To the Barricades comrades! (sorry — colleagues)

To the Editor: Dr Robert Caldwell's letter to his Aunt Ethel in the December *SAMJ* hits several nails very smartly on the head. I too have a sense of total outrage at the bully-boy tactics of the Board of Health Care Funders in trying to get doctors to pay through the nose for the issue of a practice number. That number is not necessary for a fully qualified, duly registered doctor to practise medicine. It is merely administratively useful for the medical aid schemes themselves, and to penalise doctors who are unwilling to submit to this particularly obnoxious example of institutionalised blackmail by refusing to refund fees to their medical aid patients is, to my mind, a declaration of war. That SAMA has apparently meekly acquiesced to this extortion may already have done it more harm than it has yet realised by perpetuating the feeling that the organisation is still a bunch of 'ja broers' who have not yet tumbled to the fact that there are people out there who will run rings around them, given half a chance.

So, two suggestions: First, please, *please* do not pay that levy. If none of us do, then either the whole ramshackle structure of medical aid reminbursement will collapse overnight, or a suitable alternative will need to be found by BHCF — *not* by us. I personally could not care less who pays that levy as long as it's not me or my colleagues. Second, members of SAMA who feel as I do, and as Robert Caldwell obviously does, should ensure that an urgent request is sent from their local branch to SAMA Head Office asking it to instruct all SAMA members to withhold payment of this levy until further notice. The power is there. For heaven's sake, just for once, let ususe it!

N C Lee
Former Editor, SAMJ

Flora House
Queen's Road
Simon's Town, W Cape

Kruisiging beswaar

Aan die Redakteur: Suid-Afrika se morele prognose is inderdaad baie erger as wat enigeen van ons ooit kon droom. Ons leef tans in 'n land waar 30 - 50% van ons pasiënte in hospitaalsale sterf aan MIV/VIGS, waar jy vanmiddag huistoe ry (as jy nie gekaap en vrekgeskiet word nie) verby 'n omgerolde bus waarin 40 mense gesterf het, waar jy by die huis kom en jou verkragte vrou keelafgesny in die gang vind, en waar die koerante 30 - 50% van hul daaglikse berigte wy aan geweld, moord, doodslag en tragedie en die ander 50% aan sport.

Dit wil voorkom asof ons al so afgestomp is dat selfs iemand soos professor Retief, vir wie ek die grootste agting en respek het, 'n artikel[1] kon skryf oor kruisiging in die fynste detail. Dit slaan my volkome en totaal dronk. Dat die *SAMJ* kans gesien het om so iets te publiseer, bevestig dat ons as Suid-Afrikaners en selfs die mediese professie wat streef om lewe te bewaar en te koester, die pad volledig byster geraak het. Wat die mees gedetailleerde beskrywing van die mees wrede vorm van menslike sadisme en wreedheid kan bydra tot die opbou en etiese vorming van ons professie of selfs net tot die verskaffing van verantwoordelike inligting, is vir my 'n raaisel. Ons ontspanningsliteratuur is nou die detaillering van gruwelikhede. Gedurende die maand waarin ons die geboorte herdenk van die Geneesheer van liggaam en siel, pryk op die voorblad die gruwelike afbeelding van 'n gekruisigde lyk!

Ek is seker dat daar minstens 10 artikels wag om gepubliseer te word — dit is dus nie 'n kwessie van 'n tekort aan materiaal nie. Ek is bevrees dat ons die grense van aanvaarbaarheid en normaliteit ongemerk oorgesteek het en dat ons ons nou op die vloer van die sloot bevind. Selfs mense met standvastige inbors en beginsels het oënskynlik balans verloor en ons joernaal sy etiese en 'moral high ground'.

Ek wil 'n beroep doen op ons joernaal om tog te probeer om 'n instrument van opbouende, morele en aanvaarbare inligting en wetenskaplike feite vir sy lesers te wees. Ek dink werklik dat 'n ekskuus nie heeltemal onvanpas sal wees nie.

C F van der Merwe

Fakulteit van Geneeskunde
Mediese Universiteit van Suider-Afrika
PK Medunsa
0204

1. Retief FP, Cilliers L. The history and pathology of crucifixion. *SAMJ* 2003; **93:** 938-941.

Regional anaesthesia in mountain rescue

To the Editor: I would like to comment on Chris Bateman's Izindaba article on regional anaesthesia in mountain rescue.[1] Firstly it is a very interesting concept and a superb idea. A mountain accident patient rendered pain free using a major limb nerve block only, can probably be transported from the accident site far more easily and safely than one in severe pain or heavily sedated with opiates.

