SUID-AFRIKAANSE MEDIESE TYDSKRIF

SOUTH AFRICAN MEDICAL JOURNAL

Kaapstad, 21 Desember 1974 | Deel 48 : No. 62 : Volume 48 | Cape Town, 21 December 1974

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Agtergrondskennis

There is no knowledge but I know it.
I am master of this college:
What I don't know isn't knowledge.
H. C. Beeching: *The Masque of Balliol*

Van tyd tot tyd ontvang ons briewe wat vir publikasie bedoel is, en soms selfs artikels, oor Mediese Vereniging aangeleenthede waarvan die strekking nie heeltemaal ooreenkom met die feite nie. Iedere lid van die Vereniging is ten volle geregtig om sy of haar eie opinie oor enige saak daarop na te hou, en soos ons reeds vantevore geskryf het, die kanale bestaan waarvolgens diegene wat van die amptelike beleid van die Vereniging verskil hul sieninge onder die aandag van die Federale Raad kan bring. Wat egter belangrik is, afgesien van meningsverskille wat altyd in enige vrye gemeenskap sal bestaan, is die juistheid van die feite wat gekonstateer word.

Die Mediese Vereniging het reeds 'n lang paadjie deurloop, en vele aangeleenthede is deur die jare heen oor en oor op Federale Raadsvergaderings bespreek en deur die verskillende komitees herkou. Soms is dit nodig om van standpunt te verander wanneer nuwe gegewens aan die lig kom, of wanneer omstandighede verander, maar dit staan juis tot krediet van die Vereniging dat sulke rigtingsveranderings relatief selde nodig is—dit spreek van deeglikheid van optrede en objektiwiteit van denke. Wanneer lede egter hul reg wil uitoefen om hul opinies te lug, is dit noodsaaklik dat die agtergrondskennis wel bestaan, want om met stellings vorendag te kom wat nie met die werklikheid strook nie, dien geen doel nie. In sulke gevalle is dit die redaksie se ongelukkige plig om die manuskrip aan die skrywer terug te stuur met die versoek dat hy of sy eers die nodige navorsing gaan doen.

As ons 'n brief ontvang waarin twee verskillende wette verwar word, of waarin besluite van die Federale Raad foutief aangehaal word, is die strekking van die brief nie ter sake nie, en maak dit nie saak of dit die Vereniging se beleid steun of teenstaan nie—dit bly onaanvaarbaar omdat ons ten slotte poog om 'n *Tydskrif* te publiseer waarin die gegewens korrek is.

Graag vra ons dus dat kollegas, veral diegene wat nie so nou by die werksaamhede van die Vereniging betrokke is nie, eers 'n saak met 'n ampsdraer of amptenaar van die Mediese Vereniging bespreek alvorens pen op papier gesit word. Ons vra dit hoegenaamd nie met die bedoeling dat daar 'n sweem van indoktrinasie by moet of sal wees nie, maar bloot om arbeidsverkwisting en selfs verleentheid te voorkom. Niemand hou daarvan om te ontdek dat die fondamente waarop sy argumente berus skeef en krom is nie. Om 'n uiterste, maar tog werklike voorbeeld te noem: ons het onlangs 'n brief ontvang waarin 'n kollega voorstel dat die hele probleem met mediese skemas opgelos kan word indien 'n sisteem ingestel word wat dokters sou toelaat om as 't ware 'uit te kontrakteer'. Sulke briewe is, helaas, nie aanvaarbaar nie.

Tuberculosis

In this issue we publish an article which carries a serious indictment. Tuberculosis is still an important cause of morbidity and mortality in this country, as in many other parts of the world. In fact, it is true to say that no doctor anywhere can afford to be complacent, and to assume that this disease is no longer an important health hazard. There are a multitude of factors which are responsible for its continued alarming incidence in South Africa, and on every level intensive efforts are made to combat the condition. Slowly but surely we are making progress, and with the help of every practising doctor, eventual success will come. But vigilance is the key-word.

In spite of the serious picture that emerges from reading the article by Collins, we must affirm that the majority of doctors, especially general practitioners, who practice in rural areas and among those sectors of the population where the disease is still rife, are very well aware of the high incidence, and will not easily be flummoxed. Sometimes tuberculosis can present with the most perplexing variety of seemingly unrelated symptoms, and only if the possibility of this infection is constantly kept in mind, can the correct diagnosis be made timeously.

Let us accept the warning contained in the article and let us not react negatively and say:'These are a few isolated cases that are now being used to strike at doctors.' We know, and we are proud to say, that the vast majority of doctors who have to deal with patients who are at risk, are aware of the danger, and will not omit to investigate the case, but at the same time it remains true that there are the few who are not as vigilant as they might be. If we all admit that we have made mistakes, and that we will, alas, make more in future, we can increase our awareness, and this will act as an important safeguard.

These thoughts are not only applicable to tuberculosis, but may also apply to all other diseases, especially those that are relatively rare and therefore not always in mind when a diagnosis has to be made. If a patient does not respond to a treatment regimen as could be expected, the possibility that the diagnosis is at fault must immediately become the first consideration, thereby preventing a series of consultations, each one equally ineffectual because there was no reconsideration.

Let us admit our mistakes in as far as is humanly possible, and when we do commit errors, let us learn from them, in order to decrease the incidence still further.