Ethics committees confronted with a protocol designed to answer this question should bear in mind the increasing number of reports linking misuse of anabolic steroids with acute cardiac events and that the first reported myocardial event occurred in a 22 year old man who had been receiving high dose anabolic steroids for only six weeks.[2,3]

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Health care in South Africa

Don't dismiss the private option

EDITOR,—David Woods and David Power have projected a view of the health service in South Africa seen by academics in South African hospitals.[1] The reality may be different. A different management strategy is needed, but should this be a unitary national health service?

South Africa spends 7% of its gross national product on health,[2] of which the state uses half. Five per cent of this is spent on primary health care,[3] of which primary care is part. The remaining 95% is spent on administration and tertiary institutions (mostly those attached to the medical schools mentioned by Woods and Power), which betrays the power of the academic lobby to divert funds to their own ends. Thus this group is preventing a continuum in health care incorporating the district based model from coming about and are retreating to separatist academic complexes or laagers.

Expressing a separatist philosophy, the authors describe private care as a parallel system and advocate the withdrawal of all public funding from it. The percentage of private doctors has grown from 51% in 1985 to 66% this year,[4] owing more to financial decline in the state service than to growth in private services. Taxes have doubled to 30% of the gross national product over this period, while real expenditure on public health has stagnated. At present there may not be enough money for a centrally controlled, government owned, comprehensive health service. Non-government organisations related to primary health care have increased 200-fold since 1985 (Health for All Resource Service, personal communication) and may match the state in meeting the basic health needs of ordinary people.

These factors highlight the need for a participatory management style that exploits synergy between service providers to meet the goal of health for all. This style precludes "drawing in" or directly controlling providers in a single service and mothballing thousands of private health workers whom the state cannot afford to employ and for whom Woods and Power have no plan.

Any new government may struggle to create the unified national health service funded and managed by the state that the authors advocate. An alternative is a framework of management, based on the district health care model, that also celebrates unity in diversity and the letting go of control. Whether there should be private tertiary care is questionable, but private primary care can be made more accessible and functionally integrated with state and other services. State hospital, laboratory, radiology, and management services could support and help to monitor primary health care and primary care provided by non-government organisations and the private and state sectors to ensure a dignified and accessible service within existing financial limits.

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Rural areas suffer most

EDITOR,—David Woods and David Power mention but do not really address the particular problem of health care in the rural areas of South Africa. The "homeland" health departments, which took over the former mission hospitals in the 1970s, have not been short of money, but it has been easier to spend this on prestige projects rather than sustainable upgrading of existing hospitals and building and equipping village clinics. The contractors are inevitably from white South Africa, which is no doubt happy to see its grant money thus returned. Politicians are well aware of the gains from building a hospital in their constituency —a scenario not unique to Africa.

Rural hospitals are facing a medical staffing crisis. White South African doctors doing military service have now been withdrawn, and black South Africans are able to enter (private) general practice when they complete internship, earning much more than they could as hospital medical officers. Many rural hospitals now have no South African doctor of any colour. Swiss doctors, among others, have hitherto maintained links with many hospitals through their church but now have to pass a proficiency examination and no longer seek recruitment. Hospitals are increasingly staffed by doctors who have no real choice—political refugees from Burma and Zaire, economic migrants from Eastern Europe—with Medical Council registration restricted to the homelands.

In the long term, rural hospitals and primary care facilities will have to be staffed by black South Africans. This is one aspect of the original grand plan of apartheid that is surely valid. As Woods and Power make clear, this will require major changes in teaching at the academic centres. In the short term, the staff shortage could be addressed by withholding registration for general practice until doctors have completed two further years in hospital posts after internship—this is, of course, part of the requirement for British general practitioners. This might be politically impossible, and in any event there would be no prospect of supervision or training for these newly qualified doctors. Unlike your leader writers, I am deeply pessimistic for the future.

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1 Woods D, Power D. Whither health care in South Africa? *BMJ* 1993;307:82. (10 July.)

Psychological survival after the concentration camps

EDITOR,—Caroline Garland states that the effects of the Nazi concentration camps persist in the lives of children and grandchildren of survivors.[1] In a review of post-Holocaust literature Solkoff noted that psychoanalytically oriented studies had tended to support this conclusion but community based research did not bear it out.[2] Most recently, a controlled study in Israel found no evidence of second generation effects (H Dasberg *et al*, third European conference on traumatic stress, 1993).

Those who emerged alive in 1945 mostly sought to rebuild their social and work lives and to put their traumas behind them. Postwar societies did not think of these people as carrying a permanent psychological wound and most did not have, nor were pressed to seek, psychological treatment. Today, many view the victims of torture as having a kind of life sentence and being in need of professional help. Traumas like rape or childhood sexual abuse are regarded similarly, and the general public increasingly accepts and use terms like emotional scarring. Socially held beliefs about trauma shape what individual victims feel has happened to them, whether or how they seek help, and their expectations of recovery. The search into long term effects must take into account the way that social constructions change over time and across cultures.

Since 1945 millions more people have been exposed to mass atrocity and near destruction of their social and cultural worlds. The long term impact of this is one of the resonant questions of our age but one that awaits conclusive answers. Moral outrage pushes us, rightly, to recognise victims; but human suffering, even after catastrophe, must not lightly be called psychological "damage." There is no doubt of the personal devastation for some, but it would be an affront to the overwhelming majority who do reassemble their lives to think they must be basically damaged beings who cannot but transmit this to their children. Garland may be right that Levi and Bettelheim spent their lives attempting to repair themselves, but to me their postwar output attests more to creative survivorhood and the capacity to transcend.

Clinic populations tell part of the story. However, the insights from a sociological framework might be more generalisable than those from individual psychology with its victimological focus. The effects of holocaustic experience might be traced through in shifts of collective world view and group identity and in the social and political institutions which represent these. Doctors must make common cause with anthropologists, sociologists, political scientists, writers, and the survivors themselves.

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Volunteer workforce is dwindling

EDITOR,—I and colleagues in Arthritis Care found Ian Goodrick's article on the use of volunteers in general practice interesting but wonder where these volunteers are to come from.[1] The supply of women, married or single, who do not work for a living has almost entirely dried up. There remain people who have retired and those who are either unable to work or unable to find work. Unemployed people may work as volunteers for only a short time, and training them is then expensive.

Arthritis Care has a network of volunteer visitors, who visit people with arthritis who are unable to get out of their homes. These volunteers are mainly people with arthritis themselves, who want to share their experience of managing their condition. Many of them receive invalidity benefit, and many of them are now giving up their voluntary work because they fear that they may lose this benefit if they continue. Other voluntary