NEW, GOOD DOCTORS FOR AN ALTERED SOCIETY*

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The irresistible tides of change have washed over the doctors, no less than they have covered industry and the world of economics. The time is out of joint, and so, we learn with growing alarm, is nature; our beaches are polluted with oil; our rivers, when they run at all, come down foaming with detergent, or brown with erosion; the veld is littered with beer cans. Perhaps this chill process has been less catastrophic for us doctors than it has been for, say, the theologians or the psychologists, but it has hit us, none the less. We pick ourselves up from the floor, dust ourselves down and ask: 'Who am I?' What is the idea of being a doctor, and who is the central man, the species-type of a doctor? And even if he recognizes himself, then where does he fit into society?

Time was when we knew clearly enough who the doctor was. He was the respected GP, the physician and friend, the repository of so much informed kindness, the man who made us feel better by just walking into the house. Perhaps thirty years ago we should have thus recognized him, a charismatic healer with more than a dash in his make-up of the priest and the prophet. And thirty years isn't very long, either. It covers the period of my own training, and takes us back into the pre-antibiotic era when we were wrestling with the bouts of vomiting brought on by the early sulphonamides. It was a time when medical treatment at least (the surgeons, even then, were highly conscious of their god-like powers) was more directed to the relief of symptom than the eradication of cause. This was of necessity. Few specific remedies were then available, except those stalwarts we still value: insulin which had been in for 20 years, and digitalis which we had had for 200 years, and the pain-killers, aspirin and morphine. Drips (does anyone remember who gave us this inestimable boon?) were administered by cut-down on the long saphenous vein at the ankle, and few physicians used anything except 5% dextrose and/or physiological saline, eked out by tragacanth gum. If life-giving sodium bicarbonate was given at all it was given orally in combination with the now (alas) defunct powder of turkey rhubarb, or Gregory powder, as it was called. Ryle had invented the nasogastric tube and taught us how to save lives by its use. We warmed our shocked patients up with brilliantly lit heat cradles, and whipped paralysed bowel with pitressin and turpentine enemas. We believed devoutly in focal sepsis as the hidden source of many ills, including—among the more outré psychiatrists,—schizophrenia.

But I'm perfectly sure, notwithstanding this rather grisly catalogue of medical oddities, that the qualities that make for good medical relationships were all there. I'm prepared to take an unscientific chance by saying that the patient-doctor relationship was then easier, more truthful than it is today, if contemporary litigation is any yardstick with which to measure. The lawyer over the patient's shoulder was then a less obvious shadow.

If it is true that the physicians of the '30s and early '40s, whose weapons were so much blunter than are ours today, could have had good and meaningful relationships with their patients, are we to conclude that there are certain qualities that make a 'good doctor' regardless of the era in which he works, and transcending the individual discipline within which he carries out his duties? And if this be true, can we catalogue these qualities, evaluate them, and determine their relevance to the altered society? Perhaps the idea of the 'good doctor' is a naivety. Possibly the concept of trying to become one is just a psychological throwback? I do not think so. I do not believe the search is fruitless, nor self-deceptive, nor yet a waste of time. Rather, I believe, we can select from our discipline's history and find the rôle we ought still to play today. For man changes very little in recorded time, and it is more than half in my mind that the sick and the frightened need reassurance and comfort in no less measure today than they needed these 1 000 years ago. We can be sure beyond conjecture that such reassurances and reliefs are very much needed within those societies of today which we refer to condescendingly as 'backward' or 'underdeveloped'. I further believe that there is evident an anxiety among doctors over the loss of identity that arises from contemporary social change. Many would wish to know more surely who they are, and are aware of the unease that results from this blurred image. It is in the highest degree ironic that we detect in ourselves uncertainty just at the moment of our greatest achievements. For we are immeasurably better equipped than our fathers were to save lives: our pills and our injections daily work fantastic miracles; our surgical skills pull innumerable rabbits out of death's black hat. Only our understanding limps; our instincts are daunted.

