plastic surgery and radiotherapy, and finally, new systemic treatments (hormonal, chemotherapeutic and genetic) have contributed to many more lives, and breasts, saved.

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Ritalin — on the bandwagon?

To the Editor: The new Ritalin-LA (long acting) was launched at the beginning of this year at a roadshow throughout the country. As with many new drugs it became so popular that almost a month after the launch it was out of stock. Unfortunately since then I have seen some very worrying tendencies appear on the horizon. It seems that Ritalin is increasingly being prescribed without thorough assessment. One such example involves 4-year-old boy who was put on Ritalin-LA 30 mg after a complaint by a nursery school teacher that he could not sit still. Another involves a girl aged 12 years with sudden regression in school performance and behaviour, who was put on Ritalin-LA 20 mg, without any response. A full evaluation revealed that she had been sexually abused. Another worrying development is that more and more mothers are phoning to ask for advice after their child has been put on Ritalin and now has side-effects, with which the prescribing doctor does not know how to deal.

Ritalin is an excellent and wonderful drug for children who need it. However, it is my impression that the roadshow (unintentionally!) might have given the impression to doctors unfamiliar with the field of developmental paediatrics that the long-acting version is now a quick fix for concentration problems. The talk on attention deficit and the functioning of Ritalin was excellent, but it is important to realise that attention deficit disorder is only one block in the puzzle of developmental paediatrics and not the puzzle itself. It is therefore important to adopt a holistic approach in the case of the child presenting with concentration problems. This includes, over and above a full assessment of the main complaint, a thorough assessment of the child's emotional status, social abilities, learning problems, other co-morbid conditions that might co-exist, and extremely important, also educational and family psychodynamics. Only when all these factors are taken into account and fully assessed can a treatment protocol for each child be individualised and put into place. If we neglect our duty in this regard we are going back to the seventies when Ritalin was dished out right, left and centre — when stopped in those days at 12 years of age, many children still could not read, write or socialise, and still struggled with behaviour problems and low self-esteem.

There is also a tendency for children to get referred from occupational or speech therapists, or even in some instances from the teacher, with the instruction that the child be put on Ritalin — and the doctor faithfully obeys.

Professor Johan Prinsloo once said: 'The most important thing for a doctor is to know when he does not know.' I know that this is general knowledge, but it is still important for any medical professional to have a sound knowledge of the functioning and side-effects of any medication that s/he uses and to have a thorough knowledge and understanding of the condition being treated. It is in the interests of all children with developmental problems that they, their families and schools can rely on correct diagnosis and continuous support. Treating these children is not a quick prescription, it is a lifelong commitment.

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Weak knees

To the Editor: SAMA online (27 February) reports the South African Medical Association (SAMA)'s comments on the pressure from the Board of Health Care Funders (BHC) to force medical practitioners to contribute to the BHC practitioner register. SAMA states that discussions with the BHC have been unsatisfactory in many ways and SAMA said that it wished to verify and clarify some aspects further.

However, SAMA then goes on to say that it recommends that all medical practitioners concede to the request, because 'otherwise they may not get paid'.

This weak capitulation is not what is expected of SAMA. It seems that SAMA has no appreciation of its powerful authority. A directive from SAMA to all medical practitioners, recommending that payment should be withheld, would stop short the BHC pressure immediately and so allow all necessary clarification.

Once a concession is made to the BHC demands, the precedent will be set, and become irreversible. After this the BHC will cock a snook at any attempts at further 'verification and clarification'.

This additional cost burden, which is of doubtful value to the individual practitioner, will then become yet another legacy of weak ineptitude to be inherited by our successors.

Not unexpectedly the 'fee' has doubled since the first stab by the BHC. Bet that it will double again.

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Stretching the journey

To the Editor: A forty-six-year-old woman, mother of six children, was referred to me with a gynaecological problem. She was from an up-country town, approximately 5 hours' drive away. I met her sitting on the steps outside my rooms when I unlocked at 07h30 in the morning. She said she was only booked for an appointment at 12h00, but that the ambulance had dropped her off shortly before. She said that the ambulance driver had other business to attend to in town. We fitted in her consultation in the early part of the morning. During the consultation she told me that she had left home the previous afternoon at 15h00. She said the ambulance had also transported several other people, not all of them patients, and that the driver had decided they would sleep over at another country town approximately half way. They all 'booked in' at the local hospital, where they were 'allowed' to sleep on the floor in the corridor in the casualty department. They resumed their journey at 04h00 in the morning, the morning of her consultation. No 'dinner, bed or breakfast' was provided, or even morning coffee. The patient said that she preferred to 'use the bushes' at a mid-morning stop next to the road — because the toilet at the hospital where they slept was badly neglected and also because the door couldn't lock. It became clear that her husband was unemployed and she held a job as cleaner at the school hostel, and therefore had the benefit of a medical aid. She could therefore afford the luxury of using the ambulance service. She had no money on her as she had expected the said ambulance service to provide the basics. The patient had therefore been without food or beverage since the previous afternoon at 15h00. It was now 17 hours later. We were happy to provide some basic sustenance, which was greatly appreciated. She was picked up again at 13h00, after spending the whole morning watching the comings and goings in my waiting room.

This unlikely but true story is reported to remind medical colleagues, especially in the rural areas, what may happen to their patients when they are entrusted to the mercy of some ambulance services. I presume the patient's medical aid was expected to pay for her excursion to the specialist and back.

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