DIE MEDIESE KONGRES

Die 43ste Mediese Kongres van die Mediese Vereniging van Suid-Afrika sal gedurende die week 24 - 30 September 1961 in Kaapstad gehou word. Alhoewel dit nog betreklik vroegtydig is, het die organiserende komitee alreeds begin om die nodige voorbereidings vir die Kongres te tref. Die eerste omsendbriewe (in Engels en in Afrikaans) is alreeds in die uitgawes van die *Tydskrif* van 12 November en 3 Desember gepubliseer, met die doel om alle belangstellende lede so vroegtydig en volledig moontlik in te lig oor al die fasette van die Kongres.

Soos in die verlede sal daar voltallige sittings gehou word, sowel as byeenkomste van afdelings en groepe. Die wetenskaplike komitee het besluit om aan te beveel dat daar twee voltallige sittings gehou word, en as onderwerpe vir bespreking op die voltallige sittings, is *Diabetes* en *Die versorging van bejaardes* aanbeveel. Hierdie onderwerpe sal sonder twyfel die belangstelling van 'n groot aantal lede wek.

Die vordering wat daar gemaak is op die gebied van navorsing oor en die behandeling van diabetes gedurende die afgelope aantal jare, is niks minder as fenomenaal nie. Die studie van diabetes het eintlik 'n hele wetenskap op sy eie geword. Daarby is dit 'n onderwerp waarin dokters uit alle vertakkinge van die medisyne belangstel.

Die probleem van die versorging van bejaardes is 'n ander onderwerp wat onlangs besonder in belangrikheid toegeneem het. Daar is dwarsoor die wêreld 'n neiging tot relatiewe en absolute vermeerdering van die aantal bejaardes in die bevolking, en dit lei tot die ontstaan van mediese en ander probleme op hierdie gebied op 'n skaal wat vroeër heeltemal ondenkbaar was. Hierdie twee onderwerpe moet al op hul eie baie lede aanspoor om die Kongres by te woon.

Wat die byeenkomste van afdelings en groepe betref, het die organiserende komitee die voorneme uitgespreek om so veel as moontlik te probeer om groepsbyeenkomste te kombineer. Dit sal daartoe bydra om bespreking te stimuleer tussen lede van verwante groepe. Almal wat voordragte wil lewer word versoek om sonder versuim in verbinding te tree met die sekretaris van die betrokke afdeling deur die kongreskantoor. Die sluitingsdatums vir die ontvangs van opsommings en voltooide bydraes is 1 Junie en 1 Julie 1961 respektiewelik.

Soos in die verlede sal daar ook wetenskaplike uitstallings gehou word, en uitstallings van mediese en chirurgiese produkte en van stokperdjies (kuns en handwerk). 'n Program vir onthale sluit in 'n kongresbal en banket. Daarby sal erelidmaatskap van verskeie klubs (sport en andere) in Kaapstad en omgewing vir kongreslede gereël word.

'n Spesiale vertoning van beeldradio beloof om besonder interessant te wees. Volgens verwagting sal geslote-baan beeldradio (in kleur) van chirurgiese operasies, wat by een of meer van die plaaslike opleidingshospitale uitgevoer sal word, en geprojekteer sal word vir 'n groot gehoor, een van die hoogtepunte van die Kongres wees. Daar sal gesinkroniseerde kommentaar deur die chirurg en 'n paneel van deskundiges wees.

'n Voornemingsvorm wat deur lede wat die Kongres wil bywoon, ingevul moet word, word op p. xxx van hierdie uitgawe van die *Tydskrif* geplaas. Die Kongreskomitee sal dit baie waardeer as lede die invul van die vorms so veel as moontlik wil bespoedig. Die Tak Wes-Kaapland wat as gashere vir die Kongres optree, koester die verwagting dat lede van die Vereniging self ook hul deel sal bydra om van die Kongres 'n groot sukses te maak.

Op kongresse soos hierdie word dit moontlik gemaak vir alle lede van die professie om op die hoogte te bly, nie net van vooruitgang op hul eie gebied nie, maar ook op alle ander gebiede van die medisyne. Daarby word die geleentheid verskaf vir kollegas en vriende, wat deur omstandighede uit mekaar gedryf het, om weer met mekaar kontak te maak.

