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 2) - 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.

In my early years, cases of diphtheria, poliomyelitis, typhoid and typhus occurred every year and were reflected in the annual health report I did from 1954 to 1982 as assistant and, later, as district surgeon. In the ten years 1954 to 1964 I had 45 cases of diphtheria to treat, using immune serum, and there were 14 deaths. Before my time and prior to the use of immune serum, 2 out of every 3 cases died and so serum treatment only halved the death rate. Diphtheria still remained an extremely serious illness. After 1965 no case occurred. By this time all children were protected with the 3 in 1 vaccine against diphtheria, whooping cough and tetanus. Although the vaccine gave good control against diphtheria, its tetanus component - whilst invaluable in preventing tetanus in older children - could not help the newborn infant infected at birth. Tetanus of the new born was a great killer of African babies as a result of the traditional habit of applying mouse droppings to the cord at birth - a habit that persisted even in more educated families - probably a traditional cord handling technique of the woman handling the confinement. The sight of a baby brought on the 8th day of life with pursed lips was a tragic one, because death invariably followed in a day or two. Only with hospital delivery of almost all Africans living in town, and many of those living on farms, has this ceased.

Poliomyelitis was also an ever-threatening problem if an epidemic occurred. I only had 15 cases prior to the vaccine - initially by injection and latterly by mouth - but one saw in the later crippling how many cases must have occurred regularly throughout the preceding years. I once had to go and break the news to an old couple that their much beloved, 14 year old grandson had died of bulbar polio, having been sick for a few days only. The father had phoned me from Durban asking me to break the news.

When, with immunization, whooping cough ceased to be the greatest killer of black babies, measles took over and epidemics occurred every few years - wreaking havoc with malnourished babies, who died from secondary complications. Death also occurred amongst well-nourished breast fed babies early in the disease. There is no doubt that measles was introduced into Africa from Europe and is a much more severe disease amongst blacks than in whites. Since 1978, with the vaccine available for general use, there has been a tremendous improvement but, even so, laziness and carelessness in getting this immunization still results in cases being seen in unprotected children. The usual excuse offered is that the child was sick and could not receive the injection. Typhoid fever was a great problem for my predecessors in this practice, due to the water supply to the town being via open furrow. With animals wandering about, an indigenous population living in the same area and doubtful sanitary provision, contamination of this water was inevitable. With piped water this ceased, but I still saw an occasional case - 24 in the earlier years and none since 1973.

Of the infectious diseases, pulmonary tuberculosis has remained the one where the incidence has in no way decreased throughout the years. This has spanned a period when all one could do was to note down names and wait for the patients to die - to the early treatment period (which seemed such a break-through) when I treated cases in my surgery with streptomycin and isoniazid, with my surgery nurse keeping the records. This was followed by a period when all early cases could be admitted to a SANTA centre in Fort Beaufort and, later, by the present period when a shortened course of treatment (instead of the two year course) is available at the municipal clinic - using a wide range of drugs under the guidance of a visiting consultant. For the individual sufferer who complies with treatment, the outlook is much better, but the disease remains a most serious public health problem in this country. No doubt, it is a good monitor of socio-economic conditions and, as in Europe, will not be mastered until housing, income and nutrition of the black and coloured communities improve.

Meningococcal meningitis occurred fairly frequently, but never as an epidemic in my experience. It has continued unchanged throughout the years, treatment improving as antibiotics improved. Very often it was simply diagnosed as purulent meningitis because of the delay in getting cerebrospinal fluid specimens to the lab in Port Elizabeth or East London by train. By the time they arrived, they invariably gave no growth on culture. The cases were probably meningococcal meningitis and were treated as such anyway. Sending a smear by Gram's stain of the centrifuged fluid would probably have been helpful, but the time factor and one's reluctance to handle this highly infectious fluid put one off. I did this on occasions, in particular in one case of meningitis in a four-month-old white baby I had delivered. I stained the slide with methylene blue and saw diplococci. The lab reported diplococci, which could be either pneumococci or meningococci. The culture as usual yielded no growth. My father came and stayed with us just after this and I showed the slide to him. "These are meningococci," he said without hesitation. "The cocci are parallel with concave surfaces facing each other and not in chains, as pneumococci would be." I sent his comment and the slide with some hesitation to the lab. They phoned me back to say they had asked the chief pathologist to look at the slide and he quite agreed with your father. This was a relief to me knowing that it was not a pneumococcal meningitis, with its much greater likelihood of complications; also a relief to the parents, who would now obtain free hospital treatment of their child as this was officially an infectious disease. What a tribute to Dad and his generation of doctors.

One 'side-room' procedure, which I continued to do in practice, was the white cell count. I had become experienced at this while an army doctor. I had earlier bought a good haemocytometer, took my microscope with me on active service and learned to do these quickly; I also learned to stain blood smears and look for malaria parasites in the many cases of relapsed malaria we had after the North African and Indian campaigns. This stood me in good stead and, throughout my medical career as a GP, I found the white cell count invaluable as a diagnostic aid. This was particularly so in cases of appendicitis and in babies with fevers with nothing else found to determine whether the infection was pyogenic - requiring antibiotics or not. On one occasion the pointer it gave me to an acute appendicitis, I ignored at my cost. I saw a little girl with pain in the right iliac fossa for 24 hours - she had vomited about 8 times. There was no fever, a clean tongue, no increase in pulse rate, very slight tenderness in the right iliac fossa with no guarding and no masses or tenderness rectally. The child had walked into my surgery without discomfort. When I did the rectal the glove was covered by a loose slimey stool on removal. The only disquieting thing was a white cell count of 25 000. I wanted to admit the child but the mother asked whether they could not spend the night at her in-law's farm, only 15 miles away, keep me posted about progress and bring in the child the next morning. I felt the chance of it being appendicitis wasn't very great, so consented. The child was slightly better when I phoned that night and when I phoned the next morning she had slept all night, though restlessly. I saw her when they brought her in at 8.30am and it was obvious that she had a very acute appendix, which had probably perforated. The problem was what to do. It was the 2nd January, Dr Vosloo was away on holiday, as was his brother in Somerset East. In those days Adelaide had no hospital so I knew nothing of the operative competence of the GP there, Dr Louw. To get someone up from Port Elizabeth would take time, even by air, and everyone would be busy the day after the holiday. So I phoned Dr Hofmeyer in East London and asked him to get everything ready and then took the child down in two and a half hours. She stood the journey well, and had a gangrenous appendix, which had perforated. The base of the appendix was normal and the tip gangrenous - surrounded by a loop of bowel, which had probably prevented it from being tender, and caused the diarrhoea. I felt dreadful about it, not insisting that she stay in hospital. It taught me two lessons - to insist on hospital admission if I am worried and, especially, not to ignore a high white cell count. Fortunately she did very well but I did not really feel relaxed about this until in due course the patient married and had a baby and I knew that peritoneal adhesions had not caused sterility.❐