



Drug-impaired doctors

The majority of 'impaired' doctors seen by the Health Committee of the Medical and Dental Professions Board had problems of substance abuse. This committee had developed a system designed to protect the public from doctors who were impaired. The process was also designed to assist doctors with temporary disabilities, including substance abuse, to become rehabilitated. Strict anonymity was respected to ensure the protection and co-operation of all concerned, and a moderate success rate was achieved.

Chris Bateman (p. 726) reports on a unique study of a group of substance-abusing doctors enrolled from rehabilitation centres around South Africa. The findings echo those from studies overseas. Chemical dependency appears to be the single most frequent disabling illness affecting the medical profession and poses a major problem for the profession and society. Part of the problem is the reluctance of colleagues to become involved, and the 'conspiracy of silence' was reinforced by a pervasive set of collegial attitudes towards the afflicted doctor.

Expert observers are reported as being concerned about a perceived loss of expertise, as the Medical and Dental Professions Board Committee was absorbed into the Health Professions Council earlier this year. Certainly with its closer medical relationships the former committee would have been more readily able to take action on such matters as placing vulnerable interns, as reported by their respective universities, in positions where they could be adequately supported and supervised.

Pethidine was found to be a particularly problematic agent, leading to the recommendation by the former Health Committee to the Medicines Control Council of limiting its use. A convincing case has yet to be made as to why it should not be banned entirely, since safer and more effective drugs are available.

Menopausal hormone therapy

The *SAMJ* has carried several reviews and letters to the Editor on the topic of menopausal hormone therapy (HT) after professional and lay press airing of the topic following the reports of large long-term studies. The South African Menopause Society provides a consensus statement (p. 760) that summarises their findings 'of evidence-based medicine'. But before providing their interpretation of the present knowledge regarding menopausal HT they give reasons why the strongest evidence available may be difficult in this instance, including:

- The results of a given clinical trial can only be applied to the specific population and circumstances as applicable to the study in question.
- The perception of the patient is always relevant. A weak association between HT and breast cancer may be more important to women and the lay press than a strong association between HT and thrombo-embolic disease.

- Cancer, metabolic diseases, vascular disorders and brain ageing are not only the concerns of women on HT, but are of universal concern to women past reproductive age.

The current knowledge regarding menopausal HT is summarised, including:

- Systemic HT improves vasomotor symptoms and/or associated sleep disorders of early menopause.
- Systemic and local HT is effective in the prevention and treatment of vulvar and vaginal atrophy.
- HT is effective in preventing bone loss associated with early menopause and in decreasing the incidence of vertebral and hip fractures.
- Oestrogen combined with progestogen is associated with a modest increase in risk of invasive breast cancer and reduces the risk of colorectal cancer.
- HT does not offer secondary protection against coronary heart disease or stroke and is not indicated for the prevention or treatment of Alzheimer's disease.
- The risk of venous thrombo-embolism is doubled with HT

The position statement also provides clinical guidelines. However, the recommendation 'that ideally all postmenopausal women should be encouraged to undergo yearly mammography' is contentious and cannot be applied in the public sector which serves the vast majority of the population.

Racial discrimination at UCT

UCT considers itself an enlightened university. But its history hides many shameful episodes of direct racial discrimination or of unthoughtful acts by staff or students that made the studies of black students (if and when they were admitted!) distinctly uncomfortable. Perez and London (p. 764) explore some of this history through the stories of two students who attended the medical school 45 years apart.

One of the consequences of South Africa's history of racial discrimination is the impact it had on the training of black medical students. Blacks, and particularly those classified as African under apartheid's classification, were restricted from entry to medical school by a permit system introduced in 1959 and only rescinded in 1986. Although whites constituted less than 20% of the population, 83% of all doctors and 94% of specialists in South Africa were white.

From the respondents' experiences three main themes emerged: (i) the importance of students' educational background (the inferior black education system put students at a significant disadvantage); (ii) the educational discrimination they suffered during their academic training at UCT; and (iii) the social exclusion they experienced at the hands of most other students and staff.

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