EDITORIAL / VAN DIE REDAKSIE

SAMJ — the road ahead

First of all, I would like to express my gratitude to the Medical Association of South Africa for their confidence in appointing me Editor of the *SAMJ*, and to MASA Secretary-General Dr Hendrik Hanekom in particular, who handled the selection process with great thoroughness and professionalism.

There can only be but one *SAMJ* Editor at any given time and, taking into account the extremely infrequent intervals at which this position becomes vacant, I consider myself very fortunate indeed to have been the right person in the right place at the right time. Now, any pretender to my editorial throne will have to wait another 15 years!

The *SAMJ* has already established itself as an important medical publication both at home and abroad. Here at home, the *SAMJ* reaches more medical practitioners than any other medical journal currently in circulation, and is looked upon as South Africa's premier medical journal. At the international level, the *SAMJ* is rated the ninth most frequently cited journal among the hundreds of refereed publications constituting the world medical literature.

That the *SAMJ* is, first and foremost, a *scientific* journal can therefore not be overemphasised, and my first task will be to *maintain the scientific standards* already established by my predecessors. To achieve this, I shall continue to need the support of those who have contributed to the *SAMJ*'s success story: those who offer scientific articles for publication in the journal; the experts who peer review those contributions for scientific soundness; the editorial support staff in Pinelands who put the journal together; the MASA Publications Committee who advise the Editor on matters of broad policy; the printers who are responsible for the final product; the advertisers whose faithful support keeps the journal alive; and, most importantly, the medical practitioners across the country who make up the readership of the journal.

The *SAMJ* will continue to serve as the vehicle for disseminating news and scientific information from research centres such as the Medical Research Council, the South African Institute for Medical Research and the various medical schools around the country, and from ordinary practitioners who have something worth while to report.

In addition, it is my hope that, as South Africa regains normal relations with central, east and southern Africa, the *SAMJ* will begin also to meet the needs of colleagues in these countries. Certainly, we have the human and material resources to become a *regional medical journal* for the benefit of all concerned.

The *SAMJ* is owned by the Medical Association of South Africa in the same way that the British, Canadian and American journals are owned by their respective medical associations. Therefore, editing these journals is often a balancing act between the needs and aims of the proprietors, and the editor's prerogative to maintain autonomy in deciding what goes into the journal. Not too long ago, the *SAMJ* was regarded as 'his MASA's voice' by a significant segment of the medical profession, at a time when the MASA did not enjoy uniform approval within the medical fraternity.

Fortunately for me, I come at a time when this dilemma has largely been resolved as a result of two developments. The first is the profound transformation within the MASA itself, which has enabled it to shed its image as an exclusive club serving narrow conservative interests, and to become a truly national medical association serving the entire medical community, with genuine commitment to the promotion of optimal and comprehensive health care for all South Africans.

The other development is the explicit mandate from the MASA strategic planning conference in 1992, that the *SAMJ* become the voice of the entire medical profession rather than of the MASA *per se*, which I interpret to mean that the journal is no longer constrained to reflect only the 'official position' of the Association (if and when such a position exists) in contentious health care matters, but that it is free to give a voice to all sides.

My vision, therefore, is that the *SAMJ* will continue to provide a platform for the *open debate* of those health care issues that are vital for the future of our country. South Africa is on the threshold of profound social and political change and, as elsewhere in the world, health care questions constitute a significant part of the political debate. Therefore, issues that underlie current political controversy, such as institutional democratisation and the equitable distribution of resources, are bound also to affect the medical profession. Other great debates which will undoubtedly feature in the pages of the *SAMJ* include the nature, structure and financing of health care in the future South Africa; population growth, contraception and abortion; the appropriateness of current medical education and research in South Africa; the AIDS epidemic and how to deal with it, etc.

