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VAN DIE REDAKSIE : EDITORIAL

KOLLEGIALE LOJALITEIT

Die kaptein van 'n skip is die absolute heer en meester op die oop see. Niemand mag sy outoriteit in die minste in twyfel trek nie en selfs die geringste weerstand word beskou as muitery en is streng strafbaar. Tog kan alle skeepskapteins nie onfeilbaar wees nie. Sommige van hulle moet foute maak en dit moet van tyd tot tyd gebeur dat lede van die bemanning die foute raaksien en dit sou kon verbeter. Nogtans mag hulle dit nie doen nie al besef hulle dat stilswye die hele skip in gevaar stel. Hierdie onderwerp is reeds herhaalde kere as tema vir romans gebruik; die onvermydelike onheil wat nie afwendbaar is nie.

Waarom bestaan die onwrikbare reël op see? Waarom beskou die gereg dit nog as strafbare muitery selfs al het die opstand van onderoffisiere die lewens van die bemanning gered? Die antwoord is eenvoudig. Dit is gebaseer op jare se bittere ervaring—die kaptein is meestal reg omdat hy oor feite beskik wat nie vir die bemanning duidelik is nie en om sy outoriteit te ondermyn is in 99% van gevalle katastrofies vir die skip se veiligheid. As dit 'n rare, enkele keer gebeur dat die onderoffisiere wel beter geweet het moet hulle maar beskou word as die martelare wat ongelukkig altyd in 'n gemeenskap met komplekse lewensgewoontes moet opduik.

Dit gebeur herhaalde kere met iedere dokter dat van sy persoonlike vriende te lande kom by 'n kollega wat hy nie kan veel nie of wat hy oortuig is nie die kennis en vaardigheid besit om sy vriende te versorg nie. Wat moet mens sê? Selfs al weet mens voor jou siel dat die voorgeskrewe behandeling verkeerd is het geen dokter die reg om dit aan selfs sy intiemste vriend te sê en sodoende die aansien van die kollega te skaad nie. Net soos in die geval van die skeepskaptein sal ondersoek aan die lig bring dat die behandelende dokter meestal die een is wat reg is en die sitkamer-diagnostikus wat die behandeling van sy vriend of vriendin vanuit 'n leuenstoel waarneem kan nooit verwag om oor al die gegewens te beskik nie.

Is ons geneeskundige moraliteit egter gewillig om die martelaars-prinsiep van die skeepvaart te aanvaar en die enkeling wat doodgaan weens verkeerde behandeling maar te beskou as die prys wat mens vir goeie lojaliteit moet betaal? Geensins nie. In ons geval is die oplossing voor die hand liggend. Dit is nie met die pasiënt wat gepraat moet word nie, maar met die behandelende dokter, en dit kom dus daarop neer dat iedere geneesheer moet besef dat kollegiale lojaliteit 'n wedersydse verskynsel moet wees. Moenie jou kollegas by pasiënte beskinder nie en verwag met reg dat hulle ook nie oor jou sal kwaad praat nie; maar onthou dat hierdie beskerming slegs gegee kan word mits jy gewillig is om na die advies van 'n welmenende kollega te luister. As 'n opregte benadering deur 'n geneesheer vriend van een van jou pasiënte nie die korrekte dankbaarheidsreaksie by jou uitlok nie het jy nie die reg om aanspraak te maak op die tradisionele lojaliteit van die professie nie. Dan sou die lojaliteit soms die pasiënt ten kwade strek en die heil van die pasiënt is waaroor dit gaan, nie die aansien of kudde-instink van die dokters nie.

Dit is pateties om te dink dat daar moontlik geneeshere praktiseer wat so min kennis besit dat hulle slegs pasiënte kan bekom deur hul kollegas te vertrap. Gelukkig het die ervaring geleer dat sulke dokters nie lank haantjie kraai nie. Jan Publiek is nie heeltemal onder 'n kalkoen uitgebroei nie en dit is opmerklik hoe dikwels die kwaadstekerdokter van praktyk verwissel.

As Nuwejaarsvoorneme kan ons gerus hand in eie boesem steek en seker maak dat die klein oortredingtjies wat iedereen van ons daagliks op etiese gebied begaan nie meer sal voorkom nie, en dit sal nie help om te dink die skoen pas slegs aan die opposisie praktyk se voet nie; ons twyfel of daar 'n enkele geneesheer in die land is wat in alle eerlikheid kan sê dat hy op strenge etiese gebied blaamloos is. En dit gaan nie noodwendig om die ernstige etiese oortredings wat voor die tugkomitee van die Mediese Raad uitgespook word nie, maar oor die alledaagse klein misstappies wat ons kollegiale onderlinge verhoudings versuur en daardeur ons publieke aansien 'n vaal kleur gee.

Selfs die begrip van opposisie praktyke is op die keper beskou nie heeltemal aanvaarbaar nie omdat dit die gedagte inhou van pasiënte afrokkel of van 'n mededinging op professionele vlak. Ons kan sodanige wedywering maar gerus daar laat tot tyd en wyl ons werklik soveel geneeshere beskikbaar het dat ons mekaar moet verdring om 'n bestaan te maak. Die dokter in ons land op die huidige oomblik wat met of sonder die Wet op Mediese Skemas, uit- of ingekontrakteer, nie 'n bestaan kan maak nie behoort nie toegelaat te word om te probeer nie want hy is dan beslis nie professioneel opgewasse tot die taak nie. Daar is slegs 'ons praktyk' en 'ons pasiënte' en 'die ander praktyk' en 'hul pasiënte', en teenoor die publiek is die behandeling van alle kollegas korrek. As 'n vriend uitvra oor die professionele bekwaamheid van 'n dokter kan die fyngevoeliges onder ons geledere maklik hul gewetenswroegings oor wit leuntjies sus deur te sê 'ek ken hom natuurlik slegs as vriend en weet niks van sy werk af nie'.

