The South African Academy of Family Practice's Rural Health Initiative (RHI) is proud to be able to bring you the following section of the journal, that concentrates on issues pertaining to rural health in South Africa. We seek to provoke discussion on these issues and would encourage anyone interested in rural health to offer contributions to future issues.

Country Practice (Part 3) - Memoirs of the late Dr. DH Girdwood (Bedford, Eastern Cape)

The RHI presents the reflections of a rural GP, the late Dr DH Girdwood, written in his retirement a few years ago. Dr. DH Girdwood was a general practitioner who had his practice in Bedford, Eastern Cape, from 1949 until he retired in 1983. He passed away in July 2001 and permission to publish these memoirs was obtained from his son, Dr. AH Girdwood, who is a gastroenterologist practising in Pinelands. It provides a fascinating account of the experiences of a rural doctor, in the South African context. These reflections have been artificially divided into 4 parts. We welcome similar reflections on past experiences from other readers.

Looking back over the years in general practice, I think that maternity cases are the most memorable ones in that one has a reminder of these when seeing the offspring over the years - even in some cases delivering these offspring of their own babies many years later. Just the other day in my retirement, I saw a woman in the jeweller shop in the village with a vaguely familiar face. She came up to me and said, "do you remember me?" This is a fatal question for me because my memory for names is abysmal. I said I remembered her face. "I'm the woman with the hang-over," she said. It all came back.

My partner was out shooting on a Saturday afternoon and I delivered one of his patients, who lived out of the district, of a baby girl. She was bleeding a bit more than I liked and the placenta hadn't separated. I quickly put up a drip and tried to express it without success. Willem Vosloo came in at this point and we decided on a manual removal under general anaesthesia. I gave chloroform and he tried to remove it - usually not too difficult a procedure - but he only managed to get out a very ragged piece and she continued to bleed. In those days we depended on our panel of local blood donors. I phoned two universal blood donors in the village and both were at the club, this being Saturday at about 7pm. I went there and found them both fairly steamed up at this stage, brought them to hospital, cross-matched them with the patient, took a pint each of their alcohol primed-blood and ran it in. The patient felt fine and later that evening a specialist from Port Elizabeth came up. I anaesthetised her again and he tried to remove the placenta and found it to be a true placenta acreta and decided on a hysterectomy, which he proceeded to do. The next day she not unnaturally felt pretty wretched, which we explained was partly due to the hangover from the blood we gave her! The woman in question then told me that the baby I had delivered and not seen since was in the car outside the jeweller shop. I went out and introduced myself to a pretty 30-year-old woman with twin babies, born a few months previously.

Anaesthetics became very much a feature of my life in practice though not through choice, but because my partner gave no anaesthetics. So once Mrs Colohan (a former partner) left the practice - which she did within a few years - I was the only one able to give anaesthetics. For this reason, my surgical activity, apart from what I could do under local anaesthesia, withered away. I was not particularly unhappy about this and concentrated on anaesthetics. Fortunately, I had previously had the advantage of a period of apprenticeship with an excellent anaesthetist in Glasgow. Because of this I had become quite happy about induction with nitrous oxide and maintenance with ether, and had learnt to intubate blind - i.e. without the use of a laryngoscope. For some years after this time chloroform was still in use and, being a graduate of Edinburgh where it was first used, I always found it a delightful anaesthetic to give - especially for the fitting eclamptic and for women in labour, as was used for the first time on Queen Victoria. It was also so useful in an African hut, with minimal equipment, and with no fear of fire. I gave all the anaesthetics in Bedford and continued to do so until I retired. For many years this consisted of thiopentone, nitrous oxide and ether which was undoubtedly an extremely safe anaesthetic and capable of being used for all normal surgical procedures. For children I induced with nitrous oxide, having explained before to them what I was going to do, lowering the mask slowly to the face with nitrous oxide alone, and then adding oxygen and having them unconscious before gradually adding ether. With the arrival of trichlorethylene to lessen the impact of ether, this was made easier. A tonsillectomy was the main operation in children and my partner did this extremely well. One never had to worry that bleeding would recur later. In this operation I gave the ether long enough to last the length of the operation once the mask was removed, after which ether was blown in with the Boyle Davis gag. I even used this technique occasionally for adults in the early years, but this was

more difficult. In the later years, intubation and halothane made this much easier.

Once relaxants and halothane became available, I needed more training so spent three separate weeks attached for practical tuition, first, at the Johannesburg general hospital with Prof Hugh van Hasselt; then, through his influence at Groote Schuur hospital and finally with an anaesthetist friend of mine in Port Elizabeth. I also went to a GP anaesthetics course at Wentworth hospital in Durban. With this help, I was able to make use of modern anaesthetic techniques, which undoubtedly made it easier in some ways but more worrying and complex in other ways. The occasional anaesthetist has really become a thing of the past. Anyone doing anaesthetics today should first have done a full time anaesthetics job for at least 6 months and probably have a DA. In those early days all doctors were expected to be able to give anaesthetics and did so. I remember when I was in the army, stationed in the Scottish Highlands, I had a young soldier with an acute appendix. I brought him into the hospital town of Granton-on-Spey and the local GP decided to operate in the local cottage hospital. He naturally asked me to give the anaesthetic, which I did with chloroform and ether.

In the early days in Bedford the patients tended to want surgical procedures done locally and, with more complicated procedures, surgeons were quite willing to come to Bedford to operate. The tempo of surgery varied quite a bit but one usually had one or two major operations a week. In a letter to my parents in 1956, I mentioned that we had been rather busy lately with 26 major operations in the proceeding two and half months. By 1959, Adelaide hospital had become fully functional and, as Dr le Roux gave no anaesthetics, I did all the anaesthetics there for Dr Charles Louw who was a keen and excellent surgeon. This added significantly to my workload but I always enjoyed going there and the atmosphere of the Adelaide hospital. On rare occasions I also went to Somerset East to give an anaesthetic for Dr Andries Vosloo.

When any outside surgeon came to Bedford, the anaesthesia and post-operative care was left to us, so I gave the anaesthetics for all the usual emergency procedures as well as for many hysterectomies and occasional cholecystectomies, gastrectomies, and on one occasion a thyroidectomy. A lot of these were worrying but oddly enough the most worrying were tonsillectomies, multiple teeth extractions and caesarean sections - the worry being compounded by knowing the patient and family intimately, and the patient sometimes being a very special only child. Fortunately nothing awful ever happened, but one sweated blood on many occasions with emergency surgery in fat, florid, heavy drinking males. In fact on retirement, I was quite thankful to see the end of it at the time when we acquired a new, modern, rather terrifying Boyle's machine at the hospital, with its complicated safety features, bleeps and monitors. I felt much happier with my old familiar Boyle's machine.❐