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VAN DIE REDAKSIE : EDITORIAL

SUID-AFRIKAANSE GENEESKUNDIGE EN TANDHEELKUNDIGE RAAD

By die algemene publiek bestaan 'n groot verwarring tussen die Suid-Afrikaanse Geneeskundige en Tandheelkundige Raad aan die een kant en die Mediese Vereniging van Suid-Afrika aan die ander kant. Daar word dan ook baie dikwels van die een gepraat as die ander bedoel word. Verbasend genoeg is daar ook 'n groot gebrek aan kennis oor die spesifieke aard en doel van hierdie twee liggame, selfs by baie medici.

Die Mediese Vereniging van Suid-Afrika is 'n vereniging van geneeshere, met vrywillige lidmaatskap, wat as primêre doelstelling alle sake in belang van die mediese professie bevorder. Hy doen dit dan ook op baie terreine, soos byvoorbeeld die reël van mediese kongresse, die publikasie van hierdie *Tydskrif*, die onderhandelinge oor doktersgelde, ens. Hy beywer hom nie slegs in belang van sy lede nie, maar verkry al hierdie voordele ook ten bate van alle geneeshere, selfs diegene wat verkies om nie aan te sluit nie en wat op parasitiese wyse teer op die voordele wat deur hul kollegas binne die Mediese Vereniging vir hulle ook verkry word. Die hoogste gesag in die Mediese Vereniging is die Federale Raad wat saamgestel word uit verteenwoordigers van elke tak van die Mediese Vereniging oor die hele Republiek van Suid-Afrika en Suidwes-Afrika.

Die Suid-Afrikaanse Geneeskundige en Tandheelkundige Raad, daarenteen, is 'n statutêre liggaam wat deur wetgewing daargestel is, met sekere pligte en magte soos in die wet omskrywe, en met die primêre doel om alle sake rakende die gesondheid van die hele bevolking van Suid-Afrika te behartig. Dit is gevolglik 'n liggaam met sowel regspersoonlikheid as regsgesag.

Om gesondheid as 'n geheel te bevorder is dit noodsaaklik dat die Mediese Raad moet sorg dat daar genoegsaam goed opgeleide geneeshere is om in al die behoeftes van alle sektore van die bevolking te kan voldoen. Die besonderhede word onder werksaamhede van die Raad genoem.

Die Minister van Gesondheid benoem 7 lede van die Raad, waarvan 4 geneeshere moet wees, een 'n tandarts en 2 leke lede. Tien lede word deur al die geneeshere wat op die register is gekies. Van hulle moet minstens een, en nie meer as 4 nie, uit enige van die 4 provinsies afkomstig wees. Vier lede word deur al die tandartse op die register gekies, een uit elke provinsie. Vyf lede word benoem (een elk) deur elke universiteit met 'n Geneeskundige Fakulteit en 3 lede word benoem (een elk) deur elke universiteit met 'n Tandheelkundige Fakulteit. Twee lede van die Verpleegsters Raad word deur daardie Raad self benoem. Daar is dus 'n totaal van 31 lede wat goed verteenwoordigend van alle sektore van die professie is.

Alhoewel dit so is dat, in die huidige Raad, professore en spesialiste in die verskillende vakke oorwegend aanwesig is, vind mens tog dat die Raad as 'n eenheid funksioneer en in alle sake 'n goeie perspektief behou, sodat alle elemente in die professie gelyke beregting geniet. Die Raad se doel en funksie is dan geensins om persoonlikhede te dien, of seksionele belange te bevorder nie, maar die gesondheid van die bevolking as 'n geheel te versorg.

Die Raad is voortdurend besig om toesig te hou oor opleidings standaarde van beide die voorgraadse leerplanne asook die opleiding en ondervinding in die intern jaar. Die verdere nagraadse kursusse met die oog op hoër kwalifikasies en spesialisasie word ook beheer.

