THE SEVEN AGES OF MEDICINE*

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'All the world's a stage,
And all the men and women merely players:
They have their exits and their entrances;
And one man in his time plays many parts,
His acts being seven ages . . .'

This quotation, from that great poet, playwright and sage, William Shakespeare, epitomizes the evolutionary stages of any kind of man, whether he be uncultured or cultured, beggar or king, patient or doctor. I speak as a humble member of a profession which struggles with all its might to keep pace with the economic revolution of this day and age on the one hand, and to maintain its traditional nobility of character, on the other. In this tremendous battle the medical practitioner finds himself confronted with the most intricate of problems; if he has a conscience he finds himself at times well-nigh split asunder in his endeavour to maintain the high ethical standards on which he was reared, and at the same time maintain the high social and economic standards which are expected of him as a member of that stratum of society into which he is always classified.

*Valedictory address.

Dr. Beiles

The reason for this struggle, and the events leading up to it, merit careful examination and analysis. It is my object to conduct this self-scrutiny, and, to facilitate this, I propose to divide our lives into 7 ages, with no apologies to the memory of the greatest English man of letters.

'At first the infant, mewling and puking in his nurse's arms'. How like this babe in the cradle is the 1st year medical student, and whence did he come? He came from a high school, a boy so immature in mind and body that the very thought of his commencing on a medical career is, to say the least, quite laughable. And how was he selected? Is the average matriculant at 17 years of age sufficiently mature to em-

bark upon a medical career? Should he not perhaps in the first instance be nursed through a less narrow university course, so that his already pinched high school education is not forced to continue in this confined manner? So that, in fact, he may ultimately emerge from the medical school, not a peculiar specimen of humanity with a highly scientific knowledge of medicine and nothing else at all, but an individual able to take his place in society alongside any man, able to discuss the arts and the humanities—a man with that broad outlook and vision expected by the layman of his medical advisor. When we stepped up to the dais at our graduation ceremony, did not each one of us ask himself: 'What is the knowledge that I have? What do I know?' Did we not enter the cruel world, from the sheltered existence of high school, medical school and hospital, with a feeling of utmost apprehension? Why this nervousness, why this lack of confidence? Surely the background of a university arts course, with its broadening outlook in the arts and the humanities, would have prepared us to make better medical practitioners, right from the very start.

More than ever before thought is being given in medical schools in this country to the selection of students, and yet up to the present time not much advance has been made in this direction. The characteristics to be considered in an applicant for a medical course at university are two-fold, *intellectual* and *non-intellectual*. In considering the intellectual aspect, it is agreed at the outset, by authorities who have made a life's study of student selection and medical curricula (not the least of whom is Dr. G. E. Miller, of the University of Illinois), that the most consistent single predictor of a medical student's success, measured in terms of academic achievement, is his matriculation aggregate. In American schools 90% of those who enter medical schools ultimately graduate, and only half of the remaining 10% withdraw for academic reasons.

Among the so-called non-intellectual characteristics are motivation and mental stability. What are our motives in entering the medical profession? To be able to help people is often given as one of our main motives, but it is doubtful whether this motive is initially a very honest one. A far more likely motive is to gain status and position in society. In any event a personal interview is required in order to discover non-intellectual characteristics, and this is by no means an easy ideal to achieve. I understand that at the Hadassah Medical School in Jerusalem, Israel, such personal interviews are carried out. I understand, too, that there selection is considered to be of major importance, and that as a result student failure in any year of the medical course rarely if ever occurs. Here, surely, is a virgin field for study by our medical school administrators and teachers. And we know, and are indeed proud of the knowledge, that in this city the first National Conference on Medical Education is being held in July of this year, organized by teachers in the Medical School of the University of Natal. This we must watch with the keenest of interest, and make quite sure that the pearls that will be dropped by the experts from America, the United Kingdom and Europe, as well as from within the Republic itself, will not be cast among swine, but will be nurtured, recorded, and used to the greatest possible advantage in all the medical schools in this country.

