PERSONAL VIEW

To have unorthodox views and thought is regarded as criminal by the medical establishment. I can recall when about to give an address at a certain interior centre in this country hearing someone ask, in Afrikaans, who was due to give the talk. The answer was, "*daardie malmens van Durban*" (that madman from Durban). I'm sure I gave them value for the time they spent. Professor Frank Crew used to say that any lecturer who didn't infuriate his audience into thinking and inquiring for themselves wasn't worth his salt. Also I can't help recalling A. P. Herbert's excellent dictum in *Uncommon Law* that "*melior est bombinantis quam moribundi*" (it is better to have bees in your bonnet than to be moribund)—something that might be well borne in mind by those only-too-many pedestrians who grace the teaching staff of some universities.

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There's a good deal of ink spilt in local medical circles—and I've done my share in spilling it—but I can't help remembering a rather pompous and prosy paper on medical education by one of the younger and most avid ink-spillers. In it he said, "A good physician makes a good registrar." What nonsense, I thought. The exact opposite is almost always the case—certainly in the large number of hospitals not attached to medical schools—good registrars make good physicians. I was speaking to a senior colleague and he expressed the most up-to-date and informed views on a certain subject. I was most impressed, and asked him how he knew so much. "Well," he said, "I've got a very good registrar, and he keeps me up to date." This senior consultant wasn't ashamed to say that his method of practising benefited by having a really good registrar. Perhaps this is true of more professorial units than one would like to mention. So I'd like to say that "a good registrar is a profound benefit to the community."

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I've been fighting a losing battle in my attempts to encourage my colleagues in Natal to try to learn to speak to their Zulu patients in their own language. If a Polish-speaking doctor were to ask for a job handling European patients without being able to take a history, he'd be shooed away (in English) in horror. Yet if you asked the shooers when they work with Zulu patients to learn to speak enough of the language to take a history—and it doesn't take all that long—they would cackle in your face.

Large sums of money are being spent on providing interpreters (or rather nurses who act as interpreters) for doctors, and since there's a grave nursing shortage such nurses could be far better employed elsewhere. But a suggestion which I made, that after one year's service in the local hospitals those doctors who by that time hadn't taken the trouble to learn Zulu should pay for the services of their interpreters, didn't find any favour.

An incident which illustrates this occurred one day when I was asked to see an elderly Zulu with diabetes who wasn't truly dependent on insulin and yet was poorly controlled on oral therapy because of a high consumption of carbohydrate. After I'd spoken to him at some length, examined him, and studied his laboratory test results, the registrar asked me what he should do. I said, "Teach him how to fish." Understandably, the registrar was taken aback. Though he'd lived in the province for many years, he knew neither his province nor his patients. He didn't know how to talk to the patient in his own language, nor was he fully aware of how impossible it was to use insulin under those particular home circumstances.

During my short talk with the patient I'd learnt that he lived at the mouth of an estuary in Zululand where skates and sharks abounded all the year round (having fished there many times, I knew this well). All he ate was a large amount of ground mealies, some bread, herbs, and the inevitable sugar—which has gone everywhere into the rural areas in South Africa—and a little in the way of milk products plus a fairly liberal intake of Kaffir beer. Eating a lot more fish, which was readily available, would have made the difference between very poor control (discomfort) and fair control (less discomfort) once we'd replaced his sugar with saccharin. "If you give a man a fish, you feed him for one day; if you teach him to fish, you feed him for many years." The Chinese have always been noted for the wisdom of their dicta.

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An Italian once said, *Si potrebbe vivere ancora, voglia essere uno cano in Inghilterra*—"If I could live again, I would like to be a dog in England." All people love their pets, and this is no less true of people in South Africa.

For some years I've run a consultative service for veterinary surgeons for what they call diabetes in "small" animals, and it's been very rewarding. We never see diabetes in "large" animals, presumably because most farmers shoot animals that fail to thrive as soon as possible, and, in spite of asking vets to let us know of such cases, I've yet to see one. The thing that's impressed me so forcibly is the remarkable regard that people have for their small pets—it exceeds greatly that of certain parents for their diabetic children—a cynical remark, perhaps, but a true one. I've yet to see more carefully kept records—not only of four-times-daily urine tests, but twice-weekly random blood-sugar Dextrostix tests—than were presented to us by the elderly spinster owner of a beautiful Siamese cat when the animal was brought 130 miles to see the veterinary surgeon and myself promptly every month. Having been a severe insulin-dependent spontaneously diabetic cat for some 18 months, the cat went into a total remission and hasn't needed insulin for three years. I couldn't have wished remission for a more loved patient.

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One must always cut one's coat according to one's cloth. But can we possibly afford to keep up the standards to which we've been trained to strive? It's distressing to see how we have to skim through patients when there's a staff shortage and come to rely increasingly on the trained eye of the clinic orderly, who can often pick out the patients who are ill simply by walking down the clinic queue.

One glorious—or rather should I say inglorious?—day two doctors "saw" 237 diabetics in the space of four hours in my clinic. The orderly's eyes were very vigilant, and I feel that in spite of the tragic standard of medicine that we had to adopt that day no one who was really sick was sent away. It got to the stage—during a period of extreme staff shortage—when patients used to prepare statements in writing. I've one in front of me from an Indian patient suffering from a chlorpropamide light-sensitivity dermatitis. It ends as follows: "N.B. I am sorry for I cannot say all this to you as the crowds of people are prolific and I know that time is important. In fact I have had diabetes for 28 years. I hope that you will accept my mistakes." *Sancta simplicitas!*

In this matter of interpreters, I was very interested recently when compiling a chapter on life assurance in the African to solicit the opinions of the emeritus professor of law at a local university. On no account, he said, would any contract of life assurance based on the use of interpreters be valid; he emphasized that any claim on such a basis would be cackled out of court. If, therefore, such a contract has no basis at law if negotiated through the interpreter, why then should we tolerate shoddy "clinical information" taken by interpreters and published by doctors under their own names? It would appear that what is patently lacking at law is sufficient for medical men.

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