Suid-Afrikaanse Tydskrif vir Geneeskunde : South African Medical Journal

Kaapstad, 14 Oktober 1961 Deel 35 No 41 Volume 35 Cape Town, 14 October 1961

PRESIDENTIAL ADDRESS AT THE ANNUAL GENERAL MEETING (M.A.S.A.), CAPE TOWN*

J. A. CURRIE, M.S. (LOND.), F.R.C.S. (ENG.), *President of the Medical Association of South Africa*

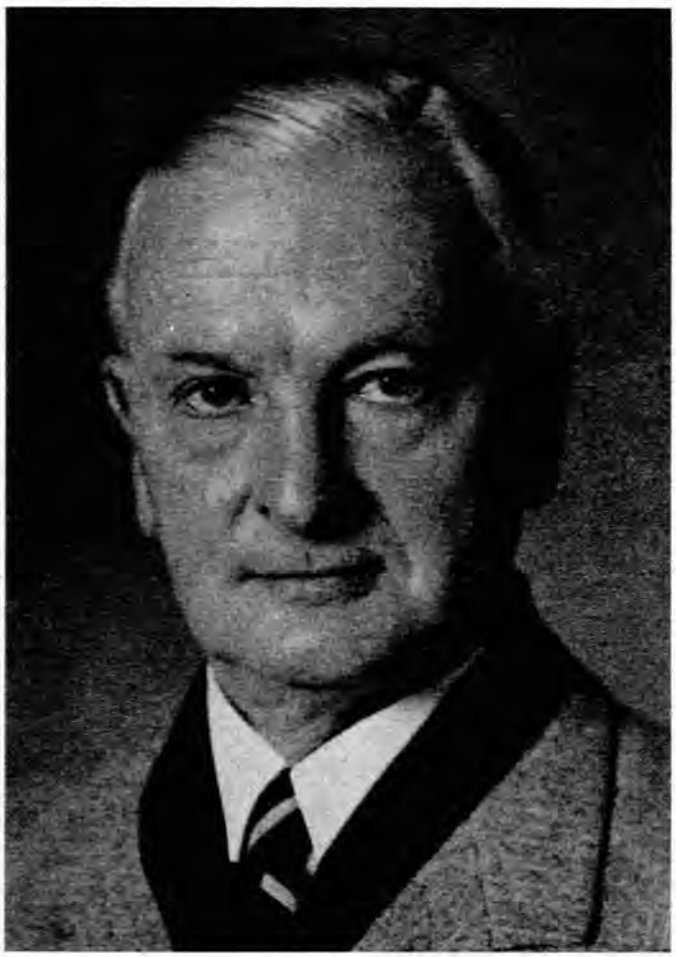
The perpetration of a cliché at the commencement of a Presidential Address requires a certain amount of courage. This is particularly so when the thought expressed is not only hackneyed and time-worn, but also widely questioned. I propose nevertheless to adopt as my thesis the idea that general practitioners form the backbone of the medical profession.

The functions of the vertebral column have been defined as the support of the trunk, the transmission of its weight to the pelvis and lower extremities, and the protection of the spinal cord.

If this analogy be accepted as not too fanciful, our medical backbone can be regarded as supporting the whole body of the profession, bearing its burdens and giving it momentum, and by wise interpretation and assistance helping patients to understand the activities of consultants.

To do this the general practitioner must be educated in an appreciation, at least, of the techniques and approaches of the specialists he advises his patients to consult. His training must be sufficiently catholic to enable him to speak with some authority on all branches of medicine. It is of course only right that years of arduous and often unremunerative preparation should be recognized and rewarded in the case of the specialist, but I sometimes feel that it is the general practitioner, if he is to be a good one, who should be specially selected and specially prepared for his task.

This preparation must of course be shared with all other types of doctor. Whatever their future, medical students cannot be expected to appreciate all the factors involved in their selection of any particular medical career until they have had considerable contact with medical matters. Early differentiation, even in ambition, is a mistake, for youthful enthusiasms can be aroused and imaginations stirred by a succession of attractions.