I totally agree with all of Dr Evanepoel's comments and cautions. The safe performance of major peripheral nerve blocks requires regular practice and additionally full anaesthesiology skills to know about, avoid, recognise and treat the potential fatal complications of each different nerve block. Regional anaesthesia can potentially kill with great rapidity.

I strongly disagree with Dr Smith, the deputy director of Metro Rescue in the Western Cape, when he says that training paramedics in regional anaesthesia may be compared to training them to administer morphine and midazolam and 'wouldn't be too much of a step up'. That is an ill-informed and dangerous belief. Even medical rescue generalist doctors, I believe, are unsuitable persons to train to attempt occasional major nerve blocks on the mountainside.

Dr Decker's suggestion of rather training anaesthesiologists who already have regional anaesthesia skills to be part of the rescue team is the logical approach. Unfortunately medical schools will also need to expand on the regional anaesthesia teaching programme for anaesthesiologists. Skill in performance of major nerve blocks is not a requirement to graduate as an anaesthesiologist, and few graduate anaesthesiologists are skilled in various limb nerve blocks, if any at all.

I wish this initiative every success, and must repeat that performing major nerve blocks is definitely not for paramedics.

R M Raw

73 Valerie Avenue
Northcliff
Johannesburg

1. Bateman C. Regional analgesia abseils into the limelight (Izindaba). *S Afr Med J* 2003; **93:** 730-731.

Overproduction of food as the ultimate cause of obesity in the developed world

To the Editor: The timely editorial by Du Toit and Van der Merwe[1] on the epidemic of childhood obesity raises some interesting questions. Is it true, for example, that 'approximately half of the world's adult population [is] affected by either overweight or obesity'? How is this statistic derived? For this seems at variance with the concept that poverty and malnutrition affect a majority of the earth's population. I suspect that many of the readers of this journal might be under the impression that obesity, at least in the developed world, is associated with increasing affluence, impelled perhaps by the emotional stress of not quite making it in those societies that promote material wealth as the defining value.[2] The authors correctly stress the important aetiological role of dramatically decreasing levels of habitual physical activity and physical fitness levels of succeeding generations of young South Africans.

The authors also address the issue of marketing which, if recent experience with the commercialisation of sports drinks is correct,[3] may be the greater problem. But perhaps the ultimate cause of obesity is not marketing but rather the overproduction of food in developed nations. Marketing is perhaps just the symptom rather than the cause of the overproduction-driven, marketing-hyped overconsumption. The economic reality is that if there is not an overproduction of food by the food companies, and if that food is not sold and eaten, there cannot be progressively rising profit as required by modern economic realities (as in my fiscal ignorance I understand them). Hence the need to drive humans chronically to eat beyond satiety in those countries where there is an overproduction of food.

Indeed the growing enslavement of the US population to overeating[4] is somewhat analogous to their commercially driven enslavement to over-drinking, especially during exercise,[3] based on the unproven and highly improbable dogma that thirst is an inadequate guide to what the real fluid requirements are during exercise. Hence athletes must be encouraged to drink 'as much as is tolerable' during exercise. As a consequence, there have been a number of self-induced deaths from over-drinking during exercise in US military pesonnel and female marathon runners/walkers. The effects of the over-marketing of the food surpluses generated in the developed world are of course far more widespread and dire, but the underlying economic principles appear to be the same.

The introduction of attempts to regulate the tobacco industry makes one wonder whether similar restrictive controls will ever be introduced to limit the overproduction of food in order to arrest the growing epidemic of obesity and diabetes in developed countries. Political and economic realities suggest that this is highly unlikely, at least in the USA.[4,5] Indeed my understanding, hopefully incorrect, is that the effects of the antitobacco legislation in the USA have, paradoxically or perhaps by political design, had relatively little effect on tobacco production and hence on the tobacco farmers in that country.

T D Noakes

MRC/UCT Research Unit for Exercise Science and Sports Medicine
Department of Human Biology
University of Cape Town

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2. Critser G. *Fat Lands*: *How Americans Became the Fattest People in the World*. New York: Allen Lane The Penguin Press, 2002.
3. Noakes TD. Overconsumption of fluids by athletes. *BMJ* 2003; **327:** 113-114.
4. Schlosser E. *Fast Food Nation*. *What the All-American Meal is Doing to the World*. New York: Allen Lane The Penguin Press, 2001.
5. Moore M. *Stupid White Men*. New York: Regan Books, 2001

On being politically correct

To the Editor: Political correctness seems to have become a new overarching value in our society, and one that limits honest dialogue even in medicine. Every health worker will acknowledge that being politically correct is a foolish position to hold when political correctness flies in the face of the