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VAN DIE REDAKSIE : EDITORIAL

GENEESHEER EN VLIEGTUIG

Die onlangse artikel van Majoor Horak in hierdie *Tydskrif*[1] vestig opnuut die aandag van die geneesheer op nog 'n ‚wind van verandering' wat ook oor die geneeskundige wêreld waai, nl. die wind van die spuitvliegtuig. Hoewel die meeste geneeshere nie onmiddellik gemoeid is met ruimtevlugte, orbitale- en ontsnappingsspoed nie, mag hy wel te eniger tyd in aanraking kom met pasiënte wat lugvervoer nodig mag hê. In 1960 het 402,308 passasiers deur Jan Smuts-Lughawe gegaan, 'n respektiewelike vermeerdering van 16% en 22% op die voorafgaande twee jaar. Hiervan het 243,406 op binnelandse roetes gereis.[2] Hieronder was sekerlik ook siek mense of mense wat aan die herstel was. Moontlik was daar ook 'n hele paar met angina of onlangse miokardiale infarksie.

Wat sou u byvoorbeeld sê vir 'n pasiënt met 'n onlangse miokardiale infarksie of emfiseem, of 'n vrou tydens swangerskap as sy 'n vlug vir vakansie of besigheidsdoeleindes beplan en u advies inwin? Dit mag nodig wees om 'n pasiënt met anemie, leukemie, of 'n pasiënt wat onlangs 'n operasie gehad het, na 'n beter toegeruste sentrum vir spesiale behandeling te vervoer. Dit is soms nodig om te oorweeg of kommersiële, private, of ambulans-vliegtuie gebruik moet word.

Selfs met drukgekontroleerde passiersruim bly die druk nie konstant nie. Die Douglas DC-7 kan byvoorbeeld seevlakdruk in die kajuit hou tot op 'n hoogte van 12,500 voet, maar daarna verminder die kajuitdruk sodat op 'n hoogte van 25,000 voet die gesimuleerde hoogte in die kajuit ooreenkom met 'n hoogte van 8,000 voet. Hierdie syfers verskil van vliegtuig tot vliegtuig.[3]

Schwichtenberg e.a.[3] gee die volgende algemene oorwegings aan om die geneesheer te help in sy advies aan die pasiënt. (*a*) Hoe nodig is die reis. Vir 'n persoon met 'n tydelike siekte mag dit verkieslik wees om die reis tydelik uit te stel. Die erns van die toestand en die dringendheid van die vlug moet teen mekaar opgeweeg word. (*b*) Baie passasiers vlieg oor sakeredes of vir vakansie, en die beperkte ruimte bring hulle in kontak met die sieke. Die pasiënt word van sy privaatheid beroof en sy mede-reisigers mag ontstel wees deur sy siekte. (*c*) Sommige vliegtuie het nie druk-kajuite nie, en in so 'n geval is die hoogte waarop gevlieg word van groter belang. (*d*) Hoe moet hy na en van die vliegtuig vervoer word? Kan hy loop, moet hy gedra of per draagbaar gaan? Is 'n ambulans nodig op die einde van sy reis? (*e*) Moet spesiale voorsiening vir suurstof tydens die reis getref word? (*f*) Moet 'n verpleegster of geneesheer hom vergesel? (*g*) 'n Ononderbroke vlug is gewoonlik verkieslik vir 'n siek pasiënt.

Angina is nie 'n kontra-indikasie nie tensy ruspyn voorkom. Sulke persone moet liefs met suurstof reis en 'n genoegsame voorraad nitrogliserien. Die meeste interniste voel dat 'n miokardiale infarksie ten minste ses weke oud moet wees voordat 'n pasiënt 'n lugreis onderneem, terwyl sommige 'n periode van 6 maande verkies of ten minste eers nadat die E.K.G. gestabiliseer is.

Pasiënte met emfiseem is swak risikos aangesien die meeste selfs by seevlak hipoksies is. Die gasverstrikking vergroot die risiko van hipoksie namate dekompressie plaasvind.

Pasiënte wat 'n lobektomie of pneumonektomie gehad het, is ook swak risiko-passasiers in die eerste 3 maande na die operasie.

In gevalle met anemie moet die hemoglobien verkieslik 60% of hoër wees, of die rooiseltelling moet meer as 3 miljoen wees. Suurstof moet in elk geval beskikbaar wees. Leukemie-lyers moet verkieslik 'n bloedtransfusie voor die vlug ontvang.

Diabetiese pasiënte met 'n neiging tot seesiekte moet vooraf pille neem om dit te bekamp. Die insulien dosering word soos gewoonlik gehandhaaf, maar hulle moet ook suikerklontjies saamneem vir moontlike hipoglisemie indien swak eetlus en vomering tot dié komplikasie mag lei.

