EDITORIAL : VAN DIE REDAKSIE

A UNIVERSITY NUMBER

This issue represents a departure from the customary form of the Journal in that its subject matter deals almost entirely with the medical faculties of the South African universities. As a 'University number' it corresponds—to a certain degree—with the annual 'educational number' of overseas medical journals. It follows a suggestion made some months ago in the correspondence columns that a number of this kind should be issued by the Journal. The object is to keep the profession in touch with the medical faculties, and in particular with contemporary trends in postgraduate teaching in this country.

For this issue articles have been contributed by members of the professorial staff of the medical schools, and the opportunity has been taken to include important pronouncements recently made by the Principal of Cape Town University and the Rector of Stellenbosch University. The Director of the South African Institute for Medical Research also contributes an article on postgraduate studies. A description of the new Durban Medical School will be read with much interest. It is contributed by the Dean, Dr. G. W. Gale, whose departure is greatly regretted. Dr. Gale has had a distinguished career in South Africa, and now leaves us to take up the chair of Preventive Medicine in the University College of East Africa at Kampała, Uganda.

Remarkable developments of medical education have taken place in South Africa during the past 40 years. Before that time all medical practitioners in the country, whether born in South Africa or not, received their training and qualifications abroad (chiefly but not exclusively in Great Britain and Ireland), there being no South African schools of medicine. The Universities at Cape Town and Johannesburg were the first to institute medical faculties in cooperation with the local hospital authorities, to be followed in later years by Pretoria and Durban; and the Stellenbosch University is about to establish the fifth medical school in the Union. There are now ample facilities in the Union for the medical education and training of White South Africans, in both the English and Afrikaans languages, and one medical school primarily serving the other ethnic groups of the South African peoples. At the end of last year 67% of the medical practitioners registered in the Union had qualified at South African universities, and year by year the proportion is increasing. Thus South Africa has fallen into line with other great countries in providing within its own borders for the undergraduate training of its medical profession.

Undergraduate teaching is by no means the sole function of a medical school, any more than it is the sole function of other university faculties. Though medicine is international, every country aims at contributing to the universal store of knowledge and not remaining in the less honourable position of a mere recipient or beneficiary. South Africa has already made good progress in that direction, and for this the medical schools and certain other centres of medical research are responsible.

It is these developments that have furnished the academic facilities for postgraduate study (to use this word in its widest sense), and as the medical schools have developed as centres of research so they have found it possible to develop their postgraduate teaching. To an increasing extent South African graduates who desire to take higher degrees or diplomas, or qualify for specialist practice, can find in their own country the facilities they need. Refresher courses for practitioners are also provided by the medical schools; there is ample evidence of the value of these and the appreciation in which they are held. Postgraduate work is a strong link between the University and the practising profession. It is a form of cooperation that stimulates medical progress both in the university and in practice.
STUDENT HEALTH SERVICES

The idea that a university should accept responsibility for the health of its students, and perhaps its staff, is rapidly gaining ground all over the world. Where it has been acted on, the service provided varies greatly in scope and nature. Its different facets—preventive health, curative services and general usefulness—are discussed in Dr. H. T. Phillips' article on page 443 of this issue.

The concept of a practice at the university is likely to have a highly selective appeal amongst medical men. Special qualities are essential for success. The full-time university health officer must needs be an enthusiast in public health and social medicine as well as a good clinician. At best he will be a man well-equipped in these respects, acceptable in an academic atmosphere and interested in the preservation of health as much as in the cure of disease; at worst a practitioner who wants an easy job. The scheme might thus stand or fall upon his selection.

What should the objects of a students' health service be? Preventive only, safeguarding the student body against disease and perhaps 'promoting'—to use the social medicine word—the health of the individual student? Or should it be comprehensive like the Minnesota scheme, including everything possible in the medical field?