In an investigative report published in 1992 entitled *Medicine Betrayed*,[2] the British Medical Association documented the involvement of medical doctors in political torture and other violations of human rights around the world (including the UK), and demonstrated beyond a doubt that the medical profession is not immune from being party to such abuses. The South African medical fraternity has had its own painful experiences in this regard, but I am not making this reference in order to look back. I am making it in order to look ahead, and to caution that we should not be so naïve as to assume that political torture and human rights abuses will not occur under a future government of the new South Africa, that doctors will not be party to such abuses, or that covert pressures will not be brought to bear on the media to conform to the political *status quo*. For there is no shortage of examples in history (going as far back as the French Revolution) where the 'liberators' of today have turned out to be the populist oppressors of tomorrow.

The medical fraternity might yet find itself having to confront predicaments such as hunger strikes, torture and unexplained suicide in police custody, and the political abuse of psychiatry. My vision, then, is that if and when such events occur, the *SAMJ* will provide the medium for the profession openly to address those issues, and will not shrink from *editorialising on health care-related human rights abuses*, by individuals or by government, which violate well-established international medical codes of ethics, such as the Tokyo Declaration.

There will not always be earth-shattering applause for the views expressed within the *SAMJ*, but as Stephen Lock, past editor of the *British Medical Journal*, has said, it is part of an editor's job to tell people things that nobody wants to hear.

DANIEL J. NCAYIYANA

1. Garfield E. Which medical journals have the greatest impact? *Ann Intern Med* 1986; **105:** 313-320.
2. British Medical Association Working Party. *Medicine Betrayed: The Participation of Doctors in Human Rights Abuses*. London: Zed Books/BMA, 1992.

EDITORIAL / VAN DIE REDAKSIE

Inappropriate antenatal care

Several recent symposia and publications have suggested that the content and even the value of present prenatal care is open to question.[1-4] Evaluation of antenatal care should consider not only pregnancy outcome, but also patient satisfaction, and should include cost-benefit analysis.

F. J. Browne,[5] one of the first proponents of antenatal care, believed that antenatal care *per se* was responsible for lowering the maternal and perinatal mortality rates. However, it has become increasingly apparent that the improvement in pregnancy outcome has largely been due to socio-economic upliftment, improvement in women's health, planned parenthood, advances in neonatal care, and much less to traditional antenatal care.

The major causes of maternal mortality and morbidity, namely haemorrhage, hypertension, sepsis and thrombo-embolic disease, except for the identification of high-risk cases, are not prevented by antenatal care. Most cases of eclampsia and fulminating severe gestational proteinuric hypertension present as emergencies[6] and although management has improved, antenatal care has not reduced the incidence significantly.

The major causes of perinatal loss[7] — preterm labour, unexplained stillbirth, abruptio placentae and sepsis — are little influenced by antenatal care, and the lowering of the perinatal mortality rate owes more to greatly improved neonatal care than to prenatal care, or to the introduction of new technologies such as cardiotocography and ultrasound.

Broader educational opportunities presented by antenatal care have the greatest potential for improving perinatal outcome in deprived communities. Regrettably the education aspect of antenatal care is often hurried, neglected or delegated to persons without correct training who advise patients according to their own personal experiences. Holistic antenatal care should provide adequate time for women to discuss their problems and participate in small group sessions to discuss topics such as nutrition, neonatal care, sexual hygiene and family planning, as well as pregnancy itself.

The major responsibility of the obstetrician should be the initial consultation and risk assessment.[8] Patients at risk should have selected investigations performed and receive appropriate care, while low-risk patients should be regarded and treated as normal and receive antenatal care which is more educationally than medically orientated.

The components of antenatal care, such as routine weighing, blood pressure and urine examinations, have all been subjected to critical review.[2,3,9] Apart from the important initial measurement at the booking visit, routine repeated weighing of patients is of little value and could probably be discontinued.[10] There are wide physiological variations and patients with pre-eclampsia may fail to gain weight or gain weight excessively.

