

'Politically correct' behaviour change – an HIV/pregnancy threat?

The vigour of youth is a marvellous thing when harnessed to the traditional caring values of the physician, and can work wonders in society – as modelled by a young Charlotte Maxeke/Johannesburg General Hospital surgical medical officer profiled by Chris Bateman in Izindaba this month.¹ The cautionary comments by the doctor's more politically and professionally seasoned colleagues (he and his colleagues are delivering 'shock therapy' lectures at Johannesburg schools where teenage pregnancies are a real problem) are valid, given the sexually conservative nature of parents across cultures. But most importantly, the junior doctors are filling a hiatus consciously left by the departments of Basic Education and Health via a decision to cease all HIV testing at schools (and thus associated pregnancy prevention). Why? Youth activists persuaded Basic Education Minister Angie Motshekga that it was untenable to perform HIV testing without appropriate and sufficient psychosocial support. Her health counterpart, Dr Aaron Motsaledi, agreed, saying that the upcoming pre-national-health-insurance-integrated school health programme would address current short-falls. The result? Six months to a year of no official behaviour change intervention just as our teenagers enter a more sexually active, age-differentiated and far higher HIV-prevalence societal pool. Perhaps the gap-fillers need some considered official backing?

Foreign green pastures for South African doctors

There is an absolute shortage of >4 million skilled health workers worldwide. In developed countries this is partly because of increasing demands for healthcare, with ageing populations and fewer young people available and opting to go into the health professions. Dambisya and Mamabolo² review the advertisements for foreign posts in the *South African Medical Journal* (SAMJ) over a recent period (2006 - 2010) and compare these with similar advertisements over a previous period (2000 - 2004), in order to establish trends as a measure of active recruitment campaigns for such personnel.

In developing countries a combination of factors leads to poor investment in the production and retention of health professionals, especially in rural and remote areas. 'Pull' and 'push' factors in developed and developing countries, respectively, contribute to the migration of health professionals; typically from poorer to wealthier areas (what a colleague called a 'transfusion from the anaemic to the plethoric' and what has also been called 'the great brain robbery').

There were 1 176 foreign advertisements placed in the SAMJ in the review period, reducing from 355 in 2006 to 121 in 2010 (also down from an average of 504 foreign advertisements per year in the previous period). The originating countries were primarily Australia (36.4%), Canada (24.3%), New Zealand (16.2%), the United Kingdom (UK) (9.2%) and Ireland (3.7%); others were the United Arab Emirates, Saudi Arabia, Namibia and Botswana (10.1%).

The reduction in foreign advertisements can be attributed to many factors, including: geopolitical changes in Europe (healthcare workers from Eastern Europe were able to work in the European Union, including the UK); differing health systems in the top four destinations; and the utility of bilateral governmental arrangements to discourage such recruitment.

Medical internship and community service slaves

Owing to a chronic shortage of medical staff in South Africa, sleep-deprived medical interns and community service doctors work up

to 200 hours of overtime per month under the state's commuted overtime policy. Nicolette Erasmus³ explores the legal and moral aspects of this exploitation in a hard-hitting paper that challenges the existing system and recommends changes.

Nurses also moonlight in circumvention of the Basic Conditions of Employment Act. For trainee doctors, overtime over 80 hours is unpaid and rendered involuntarily under threat of not qualifying to practise medicine in South Africa. As forced labour, and sleep deprivation amounting to cruel and degrading treatment, it is outlawed in international law. No other professional group in the country is subjected to such levels of exploitation and discrimination by the state.

Erasmus suggests *inter alia* that these abuses should be challenged under the Constitution and investigated by the Human Rights Commission. Spurred by her suggestion that structural concerns, including policy and market failures, should be addressed, a few simple changes are proposed in the editorial⁴ that can contribute significantly to a long-term improvement in our medical services. These are: returning to the 6-year medical curriculum; restructuring the 3-year internship and community service into a 2-year programme; and increasing the number of medical officer posts. These would improve services and supervision, and lighten the financial load of graduates bearing the heavy burden of study loans.

Challenging infective endocarditis prevention

Ingrained beliefs, whatever their derivation, are hard to shift. It took many centuries for medicine to abandon the Hippocratic theory of four humours that led to logical treatment: bleed to get rid of bad humours; starve to prevent new ones from forming; or purge to get rid of the rest, from above, from below or from any other exit. Parrish and Maharaj⁵ challenge conventional beliefs on the prevention of infective endocarditis (IE) in developing countries.

In Europe and the USA, guideline bodies have limited their indications for IE prophylaxis, and in the UK it is not recommended at all.

Bacteraemia may occur after more than 20% of toothbrushing episodes. IE can develop despite prophylaxis. In dental sepsis it is conceivable that the underlying condition produces more cumulative bacteraemia than the extraction.

The authors explore reasons why existing practices continue despite lack of evidence that they are beneficial. When differing international guidelines make differing recommendations based on the same evidence, it becomes important to achieve local clarity. A pragmatic approach might be to emphasise both good dental hygiene and early recognition and treatment of established endocarditis, and to de-emphasise reliance on an intervention of uncertain benefit.

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