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.

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1. Bateman C. Ignore incoming needs laws at your peril (Editorial). *S Afr Med J* 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?

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1. Kachieng'a MO. An African safari in health technology — from Cape Town to Nairobi in 10 days (Forum). *S Afr Med J* 2002; **92**: 344-345.

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

therapeutic radiopharmaceutical, which destroys diseased tissues. 'Follow-up' is to monitor the success of treatment using the same diagnostic radiopharmaceutical employed in the original diagnosis of the disease.

Nuclear medicine is under-utilised in South Africa. Since a significant cause of this is limited undergraduate teaching, it is important that with revision of curricula at medical schools, the role of nuclear medicine should be emphasised and it should not be regarded purely as a postgraduate subject. Applied appropriately and cost-effectively is has an important role to play in patient management, but with the constraints placed on South Africa as a developing country, we are in danger of falling irrevocably behind rapid developments in the field. Therefore it is vital that nuclear medicine in South Africa continues to reflect these exciting international trends. We invite colleagues to visit the website of the South African Society of Nuclear Medicine at *www.sasnm.de.vu* for more information.

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Ethical standards

To the Editor: Discussions with various colleagues (GPs and specialists, including pathologists) show that a great deal is lacking in the behaviour towards, and relationships between, colleagues. It wasn't so in days gone by and the present state of affairs must be corrected.

Pathologists complain that the request forms they receive often omit essential information, e.g. age, sex of patient and suspected diagnosis, and that there is altogether a complete lack of clinical information. An example would be a request for a thyroid profile, without telling the pathologist that the patient is on Eltroxin. How can s/he be expected to interpret results under those circumstances?

This reflects the lack of concern specialists speak of. They seldom receive a letter of referral when a GP refers someone. They need to know why there is a referral, what relevant history has been elicited and what investigations and X-rays have been done. Above all, they need to receive either the results or copies of the results and reports to avoid duplication.

GPs say that if they refer a patient they rarely receive a report back and often never see the patient again as the specialist tells the patient to return in 3 months or so for another EEG or whatever. Alternatively, what often happens is that the specialist refers the patient to one or more other disciplines and the GP — the so-called gatekeeper — is not even informed of this, either by the original specialist, or by his colleagues who see the patient. Personally, I can recall sending a patient to a neurosurgeon who referred the patient to four other specialists. I found all this out from the patient much later.

The 'good old days' of specialised doctors being 'consultants' also disappeared years ago. Was it the advent of the Medical Schemes Act of 1967, or the fact that the Medical Council (now the Health Professions Council) issued an edict stating that it was the right of patients to see any doctor of their choice? Consequently, despite the medical aid injunction that all cases going to specialists must be on a GP's referral, patients in the urban environment all have their own gynae, paediatrician, ENT specialist, etc.

Let's get back to good conduct between colleagues, which at least will show respect for what the other person is doing.

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The Employment Equity Act — putting the record straight

To the Editor: The authors of the 'Personal View' entitled 'HIV testing and the Employment Equity Act — putting an end to the confusion'[1] have been tardy in responding to my first article on the topic,[2] and their information is misleading. It unkindly tries to position my letter published in 2000 as being 'against the EEA and its extremely powerful tools for equity, redress and social justice'.[1]

It was very clear (and this is re-emphasised) that the critique was focused and limited to Section 7(2) of the EEA, which was the only section about which the tripartite stakeholders in Nedlac were not consulted.[2] Furthermore, the attempt by the authors to single out the undersigned as the only party ever to have questioned the legal meaning of Section 7(2) is dishonest (or else a case of denial), as at least one if not all of the authors have been central to the debate and participated in surrounding actions to try to rectify the situation and the interpretation (including senior counsel legal opinion) of that section.

My original piece on the EEA[2] aimed at creating debate to end the confusion, or at least result in constructive efforts to correct it. The fact that it was published as a 'Personal View' was an editorial choice and unfortunate, reflecting the sensitivity of the issue and the reluctance to discuss or even confront it constructively at the time. The very late response from London *et al.*[1] may unfortunately revive the issue rather than put it to bed, as I believe the confusion surrounding section 7(2) of the EEA has been replaced with lenience and