Mr. Currie

A Good General Education

The first pre-requisite is a good general education. It cannot be emphasized too strongly that doctors are and should always be members of a learned profession. However refined and accurate the technocracy which they adorn, they will never reach full stature without the human breadth given by some initial capacity for a general interest in a variety of subjects. Others have written of the two cultures, Science and Humanism, with medicine in between, steadily tending to move in an Arnethian shift to the left away from the broader cultures. I feel that we must keep our students in contact with those in other faculties. Mercifully, the social and athletic activities of academic life tend to de-segregate the doctor.

One desideratum in an educated man is the gift of being explicit and articulate in language. In a bilingual country such as ours, the really perfectly bilingual have so great an advantage in mental agility and elasticity that they are to be greatly envied, provided that the trap of mediocrity in both languages can be avoided. This projection into another language should usually make it easy to have some acquaintance with a third, and I feel that doctors should learn one of the major European languages for its interest, its literature, and the access it gives to appropriate medical publications. To this polyglot

* Held at the City Hall, Cape Town, on Monday, 25 September 1961.

equipment might well be added a basic knowledge of the Bantu tongue most prevalent in the area.

Medical Training

We will assume that our embryo doctor is reasonably well educated, is interested in ideas, and has reached a medical school. He is now subjected to a series of disciplines which should not only give him a smattering of science, but should also fill him with an appreciation of main principles, perhaps in some cases useful memories of certain scientific details, and a mode of thought which will fit him for his career.

From then on his education is in the hands of a variety of medical specialists and it is often claimed that this is wrong, since no training is given for general practice. I do not agree. Training for general practice must come, but it is right to subject the student in his training to the full pressures of academic thought. He is still undifferentiated, a pluripotential cell in the medical blastema, and his evolution demands these pressures. One of my worries about students, however, is the quickfire changes to which they are subjected. In my day we attended outpatient sessions for hours, postmortems for what seemed like ages, and lectures whenever we could not avoid them. Nowadays the life of our students is parcelled out in a series of short, high-powered sessions, and I wonder that they ever have time for any continuity of thought. However, the results seem to be good.

Teaching for general practice is of course a necessity, unless general practice vanishes as some think it will. A shining example of what can be done is to be found in the General Practice Teaching Unit of Edinburgh University, where two groups of general practitioners, each associated with a nurse and an almoner, all holding University appointments, are responsible for the compulsory training in General Practice of all the medical students at the University. Some such scheme as this should, I believe, be adopted everywhere.

Having now converted our embryo medical practitioner into a basic doctor (a horrible phrase for which I can find no substitute), thoughts on differentiation, previously entertained, must come to fruition; but I do not think that the future general practitioner should immediately launch himself into practice. Some people advocate three or four years of postgraduate work for the practitioner. This is obviously impracticable for economic reasons, but it should be as long as possible.

The Present State of Medical Practice

I wish at this stage, having brought our doctor to his practice, to examine the present state of that practice. To revert to my earlier analogy, we shall now examine the disc lesions, subluxations, and other disabilities which affect our medical backbone.

A study of general practice must necessarily take into account variations in practice in different countries, and even from place to place in the same country. In some places doctors seem to be as yet unaffected by the dissatisfaction which oppresses their colleagues elsewhere.

The main complaint of general practitioners is that, owing to the development of specialities on the one hand and health services on the other, more and more of what used to be their work is being taken from them. In some countries, moreover, they are steadily losing all real contact with hospitals. They cannot treat their patients in hospital, they are deprived of those daily informal contacts with colleagues which form so vital a part of medical education, and, worst of all, the limitation of their activities leads to the assumption that they are a very ordinary sort of doctor, inferior in status to the specialist, and lacking in superior skills. To have the right to expertness denied to one is even more galling than to have one's living curtailed, and however much the position of the general practitioner needs re-appraisal in the light of the advance of specialization, this position becomes emotionally intolerable unless the importance of his functions is clearly established and widely recognized. In countries where differentiation between specialists and general practitioners is most marked, a widening gulf between the two groups is inevitable unless special steps are taken.

