases such as dermatomyositis, scleroderma, disseminated lupus erythematosus, calcinosis universalis, and rheumatoid arthritis; while there may be cases unrelated to the collagen group.

It would appear that there is a syndrome of idiopathic polymyositis with the features indicated above. Polymyositis is an acute, subacute or chronic condition which may occur at any age, in either sex, in any form, in any site and with malignant disease. Weakness of muscles occurs particularly in the girdle and proximal limb muscles; variable constitutional symptoms and possibly florid skin or joint lesions may occur as well. The course of the disease may be rapidly progressive to a fatal termination with myoglobinuria in some very acute cases, or it may be subacute or slow. Some cases recover spontaneously, or only after steroid or corticotrophin administration.

1. Walton, J. N. and Adams, R. D. (1958): *Polymyositis*. Edinburgh and London: Livingstone.