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VAN DIE REDAKSIE : EDITORIAL

UITKONTRAKTERING

Our gayness and our gilt are all besmirch'd
With rainy marching in the painful field;
And time has worn us into slovenry:
But by the mass, our hearts are in the trim.
Shakespeare: *King Henry V*

Die stof het nou effens gaan lê, maar dit was 'n lang en opdraende stryd. Noudat daar blaaskans is sal dit goed wees as ons 'n slag stilstaan en dinge rustig in oënskou neem. Eg menslik is ons geneig om belangrike detail uit die oog te verloor terwyl ons swoeg en sweet om ons ideale te bereik en verwesenlik te sien. Die Wet op Mediese Skemas het soos 'n wolk oor ons beroep gehang, en nog steeds moet ons 'n waaksame oog hou om te verhoed dat hierdie wilde perd nie met ons hande uitruk nie. Maar ons moet versigtig wees om nie perspektief te verloor nie, en een van die dinge waaroor ons al te maklik op 'n dwaalspoor kan beland is die kwessie van in- of uitkontraktering.

Hierdie reg van iedere geneesheer om te besluit of hy hom bereid wil verklaar om pasiënte wat aan mediese hulpskemas behoort teen die amptelike tarief te behandel is nie 'n nuwe begrip wat met die Wet op Mediese Skemas ontstaan het nie. Inteendeel, dit is 'n beginsel wat deur ons Vereniging self in die lewe geroep is, lank voordat daar nog selfs sprake van wetgewing was. Destyds, toe die Vereniging nog die septer geswaai het oor die verskillende hulpskemas en toe ons nog self verantwoordelik was vir die toesegging van ons amptelike erkenning of vir die onttrekking daarvan, het ons hierdie reg aan ons lede toegesê. Toentertyd het ons nog gepraat van 'n voorkeurtarief—die gelde wat daargestel is om die hulpskema-pasiënte tegemoet te kom; vandag is dit slegs die amptelike tarief in teëstelling met die Standaardtarief, wat ons as handleiding vir privaatgelde beskou.

Ons Vereniging het destyds besef dat dit onredelik sou wees, siende dat ons nie as 'n vakbond beskou wou wees nie, om van lede te verwag dat hulle hulself gebonde moes voel deur die onderhandelings en besluite van die Federale Raad. Derhalwe het ons die reg aan iedere indiwiduele dokter toegesê om self te besluit of hy wil saamspeel of nie. Die enigste didaktiese bepaling wat gemaak was, was dat uitkontraktering positief gemeld moes word. Met ander woorde, 'n dokter was ingekontrakteer tensy hy spesifiek anders kennis gegee het.

Daar was maar slegs 'n handjievol dokters wat hulle die reg toegeëien het om uit te kontrakteer, moontlik weens die bepaling dat 'n sodanige besluit onderhewig moes wees aan die alles-of-niks wet. 'n Geneesheer kon nie besluit dat hy net sekere hulpskemas sou erken of net sekere pasiënte as privaat sou beskou nie. Dit was 'n kwessie van uit of in —daar was geen middelweg nie. Maar dit is bloot geskiedkundige oorwegings; wat vandag belangrik is, is die feit dat dit nooit vir die Vereniging nodig was om 'n aanbeveling te maak nie. Aangesien ons self besluit het of 'n bepaalde hulpskema ons steun en erkenning verdien het, kon ons bloot deur sulke erkenning te onttrek of te weier verseker dat ons standaarde gerespekteer sou word. Ons was nie noodgedwonge verplig om uitkontraktering as 'n slaanding te gebruik nie.

Toe die eerste wetsontwerp bekendgemaak is, was dit duidelik dat ons sou moes veg om ons onwrikbare beginsels nie prys te gee nie—beginsels wat sowel die heil van die pasiënte as die belange van die beroep geraak het. Metterwyl het dit geblyk dat ons met onderhandelings nie verder sou kom nie, en derhalwe het die Uitvoerende Komitee op 18 Mei 1968 besluit om aan te beveel dat alle dokters hul misnoë met die wetgewing bekendmaak deur uit te kontrakteer. Ons het geveg met ons rug teen die muur. Enigeen, dokter of leek, wat onder die indruk verkeer dat hierdie ingrypende besluit ligtelik geneem is, is nie op hoogte van die ware feite nie. Uitkontraktering was ons enigste verdediging—ons finale 'geheime wapen'.

