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OEFENINGSTOETSE

Belemmerde vermoë om aan fisiese inspanning deel te neem is 'n algemene simptoom van velerlei siektetoestande. In hart- en longtoestande vorm die oefeningsvermoë van die pasiënt seker een van die belangrikste kliniese maatstawwe waaraan nie alleen die prognose en verloop van die toestand gemeet word nie, maar wat ook dikwels die soort behandeling sal aandui (mitraalstenose en chirurgie), en waaraan die respons op behandeling gemeet kan word. Geen geneesheer sal dus die belang van oefeningsvermoë onderskat nie. Die internis veral is terdeë bewus hoe belangrik dit is om die graad van belemmering in hierdie geval te skat.

Ongelukkig is oefeningsvermoë 'n *simptoom*. Ongelukkig is daar pasiënte wat besef dat ons dit moeilik objekties kan bepaal en deur gebrekkige medewerking kan hulle soms hulle aanspraak op kompensasie-uitbetalings verstewig met 'n numeriese indeks van hulle onvermoë tot inspanning! 'n Eenvoudige, betroubare, herhaalbare en veilige oefeningstoets word dus 'n volstrekte noodsaaklikheid, maar die ywer van uitstekende navorsers ten spyt, is daar nog nie tot op hede 'n ideale toets gevind nie.

Ons kan die bestaande oefeningstoetse in drie groepe verdeel,[1] nl. (1) Toetse gebaseer op ventilasiestudies, (2) toetse gebaseer op hartspoedbepalings, en (3) toetse wat bepalings van die maksimale suurstofverbruik benut, of die suurstofskuld, aangegaan tydens oefening, bepaal.

Harris[1] hersien die voor- en nadele van die onderskeie toetse volledig in 'n onlangse artikel. Die eerste groep sluit in die toets van Wahlund en die toets van Hugh-Jones. Ventilasiestudies berus op die feit dat dispnee ontstaan wanneer die ventilasievereistes na aan die beskikbare ventilasiekapasiteit kom. Die samewerking van die pasiënt kan hierdie toetse egter baie beïnvloed en, hoewel dié toetse in longfunksie-laboratoria baie gebruik word, is dit juis hier waar die Achilles-hiel is.

Hartspoedbepalings kan (*a*) die herstellende hartspoed in ag neem, bv. Master se traptoets, of die Harvard-traptoets, terwyl (*b*) die oefeningshartspoed in toetse van Wahlund, dié van Astraud en Ryhming, en Muller se toets, gebruik word. Laasgenoemde bereken 'n belastingsindeks (‚Leistungspulsindex', L.P.I.). Die fiks persoon het oor die algemeen 'n laer rustende hartspoed, maar omdat die fisiologie van oefenings-tachiekardie grotendeels onbekend is, is groot variasies moontlik in hierdie toetse. Geeneen van hierdie toetse kan tot dusver nog vir kliniese gebruik aanbeveel word nie.

Klinies gesproke sou dit wil voorkom of die mees bruikbare toetse onder dié wat O_2-verbruik tydens oefening bepaal, of dié wat die O_2-skuld bereken, gevind sal word, want geen pasiënt kan sy O_2-skuld willekeurig beïnvloed nie.

Hierdie toetse het dus afgebakende sektors getoon waarin verdere studie moet geskied, nl. (1) die meganisme van suurstofskuld en sy vereffening moet bestudeer word, en (2) die meganismes betrokke by die toename in hartspoed by oefening moet opgeklaar word.[1]

Uit 'n studie deur Wyndham en Ward[2] blyk dit dat hartspoed 'n liniêre funksie van O_2-verbruik is en dat beperking van oefening deur sirkulasiefaktore geskied.

Faktore wat nie so direk aan hierdie toetse verbonde is nie, tree ook na vore in gevalle met hipertensie waar longstuwing die beperkende faktor mag word en 'n beëindiging van die toets kon veroorsaak nog voor 'n suurstofskuld van enige betekenis ontstaan het, terwyl angina 'n spesiale probleem skep.[1]

Tot die ideale oefeningstoets gevind word, sal ons dus nog maar dikwels moet vertrou op die antwoord op vrae soos ‚hoe ver kan u stap op gelyk grond?' 'n Fiks huisdokter mag dalk die pasiënt se vermoë met sy eie vergelyk deur saam met hom hospitaaltrappe te klim.

1. Harris, E. A. (1958): Lancet, **2**, 409.
2. Wyndham, C. H. en Ward, J. S. (1957): Circulation, **16**, 384.

THE MEDICAL SERVICES PLAN

At the request of the Steering Committee of the proposed Medical Services Plan, we are publishing in this issue for general information draft Articles of Association and draft contracts for subscribers and participating doctors. The Steering Committee will shortly be calling an inaugural meeting* in Johannesburg of those who have signed intention cards to participate and have forwarded their loans to the Plan, at which these draft documents will be presented for final acceptance. The Plan will first be brought into operation in the areas of the Southern Transvaal and East Rand Branches of the Association, but the details of the proposed constitution will be of interest to all members of the Association. No tariff of medical fees appears in the draft documents, but it is understood that the fees will be based on the recognized customary fees without preferential deduction.

Some five years ago the Federal Council appointed, under the chairmanship of Dr. Maurice Shapiro, a Sub-committee on the Economics of Medical Practice to study the trends which were changing the form of practice and to ascertain where they were leading the profession. It was agreed that this Committee should have all the help that was necessary, and soon after the Committee commenced its activities it suggested that the Association should undertake the establishment of a medical aid fund for persons who did not fall within the scope of the existing societies. Professional assistance was obtained by the employment of an accountant with experience of medical aid and its administration to assist

* This meeting is to be held on 27 April (see p. 345 of this issue of the *Journal*.

the Committee, and he was later sent to the United States and Canada to obtain first-hand information concerning the Blue Cross and Trans Canada Plans which were meeting with great success in those countries.

The policy of the Association had for many years been to foster the existing medical aid societies and to encourage the formation of new ones; and when the proposal had been put forward earlier that the Association should itself establish a society, this had met with opposition, although it was generally agreed that provision was needed for those who were not served by medical aid societies. Enthusiasm for the establishment of a scheme seemed to be centred particularly in the Transvaal and mainly in Johannesburg and the Reef areas, where the Committee was extremely active and enthusiastically led by Dr. Shapiro who, in spite of many discouragements, has never lost faith in the ultimate success of the Plan. He has been ably assisted by a number of other members of the Southern Transvaal Branch of the Association. Although the Association decided not to establish the Plan as an activity of the Association itself, it gave its blessing to the Committee which was set up to work for the establishment of the Plan as an independent organization, and placed at its disposal the information which it had obtained through Dr. Shapiro's Sub-committee. The Steering Committee has now reach a stage when it should soon be possible to launch the Plan and bring it into operation.

We congratulate the organizers on their efforts and wish them success, trusting that both the public and the profession will derive much benefit from the Plan.