MEDICAL PRACTICE

Personal Paper

Six months in South Africa

ANNE SAVAGE

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As I clutched my white coat across my freezing bosom, and lowered my head into the blast, I reflected that this time a year ago I was lying in a swimming pool listening to the sounds of a Durban dawn, and watching the mousebirds creep through the overhanging trees. Dawn is the best time in Africa, and especially in Durban. Later the traffic jams up, the factories unroll great blankets of smoke, and the streets become dusty heat traps.

Many years ago the *Cape Times* had some fun at the expense of "experts" who wrote authoritarian articles on the state of the nation after only a few weeks' stay. In a piece of neat verse it symbolised these misconceptions. Alas, I can remember only the last two lines:

And over the cobbled natijes
The lonely biltong rang.

A pleasing image, I'm sure my South African friends will agree. So why attempt to put one's head into the same noose, and write, after only a brief six months' experience, about South African medicine. For two reasons. As an unashamed plagiarist, if someone else has a better way of doing something I think it worth trying, and in some ways they do order things better there. There is also that old, old fallacy that the grass is greener on the other side of the fence, and it is interesting to find that Durban doctors, financially Croesuses compared with their English counterparts, grumble no less, and for every British expatriate one could probably match a South African escapee. Then it was a real psychological shock, and quite unexpected,

to find that I yearned, really yearned, for the NHS. Only when I looked back over some old journals did I realise that others with overseas experience had done the same.

Hospital medicine

The first thing you notice about a South African hospital, apart from the universal bilingualism, is the cash register. It stands in the outpatients department, and everyone pays; even the slow queues that shuffle through reception in the mission hospitals proffer their coins. I have no doubt that the indigent are nodded through, but payment is expected, and I never heard any resentment expressed. It brings in, they told me in the Transkei, 10% of the hospital revenue, and is an essential part of their financing. I suspect that it may also keep out the trivial attenders, though there are fewer of these in the country districts.

Like the coin that is dropped in the till this regard for the financial aspect of medicine (so noticeably absent in England) has two sides. It starts at the beginning in that many, if not most, students are financed by a bursary system. Money may be borrowed from the provincial administration from the second year onwards to pay tuition fees, and is repaid either in service to a hospital in the same province or in cash. Salaries are high enough after qualifying not to make repayment a great burden, and the juniors I spoke to seemed to regard it as fair (and some expressed contempt for our "hand-out" system). An indirect advantage was that the province, having provided the cash, was interested in seeing that the bursary students got jobs, sometimes in preference to the self-financed. That did lead to some resentment.

The hospital where I worked was a glass and marble palace fifteen stories high, and from the top-floor dining room you could watch the harbour traffic and the surf-riders, which provided some consolation for the frustrations of vertical travel with an inadequate lift system. In the centre of the "European" complex, and largely sharing its facilities, was an

London NW11ANNE SAVAGE, MRCS, LRCP

endearing, cream-washed building, the "Coloured" section. Our patients were so varied that the exact delineation of their status was a discriminatory activity I was glad not to be concerned in. Their illnesses were mostly "Western," and investigation and treatment much as would be found in a comparable English hospital, though investigations were remarkably quick, almost all, including scans, being available in a few days. This ready availability was possibly a temptation to overuse.

There was, however, one big difference: we Motivated. This was not an inducement to self-scrutiny and definition of self-fulfilment roles, but an exercise in form-filling. If you wished to use a drug for which there was a suitable and cheaper alternative then you had to give a reason, state what other drugs had been tried, and why they had not proved satisfactory. The form had then to be signed by the head of the department. I never knew one to be refused, and I don't know how many were, but you learnt very quickly to know the relative costs of drugs, and the indications for using the more expensive ones. You could not, as I did in England recently, attend a lecture on oral hypoglycaemic agents during which no mention was made of the cost of the different products nor of why one might be preferable to another.

General practice

After a limited time in hospital I moved into general practice. When I climbed aboard that jumbo for Johannesburg I had been rather attracted by the idea of an insurance-based scheme, allied to an item-of-service payment. Experience was to disillusion me. General practice in South Africa is, to all intents and purposes, private practice, patients may shop around, and many do; no large, comforting envelope of notes with hospital summaries accompanies them, and there is no direct liaison with the hospital and specialist services, so letters are patchy and inadequate, and confusion about drugs and dosage can be worse than in England. But it was the paperwork that sank me. Forms in triplicate for any patient covered by the Workman's Compensation Act, certificates in triplicate, and further forms, only duplicated this time, to "close the case"—and all this for simply removing a foreign body from the eye, or applying a dressing. Item of service means entering a diagnosis for each consultation, something very difficult to do with conviction. We all know the patient who presents with a trivial pain, and half an hour later is still expounding the complications of a life that would make that of the House of Atreus look straightforward. Well, you can't put that in, so you sign for "fibrositis."