Regular measurement of the blood pressure is obviously important, but is 'often so perfunctory as to appear disrespectful'.[11,12] Moderate elevation of the blood pressure without proteinuria is of little significance[3] and should not lead to unnecessary intervention. Similarly, proteinuria without hypertension is seldom of significance[3] and consideration could be given to testing for proteinuria, after the first visit, only in those patients who develop raised blood pressure. This modification would need controlled evaluation before implementation.

In the final analysis, frequent abdominal palpation, although expected by patients, is of limited practical value and could probably be confined to the first visit and repeated at about 30 and 38 weeks. Measurement of fundal height has a limited predictive value[13] and as intra-uterine growth retardation tends to be overdiagnosed in low-risk pregnancies, may even lead to unnecessary investigations and 'meddlesome midwifery'.

It would seem then that we could considerably reduce the time and effort spent on ineffectual procedures and spend more time listening to problems, educating patients and providing meaningful advice and care.

The costs of providing antenatal care continue to increase. In the private sector patient expectations and fears of litigation are resulting in increased requests for expensive investigations such as repeated ultrasound examinations, which have no effect on fetal outcome.[14] There is also considerable doubt concerning the value of routine supplementary iron and vitamins and these need only be prescribed to patients with identified deficiencies or particular risks.

The time is opportune for university departments and midwifery schools to reappraise traditional and routine antenatal care and to retain only that which is appropriate so that more time and effort can be devoted to effective care according to identified risk factors. This should lead not only to cost saving, but also to increased patient satisfaction.

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1. Great Britain : Parliament, Social Services Committee. *Perinatal and Neonatal Mortality* (2nd report of the Social Services Committee, Vol 1). London: HMSO, 1980: 21.
2. Nagey DA. The content of prenatal care. *Obstet Gynecol* 1989; **74:** 516-528.
3. Lindmark G, Gnattingius S. The scientific basis of antenatal care: report from a state-of-the-art conference. *Acta Obstet Gynecol Scand* 1991; **70:** 105-109.
4. Rosen MG, Merkatz IR, Hill JG. Caring for our future: a report by the expert panel on the content of prenatal care. *Obstet Gynecol* 1991; 77: 782-787.
5. Browne FJ. The history and development of antenatal care. *Browne's Antenatal Care.* 9th ed. London: Churchill, 1960.
6. Hall MH, Chang PK, MacGillivray I. Is routine antenatal care worthwhile? *Lancet* 1980; **2:** 78-80.
7. Dommisse J. The causes of perinatal deaths in the greater Cape Town area. *S Afr Med J* 1991; **80:** 270-275.
8. President's Letter. Royal College of Obstetricians and Gynaecologists. London: RCOG, 1992.
9. Hall MH. Antenatal care. In: *Baillière's Clinical Obstetrics and Gynaecology.* London: Baillière Tindall, 1990; **4:** 1.
10. Dawes MG, Grudzinskas JG. Repeated measurement of maternal weight during pregnancy: is this a useful practice? *Br J Obstet Gynaecol* 1991; **98:** 189-194.
11. Editorial. Practice imperfect. *Lancet* 1991; **337:** 1195-1196.
12. Perry IJ, Wilkinson LS, Shinton RA, Beevers DG. Conflicting views on the measurement of blood pressure in pregnancy. *Br J Obstet Gynaecol* 1991; **98:** 241-243.
13. Lindard A, Nielsen PV, Mouritsen LA, Zachariassen A, Sorensen HU, Roseno H. The implications of introducing the symphyseal-fundal height measurement: a prospective randomized controlled trial. *Br J Obstet Gynaecol* 1990; **97:** 675-680.
14. Larsen T, Larsen JF, Petersen S, Greisen G. Detection of small for gestational age fetuses by ultrasound screening in a high risk population: a randomized controlled study. *Br J Obstet Gynaecol* 1992; **99:** 469-474.

Based on the Continental Ethicals lecture delivered at the 26th Congress of the South African Society of Obstetricians and Gynaecologists, September 1992.

