What is left indeed OF and FOR the Country G.P. when the seventies have proved beyond doubt the results of immense and powerful developments in the fields of Medicine, and the place of the Country Doctor is now in a dilemma, or is he a misfit in modern society?

Specialisation has magnetised the academics into the major centres, where obviously facilities are now increasing in prominence and effect almost daily. Costs naturally filter down to the 'end-consumer', no less an entity than the patient himself, who is lost in a wilderness of ultra-modern environments of huge hospital complexes, CAT-scans, ICU's and machines that hold life together and add up his medical bills.

What a quandary the dejected Country G.P. faces, when confronted by this dilemma, patient and all, when he asks himself how he possibly can cope with such paucity of service he renders, and what chance there might ever be of improving his lot in a community he serves, with enormous problems of cost-effective medicine that puts his own existence on a shoestring?

And then secondly, what now of the imminent development of the massive State Health Clinics being established in the country areas, which in theory should be highly effective and well-stocked, both in drugs and nurses, where the community health care is a priority issue? This must surely be welcomed and encouraged as doctors are too busy or not available to fill these outlying areas. Or are they?

What then is the attraction of Country Practice?

Gone are the days of the easy-life style and voluminous cash-flow clinics and gone are the days where standards and knowledge could be hidden in gracious country living. Gone too, are the old-style existence of cheap medication, and cheap diagnoses. Primary health care is of the utmost importance and remains at a premium always, but how effective is this challenge in the face of today's standards and costs?

Several aspects of country practice bring to mind some of the rewards that such a concept has, and it might well be correct to relate a few.

Community care is a a very real concept in the country, and high on the list. Patients are closely involved with one another, often related and know each other well. The 'inverse-care' law, where the most vulnerable patient has the least access to the doctor, simply does not exist. This naturally leads to meticulous handling of patients domiciled at home, whether seriously ill or recovering, or waiting to die. The responsibility of the country G.P. is high because of the utmost trust and confidence that is instilled in him by his patients; his attitudes, dedication and sincerity are manifest, or he will simply fail.

The community will care about the doctor and his welfare as well. His work, his family, and his interests are always being considered, and the smaller the domicile, the greater the awareness of the presence of the doctor. It is seldom that criticism is levelled at the doctor because of the difficulties he might experience in keeping a full 24-hour service, all year round. It is seldom that he is criticised because of a shortage of facility, or medication that might not be available. He is held in awe for trying, and thanked profusely for small kindnesses. In times of crisis, willing hands are always there, wanting to help and assist.

Overheads, like all values, are directly proportional to the costs of standards. If these standards are high, the overheads increase, and this must be considered in relation to the workload of every day, the demands made on and by the doctor, in his ability to justify the essential features necessary for practice. Capital outlay can be well controlled and held in check, and it is always facilitated by the communal replay again with helping hands when needed.

Compliance is in reality something of a misnomer in the country. Especially when medicinal intake is considered Holy, and community concern plays a further role in keeping the compliance at a premium. It might well be said that compliance is TOO high, because of the community's interest in each other, and it is not uncommon for everybody in the local village to express opinions about therapeutics of any given patient at any time.

Pathology is often presented in its, raw state. Or neglected sometimes, and although gross illness is no good reflection on the doctor, it does express a reluctance on the part of a patient in the country to come forward until a full blown picture makes a very obvious diagnosis more difficult to handle. And in keeping with country folk, this is quite understandable, when their lives are strictly regulated by values and beliefs in their own self-

