What remains of and for the country GP?

By CHRIS VAN SELM

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 shoe string?

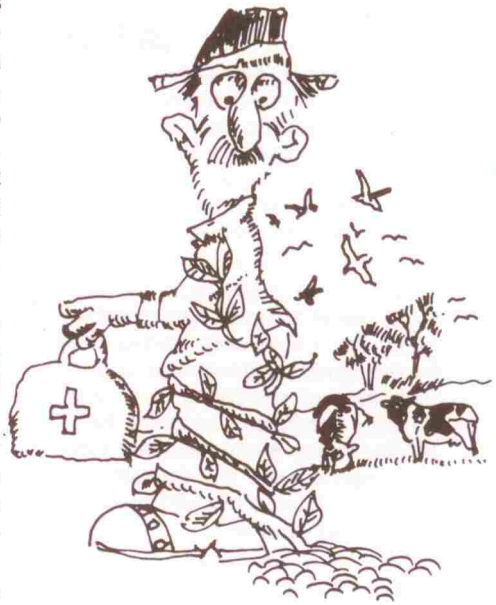
And then secondly, what now of the imminent development of the massive State Health Clinics being established in the country areas, which in theory should be highly effective and well-stocked, both in drugs and nurses, where the community health care is a priority issue? This must surely be welcomed 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 domicility, 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 wtih 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 clarity 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. conscious of the part the integral complexities of life play on that particular person, 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 catastrophies 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 sociological 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 loved and respected member of that community, but at what cost both to himself, and to his patient?

Or are we deliberately underestimating our existing country G.P.'s potential?

Chris van Selm

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 pathogenisis. 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 education 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. Beighton pointed out that in a series of South African surveys, using standardised 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, Solomon and Valkenburg, 1975). In a genetically similar urban group, the corresponding 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: "Why is osteoarthritis of the hips common 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 Witwatersrand. "This inheritied 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 co-exist in a Jewish patient, the diagnosis of Gaucher disease warrants serious consideration."

When a young White adult presents with hip-joint pain, the general practitioner 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 genetics will be as important to medicine as the introduction of antibiotics."

Other items of interest in "Rheumatology Review", issue three, include reviews on the diagnosis of "Ankylosing Spondylitis" and the "Control of Idiopathic-Type Pain".

Copies of "Rheumatology Review" are available from the Professional Services Department of Pfizer Laboratories (Pty) Ltd. P.O. Box 1600 Johannesburg.

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