'*And then the whining schoolboy, with his satchel, and shining morning face, creeping like snail unwillingly to school*'. How like this creature is our fully-fledged medical student, now in his 2nd, 3rd and 4th years. When we think back on these years of training, are we satisfied with them, and, if not, have we any constructive criticism to offer? Were we taught enough anatomy, or too much? Was not perhaps over-emphasis placed on the very detailed structure of the human frame? Could not more time be devoted far more profitably to what we call today functional anatomy, in order to bring to life a subject which has always been as dead and dull as the proverbial dodo? Surely if more emphasis were placed on developmental anatomy coupled with the important subject of genetics, the 2nd year student would emerge more a practical scientist and less a walking encyclopaedia of dry anatomical facts. I have less comment to make on our present physiological and pathological training, which by and large in the post-war years has developed to a highly commendable level. However, sufficient emphasis is still not placed upon pathology, and somehow, somewhere, more time must be devoted to a subject upon which hangs the very basis of the science which we study and profess to practise.

'*And then the lover, sighing like furnace, with a woeful ballad made to his mistress' eyebrow*'. In this category is placed the senior medical student and intern. The responsibility for the training of this group of young men and women, not in the composition of ballads, but in the practice of medicine, is placed upon a few teachers, some of whom unfortunately do not fully realize the tremendous issues involved. Habit dies hard, and habits acquired in the immaturity of the early twenties never die. How easy it is, after 24 hours spent with a doctor, to be able to assess the exact standard of his training school. We who would guide the footsteps of the future medical practitioner, let us first take stock of ourselves. Let us decide quickly and surely what is basic and fundamental, and what, from the teaching aspect, is superficial and redundant. Let us not confuse our student by forcing him to count the branches and even the leaves, when he could achieve clarity of thought by knowing merely the number of trees.

'*Then a soldier, full of strange oaths, and bearded like the pard, jealous in honour, sudden and quick in quarrel, seeking the bubble reputation even in the cannon's mouth*'. How well this describes our registrars and young general practitioners—and also a small number of young specialists, just to complicate the scene a little more. Jealous in honour—yes, how very true—and striving against seemingly insuperable odds to establish himself in the community, to make for himself a reputation which will satisfy his ambition and the ambitions of those who are near and dear to him. This group, and the next (the senior general practitioner and the specialist), make up the bulk of our profession, and it is for them that the problems of medical practice loom ahead with frightening consistency—the ever-threatening iceberg in the course of an already almost lost and floundering ship. History teaches us so many things, and this is true also of medical history. We learn that in the years before World War I, and in the early years following the war, medicine was free. By this is meant that the individual, be he patient or doctor, was free to choose and free to treat. And because of this very freedom abuse was taking place, abuse to the extent that the ethics of the profession were involved. It seems that by virtue of this freedom, of which the medical profession has been so proud, a state of affairs has come about whereby the lay public finds itself sorely tried and quite unable to afford to pay for calamitous accidents, which occur from time to time, and even for the everyday run of ordinary ailments. A multitude of circumstances (including improved diagnostic and therapeutic means becoming available in our times, as well as the ever-increasing cost-of-living spiral), which I do not propose to detail tonight, have combined to make medical and dental services and medicines quite prohibitive to Mr. Average Citizen. The Government in its wisdom has become more and more aware of this in recent years, and in its greater wisdom has set up a commission to investigate, consider and report upon all factors responsible for the high cost of medical services and medicines and the manner by which they can be reduced.

'*And then the justice, in fair round belly with good capon lin'd, with eyes severe, and beard of formal cut, full of wise saws and modern instances; and so he plays his part*'. Senior practitioners and men of responsibility and great organizational ability have gathered together to study these factors responsible for the high cost of medical services and medicines. And what have they discovered? They have found that it is necessary for the medical profession to attain and apply a higher degree of discrimination in its professional work, whether it be diagnostic, therapeutic or general patient care. They have found, too, that it is necessary for the public to get together and dilute the cost of organized medical cover over the greatest number of participants and over the longest period of time.

