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THE LOWEST COMMON DENOMINATOR

With the gravest concern we note that the Medical and Dental Council has reaffirmed its attitude that general practice is the form of service below which no doctor may sink without losing his registration. In a recently published Government Notice,[1] Rule 8 concerning the registration of specialties states:

> 'A medical practitioner or dentist may, on written request, have the name of his speciality removed from the register of medical practitioners or dentists, as the case may be.'

Zealously and correctly the Council watches over the qualifications of all specialties, ensuring that no doctor shall be allowed to tend the needs of the public unless he or she is sufficiently trained to render only the best service. The trainee surgeon is required to obtain experience in a teaching hospital under the vigilance of older colleagues and the dermatologist must fulfil the strictest requirements before he will be allowed to diagnose the various skin diseases to which man is prone. But by means of no more than the stroke of a pen or a hand-written note on his own prescription pad an ophthalmologist may declare himself to be a competent general practitioner.

Council requires that every practitioner must do two years of general practice before he may register as a specialist, but, as we all know, these two years are often spent in circumstances far removed from the actualities of domiciliary practice. Thus an ear, nose and throat surgeon who has practised his narrow specialty for 25 years may, when he finds his practice dwindling or his interest in tonsils waning, fall back on his two years as acting superintendent or district surgeon to qualify him as a general practitioner. After a lifetime of rhinology a doctor must suddenly be competent to diagnose measles and to attend a confinement, even if it proves to be a breech delivery. And that such occurrences are unfortunately not merely theoretical possibilities can be vouched for by many practising doctors.

With the full blessing of the Medical Council a retired ophthalmologist is allowed to attend to a man with a coronary thrombosis in the early hours of the morning, yet if a general surgeon should dare remove a uterus he lays himself wide open to serious disciplinary action. We are aware of the fact that there is as yet no higher degree in general practice which a doctor must attain before he may be allowed to practise. However, the newly qualified intern will at least have a fair working knowledge of all the branches of medicine, and, until such time as we can achieve the ideal of special training in general practice, we will have to make do with this background knowledge as the only qualification for family medicine. Meanwhile, let us ensure that a retired specialist may not, on the merest whim, re-enter the ranks of the GP. Why not rule that a specialist who decides to relinquish his specialty must do a two- or three-year period of postgraduate training before he may set himself up as a competent general practitioner?

Personally, we would prefer not to have our infective hepatitis diagnosed or treated by an orthopaedic surgeon.

1. Government Notice No. R. 135, 7 February 1969.

ONS HOSPITALE

Oor die algemeen beskou het ons rede om trots te wees op ons geneeskundige organisasie in Suid-Afrika. Weliswaar het ons nog nie die uiteindelike ideaal bereik wat betref aantal pasiënte per dokter nie, maar ons huidige stand is nie te haglik nie. Daar is ongeveer 9,300 geregistreerde dokters in die land. Mens moet aanvaar dat 'n sekere aantal waarskynlik nie aktief praktiseer nie aangesien afgetrede geneeshere en diegene in administratiewe posisies gewoonlik wel hul registrasie by die Mediese Raad in stand hou, maar nie te min sal die getal dokters wat van dag tot dag vir die verskaffing van mediese dienste aan die publiek beskikbaar is nie veel minder as 8,000 wees nie. As ons die bevolking van Suid-Afrika op nagenoeg 17 miljoen stel dan beteken dit dat daar 'n aktiewe dokter vir elke 2,400 pasiënte is—soos ons sê, nog nie die ideaal nie, maar tog nie te sleg nie.

Met die oog daarop dat daar seker binne afsienbare tyd nog 'n mediese skool gestig sal word, moontlik selfs meer as een, kan ons verwag dat die bogemelde syfers een van die dae sal verbeter. Daar is op die oomblik 17 mediese skole in Afrika, waarvan 5 in Suid-Afrika is, en dit ly geen twyfel dat die mediese dienste wat hier beskikbaar is en die navorsing wat hier gedoen word die res van die vasteland volkome oorskadu nie. Dit geld vir alle aspekte van geneeskunde en sluit by uitstek ons sendinghospitale in. Mens wil nie onnodiglik nagaande wees nie, maar mens wonder tog of die werk wat by Sibasa gedoen word, gesien in die lig van die wêreldreklame wat wyle dr. Albert Schweitzer geniet het, die erkenning ontvang wat dit verdien. Net soos by Lambaréné moes die sendinghospitaal by Sibasa stap vir stap uit die barre aarde opgebou word met die karigste fasiliteite en byna onoorkomelike probleme, maar vandag staan dit as monument tot die deursettingsvermoë en geloof van die mense wat dit hulself ten doel gestel het om mediese versorging aan hierdie uithoek van ons land te verskaf. Dieselfde geld vir talle ander ondernemings soos Groothoek-hospitaal naby Pietersburg en 'n lang lys van ander instansies, te veel om op te noem.

Maar ons moet nie nou terugsit en ons verbeel dat ons probleme verby is en dat ons ons plig volvoer het nie. Net so trots soos ons op plekke soos Sibasa kan wees, net so dikwels moet ons ons koppe laat hang oor die hospitaalfasiliteite wat soms in groot sentrums in die Republiek as voldoende beskou word. Goeie, prag-hospitale is daar wel en mens is bly dat ons hierdie plekke het om by oorsese

besoekers mee te smous, maar die feit bly staan dat in baie gevalle die hospitalisasie moontlikhede in ons land nog jammerlik te kort skiet.