It is interesting to note that in Great Britain, where under the National Health Service the position of the general practitioner is carefully preserved, he is at the same time denied access to hospital beds and has to seek his salvation in other directions. That he is doing

Mr. John Alexander Currie is the son of the late Dr. O. J. Currie who was a well-known practitioner in the Southern Peninsula and after whom the Currie Block of the Wynberg Hospital was named. Mr. Currie was a student at Guy's Hospital, London, and during the first World War he served as a 2nd Lieutenant in the Royal Field Artillery. He received the diploma of M.R.C.S., L.R.C.P. (Lond.) in 1923, and the degrees of M.B., B.S. (Lond.) in 1924. He practised between the two World Wars as a general practitioner, and in 1938 he received the degrees of M.S. (Lond.) and F.R.C.S. (Eng.). In World War II he served as a Major in the South African Medical Corps. After the war Mr. Currie returned to Cape Town where he has practised as a specialist urologist. In addition to his private practice he is on the staff of the Groote Schuur Hospital and the Victoria Hospital, Wynberg. For many years he was also part-time urologist to the Military Hospital, Wynberg.

Mr. Currie has contributed a number of articles on urological subjects to the South African Medical Journal. *Since his return to Cape Town, Mr. Currie has taken a keen interest in the affairs of the Medical Association of South Africa. After serving on the Branch Council of the Cape Western Branch, he was elected to the Federal Council in 1953. As a member of Council he has served on the Central Committee for Contract Practice and is now a member of the Executive Committee. He was made President-Elect of the Association in 1960.*

so very effectively is evident from a perusal of the Journal of the College of General Practitioners, of which an active Faculty exists in this country. This, and similar bodies in Canada, New Zealand, Holland, the United States and elsewhere, have been responsible for a recrudescence of the flame of learning and a spirit of self-confidence in countries where it was previously flagging. Journal clubs, the circulation amongst members of recorded talks, and an obligatory attendance at refresher courses from time to time have all tended to stimulate a renaissance of that spirit of perpetual studentship which is the need of every doctor of whatever sort. One of the duties of Medical Associations is to bring doctors together. The College of General Practitioners brings general practitioners together in a special unity of aim and a special group consciousness, but, as is clearly apparent in its programmes and publications, it also brings general practitioners and specialists together. In this respect I claim that the various colleges are merely doing what the National Medical Associations have always done, but doing it in such a way as to place special emphasis on the educational needs of the general practitioner, and to foster his pride in his task. The two types of organizations are both needed and should give one another mutual support.

Problems of General Practice

No one interested in the problems of general practice should fail to read the articles on general practice on the Continent and in America published in the *British Medical Journal* early this year. Cronhelm's enthusiastic report on Canadian practice, Fulton's more critical assessment of the position in the United States, and Fry's account of Denmark, Holland, and Sweden (in the last of which countries true general practice is apparently dead) make fascinating reading. Resemblances and contrasts may both help us to understand what we wish to have in our own country.

In America, apart from the large hospitals in great centres, all general practitioners have access to local hospitals. To deny them this access would be to deprive them of their living, since the tendency is for all seriously ill patients to be admitted to hospital.

In some of the intermediate hospitals general practitioners are permitted facilities for the performance of surgical operations, but there are many checks and safeguards. Each department in such hospitals is under the authority of a departmental head who is a specialist. Facilities may be withdrawn from an operator who seems to be exceeding his capacity. All doctors on the staff must attend staff meetings where criticism is liable to be severe, and 'tissue committees' examine specimens removed at operations. Similarly, general practitioners may give anaesthetics, but the hospital boards insist on a high standard of training and performance. I know from personal experience that some general practitioners can reach and maintain this high standard. Many of you will remember the anecdote about a well-known doctor, a habitual anaesthetist, who was asked anxiously by a patient if he was a specialist. He replied 'No, but I am an expert'.

