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.

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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.

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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.
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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.

We also have intensive contacts with the South African Police Child Protection Unit in order to identify the most efficient methods of collecting medical evidence. The current overall conviction rate of approximately 7% indicates where our society is failing the children.

Newspapers and magazines are full of sensational reports regarding child sexual abuse. Proper reporting on the real facts surrounding child sexual abuse, such as that the majority of child offenders are family, neighbours or close friends of the patient, might actually open the eyes of currently inactive witnesses. Anybody who has ever been confronted with a patient suffering from detrimental after-effects after being sexually abused as a child will agree that creating as much awareness as possible is justified.

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1. Davies M. Child rape (Letter). *S Afr Med J* 2002; **92:** 664.
2. Van As AB, Withers M, du Toit N, Millar AJW, Rode H. Child rape — patterns of injury, management and outcome (Forum). *S Afr Med J* 2001; **91:** 1035-1038.

Mass hysteria with possible pseudoseizures at a primary school

To the Editor: It was with extreme interest that I read the article by Mkize and Ndabeni[1] on mass hysteria in the September issue of *SAMJ*.

In early August 2002, 27 children at a local primary school in Stanger, KwaZulu-Natal, collapsed. Ten pupils collapsed in the assembly area while another 22 later collapsed in their classes. The first children who collapsed did so during a talk on eye care in the assembly area where the children were standing. A man who had recently injured an eye was speaking of his personal experience. He was wearing an eye patch. The principal of the school initially thought that some of the pupils found him frightening.

The children collapsed and were unconscious for a few minutes. Some also complained of stomach cramps and tight chest pains, and seemed to be shivering. The principal thought they were experiencing seizures. Paramedics, health inspectors and parents rushed to the school.

The children were taken to the local hospital. No abnormality could be found on examination. I also saw two children who had collapsed and were experiencing stomach cramps. On examination, I again found no abnormality. I have known these children all their lives and they are not epileptic. Paramedics and local health inspectors were called in. They suspected a gas leak, but their investigations revealed no such thing. The health inspectors called this an idiopathic episode.

The children were separated and sent home. The next day at school they were all back to normal with no residual health problems.

The principal of the school was glad to have a copy of the article by Mkize and Ndabeni[1] — the fact that this problem has been recorded previously is comforting.

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1. Mkize DL, Ndabeni RT. Mass hysteria with pseudoseizures at a South African high school (Forum). *S Afr Med J* 2002; **92:** 697-699.

CPD requirements — non-clinical registration

To the Editor: I have recently received notice from the Registrar of the Health Professions Council of his intention to proceed to de-register retired doctors who have opted not to seek CPD status, and to place them in a non-clinical category which will preclude the right to prescribe even for themselves. Opting not to seek CPD status is obviously based on certain financial implications, e.g. the cost of attending seminars and conferences.

Correspondence with the Medical and Dental Professions Board and SAMA has proved fruitless.

In essence my correspondence has pleaded for an ongoing strictly limited right of practice or at least freedom to prescribe for oneself, perhaps in an 'emiritus' capacity, which provides for this very limited freedom. This obtains in all other learned professions, which have inalienable. lifelong university degree status. If one has survived a working life in practice without flagrant breach of ethics or professional skill standards there must be some degree of merit in that, which should be recognised. For those retired persons whose intellectual discipline is solely in the medical sciences, the CPD issue is plain. For those with more wide-ranging interests, before 'the years condemn', the issue of CPD should not apply but they should be entitled at least to retain the right to prescribe for themselves and their immediate family members.

A qualified plumber or electrician, for example, would not be precluded from doing repairs or installations at his own home irrespective of age, new technology or the introduction of available new materials!

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