EDITORIAL / VAN DIE REDAKSIE

Adolescent health in South Africa — urgent action needed

The comprehensive focus on adolescent health in this issue is long overdue.[1-8] Previous studies in South Africa have mainly emphasised the morbidity[9] and mortality[10] of adolescents, while occasional risk factor studies have dealt with small, non-representative groups.[11]

Morbidity studies have shown that adolescents are admitted to hospitals mainly with chronic conditions (such as epilepsy, mental disease, rheumatic fever and tuberculosis), often requiring high levels of compliance at an age at which supervision is difficult.[10] A recent review of mortality among adolescents showed that 56,8% of adolescent deaths between 1984 and 1986 were attributable to traumatic causes mainly related to traffic, assault and suicide.[11] While the analysis of mortality and morbidity data are of considerable use to health planners, of even greater importance are studies that indicate likely future risks that are modifiable.

In this issue, Flisher *et al.* describe the extent to which adolescent behaviours contribute both to their current risks of death and disease and to the risk of chronic diseases in adulthood.[1-8] Overall, schoolgoing adolescents in the western Cape engage in high levels of health-damaging behaviour that demand urgent attention by health and educational authorities. Until now, these authorities have either denied or not acknowledged the very real problems of adolescents. This study shows that a high percentage of western Cape adolescents smoke,[3] drink alcohol,[4] use drugs,[5] engage in unprotected sexual intercourse,[6] and are both perpetrators and victims of violence.[7] Important variations among gender and language groups were shown. Of particular importance are the low rates of health-damaging behaviour among Xhosa-speaking girls and the particularly high rates of health-damaging behaviour among all boys.

Despite the results being presented by individual risks, the authors appropriately acknowledge that considerable interaction exists between risks and that a comprehensive lifestyle approach to promote health-enhancing behaviours is more likely to succeed in the long term than narrowly targeted programmes focusing on specific risk factors.[1] Unfortunately, in South Africa, the technical competence to design and implement such programmes is poorly developed at a time when it is most required. As is the case with many other public health disciplines, expertise in health promotion is inadequately taught within the universities and practised in the health services. To be able to design effective school-based health promotion programmes requires multidisciplinary teams consisting of health educators, social anthropologists, psychologists, epidemiologists and people with knowledge of modern communications and social marketing methods.

Internationally, it is recognised that for success, age-specific culturally relevant programmes are needed that are designed in collaboration with parents, teachers and school pupils. Most importantly, for their long-term sustainability, school prevention programmes need to be reinforced by other services and social/economic resources. For substance abuse this should include taxation policies and legislative approaches to reduce access to and affordability of alcohol and tobacco. Furthermore, controls over advertising are needed to stop the targeting of rapidly urbanising communities with regard to alcohol and tobacco. For unsafe sex, it is essential to change the emphasis on abstinence, and to openly discuss sexual activity options that do not pose a risk of unwanted pregnancy, HIV and STD.[13] In addition, easy access to condoms and other contraceptive services and STD clinics is also required.

As regards violence, the issue is far more complex. The study in this issue showed that 10% of boys carry knives to school and that a significant proportion are both perpetrators and victims of violence.[7] Importantly, the study did not attempt to estimate the level of sexual abuse and rape that is tragically so common in this age group.[12] The relatively high level of experience of violence in adolescents reported, reflects the reality of South African society. It is not sufficient to hope that sociopolitical and long-term economic change will reduce the high levels of violence in our schools and among our schoolchildren. Rather, mediation skills need to be taught at schools along with tighter control over alcohol and drugs. The emerging concept of community policing[14] is particularly useful for protecting the school environment in the context of creating safe neighbourhoods.

The study did not address the problem of school drop-out rates that particularly besets boys. Among black South African schoolchildren approximately 55% of an enrolled Sub A class find their way to the end of Std 5, and probably less than 15% of the enrolled cohort pass matric.[15] School drop-out figures reflect a dismal scenario of inequality, poverty and wasted human potential.[16] Drop-outs are more likely to smoke, drink, use drugs, engage in violent behaviour and unsafe sex (Flisher — personal communication, 1993). Since 1976, a high proportion of adolescents, mainly boys, have engaged in political and criminal activities at the expense of their own education. The long-term process of reintegrating such adolescents into society poses a major challenge for the future. Innovative work and education programmes aimed at reaching this 'hard-to-reach' group are currently being discussed by several groups formulating reconstruction plans.

