



Dispensing with doctors?

To the Editor: South Africans have been fortunate beyond belief in their access to doctors, widespread poverty notwithstanding. They are unaware of their good fortune, taking it for granted, but all good things must come to an end.

Other health care professionals cannot replace doctors at a lower cost. True, the work done by doctors can be divided up among several classes of professionals, but doing so increases the costs of care severalfold — the British and American experiences serve as proof of this.

The South African public does not think of a visit to a doctor as one for information or a diagnosis, but rather as one for treatment. This mistaken belief has meant that many attend doctors inappropriately, but it has also meant that the public has not paid for the true cost of care.

South Africans are about to discover that they cannot afford doctors, and their doctors are about to discover the same. Already highly sought after by developed economies, circumstances will force their flight, however regretfully. South Africa will find itself in the same situation as other sub-Saharan countries with regard to the numbers of doctors in relation to the population. The ratio will be woefully inadequate.

Less than 3% of any age cohort in this country is capable of studying medicine. This group must produce our accountants, lawyers, statisticians, actuaries and engineers, among others. It cannot do so completely, and of all the career options, medicine probably falls at the bottom of the scale. We already produce fewer doctors per year than we did in the past, and that number will only get smaller.

It now takes 22 years of study to produce a doctor in South Africa. Which intelligent person is going to make such a commitment in order to be paid as much as a secretary — and to have his or her place of work and residence decided on by the government? I thought the constitution outlawed slavery? And I thought that the USSR proved conclusively that a central command economy does not work? Even the Chinese acknowledge this.

The government is changing doctors' scope of practice while calling it something else. This can only end badly for all concerned if the government fails to listen to an important constituency, viz. doctors in South Africa. Pearl Harbour was not a bolt from the blue, nor was 9/11: in both cases those in authority failed to pay attention to the necessary information until it was too late.

Hegel may have been right that history teaches only that we learn nothing from the past.

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Ethics, litigation and teaching of anatomy

To the Editor: Curriculum time devoted to teaching human gross anatomy in medical and dental schools has diminished to accommodate new knowledge and other disciplines. System-based curricula have replaced classic anatomy teaching on a regional basis. 'Wet labs' have disappeared and the electronic media has taken the place of the anatomist.

Evidence-based studies show that models and computer programs are a poor substitute for hands-on dissection. Three-dimensional computing has failed to replace the need for anatomical dissection adequately. This mistake has been realised, and many older medical schools in Europe have returned to limited dissection and use of 'wet' specimens. Core knowledge of topographical anatomy has been reduced by as much as 30% and human cadaveric dissection has been abandoned. Anatomy and physiology are integrated into systems, leaving the student with a very thin base of basic sciences. Anatomy in most medical curricula is far less detailed than in the paramedical sciences such as physio- and occupational therapy. This means that medical students do and know far less anatomy than students in these allied courses. This has major drawbacks for the medical profession and raises ethical issues.

The result is that today's medical student, with a broad community-orientated training but a thin base in science and direct clinical experience, is not competent on graduation to assume patient care responsibilities without supervision.¹ Unprofessional conduct, medical errors, insufficient skills and poor communication are predictable outcomes of poor under- and postgraduate training. Superficial teaching in anatomy compromises a doctor's ability to provide patients with comprehensive knowledge regarding informed consent. Because of these hiatuses in training, full and transparent disclosure regarding intended interventions and anatomical consequences thereof may be impaired. This impinges on the patient's right to self-determination and raises several ethical dilemmas regarding modern curricula.

In order for a doctor to give an evidence-based disclosure, comprehensive medical education is imperative, including a solid training in anatomy. Doctors cannot make proper recommendations to patients if they have a faulty or superficial knowledge of anatomy.

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