

Van die Redaksie/Editorial

Chirurgie vir 'n peptiese ulkus

Gedurende die afgelope 3 dekades het verskeie studies daarop gedui dat daar 'n verhoogde risiko van premature sterfte na chirurgie vir 'n peptiese ulkus bestaan. Twee vrae ontstaan onmiddellik. Eerstens, kan die premature sterfte op enige manier met die operasie geassosieer word? Tweedens, sou hierdie pasiënte prematuur gesterf het indien hulle ulkuse medies behandel sou gewees het? Die derde vraag wat moontlik mag ontstaan, is of minder en minder pasiënte as gevolg van hierdie bevinding aan chirurgie onderwerp moet word.

'n Onlangse studie deur Ross *et al.*¹ van Edinburg bevestig weer eens dat 'n persoon se lewensverwachting na 'n genesende peptiese ulkus-operasie verminder. Hulle het sterftes en die oorsake daarvan in 779 mans wat tussen 1947 en 1965 geopereer is, ondersoek, en 'n buitensporig hoë mortaliteit in die drie hoof-ouderdomsgroepe (tussen 30 en 59 jaar oud by operasie) in vergelyking met die algemene bevolking gevind, met 'n gemiddelde verskuiwing van 9 jaar in die oorlewingskurwe. 'n Ontleding van die oorsake van dood dui egter daarop dat die buitensporig hoë mortaliteit hoegenaamd nie in verband gebring kan word met die operasie nie en dat enige verandering in die tipe operasie wat uitgevoer word dus geen effek op hierdie syfers sal hê nie. Hulle het die hoogste mortaliteit hoofsaaklik in die rook-geassosieerde siektes soos isgemiese hartsiekte, karsinoom van die long, esofagus, ens. gevind. Aangesien 83% van die pasiënte gewoonteroekers was ten tyde van die operasie en slegs 'n paar rook gestaak het na die operasie, en aangesien die

voorkoms van die rookgewoonte by pasiënte wat tans chirurgie ondergaan baie hoër is as dié van die algemene bevolking, kom die skrywers tot die gevolgtrekking dat die chirurg geensins vir die buitensporig hoë mortaliteit geblameer kan word nie.

'n Onderwerp wat met bogaande in verband gebring kan word, is die neiging die afgelope paar jaar in Noord-Amerika en waarskynlik ook in Wes-Europa om mediese eerder as chirurgiese behandeling toe te pas. In 'n bygaande redaksionele artikel merk Thompson² op dat daar in die afgelope dekade 'n gemiddelde afname van ten minste 30% was in die aantal operasies wat vir duodenale ulkuse uitgevoer word, en moontlik 'n effense toename in gastriese ulkus-operasies. Hy wys ook daarop dat die daling in die aantal operasies 'n aanvang geneem het voordat die huidige kragtige anti-ulkus-middels, simetidien en ranitidien, op die mark verskyn het. Hierdie middels sal waarskynlik die frekwensie van chirurgiese ingrepe verder verminder alhoewel terugvalle ná mediese behandeling mag beteken dat die operasie slegs uitgestel is. Die onderwerp is klaarblyklik hoogs aktueel, aangesien Thompson twee onlangse simposia oor die rol van chirurgie vir 'n peptiese ulkus aanhaal, met 'n verdere twee wat vir die toekoms beplan word.

1. Ross AH McL, Smith MA, Anderson JR, Small WP. Late mortality after surgery for peptic ulcer. *N Engl J Med* 1982; **307**: 519-522.
2. Thompson JC. The role of surgery in peptic ulcer. *N Engl J Med* 1982; **307**: 550-551.

Medical research in the RSA

Elsewhere in this issue (p. 183) the present situation regarding the support of medical research in the RSA is described. Some comparisons are drawn with countries with certain cultural and economic similarities to our own and with which we tend to associate ourselves in the field of medicine.

Although the systems by which research is supported in all of these countries differ to some extent, usually because of historical development and particular local needs and circumstances, certain areas, and particularly philosophical views, are common to all. Differing aspects do not necessarily mean that one system is superior to or more effective than another, but it may be possible to learn from one another.

The South African Medical Research Council was

launched only recently — 13 years ago — and was therefore able to mould its organization according to well-established structures such as those of the Council for Scientific and Industrial Research in this country and the British Medical Research Council. Knowledge and experience from other countries was also included.

It is therefore useful at this stage to compare aspects of our development with those of organizations in other countries. Only a few general facets will be highlighted here.

