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EDITORIAL *VAN DIE REDAKSIE*

The Loss of Technique

From surgery to singing and from motor-cars to social graces there would seem to be a slackening of the attention paid to sheer technical perfection. Our knowledge is increasing by leaps and bounds, and technical innovations follow one another with startling rapidity, but are we giving the same meticulous attention to technique as such? We wonder whether the attention to the final finish of the modern spacecraft is any more meticulous than is lavished on the average production motor-car. What would the pop song writer not give for the crystal-clear diction of a McCormack, losing not a syllable of the soul music he is composing, or what would the public speaker with a message give for the assurance that his audience will pay attention with the good manners dictated by the social graces of yesteryear?

Does the modern heart surgeon have the sureness of technique of a Simpson, or the cardiologist the clinical perfection, when he conducts an examination, that James McKenzie brought to bear? We have better facilities than those earlier doctors could command, and our sophisticated machines can certainly discover pathology with far greater sensitivity than was possible some years ago, but this very availability is inclined to cause a lack of attention to clinical acumen and the development of technique. To use singing again as an illustrative example, Caruso himself admitted that the sheer unsurpassed beauty of his voice resulted in less attention being paid to technique, so that other singers, like Battistini or De Lucia, with voices that could not equal his, nevertheless became, in the final analysis, greater exponents of the art.

With a universal tendency to accept the inferior, to create built-in obsolescence, and to insist on disposable goods wherever possible, it is not surprising that the ability to judge quality will gradually become blunted. We see it already in the acceptance by young people of standards of workmanship that would not have passed muster a few decades ago, and once accepted uncomplainingly they become the norm, so that experience of good quality becomes a rarity instead of an ingrained critical insistence. We must guard against an insidious relaxation of our standards as far as medical care is concerned, so that we do not allow a lowered quality in our instruments to pass inspection or a lesser dexterity to limit performance. We may rely on our intricate new apparatus to assist us in diagnosis and treatment, but we may not hide behind these machines and think that they will safeguard us from our lack of technique. Every doctor, even if he or she has full access to an X-ray department, can command bronchoscopy examinations, and has the backing of a laboratory, must nevertheless be able to percuss a chest and to achieve clinical accuracy in assessing a pleural effusion or an enlarged heart.

With time-honoured techniques not only at our disposal, but at our fully-trained fingertips, we can use our new-found knowledge to the best advantage of our patients, but as mere machine manipulators without the training to apply skills, we are lesser doctors than our forebears, in spite of our increased learning. Some may regard Picasso's abstract works as incomprehensible and even unacceptable, but we know that Picasso, unlike many modernistic artists of smaller talent, had the technical ability to handle conservative subjects and that his brushwork lacked nothing of the touch of artists of the older schools of realism.

Tuisbesoeke: Tydverkwisting of Noodsaaklikheid?

In 1972 het Davie 'n artikel geskryf waarin hy hom uitgespreek het teen die neiging van die meeste huisartse om gereeld tuisbesoeke by pasiënte af te lê.[1] Die artikel het, soos ons verwag het, kommentaar uitgelok,[2-6] want dit is 'n strydvraag waaroor reeds jarelank geredekawel word. Daar is drie aspekte wat in ag geneem moet word alvorens 'n mens tot 'n slotsom kan raak: die gerief van die pasiënt, die gerief van die dokter, en die wetenskaplike kwaliteit van die gedane werk.

'n Mens is geneig om sonder meer te aanvaar dat een van die redes vir die aanvra van huisbesoeke deur 'n pasiënt wat òf ambulant òf half-ambulant is, blote gemaksug moet wees. Dit is makliker om die telefoon op te tel en die dokter te ontbied as om na sy spreekkamer te ry. Dat dit in baie gevalle wel 'n faktor is, is seker nie te ontken nie, maar wat geneeshere dikwels vergeet, is die ongerief wat die huisvrou moet verduur omdat sy vir die dokter moet wag wat na haar kind moet kom kyk, en nie weet of hy vroeg voormiddag of laat in die aand gaan opdaag nie. Hoewel sy miskien by die spreekkamer ook sal moet sit en wag, sal dit beslis nie haar hele dag se aktiwiteite in die wiele ry nie.

Die gerief van die dokter behels nie net sy gemaksugtige belangstelling in werksvermindering nie, maar eerder sy belangrike tydsbesparing omdat die onnodige ryery uitgeskakel word. Dit ly geen twyfel nie dat die huisarts meer in 'n gegewe tydsbestek by sy spreekkamer kan uitrig as by die pasiënt se huis. Die vermoeienisfaktor is ook nie te versmaai nie. Maar juis die term huisarts bepaal altans 'n deel van sy werkmilieu. Hierdie aspek van die familiegeneeskunde sal ons aanstons weer verder bespreek want dit hang saam met die wetenskaplike kwaliteit van die werkverrigting.

Met meerdere instrumente en behoorlike ondersoekfasiliteite is dit vanselfsprekend dat die huisarts by sy spreekkamers beter werk sal kan doen. Dáár het hy opgeleide hulp beskikbaar, geskiedeniskaarte is behoorlik geliasseer en alles is onder bevredigende kontrole. Maar dáár duik juis die mistasting op. Die kontrole geld die dokter se behoeftes; nie dié van die pasiënt nie. Die meeste mense, selfs in ons byderwetse gemeenskap, is steeds taamlik huisvas en wanneer iemand siek is, wil hy tuis siek wees. Daar, omring deur die normale besittings waarmee hy vertroud is, voel hy nie so angstig nie, en is daar nie bykomende spannings wat sy herstel kan beïnvloed nie. Die redelike persoon sal natuurlik besef dat om uitsluitlik tuis siek te wees en versorg te word, nie prakties doenlik is nie, maar 'n mate van tuisverknogtheid gedurende siekte is tog nie 'n onredelike neiging nie.

Die huisarts wat nooit die pasiënt tuis sien nie, kan nie aanspraak maak op familie geneeskundige kennis nie. Die groepie in die wagkamer is nie 'n familie nie—hulle is slegs verwant. Hulle word eers 'n familie wanneer hulle weer tuis is.

Enige huisarts wat hom die voorreg ontsê om sy pasiënte in hul huislike omgewing te sien, gaan die gebrek voel wanneer hy te doen kry met diagnose wat 'n mate van psigiese inslag het. Daar is spesialiste en huisartse, en huisartse doen per definisie huisbesoeke.

1. Davie, G. (1972): S. Afr. Med. J., **46**, 1258.
2. Silbert, M. V. (1972): *Ibid.*, **46**, 1508.
3. Goldswain, K. (1972): *Ibid.*, **46**, 1557.
4. Maggs, R. F. (1972): *Ibid.*, **46**, 1653.
5. Loubser, J. S. (1972): *Ibid.*, **46**, 1602.
6. Dubb, S. (1972): *Ibid.*, **46**, 1706.