From these 2 factors stem a large number of recommendations and some very interesting findings with which we may or may not agree. It is recommended, firstly, that there be formed medical schemes with compulsory membership for all White employees of the Central Government, Provincial Administra-

tions and local authorities; secondly, that compulsory membership of medical schemes by employees of all firms be a condition of employment; thirdly, that schemes be created which are available to individuals, small groups and all self-employed persons. There has been strong criticism of the Medical Plans, sponsored by the Medical Association. These are envisaged as schemes planned by the doctors for their own benefit, and our bearded pards recommend that bodies in control of medical aid societies be so constituted that at least half their members are chosen by and from the ranks of members. The Natal Medical Plan has been very much to the fore in this connection, being the first, if not still the only, Plan in the Republic to have a substantial number of lay member representatives on its Board. And it may be added in all humility that other Plans in the Republic would be well advised to follow suit if they have not already done so. The benefit to the Natal Medical Plan Board of the advice of lay members whose business and organizational experience is far and away beyond anything achieved by any medical practitioner, has been of inestimable value and is frankly and without prejudice acknowledged as such. On the other hand it should never be forgotten that the Plans are in the first place medical plans, for the benefit of patients in the first instance and of doctors only in the second. 'Medical' is the operative word, the word to be emphasized, and it is of extremely great importance that the men with the knowledge of medical matters, the medical practitioners, should retain a controlling interest on the Boards of the Plans. If medical schemes are to be successful, then it is essential that self-discipline be exercised, both by patients and doctors. It is one of the duties of the Board of any scheme to keep a watchful eye on this aspect and, where indicated, to correct deviations. How very much better that a doctor, if he is to be judged at all, should be judged by his peers. We found that during the first 18 months, the doctors and lay members of the Board of the Natal Medical Plan (with the ultimate success of the Plan in mind and nothing else at all) worked together amicably and with profound integrity, achieving a harmony of understanding and purpose which can be of tremendous benefit to both subscribing members and participating doctors alike. There are people in higher places 'full of wise saws and modern instances' who damn the Medical Plans with faint praise, some who damn them with no praise at all, and some who state that the Plans are schemes established by doctors for their own benefit, controlled by themselves, and excluding the public from any administrative voice. These judges who so rashly pre-judge are earnestly entreated to study the Plans a little more carefully—to discover for themselves what I have endeavoured to point out and more, and to enter into the cooperative spirit of unity which the Plans seek to achieve; so that they, too, may perhaps give to the Plans the benefit of their own experience by expressing criticism of a constructive nature, and not, as heretofore, by indulging in destructive condemnation and a prophecy of doom.

Medical practice is at the crossroads. Tremendous changes are evolving in front of our eyes at this very moment. As a result of the recommendation of the Commission of Inquiry, ordinary private practice, as we know it, will rapidly disappear. Social security is being demanded by the public, and surely the public is entitled to this. A major portion of social security is embodied in both preventive and curative medicine. The era of prepaid medical insurance has arrived, not on our threshold, but in our very homes. Theoretically the insurance subscriptions paid to medical aid schemes should cover the claims for medical treatment, hospitilization, maternity benefits, and so on. Ultimately dental benefits must be included in all these schemes; and drugs and medicines, a tremendous drain on the public pocket, lags not so far behind. This year in Parliament a Bill may be introduced, the Medical Schemes Control Bill. This Bill will be based on the recommendations of the Commission of Inquiry of which I have spoken. There will, it is hoped, be made available to every member of the public, be he rich or poor, White or non-White, a medical aid scheme that he may join to insure himself against illness. Over and above this, medical schemes will be taxed *per capita* for the creation of a Central Fund, controlled by a representative Central Body. This fund will be used for supplementing patients who are out of benefit or who are requiring particularly costly treatment, the expenses of which cannot be borne by the medical schemes. It has been recommended that all White taxable citizens, regardless of income, should join schemes providing medical cover, in order to obtain the maximum advantage of spreading costs over the greatest possible numbers and the longest possible period.

