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VAN DIE REDAKSIE : EDITORIAL

WETGEWING OOR ORGAANOORPLANTING

'Still in thy right hand carry gentle peace
to silence envious tongues.'
Shakespeare: *King Henry VIII.*

Dit is duidelik hoog tyd dat wetgewing wat by die nuwe ontwikkelings op die gebied van orgaanoorplanting aangepas is nou gepromulgeer word en derhalwe is dit verblydend om te verneem dat 'n sodanige konsep wetsontwerp gedurende die komende parlementsitting ter tafel gelê gaan word. Die bestaande wette in verband met menslike weefsels het verouderd geraak, grotendeels omdat daar nie voorsiening gemaak is vir die spoedeisende aard van baie moderne oorplanting chirurgie nie. As ure of selfs dae beskikbaar is om die korrekte persoon te vind om toestemming te gee om 'n betrokke orgaan uit 'n lyk te verwyder is daar nie veel van 'n probleem nie, maar as dit 'n kwessie van minute is voordat die weefsel onbruikbaar word is spesiale reëlings noodsaaklik.

Die oomblik van dood moet sowel klinies as statutêr bepaal word, en hieroor is reeds baie geskryf en gepraat. Gedurende die Wêreld Mediese Kongres in Sydney is 'n verklaring betreffende die oomblik van dood opgestel en ons het dit reeds in die *Tydskrif* gepubliseer.[1] Hoe die uiteindelike wetsbepaling ookal gaan lui en hoe graag die kwaadstokers ookal allerhande grieselighede betreffende orgaanverkryging uit nog lewende liggame wil skilder, hoef ons min vrees te hê dat die mediese professie se eie etiese norme nie terdeë sal sorg dat geen vergrype sal voorkom nie. Bepaling van die doodsoomblik het vir die regsgeleerdes groot belang; vir die medici is dit grootliks 'n akademiese probleem wat in die praktyk selde gewetenswroegings sal veroorsaak.

Geheimhouding van die donor en ontvanger se name is 'n perd van 'n ander kleur. Ons wil ons nie in die polemiek oor die wenslikheid of andersins van sodanige geheimhouding inlaat nie. Daar is reeds tot vervelens toe oor geredekawel. Wat baie mense, en dit sluit selfs die joernaliste in, egter uit die oog verloor het is die praktiese uitvoerbaarheid van die voorgenome wetgewing. Is dit inderdaad moontlik om die naam van 'n donor geheim te hou as dit gaan om so 'n opspraakwekkende operasie soos die eerste hartoorplanting? Ons hoef ons ook nie blind te staar op hierdie spesifieke prestasie nie. Daar sal nog verdere epogmakende operasies gedoen word en hulle sal ook wêreldreklame uitlok. Persoonlike oortuigings tersyde gelaat, glo ons in alle eerlikheid nie dat enige wetgewing wat die donor en ontvanger se name van die publiek probeer weerhou ooit kan slaag nie.

Koerante kan die swye opgelê word; dit is nie moeilik nie. As dit onwettig is om die name te publiseer dan is dit tot daarnatoe en geen persman kan daar iets aan doen nie. Maar wat van die familielede en die vriende? Sal dit dan ook onwettig wees om oor 'n koppie tee aan jou intieme vriende te sê, 'Ek verstaan hulle het ou Piet se niere gebruik vir 'n seuntjie in Noord-Transvaal?' Miskien sal dit nie vertolk word as bekendmaking van die naam van die donor nie, maar ons het almal ervaring van die doeltreffendheid van die huis-tot-huis boodskap, en is dit billik teenoor 'n goeie verslaggewer dat hy moet droëbek staan en toekyk hoe die keurige storie die stad vol lê sonder dat hy daar iets oor mag rapporteer? Ons moet ons tradisionele konserwatisme soos goud bewaar, maar ons moet ook versigtig wees dat dit nie belaglik word nie.

Wetgewing van hierdie aard kan in ieder geval slegs van toepassing wees op plaaslike koerante. Ons parlement het geen seggenskap oor buitelandse publikasies nie. Al wat ons kan doen is om die binnekoms van oorsese tydskrifte te verbied. Toe die nuus van die eerste hartoorplanting bekend geword het was die chirurg voorblad-materiaal vir bykans iedere nuustydskrif en koerant in die wêreld. Buitelandse joernaliste het in hul honderde hierheen gestroom. Moet ons hulle nou onder die nuwe wetgewing die land verbied? Dit sou ook nie veel help nie want meeste van die bekende buitelandse tydskrifte het plaaslike, deeltydse joernaliste wat hulle van nuus voorsien. Die enigste manier om die geheimhouding te kan deurvoer sou wees om al die oorsese publikasies wat die donor se naam noem die land uit te hou—'n byna onbegonne taak. Maar as dit nie gedoen word nie sal nuustydskrifte met foto's en name kompleet op die winkelrakke pryk, skouer aan skouer met plaaslike koerante wat geen woord van al die groot nuus mag rep nie.

Al sou die sensors kans sien om hierdie uitsifting te beheer sou dit hulle nog nie veel baat nie want die radio is nie beheerbaar nie. Daar is geen wetgewing wat effektief kan verhoed dat 'n skoonseun of dergelike familielid van 'n donor 'n oorsese radio-omroeper in kennis stel van 'n gedane oorplanting nie. Dan het ons weer eens die toestand dat almal presies weet wie die donor en/of ontvanger was en welke operasie gedoen is, maar niemand mag 'n woord daaroor publiseer nie. Dit is teen hierdie tipe konserwatisme wat ons beswaar maak, want dit is sulke geveinsde onkunde wat ons belaglik laat voorkom in die oë van diegene wat 'n meer pragmatiese benadering tot die werklikheid het.

