

VAN DIE REDAKSIE : EDITORIAL

VAN ONTWIKKELING TOT BEPLANNING

By die geleentheid van 'n onlangse vergadering van die Suid-Afrikaanse Akademie vir Wetenskap en Kuns het prof. S. P. Cilliers, van Stellenbosch, op oortuigende wyse aangetoon dat ons oor die algemeen in die wêreld vandag 'n optimum graad van *ontwikkeling* bereik het en dat ons, teneinde verdere vooruitgang te verseker, nou moet beweeg na 'n era van *beplanning*.

Hierdie insig en formulering van 'n universele gegewe is ook en veral waar van die medisyne. Wat betref ontwikkeling van die mediese wetenskap en die praktyk van die kliniese medisyne het die afgelope dekades inderdaad in dié teken van ontwikkeling gestaan. Ons het byvoorbeeld die aansteeklike en besmetlike siektes (teoreties, altans, maar in 'n groot mate ook prakties) onder die knie gekry. Spesifieke, genesende behandeling het sedert die ontdekking van insulien in 1926 met rasse skrede vooruitgegaan op haas elke gebied van die medisyne. Ontwikkelinge op die gebied van die anesthesiologie en vooruitgang wat betref chirurgiese tegnieke het gelei tot vroeër ongekende ingrepe en dus tot herstellende en korrektiewe behandeling (oophart chirurgie, brein-chirurgie, chirurgiese herstel van aangebore defekte van allerlei aard, orgaantransplantasie, ens.). En ontwikkelinge op die gebied van biochemiese navorsing het hele nuwe wêreldes van kennis geopen. Dit is dus duidelik waarom ons sê dat ons wat ontwikkeling betref 'n optimum punt in die medisyne bereik het.

Daar doem nou egter allerweë probleme op wat op 'n onmiskenbare manier daarop dui dat die groot uitdaging vir ons toekoms die uitdaging van beplanning is. As gevolg van die ontwikkeling waarna ons so pas verwys het, en ook, natuurlik, as gevolg van sosiologiese en biologiese tendense, het ons nou te staan gekom voor die probleem van die bevolkingsontploffing. In 'n land soos Indië, bv., waar die bevolkingsaantal nou die 500-miljoen merk bereik het, is die *maandelikse* bevolkingsaanwas een

miljoen. Teen hierdie spoed sal dié land sy bevolking teen die einde van die eeu verdubbel tot 1,000-miljoen. Soortgelyke tendense (net meer onberekenbaar) geld ten opsigte van China en ook ten opsigte van die Afrika-lande en die kontinente van Noord- en Suid-Amerika om maar 'n paar gebiede uit te kies. Tensy radikale bevolkingsbeplanningsprojekte spoedig toegepas word, loop almal dus gevaar om binne afsienbare tyd aan die dreigende vertraptsiekte om te kom.

Saam met die probleem van onbeheerde bevolkingsaanwas hang daar natuurlik die probleem van voedselvoorsiening. Beplanning op die gebied van voedselvoorsiening dui nie net op beplanning ten opsigte van produksie en verspreiding nie, maar ook, soos ons in die inleidingsartikel hieronder aantoon, op doelgerigte metodes van sosiale en sielkundige benaderings tot die probleem. Want slegs op hierdie manier kan 'n vernietigende siekte, soos kwashiorkor, byvoorbeeld, die hoof gebied word.

Ons het reeds al op verskillende vorige geleenthede in hierdie kolomme geskryf oor die probleme van die toenemende aantal bejaardes in die gemeenskap en oor die groter-wordende bedreiging van die padongelukiepidemie. Altwee hierdie probleemgebiede is by uitstek gebiede wat slegs suksesvol benader kan word op die grondslag van oordeelkundige en verbeeldingryke beplanning.

In die voorgaande paragrafe het ons maar net na 'n paar probleemgebiede verwys wat goeie voorbeelde is van die eintlike punt wat ons wil beklemtoon—naamlik dat ons toekomsheil in baie groter mate as in die verlede afhanklik is van doelgerigte beplanning. Só gesien, kan ons dan ook verstaan waarom die rigting van vooruitgang in die medisyne loop van versorgende toesig af, deur genesende medisyne, voorkomende en omvattende medisyne tot bevorderende medisyne—wat alle aspekte van die kliniese en gesinsgeneeskunde omsluit.

PROTEIN MALNUTRITION—A WASTAGE OF LIFE

The World Health Organization has been concerned since 1948 with the over-all problem of malnutrition, particularly in developing countries. South Africa may be considered by many to be a *developed* country, with a high standard of living. However, the majority of its non-White population can hardly be considered to belong to the well-fed and well-paid stratum occupied by their White counterparts. The problem of malnutrition among them is rife, and attempts at diminishing the wastage of life that results from the non-intake of basic dietary essentials has been, is, and will be one of the priority factors in the prevention of this illness and the promotion of healthily nourished children.

Protein malnutrition in infants during weaning and in the post-weaning period is one of the commonest and most widespread nutritional disorders in the 'developing countries'. This syndrome was first described in Europe in 1906 by Czerny and Keller, who gave the name *Mehlnährschaden* to the condition that they found in infants fed for too long on starchy gruels. Many reports describ-

ing the syndrome in different parts of the world since 1933 had come to hand, and it was reported at this time from West Africa by Cecily Williams. These reports have been well summarized by Trowell, Davies and Dean.¹

The first report of the Joint FAO/WHO Expert Committee on Nutrition recommended that WHO conduct an enquiry into the various features of kwashiorkor, and Professor Brock of Cape Town was requested to carry out a survey in Africa. The report of the findings was published in 1952 and has become a standard work.² Despite the efforts of WHO, little attention has been devoted to determining the *prevalence* of protein malnutrition, with the result that knowledge of it is still meagre. The South African Government made it a notifiable disease in September 1962. Information on prevalence, according to the World Health Organization, is available for only 13 countries, whereas the condition has been reported to occur in almost every developing country in the tropics and subtropics. These reported prevalence figures refer only to clinically manifest protein malnutrition, whereas

mild to moderate deficiency is known to exist in a much larger proportion of the child population in the 1-5 year age-group.