Hierdie vereistes en toesig, soos inspeksie by eksamens in die verskillende vakke, geld eerstens vir opleidingsinrigtings in die Republiek, maar inligting met spesifieke gegewens oor opleidings- en geneeskundige en tandheelkundige onderwysaangeleenthede oor die hele wêreld word voortdurend ingewin en op datum gehou. Sodoende kan daar altyd 'n redelike opinie gevorm word oor 'n persoon se bevoegdhede wanneer aansoek gedoen word om registrasie—hetsy as intern, as geneesheer of as spesialis in watter kategorie ook al.

Om praktykvoering te beheer hou die Raad 'n register van geneeshere en tandartse. Hierdie register word noukeurig op datum gehou en niemand mag as geneesheer of tandarts praktiseer as sy naam nie daarop verskyn nie.

Verder lê die Raad reëls en regulasies neer vir praktykvoering. Hierdie reëls word altyd in die nouste samewerking, en na raadpleging met die Mediese Vereniging of Tandheelkundige Vereniging, opgestel en het ten doel eerstens 'n doeltreffende diens en tweedens om die belange van die pasiënte te beskerm.

Aanvullende gesondheidsdienste in die geneeskundige en tandheelkundige versorging van die publiek word al hoe meer belangrik namate geneeskundige dienste in diepte toeneem en die gevolglike tekort aan mannekrag op dié terrein word ook gevoel. Die Geneeskundige Raad is voortdurend besig om standaarde van opleiding asook registrasie en beheer oor praktykvoering van al 18 kategorieë van aanvullende gesondheidsdienste te oorweeg. By sommige van hulle, bv. die optometriste, radiografiste en fisioterapeute, is die saak al goed omlyn terwyl by ander die ontwikkelingsproses besig is om volle beslag te kry.

Waar redelike reëls en regulasies bestaan om die eer, waardigheid en gehalte van die genees- en tandheelkunde te handhaaf, en waar dit die mens is wat dit moet uitvoer, is dit so dat daar altyd 'n paar swart skape is wat die kudde belemmer deur hul ingebore swakhede te laat seëvier oor hul beterwete. Die talle klagtes wat kom uit alle afdelings van die gemeenskap kry dan almal dieselfde billike aandag, of dit nou 'n beuselagtigheid of 'n ernstige misdaad is. Elkeen word so objektief moontlik benader en met omsigtige, simpatieke, geregtigheid beoordeel.

Afgesien van voorgenoemde take is daar talle bykomstige aangeleenthede waarby die Raad betrokke is, soos bv. toesig oor die verkoop van skadelike geneesmiddels, wetgewing rakende geneeskunde, ontwikkelingstendense in die geneeskunde beide wat die wetenskaplike vordering betref en die toepassing in die praktyk, asook neigings in praktykvoering beide plaaslike en oorsee. Die Raad is belas met 'n taak wat die moed van 'n leeu, die geduld van Job en die wysheid van 'n Salomo vereis.

MARGARINE

The margarine controversy is not new, and the whole subject has acquired such an overlay of emotion and has become so distorted that most journalists have learnt to steer clear of it. A discussion of the preparation and marketing of margarine virtually always leads to a chain-reaction of vested interests and axiomatic assumptions, many of which would be very difficult to prove if the matter could be viewed in a calm and objective atmosphere.

Margarine first appeared on the European market shortly after the Napoleonic wars when the shortage of butter had reached such serious proportions that some substitute had to be found. It was discovered that by emulsifying various vegetable oils it was possible to make a substance which could be spread like butter and which could be marketed at a price within the reach of most people with a reasonable income level. When butter again became more freely available the production of margarine did not cease, and, because of the lower price of the substitute, the less affluent continued to buy it in preference to butter. It is therefore true, unfortunately, that margarine has carried the stigma of the poor man's substitute for butter since its very first appearance on the market.

