the tokoloshe (which is also now allegedly responsible for spreading HIV infection).[3]

It has often been argued that the search for answers to age-old conundrums cannot always be found in scientific study. Beliefs are just what they are and should be left alone. But this instance does beg the question: Could the tokoloshe be the experience of a stimulated indusium griseum? And do we here in Africa have a pre-programmed tokoloshe homunculus waiting to be activated in times of distress, dreamlike states or during a seizure? And lastly, but most challengingly, can a tokoloshe homunculus be imaged by fMRI during an episode?

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HRT prescriptions linked to 25% of breast cancers in California

To the Editor: I am a breast radiologist, running a multidisciplinary breast care centre together with two surgeons and a practitioner in oncology. We add about 90 - 100 new cancer cases to our files annually.

I am amazed to see how we doctors persist in our old ways of prescribing medicine and how reluctant we are to change, despite recent data. Our medical history is flawed with mistakes that sometimes took hundreds of years to correct (400 years to admit that vitamin C prevents scurvy, decades to admit that Semmelweis was right in washing hands and that bloodletting had no benefit). It took the USA's Food and Drug Administration (FDA) 37 years to ban diethylstilbestrol, after the first synthetic oestrogen caused vaginal cancer in female babies.

Despite many colleagues criticising the composition of the Women's Health Initiative (WHI) study[1] on hormones, it nevertheless had a major impact on breast cancer figures. Women became scared, stopped their prescriptions, and then … breast cancer figures tumbled – for the first time in 30 years[2] – and in the 1970s also dropped after the scare of oestrogen causing endometrial cancer.[3]

The Stanford University Group could find no other cause of the unprecedented drop – other than women stopping their HRT prescriptions.[4,5] A calculation by Donald A Berry, Cancer Research Professor of Biostatistics, Anderson Cancer Center, shocked us: that 25% of breast cancers in California before 2002 could have been caused by HRT prescriptions.[6] Which means that we, well-meaning doctors, caused cancer in our patients. This was 67 years after Dr Charles Dodds (inventor of the first synthetic oestrogen, diethylstilbestrol) and Dr Boris Shimkin warned that it caused cancer in their laboratory rats and that we did not know what the long-term effect might be on the human female![7]

It is high time that our patients be informed about the side-effects of prescription drugs and encouraged to make their own decisions, irrespective of whether the drug is thalidomide, Vioxx or HRT. After all, hormones are misused in a non-disease state like the menopause. How long will it take us to discard the financial gains, to admit that we are harming many of our patients, and to start changing our prescription habits?

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Medical aid double standards

To the Editor: I am distressed by obvious discrepancies in clinical standards applied by medical aids.

A friend, due for delivery of her first baby, was under the care of a midwife. When she went into labour, the midwife was unable to find her a bed at the birthing unit because all the beds were occupied by women who had had elective caesarean sections (CS). Eventually she laboured and delivered in a suboptimal side-room, with poor facilities for monitoring and delivery. She was then moved into a regular room, but she was told that she could only use it until the morning of the next day because it had been booked for another woman having an elective CS.

There are only a few institutions to which a midwife can directly admit women, and seemingly these few places are oversubscribed by largely unnecessary cases.

Elective CSs at maternal request are more costly, with longer recovery periods than elective vaginal delivery, with no clear

benefit to either mother or infant. I cannot understand how medical aids support this practice by agreeing to fund them. Many private obstetric practices have CS rates of well over 70% – three times the World Health Organization recommended rate. Surely some form of justification is required for procedures that are of no medical or obstetric benefit to a patient?

Our medical aid publishes a detailed schedule of benefits every year. It interests me that the fund chooses to limit certain benefits for recognised and manageable conditions, which must place a significant number of people in financial problems. Psychiatric benefits (for our scheme) are capped at R20 000 per year per family; this includes all outpatient consultations and therapy sessions, as well as any cost of any admission required. If a member has a major depressive episode requiring admission (which is usually an extended admission, requiring at least a week), and then needs ongoing weekly therapy sessions (a vital part of mental health management), this capped amount would very soon be used up.

However, the fund is happy to pay for known 'lifestyle' diseases, with no cap on available funds at all. Conditions secondary to chronic smoking and alcohol consumption are not excluded, and the many and varied complications of obesity are happily paid for. Any attempt at improvement of health is excluded, or only minimally funded (e.g. dietician visits, therapy sessions), but the consequences of unhealthy living are supported.

There must be a way for medical aids to restructure the benefits they offer to promote healthy living and wise choices. At the moment, we can eat, drink and be merry because we'll all be bailed out when problems arise; but if we don't, and our mood slips, we'll be queuing up at the poorly staffed government mental health services because our funds will only last a week or so.

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