First and foremost, it should be stressed that research in medicine is firmly entrenched in other countries as an integral and vital part of the medical scene, without which satisfactory training and high standards of medical service cannot be achieved. In the RSA this has not yet become

the prevailing view. Even in the medical faculties of the universities the priorities are service and teaching, in that order. Research is all too frequently seen as something which can be indulged in only as a pastime, should there be the inclination and the time for it.

A joint establishment between the health authorities (the provincial administrations and the Department of Health) and the faculties of medicine has many advantages in ensuring an academic input into the service and providing optimal access to all departments, clinical and preclinical. Whereas service with the universities demands research as an integral component, however, the health authorities unfortunately regard service as the first and sometimes the only priority. The post structure in the establishments has also not been designed to provide an equal component for each of the three aspects of a joint establishment, viz. teaching, research and service. It is essential that the health authorities recognize this and that research becomes an expected part of the service of all involved in the running of academic institutions. This should apply not only to the academic staff but also to technical and administrative staff and the total infrastructure.

A further area of consensus is that research can only be structured around people and, for that matter, particular people. It is not the bricks and mortar or the sophisticated equipment which pave the way for research. These are indeed necessary when the people concerned justify their existence, but not the other way around. All too frequently the employing authority accepts people for their service potential rather than for their academic and research qualities.

It is better to build on quality based on a few, rather than on quantity based on many, if we are to solve our medical problems for the future. The effectiveness and the competence with which work is performed are based on academic and research standards. When these are high, they lead to enhanced service at lower cost.

The need for research to be unfettered and not restricted by administrative rigidity is universally acknowledged. There is no denying that a degree of control and guidance is necessary, since research must be accountable to the public, who supply the financial resources. For this reason a national body with its own statute which provides for the assessment of projects and workers, peer review of research, high standards of service, promotion of co-ordination and avoidance of duplication of research is a necessary instrument. The existence of a national research council gives international status to the research and the researchers. With such an organization national research needs can be gauged, programmes initiated, and university and local research taken care of. Such organizations are found in all of the non-socialist, non-communist countries. They appear to be lacking in the socialist world, where research, which is accommodated as a part of a state department of health, is obviously not flourishing. One has seen no advantage and only disadvantages from such an arrangement.

In the RSA we have been particularly fortunate in that the MRC has had a fairly open field with regard to its development. It could organize its structure so as to serve national medical research needs and also to supply a research service to researchers country-wide in areas such as biostatistics, medical literature retrieval, and electron

microscopy. In this manner the RSA has made optimal use of its manpower and financial resources and has also supplied an effective research instrument on a national basis.

The system of work communities which has been developed in Holland appears to be a most acceptable way of promoting close co-operation, avoiding duplication of research and ensuring effective peer review and assessment of projects, to the benefit of both researcher and organization. This system of grouping researchers and allowing them to meet annually to review their research work critically and to come up with proposals for programmes and budgets is one which it is probably worth establishing in this country.

In Europe, and in the UK in particular, the social and political climate is such that researchers have to be assured of permanent appointments with all the accompanying social benefits. As a result 80% of research money in the UK and 90% in France is tied up in salaries, leaving little scope for development of research and for starting new projects. This is in contrast to South Africa, where full-time research posts, particularly at universities, should still be developed. About 40% of our funding is used for salaries. It is clear that somewhere a balance will have to be found and that a situation like that which has developed in certain overseas countries should be avoided.

Although research manpower is in demand in all countries, the situation is nowhere so critical as it is in the RSA. Medically qualified researchers are few in number and are becoming fewer in most countries because of the favourable competitive opportunities outside research. Non-medically trained scientists are responsible for 75-85% of research undertaken and are making great contributions. This may, however, be leading to a situation where the research is increasingly directed at scientific problems rather than at areas where solutions are required for medical problems.

The movement of both our own and visiting scientists to and from the RSA is more generously supported through our MRC than is the case in other countries. This is a matter of policy which should and will be expanded, despite our geographical position and other factors leading to some scientific isolation.

In general the MRC has fared well with the research that it supports, but it should fare much better. This country's different ethnic groups with their differing traditions and genetic make-up give rise to many unique situations requiring urgent attention. Varying climatic conditions contribute to the spectrum of illnesses found here. Our research funding is smaller, by any comparative standard, than that of any of the other countries under review. We need far more funding, we need many more researchers, and we need to see research as a vital tool for maintaining our physical and mental well-being and for the optimal development of this country, to enable it to provide scientific and technological leadership for southern Africa as a whole. It is time that medical research in all its facets should receive the same high priority that it does in other countries, and indeed that it should rank in priority with other research endeavours in this country. At present it is lagging behind.

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