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discipline and religions. So that when pathology strikes, it seems to create a
social withdrawal almost to the extent of abhorrence and shame, and very
serious concern about the effect on
the community.
Clinically the work involved from the
doctor’s point of view is always
fascinating and varied, both with visual
and practical experience which is
unheard of in a city practice, and clari-
ty of thought and careful diagnosis are
always rewarding and enriching in
management of the problem.
It is not uncommon to be consulted in
a day’s work, about anything that
does NOT involve medicine. It has
many side-effects, and problems
related to financial planning, business
problems, domestic issues, veterinary
aspects, and dozens of other aspects
can make the astute country G.P. con-
scious of the part the integral complex-
ities of life play on that particular per-
sion, when he becomes a patient. To
some extent this is compensatory for
the loss of hospital and other clinic
facilities.
Accidental or sudden death is
always a major crisis in a close-knit
community. Such catastrophes are
handled in panic fashion, rather
chaotic and disorderly, and probably
out of proportion to a similar event in a
city. This again is not out of context
when the community involvement is
so high, and limited or no facility is
available for ambulance, resuscitation
or hasty action.
Distance too, plays an integral part
in the problems with crises in the
country. The doctor is obviously
essential in the immediate approach
and his ability to cope with the
disorganisation and chaos surrounding
such crisis situations.
Many other aspects both of socio-
logical and medical roles are manifest
in country practice, but the problems
facing the country G.P. today are
whether he fits into such a role at this
present time, or should he now pack
his bags and head for town? Or must
he now reassess and reinstate his
rightful place in a community, as a loy-
ed and respected member of that
community, but at what cost both to
himself, and to his patient?
Or are we deliberately under-
estimating our existing country G.P.’s
potential?

Chris van Selin

Environment, genetics, affect
rheumatoid arthritis

Evidence indicates that the major
determination of rheumatoid arthritis
are environment factors, but genetic
factors do play a part in the
pathogenesis. Prof. Peter Beighton, of
the Department of Human Genetics,
Medical School, University of Cape
Town, revealed his findings in a recent
interview reported in “Rheumatology
Review”, a continuing medical educa-
tion publication.

Studies in South Africa have shown
that disease incidence differences exist
between Black and White races, and
between urban and rural populations.
Epidemiological surveys conducted
during the last 10 years have shown
that there are genuine geographic and
ethnic discrepancies in the prevalence
of rheumatoid arthritis and that in
general this disorder is mild and
uncommon in communities with an
unsophisticated life-style. Prof. Beigh-
ton pointed out that in a series of
South African surveys, using stan-
dardised methodology, the prevalence
of combined ‘definite’ and ‘probable’
rheumatoid arthritis in a rural South
African Black community, was found
to be 0,87 per cent (Beighton, Solo-
mon and Valkenburg, 1975). In a
genetically similar urban group, the
respecting figure was 3,3 per cent
(Solomon, Robin and Valkenburg,
1975).

The realm of geographical and
ethnic variation in bone and joint
disease is endless, said Prof. Beighton:
“When is osteoarthritis of the hips com-
mon in the White South African
population but not in the Black?” The
same holds for the relative prevalence
of intervertebral disc lesions of the
lumbar spine.

Prof. Beighton went on to discuss a
study on the orthopaedic aspects of
Gaucher disease which was conducted
over a seven year period, by himself
and Drs. J. Goldblatt, also of the
Department of Human Genetics,
Medical School, University of Cape
Town, and S. Sacks, formerly of the
Department of Orthopaedic Surgery,
Medical School, University of the Wit-
watersrand. “This inherited condition
has a high prevalence in the Jewish
population of South Africa. At least
one in 30 individuals in this
community is an asymptomatic ‘carrier’
of the gene, while about one in 3000
persons has received a faulty gene from
each parent, and develops the full
manifestations of Gaucher disease.

“For these reasons,” he added, “if
skeletal problems and splenomegaly
cocurrent in a Jewish patient, the diag-
nosis of Gaucher disease warrants
serious consideration.”

When a young White adult presents
with hip-joint pain, the general prac-
titioner should ask two questions:
Does the patient have a large spleen?
Is the patient Jewish? affirmatives to
these two questions should raise the
possibility of a diagnosis of Gaucher
disease.

“Current trends,” Prof. Beighton
concluded, “towards molecular gene-
tics will be as important to medicine as
the introduction of antibiotics.”

Other items of interest in “Rheuma-
tology Review”, issue three, include
reviews on the diagnosis of “Ankylos-
ing Spondylitis” and the “Control of
Idiopathic-Type Pain”.

Copies of “Rheumatology Review”
are available from the Professional
Services Department of Pfizer Labo-
ratories (Pty) Ltd. P.O. Box 1600
Johannesburg.

For further information circle No 201