



## Community service — or conscription?

**To the Editor:** I write to you on the controversial matter of community service, now that there is talk of extending it to 2 years.

The State invests money in universities because it knows that in the future it will need the skills of the graduates, and that it will reap the rewards of its investment over the working life of the graduate. Therefore, to hold that the student somehow owes the State is a fallacy, because as stated above the State will reap the benefits.

The student on his/her part invests intellectual capital and time in the venture and does this also with a view to future reward.

From the State's point of view it is merely a financial investment. For the student the time spent at university means that he loses income for a period of 6 years. When he does qualify his insurance premiums will start at a higher notch because of his age and he will have incurred considerable debt in the form of loans should he not have wealthy parents, or conversely, the parents have contributed a large sum of after-tax money to the exercise (not only tuition fees but also living expenses have to be met).

Originally the Minister tried to infer that new graduates needed more exposure and experience before going into practice, but this was clearly an excuse to get cheap labour as these young people are sent to remote areas where there are no senior people to give guidance, so the experience gained is a matter of hit and miss.

New graduates worldwide tend to look for places where they can gain experience. Years ago places like Baragwanath attracted young doctors from all over the world for that reason.

Instead of complaining about our young graduates leaving the country we should be asking ourselves why they are going. We should be looking more at the carrot and less at the stick.

In my opinion any new graduate who has incurred study debt and does not go abroad is out of his mind, because with the exchange rate being what it is one can pay off debt within a year. But why are they not coming back? Many do come back, let's face it — compared with the UK with its NHS and foul weather South Africa is a much better option. But when they do return they avoid the public service. Why?

I firmly believe that to reverse the trend and encourage young people to stay here we must work on the carrot and not the stick: improve working conditions in the state hospitals, encourage senior people to join or stay on after retirement (working in an academic environment is possibly the most rewarding type of practice), improve working conditions, offer tax incentives, make it possible for people in outlying areas to

stay in contact with the academic institutions, and link posts to the latter institutions.

It is a tragedy that senior people with a wealth of hands-on experience are lost to the country. I believe that upgrading the peripheral hospitals and getting senior staff will attract young graduates not only from South Africa but from other countries as well.

At present community service is nothing more than conscription, and conscription is only a means for politicians, either bereft of solutions or trying to implement policy that does not merit popular support, to impose their will. Conscription is an invasion of the rights of an individual, forcing him to do something against his will. I am sure that were it to be tested it would fail the scrutiny of our constitutional court.

Why only medical people, why not every school leaver and graduate — is this not also discrimination? Samuel Johnson once said, 'To appeal to people on the grounds of patriotism is the last refuge of the scoundrel'.

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## ACLS and PALS examinations 'sold' unnecessarily to doctors for work in the UK

**To the Editor:** It is with regret as well as a strong sense of responsibility that I inform you that some of the advertisers in the SAMJ have benefited by creating the false impression that certain examinations (ACLS and PALS) are compulsory in order to work in the UK.

These sometimes high-profile companies state that these examinations are compulsory in order to enter the UK as a doctor. Their price tag is almost R4 500 and these courses have to be renewed every 2 years. The UK General Medical Council (GMC) has confirmed that *only* registration with them is necessary in order to work in over 95% of UK hospitals, or eventually to register as a GP. Other considerations are the need for GMC registration, tax implications, length of contract and working conditions, as well as tens of thousands of rands that could potentially be claimed from candidates should they default on their agreement.

BUFA (35 hospitals), Nuffield (32 hospitals) and a few other private hospital groups similar to our Mediclinics in South Africa form a minute part of the medical arena (roughly 200 - 300 posts) compared with the majority of better-paid and



clinically stimulating jobs in the UK. A conversation with Mr Chris Dark, Medical Representative of BUPA (one such private hospital group), revealed his initiation of the enforcement of the Acute Cardiac Life Support and Paediatric Life Support courses for their particular resident medical officers due to a previous disastrous event in one of their hospitals/nursing homes. A very sound reason.

Thousands of South African doctors are being put through courses under false pretenses in order to place them in the lowest-paid medical position in the UK (around £7/hour compared with the norm of £25 - 32 per hour) and to confine them to a contract for 3 - 12 months. Doctors are also generally only allowed to work 2 weeks per month and must live off their earnings to subsidise their accommodation during their 'off weeks'. I speak from personal experience as well as on the basis of countless complaints from doctors caught up in this system in the UK.

Readers should feel free to contact me, should they wish to discuss the above.

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## Intravenous infusion — the case for keeping vitamin C in the emergency drug cupboard

**To the Editor:** In a letter to the *Journal* towards the end of 2001, Dr C E Beyers reported on the rapid response of a patient with amphetamine overdose to an intravenous infusion of vitamin C.<sup>1</sup> This serves as a reminder of the value of a safe, non-toxic acidifying and/or reducing agent for intravenous use in emergency situations. Ascorbic acid is ideal as such an agent and its clinical use outside of treating scurvy (and as a questionable prophylactic for the common cold) is worth restating.

My own experience with vitamin C as a life-saving agent began as a fairly new medical registrar at Addington Hospital. I was called in the early hours of the morning to see a young fireman who had been rushed into casualty with respiratory difficulty. The history given was that he had collapsed while extinguishing a fire in the hold of a ship in the harbour. No one could tell us what cargo had been in the hold.

A striking feature, apart from the grave condition of the patient, was a rather odd brownish-grey hue to his skin and mucous membranes in addition to cyanosis. Blood taken from the patient was a chocolate brown colour, suggesting the diagnosis — rapidly confirmed by the laboratory — of methaemoglobinemia.

The problem, of course, was how to treat this. The *Merck Manual* gave a list of causes as long as an arm but no suggested treatment. *Harrison's Principles of Internal Medicine* recommended emergency treatment with intravenous methylene blue. Ascorbic acid was mentioned as oral treatment in non-emergencies.

With methylene blue not readily available, and a reluctance to dabble in the unfamiliar in a crisis, it was decided to set up an IV infusion of vitamin C.

As with Dr Beyers' case (although the disease process being treated was different) the response to vitamin C was dramatic. By mid-morning we were having great difficulty convincing the patient to stay in the ward a little longer just for observation!

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1. Beyers CE. Rapid recovery from history intoxication. *S Afr Med J* 2001; 95: 706-708.

## Bone densitometry — role of quantitative CT

**To the Editor,** Solomon and Jacobs<sup>1</sup> feel that the Clinical Guideline published by the Osteoporosis Working Group in September 2000<sup>2</sup> understates the value of quantitative computed tomography (QCT) and make a plea that 'its complementary role should be acknowledged'. They proceed to compare QCT with dual energy X-ray absorptiometry (DEXA) and conclude that QCT 'has been shown to outperform planar imaging approaches, such as DEXA, in discriminating subjects with and without vertebral fractures'. They finally recommend that 'most modern radiology practices should have the facility on their scanners'.

As the principal author of said clinical guidelines, now over 2 years old, I do acknowledge that some updating is required. However, DEXA still remains the internationally accepted gold standard to measure bone mineral density (BMD), diagnose osteoporosis and monitor response to therapy — a view shared not only by our local Foundation, but also by the European Osteoporosis Foundation,<sup>3</sup> the American National Osteoporosis Foundation<sup>4</sup> and The Royal College of Physicians. Statements that QCT is 'the most sophisticated method of evaluating BD' and therefore fracture risk is simply not substantiated. The most feared complication of osteoporosis is a hip fracture — the best way to assess risk of sustaining a hip fracture, is to measure hip BMD.<sup>5</sup> QCT cannot measure hip BMD! The question of normative data poses another problem for the care