Daar is redes voor; sommige is selfs goeie redes, maar ons wil asseblief 'n dringende en ernstige beroep op die owerhede en almal wat betrokke is by die verskaffing van hospitaaldienste en -fasiliteite doen om nie die eg Suid-Afrikaanse slagyster af te trap en te dink dat as die verduideliking eers gegee is, die probleem opgelos is nie. Sê net hoekom die saak so haglik is, dan hoef jy nie iets daaraan te doen nie—dit is een van ons minder aantreklike landsgewoontes. Daar is verpleegsterstekorte, gebrek aan geld, morrende dokters en dwarstrekkerige administrasies. Ons weet dit; ons weet ook dat die probleme verbonde aan die oprigting van 'n hospitaal legio is, maar die feit bly staan dat ons meer en beter hospitale benodig en verskaffing van die redes vir die huidige onbevredigende toestand is nie voldoende nie—die probleme moet ook die hoof gebied en opgelos word.

Nie slegs die hospitaalfasiliteite nie, maar ook die organisasie laat soms heelwat te wense oor, en hier weer wil ons 'n beroep doen op diegene wat daarmee bemoeid is om met 'n ope gemoed die saak te benader en gewillig te wees om ingrypende veranderinge in te stel waar dit nodig blyk te wees. Ons dink as enkele voorbeeld aan die tye waarop roetine aksies soos die was van pasiënte en die verskaffing van maaltye in bykans alle hospitale plaasvind. Is dit werklik nodig om 'n siek persoon om 5.00 vm. te was? Moét 'n mens smiddags om 5.00 nm. aandete geniet? Dit is dan nog nie eens drinktyd nie! Is hierdie tradisionele tye nie miskien maar die nasleep van die ingeburgerde dienstye van verpleegsters nie? Soggens om 7.00 vm. gaan mens aan diens en die nagpersoneel neem om 7.00 nm. oor—dit is die reël, kom wat wil en niemand wil dit waag om te vra of die reël wel 'n goeie een is nie. Die arme verpleegster wat 7.00 nm. van diens af kom het noueliks tyd om te bad en die nodige opknapping te doen voor die aand se bioskoopvertoning of ete-afspraak se tyd aanbreek, en soggens moet die dokter wat 'n vroeë ronde doen ontdek dat die pas opgedaagde dagpersoneel geen kennis dra van die pasiënte se vordering gedurende die afgelope nag nie. Ons wil nie met ons karige kennis van dié aspek van geneeskunde voorstelle maak nie; ons wil slegs vra dat die bereidwilligheid daar moet wees om ingrypende veranderinge aan te bring indien dit nodig blyk te wees.

RING-A-RING-A-ROSY

We have all sung the lilting little rhyme at picnics and at children's parties and we have all come to associate it with the charm and innocence of youth. It conjures up memories of chocolate cake and jellies, and of party dresses and well-oiled, fiercely-combed hair. Unfortunately this image is a modern one; the true horror of the rhyme's origin has happily dimmed through the ages.

Ring-a-ring-a-rosy
pockets full of posy;
hush, hush, all fall down.

The black death nearly wiped out the population of Europe and England. The miseries and the horrors have been ably and amply described by many famous authors, but the most erudite pen can never hope to attain the poignancy of the simple children's rhyme. The red ring which forms when first the glands become inflamed was a rosy warning of the inevitable pus-filled swellings which would develop in a few days—pockets full of posy. And the outcome is definite . . . hush, hush. The child's mind can only accept misery and horror up to a certain point and then he reacts; then the dickensonian children start singing around the gallows at Ludgate Hill and the urchins start burning effigies of Guy Fawkes, turning it into their own private party.

It would be interesting to find out if any other similar rhymes have equally sinister backgrounds, and we invite readers to submit examples of such oddities. For instance, the name Rumpelstiltskin has to us always sounded highly suspicious, and it would not surprise us to learn that this fairytale figure also came from a broken home.

On somewhat similar footing are the mnemonical verses of our medical student days. Is there a student who can unblushingly say that his memory of the 12 cranial nerves in sequence is not aided by a totally unpublishable poem? One wonders whether such aids did not also exist during the times of Galen and have been incorporated into folklore after having been sung by tipsy students in the beerhalls of Europe. After all, it is difficult to believe that students have changed all that much during a mere 5 or 6 hundred years.

Even certain generally accepted words have curious origins. The posh English gentry of the previous century acquired their adjective as a result of their travels to and from India. The lack of air-conditioning on the old clippers made it necessary to travel outward from England on the port side of the ship and to return home in the starboard cabins; 'Port out, starboard home' gave the initials which described these *posh* gentlemen. A relatively recent article gave us the well-known U and non-U classification of the modern intellectual upper strata.

These relics of bygone days are interesting and sometimes important. The snake of Aesculapius has become the emblem of our profession and it is sad to see how often it is confused with the two twining snakes of Mercurius. We are not messengers, we are physicians, and congress organizers should take care to bear this in mind when they decorate the stage for meetings of the Association.

Perhaps the psychiatrists can help us to explain the macabre fascination which rhymes on gruesome events hold for the general public and, to some extent, for the medical profession in particular. Will some future generation of children dance round the maypole to the tune of a song on the Hiroshima atom bomb, totally unaware of its sinister origin?

Simbamba, mamma se kindjie,
draai sy nek om,
gooi hom in die sloot,
trap op sy kop,
dan is hy dood.

The charm of some of our lullabies is irresistible.