Maar ons moet ook dieper kyk by 'n waardebepaling van die betekenis van kongresse soos hierdie. Ons moet aan onsself die vraag stel of ons as doktersgemeenskap ons regmatige plek inneem in die wêreld. Omdat ons as mediese liggaam in die Mediese Vereniging gelukkig nog betreklik vry staan van ernstige innerlike tweespalt en onenigheid, rus daar op ons die verpligting om die tradisionele broederskap in die geneeskunde soos 'n kosbare kleinood te bewaar. Soos ons reeds al voorheen gesê het, is dit ons plig om ons eie, besondere professionele en intellektuele tradisie in hierdie land op te bou, maar terselfdertyd moet ons ten all koste voorkom dat ons geïsoleerd en op ons eie hier voortgaan sonder om ons gedurig te gaan drenk aan die groot wêreldwye stroom van mediese kennis en gebeure. Ons moet ons professionele vereniging deur sy lede en liggame so volledig moontlik inskakel by die aktiwiteite van ander nasionale mediese verenigings en van die Wêreld Mediese Vereniging. Want daar sal ons ons stem kan laat hoor buite die grense van ons eie wyk, en sal ons ook die volste moontlike voordeel put uit die grootste gemeenskaplike bron van kennis en ervaring, sowel vir onsself as vir die pasiënte wat aan ons sorg toevertrou is.

CONTROLLED CLINICAL TRIALS

At a recent conference the principles, organization, and scope of controlled clinical trials were fully discussed.[1] Such trials must be carried out if new methods or preparations advocated for the treatment of disease are to be accurately assessed clinically.

Every new method of treatment of a disease must be assessed by treating patients suffering from that disease. The laboratory workers will have assayed the potency and toxicity of a new drug, but before it comes into use it is only by clinical trial that its efficacy and dangers

can be properly evaluated. Scientifically designed tests will hasten the fall from favour that is the fate of most drugs put on the market. The history of medicine abounds with examples of remedies that were long and widely used before falling into disrepute.

It is the aim of controlled clinical trials to use an experimental rather than an observational approach, although these techniques are not mutually incompatible. Emphasis is placed on objective measurements, but highly skilled objective clinical judgment needs to be incorporated in a manner that is unbiased.

Human experimentation of this nature raises important ethical problems. The doctor will need to decide when treatment, possibly of value, can be withheld from the patients in his charge, so that proper comparisons can be made. There is no easy answer to this problem. Some would say that a trial is not ethical unless it is so designed that the physician would permit himself or a near relative to be included in it. It is, however, hardly possible to make valid generalizations in connection with such a difficult ethical problem as the one under discussion — except to say that in approaching the problem of human experimentation, emotional as well as rational considerations will be encountered, and these will have to be dealt with on as mature and responsible level as possible. Every proposed trial presents its own problems which need to be considered on their merits. Generally they are not insuperable. In many instances the carefully controlled trial is more ethical than uncontrolled experimentation with unproved remedies.

The voluntary consent of the patient is regarded as essential. Ideally the patient is an active intelligent participant in the clinical research, and quite often he will accept a proposal to cooperate. But many patients are too ill or too well for such trials. The consent of the patient's personal doctor may be important, and also the consent of all those who attend to the patient. Unnecessary risk and suffering, whether mental or physical, must be avoided.

Therapeutic trials are justified when a new remedy is introduced or when there is genuine difference of opinion about the value of a particular treatment. There is no hardship when the use of a new and unproved drug is compared with its omission. The patient receives the best orthodox treatment for the disease with the exception only of the disputed remedy included in the trial. When comparing the use of a drug with its absence it is usually desirable to give a placebo or dummy to allow for the psychological effects of taking medicine. The dummy is given to prevent the patient, and also the doctors, nurses and others, from knowing which is the control group until the results have been finally assessed (the double-blind trial). All patients are treated as if they are receiving the drug. There must be no systematic bias tending to favour one or other treatment. The groups receiving treatment must be similar in all relevant respects, except in the treatment they receive.

The organization of the controlled trial requires a special research team under experienced leadership. The participants must discuss and approve a common protocol before such a cooperative trial starts, and they must then accept the impositions of collective discipline. The design of records and the planning of the follow-up of the patients require careful thought in advance.

A final important task is the analysis of the results of a trial and the presentation in a report. Many individuals will have taken part in the whole undertaking, but one person as chief author will more likely produce an informative paper. A controlled clinical trial is a serious matter, and an enormous amount of work has to be done in its planning, execution, and publication. Some of the joint work of clinicians and statisticians which has been carried out in England in recent years in acute infections, pulmonary tuberculosis, rheumatoid arthritis, coronary thrombosis, and cancer under controlled conditions is available for study in an important book which has just become available.[1]

1. Council for International Organizations of Medical Sciences (1960): *Controlled Clinical Trials — A Symposium*. Oxford: Blackwell Scientific Publications.