The recent trend in Britain has been towards the less comprehensive scheme, focussed for the most part on the preventive and health-promotive aspect. This has been the approach in South Africa, where both the Cape Town and Witwatersrand Universities have stressed the need for an annual medical examination. Neither university has ventured to introduce compulsion, which is becoming the policy abroad, where it is argued that if the scheme is to be successful then all students must submit to examination—a demand no greater than that made upon entrants to the public service or the military forces. And since the universities take a financial risk upon the good health of each of the students in their schemes they are surely entitled to enforce this demand. The declining attendance figures of the Cape Town University medical service over the first 3 years make one wonder whether compulsion is not the only sure means of saving these schemes from collapse. Without compulsion they may easily fail to fulfil the fair promise they seem to carry.

Dr. Phillips sets out the manifest advantages of a properly-functioning students' health service. From the point of view of its medical officers, the possible monotony of examining healthy adults would be more than countered by its association with clinical practice, public-health advising, and the prospect of conducting

GESONDHEIDSDIENSTE VIR STUDENTE

Die mening dat 'n universiteit vir die gesondheid van sy studente, en missien ook vir dié van sy personeel, verantwoordelikheid behoort te aanvaar, wat pos oor die hele wêreld. Waar sulke dienste alredes verskaf word verskil hul heelwat in omvang en aard. Die verskillende aspekte—voorbehoedende geneeskunde, helende dienste en algemene nuttigheid—word vol­ledig deur dr. H. T. Phillips bespreek in die artikel wat op bladsy 443 van hierdie uitgawe verskyn.

Die idee van 'n universiteitspraktyk sal waarskynlik by sommige geneeshere groot byval vind. Sukses sal van spesiale hoedanighede afhang. Noodwendig moet die voltydige universiteits-gesondheidsbeamptes 'n lewendige belangstelling in openbare gesondheid en maatskaplike geneeskunde stel en hy moet ook 'n goeie klinikus wees: wat dit betref sal die beste beampte goed toegerus wees, hy sal ook in akademiese kringe tuis hoort en net soveel belang in dié behoud van gesondheid as in dié genesing van siekte stel; die swakste beampte sal die geneesheer wees wat 'n maklike baantjie soek. Waarskynlik sal die sukses of andersins van dié skema afhang van die mediese beantwoord word.

Wat behoort so 'n gesondheidsdiens te beoog? Slegs voorbehoeding deur die studente-gemeenskap teen siekte te beskerm en missien ook die bevoering van die individuele student se gesondheid? Of behoort dit 'n uitgebreide skema te wees soos dié van Minnesota wat alles moonlik op mediese gebied dek?

Die rigting wat onlangs in Brittanje ingeslaan is, is om die minder omvattende skema toe te pas wat hoofsaaklik op voorbehoeding en gesondheidsbevordering toegespits is. Suid-Afrika benader die probleem op dieselfde wyse—beide die Universiteit van Kaapstad en die Universiteit van Witwatersrand het die nood­saaklikheid van 'n jaarlikse mediese ondersoek beklemtoon. Geeneen van hierdie universiteite het dit egter gewaag om dit verpligend te maak nie, 'n beleid wat oorsee veld wen in ooreenstemming met die op­vatting dat vir die skema om te slaag studente hul aan ondersoek moet onderwerp—'n vereiste wat geensins groter is nie as dié wat gestel word aan persone wat by die staatsdiens of die militêre magte aansluit. Aange­sien die goeie gesondheid van elke student vir dié universiteit finansiële implikasies inhou, is hul sekerlik geregig om hierdie vereiste verpligend te maak. Die dalende bywoningswyse van die Universiteit Kaapstad vir die eerste 3 jaar verskerp die gedagte dat verpligende ondersoek miskien die enigste metode is om hierdie skemas van ondergang te red. Sonder hierdie ver­pligting kan die skemas wat so veelbelovend voorsien en ondersoek miskien maklik misluk.

