Internship and more

The debate about the possible lengthening of the period of internship preceded the present medical students and many medical deans. That there is confusion and anger is therefore understandable. Compounding the problem is that it has been conflated with several other issues, including allowing medical schools the choice of shortening of the medical course from 6 to 5 years; the notion of a year of vocational training following internship, to improve clinical skills before being permitted to enter independent practice; and the introduction by the State of a mandatory year of community service.

Community service after graduating is a fact of life in many countries. Community service under the former government was military service, but was confined to white men. The then Medical Association and several medical schools supported community service for all. Now we have it, and the verdict is generally favourable. With community service in, out went thoughts of vocational training, because of considerations of time before practitioners could enter independent practice. Meintjes (p. 336) provides a summary of the events leading up to acceptance of the 2-year internship training, which is to commence from 1 July 2003.

Continuing concerns about the increasing intake of poorly prepared matriculants, deteriorating teaching capacity as a result of leaching of teaching posts to primary care initiatives, and the poor facilities and supervision at many existing internship sites question the wisdom of continuing with the 5-year curriculum.

Most debilitating has been the uncertainty about the internship. Since this has now been resolved we owe it to our students and our patients to give it our best shot to make it work well.

Wet beds

Nocturnal enuresis is a distressing condition, which can leave deep emotional scars on children. Families too are embarrassed and may suffer shame and rejection. Practical problems such as the increased demands of washing can result in an intolerable additional burden for the poor.

Because of the social stigma of the condition and because it is often poorly understood by health care professionals, a multi-disciplinary Enuresis Academy of South Africa was established and has provided South African guidelines for the management of nocturnal enuresis (p. 338).

The Academy notes that for children younger than 6 years, parents should be educated and reassured and the child assessed at a later stage.

A conceptual model is described to enable a better understanding of nocturnal enuresis. Bladder instability and lack of vasopressin release may have distinctive signs. Lack of arousal from sleep can also present a problem. Using this model helps the treating doctor to decide on the appropriate treatment. The various treatments are discussed, but enuresis alarm therapy remains the most effective.

Human nature and cross-cultural depression

Two very different contributions illuminate our understanding of ourselves. Gevers (p. 354) contrasts the elation of scientists on the deciphering of the human genome, with the lack of interest displayed by social scientists. Despite our individual differences including our voices, fingerprints, faces and colour, our genomic books of life are 99.9% the same. The human genome therefore debunks racism or similar 'unscientific horrors'. Gevers does not diminish the role of the social scientist scholars, who are the people who study and penetrate the great world of the many different aspects of human capacity. But they should not ignore the fact that the rules for the game of human life have an important biological dimension.

Given that we are genomically so similar, how do we interpret and understand major cultural differences? Ellis (p. 342) explores cross-cultural aspects of depression, which as classified in the West was thought to be rare among black Africans from traditional cultures. Not so!

The patient works within the experience of his or her social and cultural life, whereas the doctor works within the criteria laid down by the *Diagnostic and Statistical Manual-IV* (*DSM-IV*) and has a list of symptoms that have to be fulfilled before the diagnosis can be made. Ellis takes us on a fascinating journey of language, including problems of translation and social and cultural construction.

Accepting the validity to the patients of their attitudes to disease, their health practices and beliefs and knowing about the therapists, who are important in their lives, provides an understanding of the many forms in which our thoughts are presented.

Harmful hormonal history

Modern medical practice emphasises the importance of consumer satisfaction. Yet medical experience is strewn with the debris of misplaced beliefs and preferences of doctors and patients alike. In South Africa politicians, scientists and patients recently clamoured for virodene to treat HIV / AIDS, despite the fact that it was clearly a harmful toxic solvent with no possible health benefits.

Perhaps somewhat subtler was the use of diethylstilbestrol some 50 years ago with the aim of reducing a variety of adverse pregnany outcomes (Bamigboye *et al*., p. 346). Despite subsequent evidence that these beliefs were unfounded, doctors kept using the drug enthusiastically, until much later harmful effects were found in the offspring. The authors' cautionary tale reinforces two important lessons. The first is that objective evidence is required through double-blind, placebo-controlled trials. Secondly, structured, objective reviews should enable individual doctors to change practices on the best available evidence.

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