in the near future, face disciplinary hearings convened by the HPCSA, and in several cases this may well result in the disruption of practices of individuals who are in fact committed to honest and ethical practice.

It is therefore with great concern that I note that the issue of receiving kickbacks has not been comprehensively debated. The HPCSA has launched into wholesale investigation of individuals who it has alleged have received kickbacks, which is immediately equated with a practice tainted by 'perverse incentives'. This assumption is fundamentally flawed, if for one reason alone — practitioners may receive remuneration from a source which provides a service to their patients without this influencing their practice profile (the manner in which they actually practise). Clearly the misdemeanour lies with the remuneration becoming a perverse incentive with regard to the modus of practice rather than receiving the payment *per se*.

As regard the issue of perverse incentives, many situations exist across the spectrum of practice which may incorporate this temptation. These include use of owned or co-owned apparatus for special investigations, the own supply of various surgical implants, as well as the basic dispensing of own drug stocks. Yet we trust in the integrity of the practitioner not to be tempted by the perverse incentive to over-service for monetary gain. The same rationale should be applied to individuals who have received payment from a practice/institution servicing their patients — the misdemeanor is in the practice profile being influenced perversely by the incentive rather than receiving the payment *per se*.

The evaluation of whether a practice profile has been influenced by perverse incentives can only be performed by the representative body of a given specialty/group in the form of peer review. Only then can evidence be led relating to possible professional misconduct.

I believe that further debate is urgently required in respect of this issue. It is imperative that SAMA, as the representative body of the profession as well as the individual specialist/group representative societies, engage the HPCSA on this matter. Once comprehensively discussed, specific guidelines should be formulated which would apply across the full spectrum of practice as discussed above, with clear definition regarding remuneration on the one hand and perverse incentivised profiles on the other.

With regard to my personal situation I maintain innocence in respect of all allegations made and reserve my rights.

I R Weinberg

Linksfield Park Clinic
Johannesburg

1. Bateman C. Illes secretary covered 'kickback' tracks (Izindaba). *S Afr Med J* 2002; **92:** 677-678.

Cannabis use in South Africa

To the Editor: In response to my initial article[1] on the subject, Pretorius and Naude[2] imply that I: (*i*) do not view cannabis as harmful; and (*ii*) support the legalisation of cannabis. On the contrary, as indicated in my article,[1] I see cannabis as being associated in some users with several adverse health consequences, including respiratory disease, adverse effects on adolescent development, cognitive impairment, exacerbation of psychosis, and psychomotor impairment — many of the effects they have highlighted in their letter. However, I have sought to list those with the strongest empirical support rather than adverse effects that might be confounded by other causal factors. Far from calling for the legalisation of cannabis, I called for decriminalisation of cannabis use (instituting civil rather than criminal penalties for cannabis possession). Legalisation is an entirely different thing! Decriminalising cannabis possession could potentially free up hundreds of thousands of rands spent per day on law enforcement and criminal justice processing of users of cannabis (not dealers). This could more profitably be used to fund a public health response preventing cannabis use among children and adolescents, and focusing on cannabis users at high risk for harm or having patterns of use that are harmful.

Charles Parry

Alcohol and Drug Abuse Research Group
Medical Research Council
Tygerberg, W Cape

1. Parry CDH. Critical issues in the debate on decriminalisation or legalisation of cannabis in South Africa (Forum). *S Afr Med J* 2002; **92:** 697-698.
2. Pretorius E, Naudé H. Cannabis use in South Africa (Briewe). *S Afr Med J* 2002; **92:** 927-928

Child rape

To the Editor: The reaction of Professor Davies[1] to our report on child rape[2] airs an atmosphere of despair.

Since we live in a country where the majority of hospital admissions are trauma-related, we feel strongly that the medical profession also has a major role to play in the prevention of trauma. However, before we are able to change anything, we will have to know exactly what is happening in our society and report this accurately. Child sexual abuse is a very sensitive issue and bound to evoke strong personal emotions. Several reports have been quoted indicating that (at least) one in four females have been sexually abused before the age of 18 years. This is a clear indication that awful things do happen in our environment. Without awareness of what is happening, changes are unlikely to occur and the situation is unlikely to improve.

Based on our research we have made presentations to the Parliamentary Task Team on Sexual Abuse against Children.