instances the effect of the new system will be to concentrate interns in the cities, and utilise the more peripheral hospitals for CS. Some of the provinces, however, have taken up the challenge to re-look at the staff establishments of their more peripheral hospitals and to strengthen their supervisory support for interns. In those institutions that will not be able to offer all 6 rotations, the substitutions of CS doctors will be the solution in that they will be better prepared after 2 years of supervised practice in all domains.

The year 2008 presents particular challenges, with a maximum of only 356 potential CS applicants countrywide, less than one-third of the usual number. This figure is likely to be even less owing to failure and dropouts along the way. Since CS was introduced in 1999, most public service hospitals have become very dependent on CS to provide a constant source of medical staff. This has been a largely positive experience for all concerned, and the temporary withdrawal of these young doctors could be disastrous for the health services, particularly in the 'difficult-to-staff' institutions in rural and under-served areas.

However, every threat is also an opportunity. All stakeholders involved in the change process need to put differences aside, tackle the challenge and show that good planning, transparent negotiations and commitment to a common goal can succeed. The common goal in this instance is the production of young doctors who can meet the challenges of the health needs of the entire South African community.

The HPCSA will ensure that only institutions adhering to the standards and regulations with regard to internship training will be accredited. This remains a continuous process and is not a once-off occurrence.

As employer, the Department of Health must help identify the most suitable institutions within their human resource plan that will offer sustainable supervision and quality of care as required for internship training.

Interns must realise that internship is an apprenticeship and that they also have a responsibility towards their employer, their patients and themselves to develop into responsible professionals who will honour our profession and its values.

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Changes in reimbursement for anaesthetic valid from January 2005

To the Editor: Having recently returned from a holiday I was extremely dismayed to read in the 11 February issue of *Medigram* that from 1 January general practitioners may charge the same as specialist anaesthesiologists for the first hour of an anaesthetic.

Such authorisation indicates nothing less than an appallingly ill-considered decision, definitely not in the best interests of patients. Any action by any properly caring medical practitioner should always be directed towards the best interests of his/her patient, and consequently whenever anaesthesia is required the most skilful practitioners available at that time should not be precluded form rendering the necessary service by this recent senseless decision. Some surgeons will inevitably feel constrained to accede to the demands of certain general practitioner anaesthetists, especially those who are the source of referral to the surgeon.

The 60-minute time limitation is utterly ridiculous because although stable tranquillity is the usual objective in anaesthesia and numerous general practitioners have experience in the achievement of such a state, life-threatening crises may suddenly occur at almost any stage during surgery, and when these serious problems do arise surely the more extensive experience of a specialist anaesthesiologist may be clearly decisive in affecting a favourable outcome.

Furthermore, bearing in mind the steady increase in population in our country, we should ensure that no regulation exists with the potential to discourage specialisation in any discipline. This will be an inevitability if this new change in reimbursement is not revoked. Specialist numbers in every discipline, and I include the discipline of general practice, should be allowed to grow *pari passu* with the population.

The subject of equal payment for anaesthetics was raised and discussed more than once during my many years of service on both the Federal Council of the Medical Association of South Africa (as it was then known) and the National Executive Council of the South African Society of Anaesthesiologists. Fortunately, sanity prevailed at that time. One is now left wondering which specialty general practitioners will next have in their sights.

What also seriously bothers me is that this recent alteration in fee structure for anaesthetics is also obviously motivated for the wrong reason of financial gain, with no thought for patient safety, which is indisputably the most vital of all considerations.

The sooner this decision is revoked the better for the specialist anaesthesiologist, those contemplating specialising in

anaesthesia, and particulary our patients, who will always require safety above all else.

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Failing primary care

To the Editor: In the past years the Western Cape undoubtedly offered its indigent citizens the best medical care in the country, albeit patchily. Superb nurses, medical officers and district surgeons formed the backbone of a system conducted mostly in hospital outpatient departments.

The teaching hospitals played a critical role and provided outpatient facilities, satellite units and ongoing training for all staff throughout the province. These powerhouses were eventually overwhelmed by the number of patients seeking the best possible care.

Some form of decentralisation was needed. But a workable system has been ditched for a nebulous primary care concept, based on political dreams and hope, certainly not on experience. Apparently a patient's first contact will be at an outlying unit staffed entirely by nurses. What nurses? Fewer nurses are being trained and their exodus from nursing cannot be stemmed.

Patients who attended the teaching hospitals were never turned away. Can this be guaranteed at understaffed primary clinics, and who will ensure quality control?

The concept of primary health care may be applicable to some provinces. It is doomed in the Western Cape unless the teaching hospitals are reincorporated into the system and accept ultimate responsibility for what goes on at the periphery. They have set a superb functional and longstanding precedent – the Peninsula Maternity and Neonatal Services – that incorporates primary, secondary and tertiary care and ensures quality control throughout. Surely this model can be applied to all aspects of health care that should be centred within the teaching hospitals. These fine-tuned throughbreds are now no more than castrated nags, and the consequences are sorely felt!

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