VAN DIE REDAKSIE : EDITORIAL

DIE BETEKENIS VAN 'N SKEPPENDE BELANGSTELLING

By die geleentheid van die Mediese Kongres wat onlangs in Kaapstad gehou is, was daar weer, soos in die verlede, 'n interessante uitstalling van die stokperdjies van dokters. As ons hierdie uitstalling volgens professionele standaarde vergelyk met ander kunsuitstallings, sal dit natuurlik minder treffend wees. Hoe kan ons dit ook anders verwag? Immers, wat ons te sien gekry het by die uitstalling van die stokperdjies van die dokters is die amateurwerk wat deur besige mense gedoen is in hul afknyptydjies.

Maar, dit is juis dít wat die belang van die uitstalling verhoog. In die tyd waarin ons leef, waarin ons daaglikse kom en gaan nou al die pas van die motor ver oorskry (ons beweeg alreeds op die projektiel-vlak en in kernbane), is dit miskien juis ons aktiwiteite in ons afknyptydjies wat die graad van ons innerlike beskawing weerspieël.

Soos Albert Schweitzer ten opsigte van ons daaglikse doen en late gesê het, dat elke mens 'n tweede taak moet hê — iets wat hy doen ten behoewe van die algemene welsyn van mense waarvoor hy nie betaal word nie, so is dit ook nodig vir ons om op die kulturele vlak 'n tweede belangstelling te hê. As dokters sal ons eerste belangstelling natuurlik moet gaan oor die kennis en insig en houdings en beginsels wat aan die grond lê van die suksesvolle beoefening van die mediese praktyk — in sy vorm as mediese wetenskap sowel as in sy vorm as lewenskuns.

Maar dan is daar nog die noodsaaklike tweede belangstelling waarna ons so pas verwys het — 'n belangstelling wat miskien geen praktiese betekenis en voordeel hoegenaamd het nie, wat dus in pragmatiese en utiliteitsterme volstrek nutteloos is, maar wat tog desnieteenstaande 'n weerspieëling is van daardie ander en dieper dors wat die wesenlike mens nog altyd gekenmerk het.

Watter spesifieke vorm hierdie tweede belangstelling aanneem, maak nie eintlik saak nie. Dit kan byvoorbeeld een of meer van die vorms aanneem van die stokperdjies wat ons op die uitstalling by die Kongres te sien gekry het — die versameling en herbelewing van amulette, skulpe, vetplante; of plastiese werk, beeldhouwerk, skilderwerk, kunsfotografie, ens.

Andere sal ander belangstellings hê. Charles Darwin het byvoorbeeld gesê: ‚As ek my lewe weer kan oorlewe, sou ek 'n reël maak om minstens een keer in die week 'n bietjie poësie te lees en na musiek te luister; want dan miskien sou daardie dele van my brein wat nou verdor is, lewendig gebly het deur gedurige gebruik. Die verlies van die smaak vir hierdie dinge is die verlies van geluk. Die verlies daarvan benadeel heel moontlik 'n mens se intellek. Baie waarskynliker benadeel dit 'n mens se sedelike karakter deurdat die verlies van hierdie dinge die emosionele deel van ons menslike natuur verarm'.

En E. M. Forster het in sy treffende essay oor ‚Anonimiteit' in *Two Cheers for Democracy*, gesê: ‚Lyric poetry is absolutely no use, and poetry generally is almost no use... What's the use of "a slumber did my spirit seal" or..."so we'll go no more a-roving"?... Imagination is our only guide into the world created by words... What there is down there — ah, that is another enquiry, and may the clergymen and scientists pursue it more successfully in future than they have in the past'.

Wat die vorm van ons tweede belangstelling is, maak dus nie so veel saak nie. Wat van belang is, is dat dit daar is en dat dit kultureel van soort en skeppend van aard is. ‚Die mens wat iets skep' — so het so 'n voortreflike beoefenaar van die lewenskuns, soos M.E.R., in ‚Ou skuld' in *Die Gewers*, gesê: ‚die mens wat iets skep — hy vergeet baie van die swaar en die skades wat hom oorkom'.

