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THE GENERAL PRACTITIONER AND THE FAMILY DOCTOR

The fundamental importance of the general practitioner in the scheme of medical practice is now generally appreciated and there is a general desire to see his status maintained and improved. The steps that are now being taken[1-4] towards the establishment of a South African College of General Practitioners will therefore be welcomed.

The question arises whether the general practitioner can be integrated with hospital services. In rural areas he inevitably remains in charge of his patient when admitted to hospital. Continuity of care by the same doctor, especially if he is the family doctor, has obvious advantages to the patient. In urban areas, however, with large hospitals, the position is different, and the patient's need for continuity of care must give way to the more urgent need for medical attention by specialists and for smooth administration of the hospital.

Here the general practitioner fades out of the picture, at least temporarily, when the patient is admitted to hospital, and it is therefore refreshing to read the description[5] by two paediatricians, Brimblecombe (of Exeter) and Lightwood (of London) of a scheme whereby the general practitioner and his patient can have the advantage of consultation by the hospital specialist and nursing assistance from the hospital while the patient *remains at home*. This scheme achieves continuity in the care of the patient, retains the interest and active participation of the general practitioner, provides specialist consultant and laboratory facilities in the patient's home, and results in substantial economy in beds and cost of hospital services. It merits consideration in all South African cities. The difficulties inherent in the collaboration of various agencies and authorities should not be insurmountable, and the benefit that would accrue to patient, doctor and taxpayer is obvious.

The family doctor alone is in a position to relate an illness to the background of the patient; he alone appreciates to what extent the recommendations of hospital specialists are practicable in the patient's environment at home and at work—for instance who shall give the insulin or who test the urine—; he is in the best position to judge concerning the likelihood of the disease to recur, or to occur in other members of the family; and he alone is able to apply preventive measures in relation to the individuals concerned.

The family doctor and the nurse are the health workers with the easiest and closest access to people, and 'these two operators in the field of family and social life are much more important than armies of psychiatrists and general physicians'. The health of the individual, and thus of the community as a whole, is much dependent on their efforts.

For these tasks the average medical practitioner is not adequately prepared. A study of the book edited by Malleson[5] (reviewed at p. 1181 of this issue of the *Journal*) will be of value to all medical practitioners and is likely to be of great benefit to their patients. The social aspects of medical practice also call for serious consideration by those responsible for the training of medical students. A patient should not be treated as a 'machine sent for repair' and it is the duty of the hospital teaching staff—although a difficult duty for many specialists—to direct the attention of the medical student to the everyday problems of family practice.

In a chapter of this book, Evans describes the functions of the family doctor, as distinct from the general practitioner. The family doctor is the person 'to whom any member of a given family, of whatever generation, automatically turns for help in times of trouble'. It is often stated that the family doctor, as the trusted and esteemed family adviser, is largely a thing of the past. This is by no means wholly true; and the need for the family doctor is as great as ever. It remains an important function of the enlightened general practitioner to fill the role of the family doctor.

1. Van die Redaksie (1958): S. Afr. Med. J., 32, 799 (9 August).
2. News Item (1958): *Ibid.*, 32, 1009 (11 October).
3. *Idem* (1958): *Ibid.*, 32, 1028 (18 October).
4. *Idem* (1958): *Ibid.*, 32, 1054 (1 November).
5. Malleson, N. ed. (1958): *The Matrix of Medicine—Some Social Aspects of Medical Practice*. London: Pitman Medical Publishing Co. Ltd.

PUBLIEKE BYDRAES VIR OORSESE BEHANDELING

Gedurende die laaste aantal jare het dit herhaaldelike kere voorgekom dat openbare lyste geopen word met die doel om pasiënte oorsee te stuur vir mediese behandeling. Teen die feit dat 'n pasiënt oorsee gaan vir behandeling as hy dit in hierdie land nie kan ontvang nie of as hy dit kan bekostig om te gaan, bestaan daar natuurlik geen beswaar nie. Trouens, die mediese professie self sou so 'n stap aanmoedig en nodige reëlings daarvoor tref.

Daar bestaan egter tog bedenkinge in hierdie verband, en wel om die volgende redes: In die eerste plaas gebeur dit soms dat publieke insamelings gedoen word om 'n pasiënt vir behandeling oorsee te stuur terwyl die pasiënt die behandeling net so goed hier kan ontvang. Hierdie beginsel is ongesond en lei tot onnodige verspilling van die geld van die publiek.

In die tweede plaas—en dit is eintlik die ernstigste oorweging—word groot somme geld soms ingesamel om pasiënte wat aan ongeneeslike kwale ly oorsee te stuur. Optrede van hierdie aard lei nie net tot onnodige verspilling nie, maar tot groot teleurstelling en verdriet omdat dit valse hoop wek by die pasiënt en by sy verwante.

'n Derde beswaar is dat die besluit om pasiënte oorsee

te stuur so dikwels nie deur mense geneem word wat bevoeg is om dit te doen nie. Welmenende persone besluit soms op sentimentele gronde alleen om sulke openbare insamelings te doen om pasiënte oorsee te stuur.

Aangesien die Mediese Vereniging reeds lank al besorgd is oor hierdie toestand van sake, is die probleem by geleentheid van die laaste Federale Raadsvergadering volledig bespreek. Die verteenwoordigers van die mediese professie wat die saak by die vergadering van die Federale Raad bespreek het, voel dat die saak in alle eerlikheid en opregtheid benader moet word om die pasiënte, die publiek en die mediese professie self te help, maar ook te beskerm. Geen kanse op herstel moet aan iemand ontsê word nie. Maar valse hoop behoort nie gewek te word op die gronde van onbesonne optrede nie.

Om dus aan almal wat by 'n saak soos hierdie betrokke mag wees reg te laat geskied, het die Federale Raad van die Mediese Vereniging van Suid-Afrika besluit om vertoë tot die Minister van Justisie te rig en hom te versoek om opdrag aan magistrate te gee om nie verlof toe te staan vir die insameling van gelde om pasiënte oorsee te stuur nie tensy sulke openbare insamelings deur geregistreerde welsynsorganisasies gehanteer word sodat die saak deeglik ondersoek is met samewerking van die mediese professie. Die bedoeling van die mediese professie is dus nie om negatief op te tree en pasiënte moontlike herstelkanse te ontneem nie, maar om raad en advies te gee en saam te werk om 'n praktyk wat dreig om vrugteloos en skadelik te wees, te voorkom.