



in the postoperative period and bringing the profession of specialist surgeon into disrepute is provocative and laughable. I'm surprised that this hearing favoured the 'expertise' presented by a retired surgical academic, who by his own admission had done very little laparoscopic surgery, over that of a professor and a specialist intensivist currently at the top of their careers. Surely experienced medical personnel should be appointed to hear public grievances? Those of us who are members of the Medical Protection Society (MPS) are concerned that in a case like this the legal representatives failed dismally. This case should have won hands down.

There is a perception among the lay public and litigation lawyers that as most of us have some form of medical protection there's no harm in 'having a go'! MPS reports suggest that medicolegal claims in South Africa have escalated way above rates in the rest of the world. It is my impression that we in clinical medicine are seen as an easily milked cash cow. We are under continual pressure from medical aids, hospital groups and the media – and now our very own HPCSA.

I sincerely hope that the colleague in question has the stamina to exercise his rights and appeal against the findings of the HPCSA, and that his surgical association reacts strongly to this disgraceful decision.

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Well done, SAMA's Industrial Relations Unit!

To the Editor: It is reassuring to know that the South African Medical Association, through its Industrial Relations Unit, has the capacity to assist doctors, especially hospital doctors, should any have reason to believe that they have been subjected to unfair labour practices.

My own experience is that about 3 years after retirement I was phoned by the hospital concerned and told that I had received a salary increase some 2 or 3 years before retirement for which I had not been paid. I was told that if I supplied my bank details I would be paid. Having heard nothing for a year I made further enquiries, only to be told that the provincial health department concern had no money.

I had no recourse other than through the SAMA Industrial Labour Unit, which was entirely successful in obtaining my back pay.

I don't hesitate to recommend to all doctors that they should become SAMA members, for this and many other reasons!

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Selective serotonin reuptake inhibitors in children and adolescents

To the Editor: The introduction of the selective serotonin reuptake inhibitors (SSRIs) was widely viewed as an important advance in clinical psychopharmacology, not only because of their broad-spectrum efficacy but also because of their tolerability and safety advantages, particularly compared with the older tricyclic antidepressants (TCAs) and monoamine oxidase inhibitors (MAOIs). Subsequently there has been considerable controversy about this class of agents, partly because of concerns about the extent to which they have been injudiciously prescribed for 'cosmetic' problems rather than for genuine psychopathology,¹ and partly because of concerns regarding their adverse effects. Most recently, attention has been paid to the appropriate use of SSRIs in children and adolescents.

The 'Drug Alert' published by the National Adverse Drug Event Monitoring Centre in the September 2005 SAMJ² is singularly unhelpful in this regard. The report takes a far more conservative stance than that taken by regulators in the USA, the UK and the EU; it may be misleading by implication and omission; and (if followed to the letter) it may cause child and adolescent psychiatric patients significant harm.

The 'Drug Alert' warns practitioners on four points. First, 'None of the SSRIs are currently approved in South Africa for any indication in children and adolescents.' It should be pointed out, however, that fluoxetine is registered with the US Food and Drug Administration (FDA) for child and adolescent depression and several of the SSRIs (fluvoxamine, sertraline, and fluoxetine) are also FDA-registered for child and adolescent obsessive-compulsive disorder (OCD).³ Practitioners should also be aware that decisions about whether to submit pharmaceutical agents to the Medicines Control Council for registration of particular indications may often be made on the basis of cost rather than scientific or clinical considerations.

Second, 'SSRIs have been associated with an increase in the risk of suicidal thinking and behaviour (suicidality) in children and adolescents with MDD [major depressive disorder] and other psychiatric disorders.' However, as the drug alert also states, 'no suicides occurred' in the 24 trials involving over 4 400 patients. In addition, a systematic review⁴ published recently found no significant difference in the risk of suicide in patients taking SSRIs compared with those taking TCAs. As several commentators have pointed out, patients with overt suicidal ideation are excluded from clinical trials and the heterogeneous nature of the trial designs employed (use of different definitions and assessments of self-harm in different study populations) further contributes to the difficulty of interpreting the data. The trials quoted were not designed to address the question of whether SSRIs increase suicidal ideation, and cannot in fact do so.⁵