Dr. Phillips sit die klaarlyklike voordele uiteen van 'n gesondheidsdiens vir studente wat behoorlik funksioneer. Wat die mediese beamptes betref sal die maatskaplike eentonigheid om gesondte volwassenes te ondersoek meer as vergeef word deur 'n afgebakende kliniese praktyk, die beperkte raadgewing i.v.m. openbare gesondheid en die kans om belangrike navorsing te doen oor belangrike onderwerpe waaroor deesdae te
research into important matters which are at present too often only vaguely talked about—physical and mental fitness, the science of athletic perfection (which Roger Bannister has brought to the notice of medical men), and the true meaning of positive health.

THE AMERICAN 1954 FIELD TRIAL OF POLIOMYELITIS VACCINE

After this special issue was compiled the Summary Report on the Evaluation of the 1954 Field Trial of Poliomyelitis Vaccine (a document of 63 + xiv 2-column pages) was received, by courtesy of Dr. Thomas Francis, Jr., Director of the Evaluation Centre, University of Michigan, together with an Abstract of the Summary Report prepared by Dr. Robert F. Korns, Deputy Director. This issue has therefore been extended, and some items held over, in order to publish without delay the Abstract and certain relevant statistical tables from the Summary Report (see page 447).

THE EDUCATION VERSUS THE TRAINING OF THE DOCTOR IN THIS INDUSTRIAL AGE

AS SEEN IN GREAT BRITAIN, AMERICA AND SOUTH AFRICA*


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Dr. Davie said he proposed to discuss the merits of the current methods of medical teaching in the Universities, and to consider what modifications, or possibly only change of stress in certain directions, were desirable. He would refer to the position in Great Britain, America and South Africa as they appeared to him.

HISTORICAL

The first production of doctors was in the age of the supernatural; today the mystical element was still prominent in primitive peoples and even in some sides of recognized medical practice. This was followed by the naturalistic age, when medicine (or, rather, therapeutics, which was then its chief element) was based on the natural properties of medicinal substances, and the principles of physiology were still mainly unknown. At a later stage professional training took the form of apprenticeship, associated with preliminary 'dissections', etc. This gradually changed to the medical-school system. Medical schools at first were not all associated with universities. Not long ago many of them were. Today all medical schools were faculties of universities.

The problem now before them included the question whether the University was the best place for the training of a doctor. In most medical schools the student found himself isolated from the rest of the university psychologically and socially—often physically owing to the distance between the different buildings of the one university. Thus the medical student often failed to get the full benefit of his membership of a university and, on the other hand restrictions within the university not infrequently induced him to demand separation of the medical school from the university.

Dr. Davie spoke of the early basis of these developments. He said that in the earliest days medicine was purely therapeutic; primitive man did not go to his doctor for diagnosis, but for treatment. The study of diagnosis took its origin in the Italian schools, where dissection of the body on any scale first began, leading to some real knowledge on which treatment could be based. Thus anatomy and therapeutics (or pharmacology) were the original basis of medicine. These subjects had in some schools become worn out and dead but recently they had been re-vivified and in some of the medical schools, especially in Great Britain, Anatomy and Pharmacology were today amongst the most active departments. Modern medicine is based essentially on physiology—which arose primarily out of the work of the physicians of the 18th and 19th centuries. The physiological attitude lead to a change of outlook in pathology, away from morbid anatomy to causation of disease. From this change many advances in surgery as well as medicine took their origin.

THE PROBLEM

Education v. Training. These two conceptions were not always easily separated; yet the distinction was not entirely academic. Dr. Davie said he would speak from the University point of view, which tended to give a higher value to education than to training. This view might not be held by everyone.

Training meant equipping with techniques, both manual and mental; with manipulative skills in diagnosis, in surgery, in obstetrics, etc., plus certain knowledge and the use of 'log books' of diagnosis and treatment (Dr. Davie said that here he was over-simpli-