It is crucial that adolescent health and well-being receive high priority during transition. It is already clear that the volatility and uncertainty of the sociopolitical process has had a profound impact on teenagers in South Africa. Inability to address the educational, health, recreational and emotional needs soon, pose a spectre of youth out of control, which constitutes a threat to the long-term stability of communities.

Reconstruction requires imagination and innovation. It requires new approaches to nation building that help youth, in and out of school, believe that a better future is possible. It is likely that this study[1-8] will jolt many decision-makers into realising that the problem of adolescent health must be given high priority.

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1. Flisher AJ, Ziervogel CF, Chalton DO, Robertson BA. Risk-taking behaviour of Cape Peninsula high-school students: Part I. Introduction and methods. *S Afr Med J* 1993; **83:** 469-473.
2. Flisher AJ, Ziervogel CF, Chalton DO, Leger PH, Robertson BA. Risk-taking behaviour of Cape Peninsula high-school students: Part II. Suicidal behaviour. *S Afr Med J* 1993; **83:** 474-476.
3. Flisher AJ, Ziervogel CF, Chalton DO, Leger PH, Robertson BA. Risk-taking behaviour of Cape Peninsula high-school students: Part III. Cigarette smoking. *S Afr Med J* 1993; **83:** 477-479.
4. Flisher AJ, Ziervogel CF, Chalton DO, Leger PH, Robertson BA. Risk-taking behaviour of Cape Peninsula high-school students: Part IV. Alcohol use. *S Afr Med J* 1993; **83:** 480-482.
5. Flisher AJ, Ziervogel CF, Chalton DO, Leger PH, Robertson BA. Risk-taking behaviour of Cape Peninsula high-school students: Part V. Drug use. *S Afr Med J* 1993; **83:** 483-485.
6. Flisher AJ, Ziervogel CF, Chalton DO, Leger PH, Robertson BA. Risk-taking behaviour of Cape Peninsula high-school students: Part VI. Road-related behaviour. *S Afr Med J* 1993; **83:** 486-490.
7. Flisher AJ, Ziervogel CF, Chalton DO, Leger PH, Robertson BA. Risk-taking behaviour of Cape Peninsula high-school students: Part VII. Violent behaviour. *S Afr Med J* 1993; **83:** 490-494.
8. Flisher AJ, Ziervogel CF, Chalton DO, Leger PH, Robertson BA. Risk-taking behaviour of Cape Peninsula high-school students: Part VIII. Sexual behaviour. *S Afr Med J* 1993; **83:** 495-497.

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9. Rosen EU. Adolescent health problems — can paediatricians in the RSA cope? *S Afr Med J* 1988; **73:** 337-339.
10. Flisher AJ, Joubert G, Yach D. Mortality from external causes in South African adolescents, 1984 - 1986. *S Afr Med J* 1992; **81:** 77-80.
11. Disler SA. Health related lifestyles of adolescents: a study of smoking, alcohol and habit forming drugs, and sexual activity in a group of high school students in Cape Town. M.Phil. thesis, University of Cape Town, 1990.
12. Elders MJ. Making a difference in adolescent health (Editorial). *JAMA* 1993; **269:** 1425-1426.
13. Hein K. 'Getting real' about HIV in adolescents (Editorial). *Am J Public Health* 1993; **83:** 492-494.
14. Nell V. Toward community policing in South Africa. Health Psychology Unit of the University of South Africa. Technical Report 93/1. Johannesburg, 1993.
15. Department of Education and Training (DET). *Annual Report*, Pretoria, 1991.
16. Gordon A. School performance in Soweto: a study of environmental constraints and academic achievement, National Institute for Personnel Research, CSIR, July 1983.

