



determination; cortical bone density can be measured in the femoral neck.

Concerning the specific modalities, their view is that dual energy X-ray absorptiometry (DEXA) sets the standard, has a low error rate, can be applied to multiple sites and requires a low radiation dose. This dose ranges from 5% up to that of a full chest radiograph. Frontal lumbar spine DEXA remains the reference technique, followed by hip DEXA.

To what extent do promotional issues cloud this debate? — Editor

Legal termination of pregnancy

To the Editor: The September 2002 issue of the *Journal* includes a valuable analysis of legal termination of pregnancy among teenagers and older women in Soweto.¹ The methods used were not indicated, but in all likelihood these were surgical.

I note that in the same issue of the *Journal* (pp. 670 - 671) there is an advertisement for the use of mifepristone and misoprostol in early pregnancy, now legalised for use in South Africa. It has been shown that some applicants for termination of pregnancy prefer this method. Are there any controlled trials being done in South Africa, looking at the practicality of the various methods and client choice? In addition, this challenging work takes its toll on staff, who may appreciate non-surgical methods.

Eleanor S Nash

Newlands
Cape Town

1. Buchmann EJ, Msimah K, Pflay F. Legal termination of pregnancy among teenagers and older women in Soweto. *S Afr Med J* 2002; 96: 729-731.

The area needs certificate

To the Editor: It was with a profound sense of foreboding and impending doom that I read the article titled 'Ignore incoming needs laws at your peril' by Chris Bateman in the August *SAMJ*.¹

This sinister legislation as it is proposed will lead to the collapse of private practice in South Africa, the nationalisation and theft of the medical profession's intellectual and physical property, the infringement of our fundamental constitutional right as South African citizens to work and derive an income in a location of our own choosing, and an absolute stranglehold on the entire medical profession as a whole. Eventually instead of solving the maldistribution problem it will worsen it, as it

will surely lead to an even greater exodus of skilled medical personnel to other countries.

Once doctors are licensed to geographical areas no doctor will be able to move without the permission of some governmental licensing board or bureaucrat; i.e. a doctor in private practice will not be able to move to a new town of his choice and a state doctor will not be allowed to move into private practice in an area of his choice. Doctors will be locked into a system where their every move will be monitored and necessitate prior approval from the governing boards in the various provinces.

To date no one has spelt out to the doctors the exact nature of these faceless licensing boards. Who will choose them, who will control them, what will be the qualifications of the board members, will there be any doctors on the board, and if so, will they come from any particular group? The very fact that we have not been informed about these questions makes one suspicious of these licensing boards.

The potential for corruption will be enormous, with doctors vying for the best positions and with bureaucrats accepting perverse incentives to place people where they wish to be.

The bureaucratic delays in deciding who goes where will be horrific, with political considerations and ethnicity playing their roles in helping to bog down the whole process.

What recourse to the law will unhappy doctors have if these measures are instituted? This should be spelt out to us before it becomes law.

These boards will be able to blackmail doctors into working where they don't wish to. For instance a busy private practitioner could be coerced into doing casualty night calls in the local government hospital if threatened with the withdrawal of his licence to private practice. It will be used as a weapon, with devastating effectiveness!

Radiologists and pathologists will not be able to acquire new and updated equipment without prior governmental approval. This will remove the incentive to improve their techniques and specialised services, thus dooming these specialties to third-rate mediocrity. No doctor in his right mind is going to invest huge amounts of money in a practice which may be taken away from him at the whim of some unknown board.

State doctors, should they become unhappy with their poor salaries, equipment, safety and working conditions, will have nowhere to go. They will be locked into government hospitals because there will be no place, of their choice, for them in the government-controlled private sector!

Allied medical services and private hospitals will also be affected and sooner or later they too will be hijacked, governed and controlled by nameless faceless licensing boards.