Practice is often governed by rewards, and it took me quite a while to fathom why antibiotics were given so often by injection for trivial infections. Procedures were graded by their cash value by the ancillary staff at least. Simply removing a finger-nail under a ring block (casualty officer's stock-in-trade) was "good," and attracted a larger fee than a vastly more complicated and skilled diagnostic exercise. Emergencies were a real problem. First catch your specialist, and at weekends he might be quite elusive. That meant sending the patient home to await developments, or keeping him in the consulting room in an embarrassing state of temporal suspension until contact was made. Medical emergencies were worse. I never learnt to solve the dilemma of admitting a patient who might deteriorate quickly to hospital under my unskilled care, or that of causing him to use up his "illness allowance" by referring him too readily to a specialist when there was no other medical help immediately available.

For there is, except in the case of the very rich, a financial "ceiling." Most Europeans of working age are covered by medical aid insurance. There are several schemes, which vary in their payment for hospital and specialist services, but in every case there is a cash limit, so that the old, chronically ill, or inadequate are the losers. Indians may join, but many don't, preferring to pay for treatment when they need it (and sometimes it is said, then finding that they can't afford it). Africans

cannot join, though some are covered by their firms' private schemes. These schemes are by no means universal. Apart from the Africans, retired people are often excluded, and may find themselves having to undergo a means test and accept treatment (usually very good treatment) from the provincial hospital. Many doctors have opted out of the medical aid system, finding the hassle of getting payment in reasonable time too much. Credit control is all, and the reception staff spend much of their time telephoning recalcitrant debtors, and for private patients who were doubtful risks a blacklist was posted.

Both sides of the coin

I cannot generalise about general practice. I have met such a great variety of quality in England. Nor can I generalise about South Africa. True, it is a land where it is very easy for doctors to grow rich. The system favours the doctor, and for the true entrepreneur there is no limit. You can set up practice where you like, once planning permission is agreed, skim off the cream, and drive off cradling the money bags. No family practitioner controls, and there is no continuing responsibility. Labour is not organised, and no trades unions are allowed, so the poor have no resort but charity. (Sadly one reflects that in the world of nature the predator always chooses the weakest victim.)

Nevertheless, there is also the other side. The morning before I caught the homebound plane I paid a quick visit to the King Edward VIII hospital. I had been there before to attend the weekly medical meetings, since it houses the medical school and the professorial unit. Given the spurious excitement engendered by the circumstances, the exuberance of the African and Indian doctors who took me round, and its undoubted problems, which are a constant threat to the African medical school (striking students and overwork), this jumbled, untidy heap had a spirit that I had sadly missed elsewhere. Here doctors of all races talked of medicine, and the problems of bringing it to those who most needed it. Here was a reminder of the mission hospital that I had so much enjoyed working in, and a basis for true multiracial co-operation. Whatever happens in South Africa, it would be nice to think that KEH survives.

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Has potassium p-amino-benzoate a place in treating Peyronie's disease?

Peyronie's disease is characterised by the appearance of dense fibrous plaques in the dorsum of the penis in the sexually active man. In the initial stage pain on erection is a feature, and curvature of the erect penis makes intercourse difficult or impossible. The cause is unknown, but the pathological features of proliferation of dense fibrous tissue between Buck's fascia and the tunica albuginea of the corpora cavernosa are well described.

An impressive variety of empirical treatments have been used in this condition reflecting that the cause of the disease is unknown and strongly suggesting that no single method of treatment is satisfactory. What has largely been overlooked is that the condition may improve spontaneously. Only relatively few patients with untreated disease have been reported, but clearly any pain usually subsides and even the penile curvature may resolve.¹⁻³ Owing to the lack of untreated controls in most reported series, an objective evaluation of the results of any form of treatment is impossible. The treatment of Peyronie's disease with potassium p-amino-benzoate (Potaba) was first described in 1959,⁴ and convincing evidence that it favourably influences the natural course of the condition is still awaited. Unfortunately, it is easier for doctors to dispense medication than to withhold it, hence the administration of Potaba, vitamin E, oral cortisone, dimethyl sulphoxide, and drinking of mineral water in treating this condition are likely to continue.

¹ Byström, J, *et al*, *Scandinavian Journal of Urology and Nephrology*, 1972, **6**, 1.

² Williams, J L, and Thomas, G G, *Proceedings of the Royal Society of Medicine*, 1968, **61**, 876.

³ Poutasse, E F, *Journal of Urology*, 1972, **107**, 419.

⁴ Zarafonitis, C J D, and Horrax, T M, *Journal of Urology*, 1959, **81**, 770.