Afri-Med Info 2000

The second announcement and registration forms for the Afri-Med Info 2000 Conference have now been sent out to those already on our mailing list, and are available from the Journal offices for others who may be interested in attending. The conference, which will be the first of its kind in southern Africa, is a joint venture between the MASA and the MRC, and will be held in Cape Town from 6 to 8 October 1993. At this juncture, it is well to recollect why it was decided to hold such an event in the first place. As in many other walks of life, new technology has revolutionised information exchange, and it is only necessary to think about computerised databases, satellite links and the telefax machine to realise just how much our lives have been changed by these innovations. However, the future promises to hold even more surprises for us, and before we are overtaken by events, it seemed prudent to take an objective look at just what the future holds with regard to how the medical profession handles communication with itself and others, and what would be appropriate in an African context. Printed journals have been the traditional way of doing so in the past, but there may be other more efficient and cost-effective ways of communicating in future, and now is the time to start looking.

The conference therefore aims to review the history of medical communication in Africa, to review present medical communication activities and needs, and to identify trends and consider how the collection, storage and dissemination of medical information in Africa should be planned to meet future needs.

From reading the abstracts of papers received so far, this meeting promises to be a milestone in South African medical history, particularly as one of the keynote speakers will be Richard Smith, Editor of the *British Medical Journal*. Those interested in attending, or who would like more information, should contact Johlette de Jager at the Medical Research Council, telephone (021) 938-0911, ext. 433, or fax (021) 938-0395. Postal applications should be sent to PO Box 19070, Tygerberg, 7505.

N. C. LEE

In praise of the word

Writing a valedictory editorial can offer some tempting options for a retiring editor. Rather like writing one's own obituary (a practice now favoured by some medical journals, which gives a whole new meaning to the word deadline) it can provide a unique opportunity for banging one's own drum, paying back old scores or inflicting a captive audience with the personal, lengthy and often tedious *weltanschauung* of the writer who is prompted to seize this last golden opportunity to convert the world, free the slaves or reveal the ultimate secrets of the Universe. However, as the availability of journal space should, even to a retiring editor, be foremost in his mind, some assessment of priority becomes necessary. I shall therefore do none of the above, but will instead concentrate on what have to me been the most significant features of the 10 years which I have spent working full-time for the *South African Medical Journal*, first as Assistant Editor, and then as Deputy Editor and ultimately Editor.

At this juncture in my professional career, the first feeling to be recorded is a sense of privilege at having been given the opportunity by the MASA to be Editor of the *SAMJ* during a period of unprecedented change in both the country and its medical profession. Looking back at the journal of 10 years ago is to see a totally different publication with a different set of priorities and a different philosophy. It would be presumptuous of me to suggest that all these changes were mine and mine alone because above all, any publication is the product of teamwork, and I have been extremely fortunate in having a team of helpers and colleagues without which the journal could never have become what it is today. Naming names can be hazardous, the hazard relating more to those who are excluded rather than those included. However, no farewell message of mine would be complete without acknowledging the invaluable help of Professor J. P. van Niekerk as Chairman of the Publications Committee whose breadth of vision, equanimity, urbanity and wise counsel have occasionally acted as a necessary brake on some of my more masochistic impulses towards honourable, journalistic self-end. Alongside JP has been Professor Ralph Kirsch, whose academic expertise and Falstaffian energies have been a constant stimulus to holding high the standard of journalistic excellence. Within the Journal's offices, my life has been made continually pleasurable by working with my friend and colleague Fred Sanders, Editor of *CME*, wit, raconteur and incomparable *mensh*; with Peter Roberts, our urbane and gentlemanly Director of Publications; and with the handful of dedicated ladies and gentlemen who actually make it all happen: Ursula Kingwell, Emma Buchanan, Tania Trebett, Carol Johnson-Barker, Marijke Maree, Peter Wagenaar, and not forgetting Lorraine Griessel who single-handedly maintains the *cordon sanitaire* around the editorial office. My heartfelt thanks go out to all of them and all those

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others both inside and outside MASA Publications who have made editing the *SAMJ* such a rewarding and memorable experience.