Swanger vrouens staan 'n vlug goed voor 8 maande, maar as miskrame of voortydse geboortes voorgekom het, is 'n vlug gewoonlik nie raadsaam nie.

In die eerste tien dae van sy lewe is 'n baba se asemhalingstelsel te onstabiel om 'n vlug aan te raai.

Die bevinding van die Amerikaanse leër in 1949 was dat elke vervoerbare pasiënt per lug vervoer kan word mits nougesette voorsorg getref is.[3] Amerikaanse syfers toon dat sterftes op kommersiële vliegtuie ongeveer een per elke twee miljoen passasiers voorkom[3]—'n rekord wat met die huidige toedrag van padongeluksyfers hierdie vorm van vervoer sekerlik baie veilig maak.

1. Horak, J. (1960): S.Afr. T. Geneesk., 34, 1117.
2. *Die Burger*, 5 Januarie 1961.
3. Schwichtenberg, A. H., Luft, U. C. en Stratton, K. L. in Gordon, B. L. (red.) 1960: *Clinical Cardiopulmonary Physiology*. 2e Uitg. Grune & Stratton: London.

THE COMMONWEALTH OF MEDICINE

The question is frequently asked these days whether we are to expect any change in our relationship with our colleagues overseas as a result of other changes so prominent in the news. Will we, it is asked, still have reciprocity with the United Kingdom and the other countries with whom relations have been cordial in the past?

Those who ask these questions seem to have overlooked the fact that we are doctors and that, as we are true to our calling, we recognize no barriers of race, colour, creed or sex in our dealings with our patients or our colleagues in the practice of medicine.

Reciprocity does not depend on barriers which may be set up by others, but is largely dependent on the quality of medicine practised. Thus one may have reciprocity which

recognizes the graduates of one or other medical school in a country, but cannot extend the same privilege to the graduates of other schools. There may be other factors which apply if the arrangements were to be truly reciprocal. Graduates seeking registration in a country with which an agreement is in force should be able to do so without any handicap that would not also apply in reverse. Some time ago it was realized that there was a difference in the conditions prevailing between registration in the United Kingdom and the Union, and when the matter was referred to the Association it proved to be unanimous in its desire to see the anomaly removed.

It is for this reason that the South African Medical and Dental Council at its most recent meeting strongly recommended to the Honourable the Minister of Health that the 'domicile clause' in the regulations governing registration in the Union be deleted at this session of Parliament. Such a clause does not appear in the regulations of countries with which we have had reciprocity in the past and the sooner it is removed, the better it will be.

The United Nations Organization, being a gathering of governmental bodies, must inevitably become concerned with the politics of the various governmental bodies that comprise it. As a profession we must strive to see that we do not become similarly involved in our dealings with our colleagues in other lands. Representatives of the many national Medical Associations present at the 14th General Assembly of the World Medical Association in Berlin last September, showed their awareness of this danger in their concerted opposition to Cuba when that country attempted to introduce what were condemned as 'politics' into the debates. So great indeed was the opposition to this attempt that the Cuban delegation walked out of the meeting, perhaps to cover their confusion.

As citizens of a country we have a duty to perform as individuals, and whatever our personal feelings may be we must steer clear at all costs as a profession of anything that savours of partisanship.

Medicine is international and the doctor is a citizen of the world. Even though our daily lives may be set in the narrow surroundings of a cottage hospital in a suburb or on a lonely mission station, it is as well that we should remember that we belong to a profession that seeks to serve the people of the world even though our membership of the profession may tie us to a very small part of it.

In South Africa we are proud of the fact that we are a founder member of the World Medical Association and also that we have been represented at all the meetings of the Commonwealth Medical Conference. We are proud of our tradition of medical education which was founded on the tradition of the British Medical Schools and we are proud, too, that our Association sprang from original branches of the British Medical Association. We have an agreement of affiliation with the British Medical Association and the Canadian Medical Association, and these are links which we cherish.

As an earnest that these links still hold, we quote from a letter received from the Medical Director of the Commonwealth Medical Advisory Bureau:

'Since the Commonwealth Medical Advisory Bureau was first opened very many doctors from South Africa have availed themselves of its services each year, and through it the British Medical Association has been able to give a welcome to those who have visited the United Kingdom.

'On the first of June the relationship between our two countries is to be altered and I am afraid some of your members may have doubts about getting in touch with the Bureau. I wish therefore to send you an assurance that they will continue to be very welcome to any services that the Bureau can supply, and that I hope they will not hesitate to write to me if they are considering coming here or if they think I can give any advice or information.

'I should be most grateful if you can give some publicity to my letter among your members.'

As an Association we welcome this assurance although we have never doubted that our colleagues would continue to look upon us as we would wish to look upon them—partners in a calling that knows no barriers.