May I begin our search in a personal way? By holding up a mirror, not so much to nature as to a society that does not necessarily accept us doctors at the valuation we put upon ourselves? Twenty-five years as a sort of doctor in the country of the Zulu has taught that what seems obvious to me is by no means so viewed by others. We learn from the untutored and become ourselves more civilized by listening to the uncivilized, a paradox which should not surprise us greatly as we see that the uncivilized are in many ways better adjusted to their environment than we are ourselves. Certainly they consume fewer tranquillizers, and get fewer coronaries, which seem to me pretty solid credentials in themselves. We learn in two ways. Firstly by trying to find out what our Zulu patient is looking for from his doctor, and secondly by listening to his criticism (which he is not slow to voice) of what he finds there. He wants results, of course. The change in heart of the Zulu people (and for Zulu you might say, Tswana, Xhosa, Sotho or what you will) towards medical science must be the greatest social revolution of the century. They have been quick to see the results of a discipline which has so radically altered lives which else had been, as Hobbes described those of the poor, 'nasty, brutish and brief'. It is a humbling experience to have a man travel 3 days by bus to have his cataracts done. It is an irrational joy (though one that never fails) to usher a baby into the world after a difficult delivery, even if you can guess that

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the world has nothing but knocks to greet the new arrival. Our know-how is unchallenged, and there is ready admiration for the regularity with which the doctor can deliver the goods. The shrewd African mind sees, accepts, uses our skills, and is prepared, moreover, to pay for them.

Then, fairly often, we hear of patients who leave hospital after a good experience there and go straight away to the medicine man, the *inyanga* let us call him, or even the diviner, the *isangoma*. The patient may be a peasant, or he may be a teacher or minister, it matters not. What does matter is our reaction to this fact. Is this a betrayal? Ingratitude? Evidence of an innate primitiveness? It is called all these things and many things besides, yet this name-calling is foolishness, surely? For we, in calling it anything at all, are making judgements, all of which will be from our own side of the sociological fence. We make asses of ourselves when we gather personal merit because we at least do not behave in this 'primitive' way, nor owe anything to this 'superstitious' mode of thought. Your Zulu goes to the medicine man because our understanding is too small. We have failed to answer his unspoken question, we have not helped him at a level where our help is seen to *be* help. Society gets the witchdoctors it deserves; and that goes for our society, too.

If we learn anything from this 'reversion' (as we so hatefully style it) to the medicine man, it is that physical healing is not considered enough in Zulu society; that man does not live by bread alone. Our Zulu patients do not just ask the ordinary question 'how?'—which we are expert at answering with our detailed knowledge of microbiology and biochemistry—but they also ask a more metaphysical 'why?' We, of course, most often do not realize that we are being asked the question at all, and almost never do we attempt to answer it. So there is a world of difference between the patient's approach if he comes from Zululand or from Bishopscourt, yet surely the need is identical?

True, we do not, in our society, become disturbed or suspicious every time we get a cold in the head, but how greatly our anxieties at this level grow when a child is found to have leukaemia! Then we say, 'But why? 'What has this innocent little child done?' (Guilts about illness are not unknown in our own culture.) 'Why does this happen in my family? I've always led a good life . . .' Our agony is proportional to our ignorance and our inability to relieve. And what do we say to our patients then? Most of us are silent, our attempts at comfort but idiocy. What criticisms do our Zulu patients give of their doctors? They upbraid me for the hurry I'm in; they importune me until I act, sitting on the doorstep of my house; they chide me for losing my temper; they shame me into gentleness; they remind me if I omit certain parts of the ritual of examination, reminding me that I haven't examined them properly. My unforgiveable sin (I don't fall often nowadays) is to forget to tell them what is wrong. And how right they are! Most of our patients of every possible hue say this about most of us: 'The doctor didn't tell me anything'. We make, I am convinced, no greater mistake. My parochialism has perhaps led me into thinking that such lessons are comparatively easily learnt in the overtly critical medicine of the third world, but of course they are as easily comprehended within the framework of our own familiar culture. Your own enormous experience will build proof on my proof, and go beyond what I have said in comprehension and action.

On familiar ground again we recognize the good doctor as one who, among many gifts, has the power to allay anxiety. Proximity to such a one makes us feel better, just as the toothache of our childhood seemed to get better the nearer we got to the dentist's waiting room. Creating calm and assurance is no vulgar trick, either; it is not an oil-slick of soothing unction on the waves of our anxious lives, but a perfectly genuine phenomenon. Not all doctors allay anxiety, alas, no. Nor does there seem to be any common thread running through that happy brotherhood of those who do so. It seems to be a capacity as non-specific as politicians' pipes, umbrellas or golf-clubs. It neither relates to age (and thus to supposed wisdom), nor sex (women ought to be better at it than men, but often are not), nor even to the doctor's air of prosperity. It is a very sure gift, and blessed are they who have it. Those who do not have this capacity will retire discreetly into pure science and grow to love their computer.