The stock in trade of editors is of course made up of words, and in our day and age when technology has made the widespread dissemination of words easier than it has ever been, words are now paradoxically under greater threat than at any time in human history. Part of the difficulty lies in their sheer profusion. All day and every day we are deluged and bombarded with words, many of them concerned with carrying commercial messages, to an extent that we become anaesthetised to the significance of what is happening to us. Words can carry data, information, knowledge and wisdom, in ascending order, but we are in danger of forgetting the intrinsic wisdom of the word itself, something which modern education glosses over, or at least undervalues. This may seem a strange topic to be considering in a journal primarily devoted to the dissemination of scientific, medical communication in which any emotive or non-objective expression of meaning is often rigidly excluded, but as medical journals, including this one, strive to become more user-friendly, we must now and again return to consideration of basic values, and the whole basis of what we are trying to communicate and the means by which we do it.

Sir Laurens van der Post also warned about the tendency to ignore the intrinsic wisdom of the word when he wrote '. . . I have been uneasily aware, particularly since the war and the arrival of television and the new kinds of newspapers, that the importance of the living word, the right, the only word, is overlooked. The word is, consciously or unconsciously, under attack and in decline. Yet nothing else can replace it.'[1] The same feeling was expressed by Lama Anagarika Govinda, a German who became a Tibetan monk, who wrote 'Words are seals of the mind, results — or, more correctly stations — of an infinite series of experiences, which reach from an unimaginably distant past into the present, and which feel their way into an equally unimaginable distant future. They are "the audible which clings to the inaudible", the forms and potentialities of thought, which grow from that which is beyond thought. The essential nature of words is therefore neither exhausted by their present meaning, nor is their importance confined to their usefulness as transmitters of thoughts and ideas, but they express at the same time qualities which are not translatable into concepts — just as a melody which, though it may be associated with a conceptual meaning, cannot be described by words or by any other medium of expression. And it is just that irrational quality which stirs up our deepest feelings, elevates our innermost being, and makes it vibrate with others.'[2]

It is this hidden, elusive quality of words which arouses such fiercely protective feelings concerning one's own language, and which can make the task of an editor of a bilingual journal decidedly uncomfortable from time to time. What hurts is not necessarily the dearth of articles in one's own language, but the thought that the language itself as a living, dynamic means of expression is being undervalued, or worse, derided. As readers will well know, much of the content of the *SAMJ* appears in English not, let it be said, because of any dark plot in the Journal offices to undermine Afrikaans as a language, but simply because the vast majority of the material which we receive is written in English. One of the greatest challenges to future editors of the Journal and other South African publications will be to give due consideration to contributors whose first language may be different from that most widely in use, while at the same time to avoid revisiting the Tower of Babel. I know that my immediate successor, Daniel Ncayiyana, shares my thoughts on these matters, and it is a source of great personal satisfaction to me that I can with confidence hand over to him the custody of the word.

I will end by again quoting Sir Laurens van der Post through whose writings, and through our all too brief personal communications, I have come to develop a love for the immense value of the word, and also the great heart of Africa. 'So one cannot just define all words rationally and use them purely rationally. All the dimensions of meaning tend to have a part in their impact. And the right word will not only touch you emotionally. Your eyes, your ears, your sense of smell, your intuition, everything comes into the greatest word. Altogether words form a system of communication which is as profound, subtle, sensitive, proven and experienced as life itself. And in a sense it is life and it gives life. Without it, life as we have known it is inconceivable.'[3]

Farewell.

N. C. LEE
Editor

1. Van der Post L. *A Walk with a White Bushman*. London: Chatto & Windus, 1986: 267-268.
2. Govinda Lama Anagarika. *Foundations of Tibetan Mysticism*. London: Rider, 1972: 17.
3. Van der Post L. *A Walk with a White Bushman*. London: Chatto & Windus, 1986: 268.