EDITOR'S CHOICE

Feeling the heat

My spell on the goldmines as a medical officer in the 60s provided a wonderful opportunity to see occupational medicine in action. Because of the geothermal gradient – the deeper you go into the earth the hotter it gets – the great depths of the mines and the presence of underground water, working conditions are very hot and humid. Heat diseases were common in the un-acclimatised. The mines therefore developed acclimatisation procedures that required new recruits to work under strictly supervised situations. They worked until their body temperatures went up to 101°F (38.3°C), when they were rested and if necessary cooled by spraying them with water and compressed air for cooling through evaporation. Supervisors gauged body temperatures by feeling with the backs of their hands. We were challenged to check their findings with thermometers, and I was greatly impressed by how accurate their findings were!

Searching today for ways to measure body temperatures reveals the use of thermometers, electronic gadgets, infrared apparatus, temperature 'strips', etc. but no reference to palpation. Dr Clough draws our attention to the fact that using palpation to assess fever is prevalent in some parts of Africa despite the availability of thermometers.[1] Compared with thermometers, how did palpation fare? Unfortunately not well! In this study, one-third of febrile patients were deemed afebrile by assessors using palpation alone, and a similar percentage of afebrile children in this study were deemed febrile. Fever in Africa, with its huge malarial prevalence, is an important finding and using palpation alone to assess it should be resisted.

Lack of adherence to ART medication

Non-compliance is a major problem, particularly with regard to medication for chronic conditions. For example, bipolar disorder patients often break down because of going off medication, complacency being one of the reasons. Maskew and colleagues[2] investigated the factors and challenges in patients on antiretroviral therapy who were lost to follow-up.

Sadly, but perhaps not unexpectedly, one of their first challenges was the staggering number of patients who could not be contacted due to lost files, incorrect details in files or no contact details recorded at all. Studies elsewhere in the world identify many causes for patients not adhering to ART. Factors associated with poor adherence have no social or cultural borders. However, in this study financial difficulty was the most commonly cited reason for not returning for clinic visits. Death accounted for 27% of the patients lost to follow-up.

There is evidence in support of providing ART free of charge to HIV-positive patients who qualify; providing ARV therapy at more local clinics in the community to make treatment more accessible; and providing several months' supply of medicine per visit to reduce transport costs.

Doctors and the HPCSA

Doctors have reasons to rue their willingness in the changing South Africa to enter into a joint 'Health Professions Council' with the other health professional groups that today make up the HPCSA. At the time it was felt that it would be good for the health professions to get together under a single regulatory umbrella in order to simplify management and to facilitate dialogue and co-operation. However the Nursing, Pharmacy and Dental Councils decided to continue on their own and to leave the rest (excluding the 'alternative' groups such as homeopathy that have their own Council) to form the HPCSA. The National Ministry of Health, following its well-known interest in centralisation and getting its hands on all the levers of power, despite demonstrable lack of capacity and of vision, is about to gain full control of the HPCSA. Chris Bateman[3] outlines the chief protagonists in this sorry saga. The Medical and Dental Board, by far the largest and most influential of the Boards, has effectively been sidelined by party political agendas and ideologies.

Strong voices are now being raised in support of the formation of a separate Medical and Dental Council.

Public-private partnership success in palliative care

The increasing burden of cancer is often overlooked because of the huge demands for palliative care for the increasing number of patients with AIDS that now comprise the bulk of patients cared for by hospices in South Africa. It is therefore gratifying to report successes in dealing with both these conditions. Hospices arose because of the need for palliative care, largely for cancer patients with limited life expectancy who were no longer adequately catered for by 'curative' services.

Jameson[4] describes the implementation of a public-private partnership to serve the diverse populations in Grahamstown. With the help of a service organisation, Rotary, First National Bank and Hospice as the private partners, and the Department of Health as the public partner, an agreement was reached to provide a palliative care ward. The successful implementation of this enhancement of the palliative care services to patients with diverse needs provides a message of hope for others who may wish to emulate this.

JPvN

1. Clough A. Palpation for fever (Clinical practice). *S Afr Med J* 2007; 97: 829-830 (this issue).
2. Maskew M, MacPhail P, Menezes C, Rubel D. Lost to follow-up – contributing factors and challenges in South African patients on antiretroviral therapy. *S Afr Med J* 2007; 97: 853-857 (this issue).
3. Bateman C. Too late for tears as Manto smells victory? (Izindaba). *S Afr Med J* 2007; 97: 807-811 (this issue).
4. Jameson C. The role of a palliative care inpatient unit in disease management of cancer and HIV patients. *S Afr Med J* 2007; 97: 849-852 (this issue).