Nor can anyone allay anxiety unless there is communication of some sort between the patient and the doctor. This may be a matter of grunts or of polished utterance, but communication there must be. It is unfortunately true that ward-rounds in hospitals are not a good ground for the establishment of such communication. And large ward-rounds are worse than small ward-rounds. The usefulness of a ward-round to the patient is often in inverse proportion to the number of doctors on the team. In the very largest ward-rounds, nobody even bothers to say 'hello' to the patient.

The doctor must not only have good hands to work with, nor even a well-stocked brain. A pair of listening ears is useful, and to use them patiently is a great virtue. How great are the errors we fall into by not listening! A woman of 30, advanced in pregnancy, came holding her abdomen: 'My baby's in my chest, doctor! there it goes, there . . .' 'Madam, you must try not to exaggerate', we all said, 'who ever heard of a baby in a woman's chest?' A few days later something went wrong which neecssitated our opening her, which we did, not, it is true, to find her baby in her chest, but crawling around the abdomen, loose outside the uterus, convulsively clinging as I suppose to the gallbladder. Yet we don't learn much from these dramatic experiences, not sufficient anyhow to give us really patient ears. And because we don't listen enough, we don't hear enough; the pattern of the good physician becomes a more remote ideal.

Maybe we're too proud to listen? Do you follow Charlie Brown? 'I'm going to be a country doctor,' says Linus, 'a humble little country doctor. I'll get in my sportscar every morning, and streak out into the country, and I'll heal and I'll heal.' Linus almost drops his blanket, so carried away he is by his enthusiasm. 'I'll become a *world-famous* humble little country doctor,' cries Linus. And I'll bet that about sums it up for many of us. We are a proud lot, I'm sad to say, however humble we are, however far out in the country. It's hard not to fall for the subtle flattery of doing good to others; it's hard to wipe the smirk off our faces when people praise our supposed devotion to the unfortunate. This is a game which we

play according to rules we make up for ourselves. We are the doers of good, and the patients are the receivers. In the world of human need it may well be more blessed to give than to receive, but it is a darned sight harder to be on the receiving end than it is to be the giver of benefits. Do we pause often enough to consider the humiliation that is our patient's lot? Do we understand how disastrous it is to a man's pride to wet the bed? To me, the recurrent wonder is that we are so often forgiven for having looked into this bluebeard's chamber of a man's privacy. We are bright and cheery: 'Don't worry, Dad, nurse will fix it all up when I've gone,' we say, from our position of total non-involvement, from the security of our own well-controlled sphincters. Do you remember the grave-digger in *Hamlet*, delineating the hollow orbits of Yorick's skull with his finger? 'Now get you to my lady's chamber,' he says to the skull, 'and tell her, let her paint an inch thick, to this favour she must come; make her laugh at that.' It is a sobering thought that we too shall soon notice the splash on our own shoes.

I think that the qualities of the good doctor bear little relation to our chosen path in medicine, save only that the first requirement in any field is that we be thoroughly competent. Nothing more awful than a ham-fisted surgeon, unless it be a dull physician. We ask first skill—skill of hand and mind and eye which is the gift given to those who continue to learn. If you never stop reading, if you discuss all the time, if you know what you don't know, then your skill will grow, silently and certainly until you wake up one day and say to yourself, 'I can do that' or 'I know that, and I shall never, never not know it again.' Your skill will become to you an inner voice, saving you from folly, making you look again at the label, bringing you up sharply before you make the mistake that your fatigue is urging on you.

The skill of the good doctor will justify him in many tense moments, and yet he will have to bind to himself an unchanging discipline which, ideally, will mean that he is as safe at two in the morning as he was at noon the previous day. I heard a Bantu doctor lecturing in Durban once. 'If you practise medicine without properly examining your patients, you will become a quack in 3 months.' We are repeatedly subject to the temptation to 'burrow'. The bra and those dreadful long woollen off-white pants they wear on the Highveld in winter remain the greatest enemies of clinical sense. I know of no way of getting through the enormous number of patients (250 and more in a day) that besiege country clinics except by observing the rigid disciplines taught in the elegant clinics of your teaching hospital. The consultant, the man at the top of his tree, is the man who is still doing at the age of 50 what he was taught to do when he was 20.