Kritiek het ons gekry, *ad nauseam;* maar dit het gewerk! Vandag kan ons terugkyk en wondelekkend onsself troos aan die feit dat, indien nie alles nie, tog die grootste gedeelte van ons besware uit die weg geruim is. Of die feit dat daar nou 'n kollega aan die spits staan iets daarmee te doen gehad het is 'n bespiegeling waaroor ons nie uitspraak wil lewer nie. Die stryd is nog nie gewonne nie, maar die toekoms is nie meer so donker nie. Nou moet ons nog geduldig wag om te sien hoe doeltreffend die regterlike kommissie wat ingestel is gaan wees. Slegs die tyd kan ons leer hoe hierdie nuut-voorgestelde stelsel gaan werk.

Die Federale Raad het 'n moeilike besluit moes neem. Wat moet nou ons houding wees? Al ons ideale is nog nie verwesenlik nie, maar ons moet darem erkentlik wees. Vele lede het gevoel dat 'n definitiewe standpunt nou aangewese is: Uit- of inkontrakteer, want 'n finale aanbeveling moet kwansuis gemaak word. Dit is 'n verkeerde houding.

Federale Raad het na lang bespreking besluit om die ou, aanvaarde *status quo* van weleer weer in ere te herstel. Ons het nog nie alles waarvoor ons veg en hoop bereik nie, maar ons het ver genoeg gevorder sodat dit vir ons moontlik is om nou te sê: 'Terug na die ou stelsel; elkeen moet sy eie besluit neem'. Daar is 'n gevoel onder ons geledere dat 'n meer uitgesproke standpunt geneem moes gewees het. Die Raad moes òf gesê het: 'Bly uit' òf hulle moes aanbeveel het 'kom in'. Die getroue, en, helaas, niedenkende lede sou so 'n onomwonde uitspraak, watter kant toe ookal, verwelkom het. As baas sê ek moet inkom, kom ek in; maar as baas sê nee, bly ek uit. Baie maklik. Dit is pap-en-lepel lojalitiet.

Ons het uitkontraktering gebruik as 'n middel om 'n verbetering in die wetsontwerp te bewerkstellig. Of dit 'n aanvaarbare rottang was of nie, is nie ter sprake nie, maar inkontraktering is nie 'n middel wat enige nuttige doel kan dien nie—dit is nie 'n standpunt wat gestel kan word nie. Al wat mens kan sê is: 'Die stryd is grotendeels gewonne. Nou is ons weer terug by die ou stelsel. Iedere dokter het die reg om te besluit of hy binne of buite die geldetarief wil praktiseer.' Dit is die aanbeveling van die Federale Raad.

Diegene wat nie tevrede is met so 'n besluit nie is in der waarheid slegs nie daartoe in staat om 'n eie, volwaardige standpunt in te neem nie. Daar moet aan hom voorgesê word wat hy moet doen. As Federale Raad gesê het ons behoort nou in te kontrakteer, sou daar luidkeels gesê gewees het: 'Nooit, ek kan dit nie bekostig nie'. Of as die besluit was dat ons buite die tarief moes bly sou vele gekla het dat dit vir hulle finansieel onmoontlik is. Mens kan

nooit almal tevrede stel nie.

Of ons weer ons stem sal moet dik maak weet ons nie. Miskien, as dinge nie reg verloop nie, sal ons weer daartoe gedwonge wees, maar ons hoop nie so nie. Op die oomblik wag ons nou om te sien wat gaan gebeur, en intussen is die aanbeveling korrek en duidelik: Terug na die ou stelsel—elkeen besluit self wat vir hom en vir sy eie praktyk stelsel die beste is. Niemand gaan vinger wys en sê: 'Jy moes uitgekontrakteer gebly het, of jy moes ingekom het'.

'Kent gij dat volk? Dat vrije volk?'

TREATMENT BY COLOUR

Edel sei der Mensch, hilfreich und gut,
den dass allein unterscheidet ihn van
allen Wesen die wir kennen.

Goethe

With very few exceptions the philanthropist is a White man. This is a sad but incontestable fact. Seen in the light of our required medical services, it is also an important fact.