Oor die wenslikheid of andersins om name geheim te hou moet andere besluit. Laat ons tog net seker maak dat die onverkwiklike tipe skinderstories wat met 'n vorige hartoorplanting ontstaan het nie weer kans kry om hul kop uit te steek nie. Onsekerheid gee altyd aanleiding tot gissings—dit is 'n bloot menslike reaksie, en om skouerophalend te sê, 'Nou goed, laat hulle dan maar gis', is 'n naïewe houding wat slegs kan spruit uit totale onkunde van die kwaad wat sulke fluisterstories kan doen en trouens in die verlede reeds gedoen het.

1. Van die Redaksie (1969): S. Afr. T. Geneesk., **43**, 50.

DISINCENTIVES AND PREPAID MEDICAL CARE

It has recently been intimated that it would not be desirable for the medical aid societies to pay the full account of a doctor who charges according to the Tariff, because such full payment would remove the disincentive effect of the 15 or 20% of the account for which the patient is at the moment himself responsible. This matter of a disincentive in prepaid medical care repeatedly raises its head and it is time that we took a leisurely look at the true facts.

There are two aspects to be considered. On the one hand, one must decide whether, in fact, a disincentive is needed; and on the other hand, one must, should it be necessary, devise some effective method which will prevent wilful abuse of the doctor's services. The first aspect has hitherto received the least attention. This sounds almost incredible when one reflects that virtually every sick fund in the world has some or other disincentive clause written into its constitution. Yet careful perusal of the world medical literature has not brought to light a single objective, statistically valid study designed to ascertain whether patients who belong to some form of prepaid medical scheme do actually tend to over-use the available services *with malice aforethought*. Every doctor who does this type of work knows, or is sure that he knows, that his sick-fund patients see him far more often than do his purely private patients. This might be so and various studies seem to prove that the number of doctor-patient contacts per year are greater for aid society patients than for private patients and are still greater for benefit society patients. But such figures are not enough because they do not answer the most important part of the question: is the service wilfully abused?

Some unfortunate head of a large household in a non-welfare state might be too poor to make sure that his family receives the medical attention it requires, and chronic diseases might go unattended. If such a man then joins a new medical scheme and suddenly finds himself able to afford the medical care for his household which he has been denying it, will this be interpreted as making misuse of the services of the doctor? We must not lose sight of the fact that the higher incidence of doctor-patient contacts among sick-fund patients is to a considerable extent caused by such factors. Repeat prescriptions, sick certificates and a host of other visits necessitated by the organization of the sick fund will inevitably tend to cause increased use of the doctor's services. It is only after all these factors have been carefully eliminated that we can justly say that the patient is abusing the facilities.

Is it likely that the average patient will, merely because he belongs to a medical scheme, intentionally call the doctor unnecessarily? There are the odd few who will do it—cranks we will always have with us—but what percentage of the total patient population of any practice, private or otherwise, will really behave in such a despicable manner? A normal, balanced housewife will surely not suddenly derive fiendish pleasure out of calling her doctor at all hours merely because she has joined a sick fund. Admittedly she might develop a tendency to call too easily, but this can usually be cured by a reasonable discussion between the doctor and the patient. In any case, the sheer relief to be able to call a doctor when it is necessary without having to wait until the last moment due to monetary worries might play a large role in the matter.

Intensive research is needed to clear up this vexed question. Above all, let us not assume, in a woolly-minded fashion, that every experienced doctor knows the answer without further investigation.

Let us for the moment accept that a disincentive is needed. What form should this take? One must decide whether the average patient who wilfully abuses the services of the doctor will be discouraged from doing so because he has to pay about 30 or 40 cents of the account. Is it likely that a man with the mentality to knowingly pester his doctor unnecessarily will be deterred by such a trifling sum? More probably he will simply not pay the account at all, in which case he is not the loser. Experience has taught that levies on prescriptions or even small cash payments for each consultation do not make the slightest difference to the number of doctor-patient contacts, and one wonders whether the inconvenience caused through the aid scheme not paying the doctor in full is justified by the rather nebulous and highly problematical disincentive effect of the present system.

THE GENERAL PRACTITIONERS' GROUP

Every organization has its passengers. These are the members who are asleep most of the year, only waking up occasionally in order to vilify those who have been doing the work in the meantime. Fortunately, most of the workers have become used to this and no longer pay much attention to this kind of interference from the passengers. It becomes irksome when a few professional trouble-makers persistently mutter about real or imagined wrongs, only to disappear underground the moment they are asked to state their case openly and clearly.

The General Practitioners' Group has been in existence for a long time and it is functioning efficiently. It would be even stronger if all the non-specialist doctors in the country were members. A circular has been sent out to all these general practitioners, but the response has been lamentably poor. Yet one finds that the very colleagues who are so vociferous in their criticism are the ones who have not joined.

The days of struggle are over for general practitioners. They are no longer trying to convince a sceptical world that they have a right of existence.[1] But now they should show a united front, not only in order to achieve what they have set out to do in the academic field, but also as far as their own rights and needs within the Medical Association are concerned. All practising non-specialists should ensure that they are members of this very active group, and those who have not yet joined should do so now. Then, when they are participating in working towards a solution and are no longer themselves part of the problem, they will have right to criticize and then to rectify what they believe to be wrong.

1. Editorial (1968): S. Afr. Med. J., **42**, 326.