With skill and discipline firmly knit together, we cannot but be useful doctors. For most ailments these two qualities alone will carry us through. What more is demanded of us? Our reactions to the stricken, the bereaved or the angry, will have to come from the human stores within us. From where else can we draw enough kindness to tell a young mother of her deformed child? Or dredge up the right sort of answer when the tired housewife asks us for 'something to put in his tea, doctor, to stop him drinking so much'? How we approach these evidences of the human predicament which it is our incalculable privilege to share, must depend upon the kind of person we are, and this, in turn, depends upon our reactions in every sector of our lives. I don't think we can be taught goodness, but I believe we can catch it, a contagion bequeathed us by the proximity of good people. How much we owe to those who made us want to be reasonably mature in our emotional lives, who made simple goodness attractive to us! I think our profession has many such people, in the universities, in the teaching posts at the medical schools, even among those we meet daily who don't even realize they are teaching us at all.

But if these desirable and kindly human qualities cannot be taught, they can, I believe, be nurtured. We become what we always were, only more so. Rose Macaulay's advice to the schoolgirls was that, if they wanted to become dear old ladies by the time they were eighty, they had better begin right away. We become mean by the repetition of mean acts, but also more human, more kindly, more sensible by the same repetitious processes.

We do not practise medicine in anything like seclusion, though. We are not only physicians but we are also members of society, and we practise medicine as members of society. The old GP with whom we began, had a clear enough position in society, but what of our own? Where, indeed, do we fit into the complex? We know of the uneven distribution of available medical resources between, say, the towns and the country. We may be falling over ourselves in Pasteur mansions, but we know that for perhaps 70% of our population there are not enough hospital beds, not enough health workers, not enough doctors, just as there are not enough desks in the schools, money in the house, hope in the heart. This is a situation grown stale by repetition, for which we know much has been done in the past, much is being done and much is waiting to be done, and we realize also that a great deal of this work will have to be carried out by our own profession. To take part in this long, disciplined, grinding yet cheerful exercise will yet be our privilege and may come to be our glory. There is, on paper, unlimited scope for us to act within society, but in practice it is more difficult, requiring a certain benevolent cunning to find ways and means through which we can act and still keep our standards high, and retain our interest in specialized and advanced medicine. Some—and it is a growing number—are willing to serve for a while at least in the rural frontlines, working a year or more in mission or other rural centres. There is no better experience; there are no better foundations to lay for a specialized career. It is a service to the needy at the right time, which could compare favourably with time spent in the armed forces, and would, if offered as alternative service, prove acceptable to young doctors of a modern cast of mind.

Others will contribute in the urban sphere, even as our medical fathers gave their services as 'honoraries' in the old voluntary hospitals. A session or two a week might prove a signal service over a medical lifetime. A few there will be who will make the medicine of the 70% their specialty. They will be the really fortunate ones who, if they have (as they will have) an inordinate number of worries and grievous, lonely anxieties, will also have the

greatest satisfactions. To see the end of wasteful, needless disease among a whole population is not least among the rewards. Perhaps what is asked of us is a sense of responsibility towards the enlarged community that is South Africa's population today. We may express it in many ways, but the truth remains that health is single and indivisible; that we are not truly well-doctored until all men are truly well-doctored, just as we are not truly well-fed while there are among us those who are hungry, nor well-clothed while there are those who go about in rags. Who will be the doctors of this wider service, this more total vision? We cannot go back to the balding family doctor with whom we began this talk, and I doubt if we really want to. Medicine is today so vast, so complex and so effective that he who imagines he can wander with equal facility through its many mansions himself requires a physician, a psychiatrist even.

Clearly the good, new doctor of the next decade is the one who learns best to work together with his colleagues in the therapeutic team. Under this new thinking we shall not, in future, see the emergence of so many 'characters' as in the past, and the 'Grand Old Man' will very properly suffer eclipse before his personal light actually goes out. This is going to demand in us all new levels of self-effacement, and perhaps, even, financial sacrifice. But under the team the patient will be safer. His life will no longer wobble in balance about the single point of individual ignorance or a solitary defect of character in one great man. It becomes our concern to see that, with his improved chance, the patient meets a kindness no less than he formerly met, a sympathy undiminished to carry him over the troubled waters of his sickness.