In die uitvoering van die opdrag: ‚medisynmeester, genees jouself', speel die aankweek van 'n skeppende belangstelling, bowe en behalwe die daaglikse verpligtings van professionele arbeid, dus 'n belangrike en essensiële rol. Maar ook vir ons pasiënte is hierdie kennis en insig van die allergrootste belang, en elke dokter wat self die verruimende en bevrydende uitwerking van 'n skeppende belangstelling leer ken het, sal dit op oortuigende wyse kan oordra aan sy pasiënte, nie net as 'n *voorskrif* vir 'n gesonde en gebalanseerde lewe nie, maar ook en veral as 'n voorwaarde vir die geestelike groei en ryping van die eintlike, wesenlike mens. Dan sal hy sowel as die pasiënte wat aan sy sorg toevertrou is, ook in staat wees om die werklike betekenis van hierdie woorde van die digter te snap:

> ‚Want zie, zoo lange tijd is aan elk mensch gegeven
> Dat zijn woord rijpe tot lied
> Voor Gods aangezicht'.

THE LANGUAGE OF THE PATIENT

In the course of his Presidential Address, which was delivered at Cape Town during the recent Medical Congress, Mr. Currie, President of the Medical Association of South Africa, said: 'One desideratum in an educated man is the gift of being explicit and articulate in language. In a bilingual country such as ours, the really perfectly bilingual have so great an advantage in mental agility and plasticity that they are to be greatly envied, provided that the trap of mediocrity in both languages can be avoided. This projection into another language should usually make it easy to have some acquaintance with a third, and I feel that doctors should learn one of the major European languages for its interest, its literature, and the access it gives to appropriate medical publications. To this polyglot equipment might well be added a basic knowledge of the Bantu tongue most prevalent in the area'.

This considered pronouncement of the President expresses the same basic sentiments that are voiced in the impassioned plea of a colleague from Durban (published on p. 1000 of this issue of the *Journal*), that every doctor in the country, practising among non-European patients, should be able to talk and understand the language of his patient. Dr. Campbell summarizes his own thoughts in this connection by paraphrasing a sentence used by Alan Paton at the Natal Medical Graduates Dinner in October 1961, in the following words: 'We should be ashamed that, as the profession least conscious of race in this country, so few of us working among non-European patients have made the slightest attempt to learn the language of the patient, or a language mutually known to ourselves and the patients'.

We feel that we must support these sentiments without any reservation whatsoever. We should even like to go a step further and state categorically that it is morally wrong for any doctor to practise 'for gain' among people unless he is able to communicate direct with them in a language which they understand well enough to express accurately; not only the overt symptoms of their physical illnesses, but also the finer nuances of their thoughts and emotions, and the true nature of their hidden hopes and fears.

We all know the numerous 'humorous' stories in circulation about the inability of interpreters, in the courts of law, to convey to the Judge the true meaning and implications of the words of the accused, and *vice versa*. These, often facetious, stories reflect an unsatisfactory reality which, in the practice of medicine (if not in the administration of Justice — but that is fortunately not primarily our responsibility), may well lead to a lowering of our standards of diagnosis and treatment — not to mention the level of our interpersonal and intercultural relationships.

In the practice of psychiatry, for instance, it is imperative and obligatory for the therapist to be able to establish a satisfactory *rapport* between himself and his patient, and also to have the ability to enter into a true empathic experience. A knowledge of the patient's language or a language mutually known to the patient and his doctor, is a prerequisite for achieving these two basic requirements for a satisfactory doctor-patient relationship in psychiatric practice. Without this we have no hope of ever overcoming the already formidable barriers to transcultural communication.

All this is bad enough when Europeans have to be treated by fellow Europeans who do not understand 'the language of their hearts'. It is infinitely worse when the needs of every person in South Africa is considered, especially in view of the fact that there is not a single, trained non-White psychiatrist in the country. For years to come it will therefore inevitably have to be the White man's duty and privilege to take a lead in building the necessary empathic bridges.

These considerations are important, not only in the practice of psychiatric medicine, but also in the practice of medicine in general. In spite of the fact that it is relatively easier (in certain instances) to treat physical conditions on the basis of diagnoses made on objective signs, our margin of error remains dangerously high (and the level of our standards dangerously low) if we have to rely on secondhand information gained from interpreters who have had insufficient training and experience in both medicine and the humanities to enable them to act as intermediaries between vague and apprehensive patients, on the one hand, and harassed and impatient doctors on the other.

It is of course obvious that true bilingualism or multilingualism will always remain outside the bounds of realization for most people — a situation which, in this country, is complicated beyond comprehension by the welter of Bantu languages. Many people, belonging to all racial groups, are in any case sadly lacking in the ability to communicate their thoughts on an articulate and explicit level. There are, in fact, people who are practically inarticulate in any language — an observation which long ago was symbolized by Fitzgerald in his superb translation of Omar Khayyam:

> 'And strange to tell, among that Earthen lot
> Some were articulate, while others not . . .'

This very fact imposes an even greater obligation on us to approach this essentially human problem of the language of the patient on a mature and responsible level and in a truly understanding spirit.