It would seem that in Canada general practice is holding its own, but in the United States it is on the wane and specialism on the upgrade, so much so that Fulton quotes a patient who laments that although she has a good gynaecologist for her menorrhagia, a first-class dermatologist for her eczema, and a very efficient endocrinologist for her tendency to hyperthyroidism, she sometimes wishes that she had a doctor.

In days past general practitioners attached to hospitals tended to give a full service, and this included surgical operations. Many of them were highly skilled surgeons and did work of the highest order, often in situations where there was no one else available to do the work. It is, however, to be questioned whether surgical work done by the mass of general practitioners was as beneficial as the work now done by those specially trained. And yet it would be, in my opinion, completely wrong to allow a man to qualify with no capacity at all for, at least, emergency surgery. And the so-called 'minor surgery', which, however minor, must still be based on surgical principles, is part of the daily life of the good all-round practitioner. In spite of modern ease of transport there are remote or less accessible rural areas where it is incumbent on doctors to be adequately trained in emergency surgery, and it would be wrong to exclude such training from the curriculum. The same applies to anaesthetics — which is certainly a highly specialized and expert branch of medicine, but one at which doctors in rural areas must be reasonably proficient. I do not, however, believe that such operations or such anaesthetics should be contemplated without training under supervision and much burning of midnight oil.

The Relationship between General Practitioners and Specialists

The rigidity of separation between general practitioners and specialists needs modification in the sense that emergence from one branch of the profession to the other should not be wholly impossible. We need more elasticity in our concepts. My eyes were certainly opened by certain editorial statements in the Journal of the College of General Practitioners for May 1961, which discussed the report on the medical staffing structure in the Hospital Service in Britain. The report was produced by a Joint Working Party under the Chairmanship of Sir Robert Platt, and included no general practitioners. Nevertheless, the working party envisaged an extension of hospital posts available to general practitioners, and contemplated in certain cases the performance by such practitioners of surgical operations. The report even went on to advocate that 'in some instances a general practitioner, who has continued to work in the Hospital Service in such a capacity, might later be chosen for a consultant post and pursue a career as a consultant concurrently with one as a general practitioner'. As the editorial suggests, surely the wheel has turned full circle!

In South Africa we have large numbers of smaller hospitals, some attaining the proportions of small general hospitals, which are staffed by both specialists and general practitioners, or, in the case of rural areas, exclusively by general practitioners. I should like to see this situation perpetuated, with the proviso that the enormous privilege

of a hospital appointment, and association with one's colleagues, should be paid for. The payment exacted is hard study and arduous work.

However, it must be realized that specialization has come to stay, and that the majority of general practitioners will not practice major surgery or give many anaesthetics. What then is the public to expect of the general practitioner, the family doctor, the friend and adviser who was formerly equal or thought to be equal, to every exigency of practice?

The Ideal General Practitioner

In the first place he must have, as I indicated earlier in this address, a broad enough knowledge of medicine and surgery and their techniques to enable him to give his patients informed advice, to quell their fears, and to encourage their convalescence. His general medical knowledge must be adequate and up-to-date, so that he can cope with the majority of their illnesses by virtue of his own intellectual resources and manual skill. He must be a clinical diagnostician, a knower of syndromes and an eliciter of clinical signs. He must be a psychologist, not necessarily wholly invested with the somewhat awesome authority of the psychiatrist, but at least versed in the main practices and concepts of the psychiatrist's approach. Perhaps he may temper this with a little common sense, a sense of the economic needs and limitations of his patients, and a vast amount of that gift for therapeutic listening which all patients value so much. He must be kind, but must never abdicate from that authoritative approach which patients in their hearts respect and, above all, he must be available. This question of availability confronts us with a problem. The modern tendency to form firms of general practitioners has the advantage of giving doctors days of leisure, days of study, and periods of well-earned leave. In this group practice it often happens that the doctor for whom a patient sends does not arrive, but one of his partners (who is not so much liked by that particular patient) comes in his place. This is inevitable. Nevertheless, the wishes of patients should be respected as far as possible, and the old rule of always going if sent for by a patient 'in the practice', should be followed. Somebody should go.