As regards non-taxable people, i.e. the non-taxable Whites and the large majority of non-Whites, loose statements have been made that they too, later, will be covered by medical schemes. We are left to wonder just how this will come about and how much later. Who will pay the piper? It seems obvious that for this group, particularly the non-White, the rural-living African, the great need is not so much for medical schemes for curative medicine, but for Government health schemes for preventive medicine. This tremendous social need should never be overlooked, and it is surely our duty as medical men and women to hammer this point home—for surely it is axiomatic that preventive measures, based mainly on the improvement of nutrition in the rural areas, will minimize the need for curative medicine in this group. When one considers carefully what is being done in preventive medicine, particularly on the nutritional side, a curious fact emerges. Industry and commerce seem to have led the way, creating depots for disposal of surplus staple foods cheaply, selling special nutritious foods at prices that even the very poor can afford, and raising the standard of living, particularly of the non-White, by increasing wages very appreciably. With a few exceptions, the medical profession comes a bad second to industry and commerce, and our administrative authorities a very poor third. Granted our professsion has been useful in many ways, advising of the requirements of proper nutrition both in childhood and in adult life. But have we as a profession, with the special knowledge that we have in this connection, really made our voice heard sufficiently clearly in the right places? Are we doing all we can to impress upon the Government, whether it be central, provincial or local, the dire need for tremendous and continued effort to feed the hungry in the correct manner, so that all the time and effort required for curative medicine may by this simple expedient be cut down to a comparative minimum?

So much for the public and the benefits to be derived by them in the new order of things. But what about us, what of the medical profession? Is it a good thing or a bad thing for all our patients to be insured against medical treatment? That the principle is a good one cannot be denied. A patient will now approach his doctor without the complicating anxiety of how is he going to pay his bill. He will have that feeling of security which will immediately be conveyed to his medical adviser. He will not postpone calling his doctor because of financial considerations, and consequently his ailment will be treated early and cured more easily and more quickly. Nor will the medical practitioner ever have to have a thought or a doubt about possible non-payment for his services. Surely this is an insurance for the doctor as well as for the patient. The doctor-patient relationship, so sorely tried in recent years because of a number of factors—not the least of which have been bogus medical aid societies, with the ever-selfish ulterior motive of self-gain, often indirect, often cleverly concealed, but characterizing their every action—will be restored to its former happy and harmonious state, with financial considerations eliminated and time for thought to be given by both parties to the medical problem at hand. Surely we must all welcome such a state of affairs.

However, the Medical Association, although accepting the idea of medical aid for all in principle, has wisely requested the opportunity to scrutinize and comment on the recommendations of the Commission of Inquiry. Memoranda with constructive criticism of these recommendations and of those of the sub-committee for medical aid schemes have been submitted by all branches and sections of the Association to Federal Council. All this information, we understand, has been collated, and ultimately the Parliamentary Committee of Federal Council will have an opportunity of making its recommendations to the Minister.

The necessity for all this is obvious. The Medical Association feels quite rightly the responsibility of safeguarding the interests of both the public and its own members. The accept-

ance of the Medical Schemes Control Bill in time will change the face of medicine in this country, and it is at a time like this that the need for unity in the profession arises more than ever before. When we are assured that the interests of our patients are well looked after, then and only then must we look to our own interests and make sure, above all, that we retain the freedom which our profession has always enjoyed. There must of necessity be *some* control of medical schemes. Let us, in all urgency and as one composite body, convince the Government that we are not prepared to be bogged down by red tape; let us make it quite clear that although on the one hand we are prepared to cooperate to the hilt to make it possible for every single person to have medical cover, we are by no means ready to forfeit our birthright—the freedom to choose, the freedom to treat as we think fit, and the freedom to determine our own destiny. For if we are, we shall find ourselves shifting into the sixth age—'*the lean and slipper'd pantaloon, with spectacles on nose and pouch at side*', and, may I add—with shackles on his wrists and chains on legs, a pathetic figure unable to call his soul his own, shambling along unhappily under the yoke of a new master. To avoid slipping unobtrusively into this pathetic state depends entirely upon ourselves; there may well be need for closing our ranks in order to achieve a unification of effort in the medical profession as never before; lest without it, without unity, without a concerted fight for our rights, we lose all for which we studied —our hopes and aspirations, the dignity of our profession, the nobility of our status, our independence of spirit, and the freedom of thought and action which we have enjoyed since the beginning of time.

Little do we realize how important these blessings are until we find ourselves in danger of losing them. Let us preserve them always, lest symbolically we slide rapidly and ungracefully into the last scene of all which ends this strange eventful history—'*second childishness, and mere oblivion, sans teeth, sans eyes, sans taste—sans everything.*'