People say that this licensing is the norm in the USA, Canada, Australia, etc. However we are a very different



country with a very different set of circumstances. We are a developing country with a government which still has not come to terms with the fact that HIV is the cause of AIDS and which still proposes to spend R65 billion on armaments instead of spending it on agriculture, education, housing, schooling and stopping the AIDS holocaust.

The way forward medically in this country is not through threats and licensing but through government-sponsored incentive schemes where the medical profession is welcomed on board, treated with openness, transparency and honesty, and where our wealth of knowledge, expertise and vast good will (which is still out there) is harnessed and utilised in a sane and sensible manner.

Doctors and medical personnel of all types and backgrounds will respond positively to an incentive-driven system, but they will not respond positively to draconian threats of jail sentences of 5 years, fines of R100 000 and auditing of their practice assets.

The reason for the very poor response to the survey is that very few doctors up to that time were aware of the proposed legislation and its implications for the profession. The blame for this lies squarely at the door of SAMA since at that time they were occupied with infighting and were not disseminating information timeously as they should have been.

As this article says, we ignore the incoming Needs Law at our peril for it will be an unmitigated disaster for our profession and the people of our beloved country, leading to an ever-greater exodus of medical skills.

D W Paterson

8 Chumier Road
Kimberley
8301

1. Babinian C. Ignore incoming needs laws at your peril (Continued). *J Afr Med* (2002); 92: 574-575.

An African safari

To the Editor: In his article entitled 'An African safari in health technology — from Cape Town to Nairobi in 10 days',¹ Professor Kachieng'a recounts that Professor Power was one of only a few 'white' doctors to work in the so-called homelands.

Just a few facts on this point with reference to the homelands in the previous Northern Province, now called Limpopo:

In 1955 there were already 9 hospitals functioning in that area. From 1955 to 1975 an additional 10 hospitals were added to this. Thus 19 hospitals were operating in the homelands in the previous Northern Province.

According to my knowledge all were staffed by so-called 'white' doctors, although I stand to be corrected. Another

interesting fact is that as far as I know all worked voluntarily without legislation or community service.

So, Professor Power, there were not a few but quite a lot of 'white doctors' in the so-called homelands.

With this letter I pay homage to all doctors who worked in the homelands without a pension fund or overtime remuneration. What about today?

J H Muller

PO Box 133
Lerab
0929

1. Kachieng'a MC. An African safari in health technology — from Cape Town to Nairobi in 10 days (Continued). *J Afr Med* (2002); 92: 544-545.

Nuclear medicine in South Africa

To the Editor: Nuclear medicine as a specialty is over 50 years old, with its origins in the management and treatment of thyroid disorders using I-131. In contrast to the other radiation specialties of radiology and radiation oncology, nuclear medicine involves the use of unsealed sources of radioactivity that are injected, ingested or inhaled by the patient. Although overlap can occur between these specialties, their roles are complementary due to the different nature of the information obtained. Nuclear medicine focuses on functional changes within organ systems based on processes at the microscopic and molecular level. It plays diagnostic and therapeutic roles in most other medical specialties including oncology, orthopaedic surgery, psychiatry and many subspecialties of internal medicine. Established roles are in the management of hyperthyroidism and thyroid nodules, and there are many indications for its use in bone scintigraphy, lung scintigraphy as a non-invasive technique for detecting pulmonary emboli, renal scintigraphy for renovascular dysfunction, cortical scarring and renal outflow obstruction, and myocardial perfusion imaging. Newer applications include sentinel node detection, functional brain imaging and tumour therapies. The large variety of new radiopharmaceuticals that are being developed has resulted in an increasing number of investigations, revealing new pathophysiological information.

Nuclear medicine is undergoing significant expansion in the use of positron emission tomography (PET) scanning. Also expanding is the use of unsealed sources for targeted radiotherapy of an increasing number of tumours. Its contribution to oncology is indicated by the three F's: Find, Fight and Follow-up. 'Find' refers to early diagnosis using a diagnostic radiopharmaceutical to track down diseased cells at a molecular level. 'Fight' refers to a targeted attack by a