From the point of view of the specialist I feel that the general practitioner is indispensable. Domiciliary visits by specialists are not as unpopular in Canada or America as they are here or in Britain. I believe that they are a mistake, except when undertaken at the request of a general practitioner or in consultation with him. The patient should be in his doctor's care before going to hospital or a nursing home, and should return to that care afterwards, and the doctor should know what has been going on. He is the hub of the wheel, whose radiating spokes lead to a variety of consultants. Shopping around at the periphery, with no one knowing which spoke the patient will flit to next, is a profitless procedure.

If a doctor does this job well, he will enjoy his life, benefit his patients, further the cause of medicine, and do something to merit Robert Louis Stevenson's somewhat extravagant praise of doctors as the flower of our civilization.

Such a doctor deserves reasonable emoluments and does not always get them. I have sedulously avoided, in this address, a consideration of the vexed question of medical economics. That, as Kipling says, is another story.

Die Broederskap van Geneeshere

Alhoewel dit nie die langste deel van my toespraak is nie, handel hierdie deel wat ek nou in Afrikaans wil lewer oor 'n onderwerp wat baie na aan my hart lê en waaroor ek besonder sterk voel. Die feit dat ek dit in Afrikaans lewer, beteken egter nie dat ek dit net aan my Afrikaanse kollegas rig nie. Ek dink hier aan die hele professie.

Wat ek wil sê, handel oor die noodsaaklike eenheid van alle dokters as een groot geheel — 'n groep geesverwante wat, soos Nelson se kapteins, bymekaar gehou word deur die gemeenskaplike bande van veeleisende opleiding, gemeenskaplike belange, streng dissipline, en toewyding aan 'n ideaal wat deur almal aanvaar word.

Die tye het egter verander. Die eise wat deur die Mediese Professie gestel word, is grotendeels eise wat ons op onsself lê, en ons kan ons doelstellings slegs bereik deur oortuigingswerk te doen.

Die uitgesproke doel van die Mediese Vereniging van Suid-Afrika is om die eer en belange van die mediese professie te bevorder, en dit is belangrik om hier daarop te let dat die woord ‚eer' eerste genoem word.

Ek voel oortuig daarvan dat hiermee bedoel word dat ons ons pligte sowel as ons voorregte naarstiglik moet koester, dat ons die belange van ons pasiënte bo ons eie belange moet stel, en dat ons ons mededokters as vriende en kollegas moet bejeën in die gees van welwillende en hulpvaardige mededinging.

Die Tak Wes-Kaapland is u gashere by hierdie Kongres, en, ten spyte daarvan dat die Kongres noodsaaklikerwyse in die Moederstad plaasvind, moet dit onthou word dat ons ten volle put uit die beste vermoëns en bronne van altwee ons mediese skole. Ons funksioneer inderdaad nie as teenoorgesteldes nie maar as aanvullendes. Die verskillende tale wat ons praat is nie 'n belemmering nie, maar 'n uitdaging. Die herkoms van ons leermeesters, van ons studente, en van ons pasiënte mag verskillend wees; maar hierdie verskille sal verdwyn, en ons twee universiteite sal enerse, aanvullende en gelyke mededingers word — die Yale en Harvard of die Oxford en Cambridge van ons land.

Die strewe van die Vereniging is om genoegsame vergoeding vir dokters te verseker, om wetenskaplike standaarde hoog te hou, om ons pasiënte te beskerm, en om die dokters self gelukkig en besield te hou. Bowe alles wil ek egter graag hierdie beginsel beklemtoon — dat alle dokters vandag, afgesien van hul ras, taal, of oorsprong, ons professionele kollegas en goedgesinde bondgenote is.

As alles wat ek hier genoem het werklik ons oogmerke is, moet ons die volgende vraag aan onsself stel: nie wat het die Vereniging vir my gedoen nie, maar wat het ek vir die Vereniging gedoen?