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THE ILL-TREATMENT OF CHILDREN

The physical assault by parents and others on a relatively helpless child has often raised the indignation of hospital medical officers who suspect that the reasons for the child's symptoms and signs are various forms of cruelty and ill-treatment. The subject is a topical one and deserves to be brought to the notice of medical students and junior casualty officers who too seldom are aware of the traumatic aetiology in the child patient who is seen.

In cases of this nature there are important medico-legal aspects to be kept in mind. In this article we do not, however, wish to discuss these aspects; we only intend once again drawing the attention of our colleagues to some of the more important clinical and social aspects of the phenomenon of the abused child syndrome.

The community is shocked when the isolated case of maltreatment is presented to them in the press, but those doctors in the casualty departmen s of paediatric hospitals are often puzzled by the discrepancies in the parents' history of the accident (or other suspect information) and the severely injured child that awaits examination.

We have been alerted to the syndrome described by Caffey,[1] the *Canadian Medical Journal's* London Letter[2] and an article in the *South African Medical Journal* by Krige,[3] a radiologist, whose concise article on 'The abused child complex' diagnosed by X-rays has helped to stimulate us to write on this theme.

Many 'problem families' are known to the relevant agencies and authorities, but let it be stated immediately that not all these families belong to the complex of lower social class, education and income. The problem unfortunately exists commonly all over the world and in all social strata. We are not discussing simply the awareness and recognition of the syndrome, but our thoughts turn to 'apparently normal' families in which the most grievous assault is inflicted, more often on an unwanted and rejected child. The medical and surgical care of such a child is the first consideration, and the prevention of a recurrence, the second. It would of course be far better if we could reverse the above two considerations. This is parent delinquency,[3] and efforts should be made to deal with the problem in the family *milieu*. It does not only occur in the homes of alcoholic parents, nor in those where mental illness is an obvious factor. That psychiatric help and not punitive retribution is more likely to be the answer, is probably a reasonably correct statement, but anger and emotional factors sway our reasoning, and with good cause, but not necessarily with the most satisfactory results.

Bruising, welts, fractures and the tragic possibility of brain damage or permanent physical crippling (and possibly death) are results of severe physical assault sometimes administered in a cold-blooded detached way and not in the 'red mists of violent rage'.

That more cases occur than ever get to treatment facilities is probably true. Guilt may be felt by some parents or total disregard of the consequences of their actions, by others. Although the child can hardly be held to blame, there are difficult, demanding, rebellious children who are likely to be this way because of disharmony in the home. We live in times of stress, our tempers are far from equable at the end of a demanding and tiring day and often we just don't feel like having our children around us —but we should, and if the home is a warm and affectionate place it should be a place of sanctitude after stress, a retreat from the worries and insecurities of the world outside that doesn't really care.

This syndrome occurs so frequently and its defenceless victims are often under the age of two. Time-lags between the 'alleged accident' and the bringing of the child for medical or surgical care is a pointer to the diagnosis.

Our psychologist and psychiatric colleagues may have some thoughts on this pathetic state of affairs and we should be glad if this article arouses their interest.

1. Caffey, J. (1957): Brit. J. Radiol., **30**, 225.
2. The London Letter (1966): Canad. Med. Assoc. J., **94**, 1189.
3. Krige, H. N. (1966): S. Afr. Med. J., **40**, 490.

DIE LIEFDADIGHEIDSFONDS

Soos dit gebruiklik is, wil ons graag ons lede voor die einde van die jaar weer eens herinner aan die bestaan en behoeftes van die Liefdadigheidsfonds van die Mediese Vereniging. Verder wil ons ook wys op nuwe planne en ondernemings (soos alreeds aangekondig by 'n vorige geleentheid[1]) om die fonds te versterk.

Die Liefdadigheidsfonds van die Mediese Vereniging is 'n aantal jare gelede opgerig met die doel om 'n trustfonds daar te stel waaruit behoeftige weduwees en ander afhanklikes van mediese praktisyns gehelp kan word. Daar is in die vooruitsig gestel om 'n aansienlike kapitaal op te bou wat dan belê kan word sodat die rente daarop (plus sodanige ander gelde as waartoe die Vereniging van tyd tot tyd mag besluit) gebruik kan word om verdienstelike gevalle van afhanklikes van dokters wat sonder leeftog nagelaat is, te help.

Die Fonds word soos volg geadministreer: Die kapitaal word belê en 'n bedrag wat ietwat groter is as die bedrag van die rente, en wat kom uit die lopende bydraes, word saam met die rente gebruik om gereelde uitbetalings te maak aan hulpbehoewende afhanklikes van dokters. Die uitbetalings word deur die Bestuurskomitee van die Fonds gemaak nadat elke aansoek eers goed ondersoek is deur lede van die Tak waarin die behoeftige woon. Die afhanklikes van geneeshere wat voor hul dood lede van die Mediese Vereniging was, kry gewoonlik voorkeur, maar die afhanklikes van nie-lede word ook soms gehelp.

Die Liefdadigheidsfonds is goed bekend aan die meeste lede van die Mediese Vereniging, wat oor die algemeen en op hul eie gereeld die Fonds ondersteun. Ook het die meeste Takke van die Vereniging gereeld hul ondersteuning aan die Fonds toegesê. Nogtans is dit nodig om die

Fonds gedurig te versterk ten einde in staat te wees om almal wat behoeftig is te help en om ook die kinders van gestorwe kollegas te help om 'n bevredigende opvoeding te kry.