A great deal is known about the aetiology of this condition as well as about its treatment. The deficiency is usually initiated by inadequate and unsatisfactory supplementary feeding, and by lack of protein of high biological value and of calories playing an equally important role. The resulting syndrome, which includes kwashiorkor and marasmus and intermediate stages, is designated by the term 'protein-calorie deficiency' disease.

The growth pattern of infants among the low socio-economic groups in the developing countries is satisfactory while breast feeding is taking place. The first sign of growth failure appears around 6 months and coincides with the use of supplementary feeds to augment the diminishing quantities of breast milk the mother is able to supply. The nature of the supplementary foods varies and is often deficient in both quantity and calories. Unhygienic feeding practices and poor states of environmental sanitation complicate the picture as does infection, usually gastro-intestinal or respiratory. These in turn increase the protein loss and diminish the appetite. Food intake is often drastically curtailed during both the acute and convalescent phases. Infection alone could not precipitate kwashiorkor if the child was already well nourished.

It is not our intention to reiterate here what every paediatrician knows about this illness, regarding both its causation and treatment, since work on most aspects of this subject, particularly in this country, has been profuse. The important factor to be considered is the prevention of a killer disease that is preventable.

Supplementary feeding programmes are of benefit but

often not utilized by mothers who claim that the dried skimmed milk is the cause of the persistence of the diarrhoea (and this may often be the case if insufficient quantities are utilized or the powder is prepared wrongly or unhygienically). In the course of supplementary feeding programmes special efforts *must* be made (not *should* be) to educate mothers attending welfare centres with their children or at hospital, if this is the stage already reached, about the appropriate use of the supplementary protein-rich and other nutritious foods available, and to change those feeding patterns detrimental to the child's nutritional welfare.

Do we make the fullest use of preventive programmes that could be offered by our health services? The answer is 'no'. To be practicable, preventive action combining the various activities mentioned should be adapted to the socio-economic background, personnel resources and material and dietary practices of the community. Health personnel should be trained in educative techniques and, as mentioned before,³ 'throwing in the sponge' on the grounds of ignorance and ineducability of the community we serve, points the finger of failure at our own inability to cope with what are immense but not insuperable problems. Although this advice 'do not fill empty bellies with children' concerns itself with certain aspects of birth control; once the infant is born, it is our responsibility to see that it does not succumb to *preventable illness*. What is the point of procreation, the full gestational period, birth and 6 months of thriving before a *preventable disease* adds its toll to the infant mortality rate?

1. Trowell, H. C., Davies, J. N. P. and Dean, R. F. A. (1954): *Kwashiorkor*. London: Edward Arnold.
2. Brock, J. F. and Autret, M. (1952): *Kwashiorkor in Africa*. World Health Organization Monograph Series, No. 87. Geneva: WHO.
3. Editorial (1966): *S. Afr. Med. J.*, 40, 157.

Abstract

A COOPERATIVE VENTURE IN PSYCHIATRIC CARE

General practitioners see all types of patients in their busy practices and a large proportion of these are children, which they can often handle without the advice of paediatricians except in special cases. A sufficiently large proportion of their practice load are patients requiring psychiatric care but not necessarily the care of psychiatrists. 'The London Letter' which is published below is an interesting and apparently fruitful cooperative venture between psychiatrists and their colleagues in general practice.

The two experiments in Saskatchewan in which general practitioners, supported closely by psychiatrists, have been treating their own psychiatric patients in general hospitals and in the community may not be as well known in Canada as they deserve to be. It may therefore be worth while recording that the Maudsley bequest lecture at the University of Edinburgh was delivered this year by Dr. D. G. McKerracher, and that in it he demonstrated the hypothesis that by providing the GP with support, the specialist could help him to cope more easily and effectively with the psychiatric problems in his practice.

The two projects concerned an "urban" and a "rural" community, respectively. In the urban project, general practitioners in Saskatoon have been treating their own patients in an open 40-bed psychiatric ward, which admits all types of patients and has only had to transfer a negligible number of the latter because they were too violent for care in the general hospital setting. This

arrangement has brought benefits to the teaching program and even greater benefits to the general practitioner and his patients who preferred being looked after in hospital by their family doctor. Contrary to expectations, a large number of GPs were willing to participate in this program, and McKerracher thinks that all general hospitals should allow and encourage GPs to follow this example.

The second experiment is in progress in a rural community, Central Butte, where the three GPs with a 30-bed general hospital asked Professor McKerracher and his Department of Psychiatry at the University to help them set up a program in which they could treat all their psychiatric patients in their own community. During the first 12 months of this project, family doctors have needed to telephone a psychiatrist for advice on a case on 25 occasions, mainly during the first three months. They are able, of course, to send the patients to the psychiatrist for emergency consultation, but during the period described, this has happened on only three occasions. The psychiatrist visits Central Butte once a fortnight, primarily to compare notes with the staff. The general practitioners like the program, as do the psychiatrists. Nursing staff and patients are both enthusiastic. Time will show whether treatment and management of confused, depressed, anxious and deluded patients at home or in a rural hospital can be satisfactory, but the early results are encouraging.

1. Gilder, S. S. B. (1966): *Canad. Med. Assoc. J.*, 94, 155.