Job's syndrome

To the Editor: For some decades recurrent boils have been labelled Job's syndrome, and Andronikou *et al*.[1] make this diagnosis in the case of a young child with skin disorders and abscesses plus lung pathology. I think it is possible to diagnose the biblical Job's illness more accurately.

Job became ill with 'running sores from head to foot' (2:7 *New English Bible*). The Hebrew *shechin* is nonspecific ulcers, boils or sores ('foul ulcer' Septuagint) which he scraped with a broken piece of pottery (2:8), a method of relief still practised by Bedouin sufferers from yaws.[2] Rural Egyptians call the extensive ulcerating lesions *manes ayoub*, the malady of Job.

Job writes that his 'skin is broken' and sloughed off (*vayimaes*, Hebrews, 7:5) or scabbed (*New English Bible* 7:5). He describes himself as having multiple lesions (9:17). He also complains bitterly of painful bones (2:5, 19:20, 30:30, 33:19) especially at night (30:17) when he can't sleep (7:3,4); he can't eat (33:20) and is wasting away (33:21).

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1. Andronikou S, Eimany A, Robinson PJ, Kemp A. Mycoplasma pneumatoceles. *S Afr Med J* 2004; **94:** 166-167.
2. Levin S. *Adam's Rib: Essays on Biblical Medicine*. Los Altos, Calif.: Geron X Inc, 1970: 79-80.

On the rewards of dedication and commitment

To the Editor: I find myself deeply disturbed by the criteria used in appointing personnel to the Department of Health. Personnel who have served with dedication and commitment are passed over when they apply for promotion as though years of dedicated and committed service are of no moment.

I know of many examples. Here are just three.

1. An acting personnel manager had served a hospital with distinction for nearly two decades. She ran her department so well and with such effective attention to the needs of the staff, that the hospital's service was not disrupted for a single day by strike action in the turbulent 90s. She lived in that community, and intended to serve there indefinitely. Yet, when her post was advertised, the hospital manager had to fight to get her onto the short list. And she was replaced by a person who has the right papers, but not her experience or her dedication to the community.

2. An acting laboratory manager who is very highly qualified was not even informed that her position was being advertised. When she found out and applied, she was told that her application was not considered — yet the laboratory is meticulously well run.

3. A clerical person who had served meticulously in a position of leadership for two decades was passed over in similar fashion.

In each case, local sentiment and judgement were overruled by regulations with mainly racial intent. Very frequently, secure, effective service has been brought to an abrupt end as really excellent members of staff have realised that there is no prospect of advancement for them in this department, and have left to further their careers elsewhere. This has been a tragedy for them and a tragedy for the hospitals they have served, as they are often replaced by personnel who do not have the same level of dedication or commitment.

It is a mystery to me why past level of service excellence and the duration of past service seem to weigh so lightly in decision making about appointments. But there is no doubt at all that this contributes very considerably to a drop in morale and the loss of experienced personnel from this struggling health department.

It is surely time to review these regulations in the interests of our health service.

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Kruisiging beswaar

Aan die Redakteur: Professor Van der Merwe se brief[1] bewys net weereens hoe mense se persepsies en opinies kan verskil. Ek het die artikel van Retief en Cilliers[2] baie insiggewend gevind. Die wetenskaplike inligting het my as Christen aangegryp en diep onder die indruk gebring van die lyding wat Jesus (onskuldig) deurgemaak het. Ek was nie regtig bewus wat kruisiging werklik behels het nie. Grusaam, sekerlik, maar moet dit nou bedek of dekamoefleer word, en om welke rede? Dit het my net met groter liefde en bewondering vir my Verlosser vervul.

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1. Van der Merwe CF. Kruisiging beswaar. *S Afr Med J* 2004; **94:** 8.
2. Retief FP, Cilliers L. The history and pathology of crucifixion. *S Afr Med J* 2003; **93:** 938-941.

Conned again?

To the Editor: According to a recent Izindaba article entitled 'ANC comes out swinging on CON',[1] the ANC argues that the 'constitutional right of doctors to practise wherever they

wished had to be balanced with the constitutional right of access to health care for patients and the constitutional obligation of the state to ensure that access.'

The question to be answered is whether this measure (i.e. denying doctors their constitutional freedom of choice) will really improve access to health care as envisaged by the ANC.

Let us consider only one practical implication of this policy (which is not something the Department of Health or its minister is fond of doing). Let us say that Dr B, who originally wanted to open his practice in Queenstown, is forced (under the proposed legislation) to work in Tshani in the Transkei.

The ANC obviously anticipates that the arrival of Dr B will be greeted with great joy by the local population — and that the political gains will not be insignificant.

However, the nearest radiological services, laboratory and chemist are all 50 or 100 km from Tshani. So how is (a probably resentful) Dr B, armed with a thorough training in modern medicine and a stethoscope, going to make a meaningful contribution to the health of Tshani's inhabitants?

The moral of the story is that no amount of doctor shunting will make any difference to health care delivery if the medical infrastructure is not upgraded from top to bottom at the same time. Given its track record over the last . . . yes, 10 years, one can assume that if the state is under no obligation (by force of law) to improve infrastructure in rural areas before sending in any doctor, it simply won't.

With this in mind, there is really no reason why a choice should be made between the constitutional rights of doctors and underprivileged rural patients.

Denying the one will not ensure the other.

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1. Bateman C. ANC comes out swinging on CON (Izindaba). *S Afr Med J* 2004; **94:** 248-249.

Erratum

Readers' attention is drawn to an error in the Hypertension Guideline 2003 Update (Part 2 of the March 2004 *SAMJ*). In the final paragraph of point 8.2 (p. 216), second-last sentence, the words '*thiazide diuretic*' should have read '*thiazide-like diuretic*'. The correct full sentence should be: 'Step one drug therapy in uncomplicated hypertension is a low-dose thiazide-like diuretic.'