EDITORIAL : VAN DIE REDAKSIE

'COMPLICATIONS' OF DIABETES

If we were asked, 'What is diabetes mellitus?', we should probably all give some sort of answer based on high blood sugar, loss of tolerance to glucose or, more vaguely, abnormalities of carbohydrate metabolism. It could, however, well be argued that, from the patients' point of view, the metabolic derangements are no longer of great importance. The loss of health and of life associated with ketosis is now very largely abolished by the use of insulin. But, lurking in the background in all diabetics, whether mild or severe, is a much more sinister bogey—the hazard of vascular disease, bringing with it blindness, gangrene, heart disease, renal failure, and death.

As a working hypothesis we may consider the retinopathy and the Kimmelstiel-Wilson nephropathy as specific diabetic lesions affecting tiny blood vessels; the peripheral vascular lesions in the diabetic which affect small arteries may also be in part specific phenomena;[1] coronary atheroma is increased in diabetes—most markedly in pre-menopausal diabetic women, in whom the incidence of ischaemic heart disease is equal to that of men of the same age; and the neuropathy most likely has a vascular basis, although this cannot be considered proved. The outstanding questions concerning these lesions are, first, what is their pathogenesis and what relation do they bear to the hyperglycaemia and other metabolic aspects of diabetes and, secondly, how can they be prevented or ameliorated?

With regard to the first question, many people are coming to believe that these lesions are not 'complications' of diabetes at all, but are integral features of the innate disease. In other words, when one inherits the genetic 'tendency' to diabetes, this automatically includes a deficiency in blood vasculature likely to lead to the conditions mentioned above. If this is so it becomes plain that 'control' of the hyperglycaemia of diabetes, however good, cannot be expected to prevent the vascular disorders. Nevertheless, the evidence is now rather convincing that good diabetic control does tend to lessen the likelihood that vascular disease will appear and to reduce its severity after it has appeared. Indeed it is really in this belief that we bother to control diabetes at all beyond maintaining well-being and preventing hypoglycaemic attacks. Impressive recent evidence has been provided by Professor Dunlop,[2] of Edinburgh, who changed over from the use of free 'diet-and-let-control-go-hang' to careful control, and found a gratifying reduction in vascular disease.

In an article published in this issue of the *Journal*, Markman, Allen and Jackson[3] analyse the findings in a sample of the patients attending the Diabetic Clinic at Groote Schuur Hospital, Cape Town. It is a pity that the sample could not be larger, but surveys of this nature are not easy to organize and are immensely time-consuming. As might be expected, the control of the diabetes was in general poorer in non-Europeans (they were almost all Cape Coloured) and there was a higher incidence of retinopathy in this group, particularly in females. The incidence of vascular disorder was probably much the same as reported in Britain and America, though perhaps lower if anything—for instance, evidence of nephropathy was very seldom found. Poor control of diabetes appeared to carry with it a significantly higher incidence of retinopathy and neuropathy, but made no difference to the amount of coronary heart disease. This finding is important; it is presumably related to the fact that retinopathy and neuropathy are specific diabetic lesions, whereas coronary atheroma in individual diabetics differs in no way from atheroma in non-diabetics. In this series the sex incidences of coronary heart disease are virtually equal, suggesting, as has been seen from larger evidence elsewhere, that there is something in diabetes that annuls the advantage of being born a woman!

It appears that, in general, there is little or no difference between the diabetes in the European and that in the Cape Coloured population. We await with great interest a similar comparison which will include the Bantu—and also the West African and the American Negro—which, as far as we are aware, has not yet appeared, despite the great need for it and the ease with which one part of it could be carried out in the United States.

1. Lundbaek, K. (1953): Acta med. scand., 145, suppl. 277.
2. Dunlop, D. M. (1954): Brit. Med. J., 2, 383.
3. Markman, P., Allen, E. A. and Jackson, W. P. U. (1959): S. Afr. Med. J., 33, 682.

EMOSIONELE DEELNAME EN DIE DOKTER

Anders as wat die geval is met die meeste ander professies, bring die spesiale soort taak van die dokter dit mee dat hy gedurig diep verwikkel raak in die emosionele en persoonlike reaksies en spanninge van die pasiënte met wie hy werk, sowel as van hul naasbestaandes en bekendes. Hierdie emosionele deelname, wat 'n onafskeidbare deel vorm van die werk van die dokter, lê 'n groot addisionele las op hom. En, in die gevalle van baie dokters is dit nie soseer die hoeveelheid en die omvang van hulle werk as sodanig wat tot vermoeienis lei nie, maar wel die eise wat aan hulle gestel word ten opsigte van die emosionele deelname aan al die innerlike leed en verwarring en ontreddering en hulpbehoewendheid waaraan hul pasiënt van tyd tot tyd blootgestel is.

Dit moet vir almal duidelik wees dat die dokter nie kan toelaat dat sy psigiese energie heeltemal verteer word deur te diepe verwikkeling met die emosionele lewe van elke pasiënt wat hy behandel nie. Want dan sal sy doeltreffendheid as mens en as dokter skade ly en sal hy tot 'n mindere mate in staat wees om in elke geval sy beste dienste te lewer. Die

dokter moet dus in staat wees om in 'n sekere mate afsydig te staan teenoor wat om hom gebeur, sonder om egter onsimpatiek te wees.

Om hierdie balans tussen gesonde afsydigheid en noodsaaklike deelname te behou, is geen geringe taak nie. Dit vereis 'n ryp en verstandige gees by die dokter en insig in dié uitspraak: ‚mens wees—dit is die groot gebod'. Hoe kan dit anders, want die dokter moet sy werk doeltreffend doen in die aansig van sulke omstandighede soos die verlies van werk en finansiële ineenstorting by sy pasiënte, gebroke gesinne, emosionele versteuring, wanaanpassing, verminking, liggaamlike siekte, en die dood.

In die verlede het elke wyse en verstandige dokter hierdie probleem op sy eie manier benader en opgelos. En, in soverre as wat hy daarin geslaag het om die delikate balans tussen meelewing en die behoud van eie kragte te bereik, is hy deur sy pasiënte beskou, nie net as 'n goeie dokter nie, maar ook as 'n groot en begenadigde mens. Met die opkoms van wat ons kan noem die moderne ‚industriële revolusie' in die medisyne, het hierdie basiese probleem egter na 'n ander vlak verskuif. Spesialisasie en hiperspesialisasie, wat aan die een kant lei tot byna foutlose, maar tog robotagtige, mediese dienste, lei aan die ander kant ook daartoe dat die persoon van die dokter al meer op die agtergrond raak.

Wat ons nou net gesê het is veral waar van verskeie gespesialiseerde vertakkinge van die medisyne, maar ook van sekere maniere waarop die algemene praktyk bedryf word. 'n Angstige, ontstelde pasiënt word soms onderwerp aan 'n hele reeks toetse en ondersoek-prosedures sonder dat daar genoegsame persoonlike kontak tussen hom en sy dokters is. Wat die oplossing van hierdie probleem is, weet ons nie. Wat ons egter wel weet, is dat dit in terme van die uiteindelike welsyn van die pasiënt—liggaamlik en geestelik—nie 'n gesonde toestand van sake is nie. Die behoefte van die mens aan 'n intieme vertroueling is nou eenmaal te diep gewortel om so summier misken te word. En die dokter van die toekoms sal op een of ander manier 'n formule moet vind wat dit vir hom moontlik sal maak om te voldoen aan die vereistes van die moderne tegniese mediese praktyk sonder om sy pasiënt as mens en vertroueling van hom te vervreem.