



opportunity to access these powerful resources, which enable the concentration of clinical, molecular, and computer approaches, should be seized in order to obtain a deeper understanding of the various genetic diseases that collectively afflict so many South Africans.

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## SAMA and sexuality – breaking the silence

**To the Editor:** Jon Larsen's letter entitled 'Doctors and sexuality'<sup>1</sup> is commendable for its clear, forthright approach. It adds an important dimension to the politically correct view offered by the SAMJ's Deputy Editor on the subject.<sup>2</sup>

Yes, SAMA is silent on these issues, but it should speak out against all practices that affect the mental, physical, emotional and spiritual health of the population. Jon Larsen's comments are particularly pertinent. It is indeed amazing that despite every major religion denouncing premarital and extramarital sex, the medical profession remains silent on the issue. To be practical these goals may not be attainable for the majority in our present culture, but do we give up promoting abstinence before marriage and faithfulness within it? Do we simply cut our losses and promote safe sex for all irrespective of any moral considerations, even those that may impact on health?

We are inextricably linked to our consciences and if our sexual practices do not fall in line with the fundamental teachings of our churches, mosques and synagogues then surely internal tension and in some cases even turmoil may result. That this must impact on individual health is logical. We therefore have the choice of either trying to modify our consciences to stay in line with society's changes, or attempting to halt that change by speaking out against the practices we believe will affect us and our patients at some level at some point in time. The morality of modern day society moves continuously in small increments in the direction it pleases, but never without consequences. Individually and collectively the medical profession has the choice to stand firm or follow. If we choose the latter then what we believe to be unacceptable today we may find acceptable tomorrow, and our practice of medicine will become progressively more devoid of absolutes. (It is worth recalling that in this country the legal abortion of healthy babies on request was once regarded as morally beyond consideration).

In the past medical practitioners were viewed as more than physical healers. We were held in high esteem for our professionalism, our ethics and our adherence to high moral standards highlighted by our Hippocratic oath.

Our silence on these aspects of sexuality may be interpreted by many as condoning the practices outlined by Jon Larsen while showing no regard for the health consequences of such behaviour. It is quite likely that this will lead to our further diminishment in the eyes of those we care for.

Yes, SAMA should not be silent, but perhaps it is time to stop and think about how to break that silence. If we only adhere to what seems politically correct then the medical profession, which has the ability to set a precedent, may lose the opportunity to take the lead on those moral issues that impact on the physical, mental, emotional and spiritual health of our people.

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## Legal, but is it right?

**To the Editor:** Specialists in private practice have the legal right to charge whatever fees they wish, but sometimes they leave behind frustrated people.

A 59-year-old widow developed a breast lump. The surgeon told her that she would need 'an operation and a reconstruction' and that 'medical aid will take care of the payment'.

Medical aid paid the hospital fees. The surgeon's fees were three times higher than the medical rate. The medical aid refused to pay the reconstructive surgeon, demanding an adequate motivation as to why she needed reconstruction. The widow had no extra finances. A relative paid R4 000 to the primary surgeon over the medical aid rate and R8 000 to the second surgeon.

When the patient tried to obtain a motivation for the reconstructive surgery to send to the medical aid, the primary surgeon's practice refused to provide one. 'This is a super-specialist practice and not a discount supermarket. The patient was fully informed about our fee structure,' she was told. This was not true! She was also told that 'the reconstructive surgeon must write the motivation'.

The old medico-legal adage applies. If it was not written down, it was not done.



Surely informed consent in private sector medicine includes telling the patient how much money they are going to have to pay over and above the amount that their medical aid will contribute? There may not be a legal obligation in this regard, but doctors treat people, not isolated organs attached to unlimited bank accounts.

It eventually took 4 months before medical aid refunded 75% of the payment for the second surgeon.

By the end of her chemotherapy this 59-year-old widow had no sensation in her hands and feet, a situation that persisted for months after the end of chemotherapy. Towards the end of her chemotherapy she was informed that because she had had a reconstruction operation it was more important that she have radiology than it would otherwise have been. Surely this is information that she should have been given before signing consent for a reconstruction operation?

Unable to feel the floor or the pedals under her feet, unable to feel her steering wheel, somehow this woman, who lives alone, succeeded in driving 60 km a day for 4 weeks for daily radiotherapy. At the end of radiotherapy her reconstruction was angry, red, painful and extremely tender.

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## African traditional healers

**To the Editor:** Meissner writes of African traditional healers that 'their calling comes from God or the ancestors . . . [they] regard dreams and revelations as the source of their knowledge . . . traditional healing is part of African culture and essential for the health and well-being of a great part of the black population. The healer understands the significance of ancestral spirits, he shares the belief in supernatural forces, and he identifies with the reality of witches.'

In biblical times the ancient Israelites shared such a world view but they featured emphatic rationalists as well: forbidden is a 'soothsayer, or diviner or sorcerer . . . or traffic with ghosts or spirits' (Deuteronomy 18:10, 11); 'men will say to you "seek guidance of ghosts and familiar spirits . . . but what they say is futile"' (Isaiah 8:19, 20); 'do not listen to your prophets, your diviners, your wise women, your soothsayers and your sorcerers' (Jeremiah 27:9); and 'diviners see false signs, they tell lying dreams, and talk raving nonsense' (Zechariah 10:2, *New English Bible*). See also Exodus 22:18 where the word 'witch' may also be interpreted as poisoner; Leviticus 19:26, 31 and 20:6, 27; 2 Chronicles 33:6; Isaiah 47:12, 13, 15; Ezekiel 13:23; and Micah 5:12.

Now while such pronouncements are to be seen in a cultural and political ambience, they do illustrate the fact that such

rational views could have extended into medical practice. I do appreciate something of the force of the traditional African attitude to sickness, and four times in over 40 years of practice I have successfully exorcised the fabled *tokoloshe* from the habitations of domestic workers.

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## The plague of socialism

**To the Editor:** Trying to make ends meet, I spent about 2 years in the UK, earning more in a month than in a year here. Yet after experiencing first hand the workings of the National Health Service my conscience drove me to write an article that duly appeared in the *British Journal of General Practice*. The following excerpt explains it all:

Observations:

1. South Africa. Poor 'Third-World' country. 45 million people, about 30 000 doctors (1/1 500).
2. The UK. Prosperous 'First-World' economy. 60 million people, more than 140 000 doctors (1/400).
3. South Africa's *surplus* doctors are desperately needed to relieve the critical *shortage* of doctors in the UK.

As one of these doctors, I have experienced first hand the delivery of health care in both systems. I would fly back to South Africa should I be taken ill in the UK.

Now back in this country, I stand by this assessment. But don't get excited too soon: apparently the 'powers that be' are intent on taking South Africa along the same route as the NHS.

An example: When I left my practice in South Africa, I had been dispensing medicine to my patients for almost 20 years. This saved them costs, time and travel. They received their treatment timeously, which prevented complications. The system was working well and to the advantage of all concerned. By the time I returned, someone had decided that we now need to spend a few thousand rands a year on being 'taught' how to dispense medicine, then thousands more on a licence to do so. This money will eventually have to come from the patient, either directly or indirectly. And what for? I quote verbatim extracts from the academic material from the 'course' I had to study (my comments in square brackets):

- 'The involuntary nerves . . . automatically takes your hand away when you burn your finger'
- '. . . the red blood cells . . . transport glucose through the body . . .'