We in South Africa have to provide medical services to a variety of citizens—Black, Coloured, White and Indian—and we have only a limited number of doctors to do the job. However thinly we spread the butter, we are going to be left with corners uncovered. From all sides we are being inundated with requests for medical help, and we cannot deny the importance or the legitimacy of such requests. We, the doctors, are constantly telling our patients that they must come to us for help prophylactically, or for treatment. If we stop to think, we will realize that the recommendation that every woman over 35 years of age should have a Papanicolaou smear done every year spells a work load of over 4 million consultations a year. Can we provide such a service? With some 5,000 doctors in active practice of all kinds this would mean more than 1,000 consultations per doctor a year, or from 2 to 3 consultations a day, merely in order to take the smears, let alone examine them.

The above figures apply to our total South African population. It would be easy to say that the 3·5 million Whites can be adequately cared for by the 5,000 doctors in practice; but what about the other races in our fair country? We cannot, with our present complement of doctors, hope to cope with the demand, and therefore we will have to train more men and women. Whom do we train?

The immediate answer which comes to mind is that we should go all out to train more non-White doctors, be they Coloured, Indian or Bantu. This is more easily said than done. To provide facilities for the training of one doctor costs the State, and that means the taxpayer, about R15,000—a princely sum. That kind of money must be spent wisely, or the taxpayer will quite rightly have something to say about it. The casualty rate of medical students is unfortunately very high; even with the most careful selection we must accept that only about 70% are going to complete their medical course in the prescribed 6 years. And let us face facts: at the moment, the casualty rate for non-White students is far higher than this. Whether such a high rate of failure is due to incorrect teaching, bad preschool environment or low matriculation standards is outside the scope of this article. Whatever the reason, the fact remains that in this present day and age it takes longer on the average to train a non-White doctor than to train a White one, and such a time difference costs money.

It is the policy of our Government that every racial group should eventually be treated by men or women of the same ethnic heritage. Such an approach has obvious advantages. The Zulu who is being cared for by a member of his own race will inevitably have more rapport with his medical advisor than if he was in the care of an Indian or a White doctor, who would have only the haziest notions about his beliefs and ingrained racial prejudices. Or, to get away from our own emotionally charged atmosphere, an Eskimo who is cared for by a fellow Eskimo will have less to explain about his likes and dislikes than the Eskimo who is treated by a New York specialist.

If we had the money and if we had a sufficient number of correctly qualified matriculants, we could presumably train enough non-White doctors to cope with the demands made by the 12 - 14 million non-White potential patients. For this we would need more medical schools, but they could be founded. And then, what would happen? Our well-trained non-White colleagues—Indian, Coloured or Bantu—would find work in the large hospitals in the big centres or would practise in predominantly White areas, and the vast majority of the medical services for the Bantu population would have to be provided by the White doctors.

At present a large proportion of the hospital appointments in the United Kingdom are held by non-White doctors. It would be interesting to find out what percentage of hospital posts in Africa are held by White doctors. Such figures would be extremely difficult to come by, and at the moment we can only guess at the answer, but we have an idea that the percentage would be very high.

One must be reasonable. For a member of a developing nation to reach the status of a medical doctor is an achievement of which he or she may be justly proud. There are a host of difficulties to be overcome, of which the average White student is not even aware. Must such achievement now be hidden away in the tribal hinterland? Quite understandably the non-White doctor prefers to work in an environment where he will be able to give expression to his new status and to his broadened outlook.

But who cares for the tribal chief back home? He needs medical attention as much as any of us. The answer is that the philanthropist is a White man, and it will remain so for many years to come. It is to be hoped that eventually we will reach the stage where the back-breaking and often thankless medical work in outlying areas will be undertaken by members of the ethnic group concerned, but at the moment we must be realistic and accept the fact that it is not yet possible. For a very long time still we will have the curious anomaly that non-White doctors anywhere in the world will work largely among White people, and the medical care of the non-White races will be the responsibility of the Whites.

If this be the case, it would seem more logical to train the maximum number of White doctors in order to cope with the enormous demand, and thereby save money because of the lower cost of qualifying a White student. That is a pessimistic outlook, but the only way it can be overcome is for our non-White colleagues to prove us wrong, and we sincerely hope that they will do so in the near future, not through coercion and not for financial gain, but purely in order to change the colour of philanthropism. At present there are hospitals in the Transkei which have to remain empty for want of medical personnel, in spite of the overwhelming needs of the inhabitants. May we ask our non-White doctors to extend a helping hand?