For many decades everybody felt—and some felt very strongly—that margarine must be regarded as a second choice, to be used only if butter was not available or when the price of the dairy product was beyond the means of the margarine consumer. But the time has now come to take a new look at this important product. It seems that our justified fear of coronary thrombosis results in the discovery of an ever-increasing number of causes which are as much subject to seasonal changes as are women's fashions. Stress, sugar, corn meal, tobacco and a host of other substances have had their moments of glory, but it would appear that animal fat, i.e. saturated fatty acids, has outlasted most of them. There can no longer be any serious doubt that the consumption of animal fat is at least one of the causes, if not the most important cause, of our alarmingly high incidence of atherosclerosis.

Hitherto it has been a question of 'May one eat margarine?' and not a statement that 'One should eat margarine.' If we daily tell our patients that they should cut down on their intake of saturated fatty acids, is it not logical then to say that in place of butter they should spread their bread with a polyunsaturated fatty-acid substance? We advise the use of various vegetable oils for cooking, and most people have come to accept them as a part of their daily diet. Some 10 or 15 years ago sunflower seed oil had to be sought in special shops, whereas today every supermarket carries a wide range of brands.

In a recent editorial we commented on the lack of legislation against the sale of tobacco and we pointed out that the vested interests of some 10,000 people could not be ignored.[1] Although it is the duty of every doctor and of our Association to combat the cigarette-smoking habit, it is still the right of every individual to smoke and thus injure his health if he so chooses. So here we have a known noxious agent which is not restricted by law, except by means of taxes, and we must agree that restriction should not be compulsory. We do not want our every action to be controlled by legislation.[2]

On the other hand, the Dairy Industries Control Act, with its various amendments, specifically prohibits the manufacture or sale of yellow margarine, and by means of a quota system the production of margarine is also limited to a certain extent. This colour discrimination is designed to protect the butter industry. Although it is true that butter very often has to be artificially coloured to make it yellow, and many margarines, depending on the oil used, have to be bleached to comply with the colour specifications of the Act, we have become so used to yellow as the colour for a spread on bread that this is the only hue aesthetically acceptable to us.

With our modern knowledge of atherosclerosis and cholesterol metabolism we can now say that polyunsaturated fatty acids are not noxious; on the contrary, they are beneficial as a source of calories. And yet we legislate against its presentation in a form which we know will be the most acceptable to the average consumer. Of course it is true to say that there is nothing to prevent anybody from eating margarine, and that he or she will soon get used to the white colour. But that is not the point we are making. If we are not prepared to introduce a law against a harmful substance because of vested interests, why are we willing to accept restriction of a health-promoting substance?

The dairy industry is important to this country and its interests should not be ignored, but if we want to be consistent in our protection of financial investments, then we must have a law which makes the advertising of tobacco compulsory, or we must relax the tax on cigarettes. We may even go a step further and say that if we warn our potential coronary thrombosis patients not to eat butter or any other saturated fatty-acid substance, why are we worried that the sale of margarine might affect the price or the production of butter? If we want to be coldly logical and consistent we should say, 'If the sale of butter drops, jolly good; so it should.'

But of course no one can afford to be so heartlessly logical. With our present butter surplus we would be depriving a large number of undernourished people of fats which they badly need. One will need to proceed slowly, in order to allow time for a reasonable balance to be reached. The dairy industry must be given time to find other uses for their cream, thus limiting their production of butter. That is a problem outside the scope of this article and one to be tackled through a joint research project by the dairy farmers and the nutritionists.

With the exception of New Zealand and possibly the Argentine, ours is the only country where there is colour restriction applicable to margarine. It has been argued that the margarine manufacturers should stop gunning for the butter producers. There are colours other than yellow, such as the green of avocado pears, or the brown of peanut butter. These colours have been tried in other countries and they have all failed. The average consumer wants a yellow substance to spread on his bread, and no other colour will do. It has been mentioned that if yellow margarine should be allowed, restaurateurs might fraudulently serve this as butter. Quite legitimately the restaurateur could reply that he was so concerned with the health of his patrons that he could not bring himself to serve a saturated fatty-acid substance.

1. Editorial (1969): S.Afr. Med. J., **43**, 549.
2. Editorial (1969): *Ibid.*, **43**, 258