Ons status en aansien lê opgesluit in die goeie diens wat ons lewer, nie in die togas wat ons by formele geleenthede dra nie.

THE PROBLEM OF INSECT ALLERGY

In comparison with other allergens, allergic reactions to insects are surprisingly few. Some insects are known to produce up to 40,000 eggs daily, while others produce numerous offspring, all from one egg. Realizing the abundance of insect life, it is not surprising that sensitivity to the allergens of particular insects can develop, but what is surprising is that such allergies do not occur more frequently.

Various insect allergies occur throughout the year and are not confined to any particular season, but the development of seasonal allergies to specific insects can occur. Therefore, when patients have seasonal symptoms of allergies and the pattern does not fit into the classification of allergic reactions to pollen or other inhaled substances, the possibility of allergy to insects should be considered. Investigation of this source is usually not undertaken until treatment for the more usual types of allergies has failed.

The characteristic reaction caused by a biting insect begins as a hive containing clear fluid and surrounded by oedema and erythema. This may be followed by drying and the development of an eczematous rash. Such reactions are commonly seen in children bitten by bugs or fleas. Thiamine has been found useful in the prevention of symptoms due to insect bites.

The more serious type of insect allergy is that associated with stinging insects. Reactions to these insects can be extremely serious and have been fatal in some instances. The bee, wasp and hornet are the chief culprits. In a recent study by the American Academy of Allergy it was found that about one-third of persons with insect-sting allergy had a history of other allergies. However, severe generalized reactions have occurred in persons who had completely negative allergic histories for themselves and their families.

Generalized reactions can occur without a previous local reaction to the insect's sting. However, previous sensitization of an individual to the insect sting is usually followed by an increased severity of the reactions if stung again. The severity of the reaction appears to increase from the third decade, possibly due to increased sensitivity to stings over the years.

The immediate type of allergic reaction to an insect sting can vary from a simple hive to a generalized anaphylactic reaction. This immediate reaction occurs in 90 - 95% of cases. The remaining 5 - 10% experience delayed reactions with generalized muscle pain, joint swelling, fever and some hive formation, and this may occur 24 hours or more after the initial sting. Another sting during this latent period might still provoke an acute allergic reaction.

Since sensitivity to insect stings can be high, skin testing is frequently begun, using the scratch technique. If this method shows negative results, intradermal tests may be undertaken using very dilute solutions of insect extract which are gradually increased in strength. The treatment of insect allergies is dependent upon 2 factors: firstly, the immediate treatment of the acute reaction, and, secondly, the prevention of possible reactions through hypersensitization. It is probably wise for certain people with known insect skin-hypersensitivity, e.g. a farmer who keeps bees, to carry an emergency kit containing adrenaline and a syringe, and possibly some antihistaminic. This is a difficult problem in children, who, like adults, would be well advised to wear an identification tag which should, if possible, include emergency therapeutic instructions (Medic-Alert).

The more effective programme is that of hyposensitization. Usually the protection will last from a few months to several years. The length of time for which insect-sting hyposensitization should be maintained is debatable. In severe or even mild systemic reactions to insect sting, hyposensitization should be carried on indefinitely. It is believed that hyposensitization has reduced the possibility of systemic reactions in almost 90% of people treated, and this therapy should be continued until further information is accumulated. To some individuals this type of hyposensitization may mean the difference between life and death.

THE MOMENT OF DEATH

In a previous issue we published a statement on the moment of death, as prepared by the Medical Ethics Committee of the World Medical Association.[1] We have now received the final and augmented version of this Declaration of Sydney, as it is now commonly known, and we therefore republish the statement with the new wording in italics:

The determination of the time of death is in most countries the legal responsibility of the physician and should remain so. Usually he will be able, without special assistance, to decide that a person is dead, employing the classical criteria known to all physicians.

Two modern practices in medicine, however, have made it necessary to study the question of the time of death further: (1) the ability to maintain by artificial means the circulation of oxygenated blood through tissues of the body which may have been irreversibly injured and (2) the use of cadaver organs such as heart or kidneys for transplantation.

A complication is that death is a gradual process at the cellular level with tissues varying in their ability to withstand deprivation of oxygen. But clinical interest lies not in the state of preservation of isolated cells but in the fate of a person. Here the point of death *of the different cells and organs* is not so important as the certainty that the process has become irreversible by whatever techniques of resuscitation that may be employed.

This determination will be based on clinical judgement supplemented *if necessary* by a number of diagnostic aids of which the electro-encephalograph is currently the most helpful. However, no single technological criterion is entirely satisfactory in the present state of medicine, nor can any one technological procedure be substituted for the over-all judgement of the physician. *If transplantation of an organ is involved, the decision that death exists should be made by two or more physicians and the physicians determining the moment of death should in no way be immediately concerned with performance of transplantation.*

Determination of the point of death of the person makes it ethically permissible to cease attempts at resuscitation, and, in countries where the law permits, to remove organs from the cadaver provided that prevailing legal requirements of consent have been fulfilled.

1. Editorial (1968): S. Afr. Med. J., **42**, 966