Die Tak Grens van die Mediese Vereniging (Oos-Londen gebied) het die saak op 'n nuwe manier benader.[2,3] Die skema waarmee hulle begin het, kom kortliks hierop neer: Alle lede van die Tak word op 'n persoonlike grondslag genader met die versoek om te onderneem om deur middel van bank-stoporders elke maand R2 by te dra vir 'n tydperk van drie jaar. Die Tak voel dat die element van die persoonlike benadering van lede van baie groot belang is in die hele onderneming. Op hierdie manier het ons kollegas in Oos-Londen en omstreke baie groot sukses behaal en kon hul aansienlike bydraes maak ter versterking van die Liefdadigheidsfonds.

Soos die Tak Grens tereg aantoon, is daar geen rede waarom alle lede van die Mediese Vereniging nie dieselfde sal doen nie. Dit sou 'n geweldige groei-impetus aan die hele Fonds gee.

Die Tak Wes-Kaapland het alreeds besluit om die voorbeeld van die Tak Grens te volg. 'n Spesiale Komitee is gestig met die doel om die projek aan die gang te sit, en alle lede van die Tak (insluitende lede van al die Afdelings) word genader om hul ondersteuning aan dié onderneming te gee. Ander Takke oorweeg soortgelyke benaderings.

By die geleentheid van sy onlangse sitting in Pretoria is hierdie saak ook weer deur die Federale Raad van die Mediese Vereniging bespreek, en die algemene gevoel is dat hierdie benadering gerus deur al die lede van die Vereniging dwarsoor die land gevolg behoort te word. Die Bestuurskomitee van die Liefdadigheidsfonds sal die hele saak weer bespreek, en dit mag wel wees dat hulle besluit om alle Takke en lede deur middel van die Hoofkantoor te nader. Wat die prosedure ook al mag wees, wil ons graag 'n dringende beroep op alle lede van die Vereniging doen om aan hierdie saak hul voorkeur te gee.

1. Van die Redaksie (1965): S. Afr. T. Geneesk., **39**, 782.
2. *Idem* (1965): *Ibid.*, **39**, 243.
3. Briewerubriek (1965): *Ibid.*, **39**, 266.

CONTROVERSIAL ISSUES IN THE PRODUCTION OF ISCHAEMIC HEART DISEASE

It is often the discipline in which one is trained and whose theories one propounds, that conditions the viewpoint offered or line of research undertaken to prove the point at issue. Thus the geneticist will emphasize hereditary factors, the psychiatrist stress and emotional factors, the serologist haemopoietic ones and the nutritionist food factors. Cigarette smoking and obesity have concerned the physicians too.

It is obvious that once the acute diseases have been conquered by prophylaxis or therapy, the epidemiologist must plunge into 'turbulent seas' in an attempt to unravel the complex factors that may or may not be excluded in the aetiology and thereby the prevention of a major killer in our midst. The initial welter of confusion resulting from theories and the conflicting reports of therapeutic trials is to be expected, yet it is hoped that if racial or inherited factors are not the dominant ones the answers will gradually be unearthed because of the concentration of world-wide research on ischaemic heart disease.

The possible role of diet continues to occupy our attention, and particularly in the Republic—where coronary artery disease hardly exists among the Bantu, who nevertheless experience cerebral arteriosclerosis and cardiac myopathies—leaves us with the question of hereditary factor differences on the one hand and the food habits and diet of the Bantu and White populations on the other.

The high consumption of saturated (animal) fat is the hypothesis still widely held, although there are dissentients, and recent work tends to throw doubt on the validity of the 'fat hypothesis'.

Yudkin[1] in 1957 had put forward the tentative suggestion that a high consumption of sugar (sucrose) may be a responsible factor. An enormous increase in the prevalence of ischaemic heart disease occurred in Yemeni immigrants into Israel after about twenty years, coincident with a large increase in sugar intake; total fat intake increased much less, and was accompanied by a considerable decrease in the proportion of unsaturated fat.[2]

The sugar consumption theory was again found associated with a rise in prevalence of the disease in the USA in the last 70 years—the percentage increase in sugar consumption was over 100%.[3] Yudkin[4] indicated in 1963 that with sugar refining there was an increase in the individual consumption of sugar in Britain from about 4 lb. a year in the middle of the 18th century to 120 lb. a year today. Experiments with laboratory animals lend increasing support to the indictment of sugar as a significant cause of coronary thrombosis (and perhaps of adult diabetes mellitus).[5]

A plea is made to nutrition experts in the Republic to initiate surveys in order to determine the general food habits of the Bantu. It would be of interest to know whether this ethnic group consumes sucrose in excess or not.

Persuading people in developing countries, or the less educated in our own country to eat what to them are unusual foods, or children (with 'oral gratifying parents') throughout the world to avoid sugar consumption in excess—is a difficult and taxing problem for the most experienced health educator, but research and pilot studies are indeed needed. We smoke no less despite overwhelming evidence of the harm smoking can cause.

In consolation to our psychiatric colleagues—primitive man facing a sabre-toothed tiger was in a stress situation (and he probably had other aggravating and stressful situations to contend with) as was his seeking for food and basic comforts. It is not for us to argue that competitive society today is more stressful, although it may well be so. Certainly IHD is on the increase, its toll is tremendous and we hope some more positive answers will be forthcoming from the work of the epidemiologists.

1. Yudkin, J. (1957): Lancet, **2**, 155.
2. Cohen, A. M., Bavly, S. and Poznanski, R. (1961): *Ibid.*, **2**, 1399.
3. Antar, M. A. (1964): Amer. J. Clin. Nutr., **14**, 169.
4. Yudkin, J. (1957): Lancet, **1**, 1335.
5. Yudkin, J. and Roddy, J. (1964): *Ibid.*, **2**, 6.