



The harm of mechanical bowel preparation

Beliefs die hard. Despite clear evidence that some treatments have no demonstrable benefit or are downright harmful, people will clamour to use them if they believe in their efficacy. This phenomenon and other aspects of health care belief systems are explored in an editorial.¹

A belief firmly held by many medical practitioners is the efficacy of bowel preparation before gynaecological surgery, which is explored by Botha.²

The Egyptians first recorded colonic cleansing in the Ebers Papyrus carbon dated between 1500 and 1700BC. It has persisted into our time and 'colonic therapy' is practised widely in alternative medicine circles. Claims about its efficacy are widespread and they may be considered nons(c)iense as they are not based on facts. But Botha finds that the evidence is also tenuous for mechanical bowel preparation (MBP), still regarded by most doctors as standard practice before extensive gynaecological surgery.

MBP to reduce gastrointestinal content before diagnostic or imaging investigations is well established and its use for this procedure is justified. However, there is no evidence to support MBP in patients undergoing elective surgery and, because it causes significant discomfort and may be detrimental to the patient's health, it should not be offered as a routine treatment. On the other hand, antibiotic bowel preparation has been conclusively shown to reduce the risk of bacterial infection after inadvertent bowel injury.

Influencing health professionals for rural practice

Recruiting doctors to work in rural areas is an important global concern for health managers and educators. By using qualitative individual interviews Couper and colleagues set about studying how health care professionals (HCPs) choose to work in rural areas and how education influences this.³

They found that many positive and negative factors affect recruitment and retention of rural HCPs, and their problems need to be tackled using a multidimensional approach. A partnership between medical educators, rural health service authorities and rural communities is crucial. They suggest that educationalists should work on areas including: selection of HCP students from rural areas including scholarships; assisting them to connect with their own roots and values; appropriate rural exposure and engagement; rural communities to become more supportive; and managers to develop a more participative style.

A success story that addresses the above problems is reported by Andrew Ross.⁴ While the title is 'Success of a scholarship scheme for rural students', it addresses much wider issues than mere scholarship.

The setting is a district in rural KwaZulu-Natal that has a high prevalence of preventable disease, high levels of unemployment and a poor standard of education. Recruitment and retention of professional staff is a major challenge for the hospital management. In an attempt to provide HCPs for their district the Friends of Mosvold Scholarship Scheme (FOMSS) was established in 1998. Twenty-four students from the district supported by FOMSS have graduated; 18 are working in the district, 1 has died, 2 have completed their contract time, 1 is doing further studies and 2 are completing their internships.

Factors contributing to the success included appropriate selection of candidates, high level of support provided (also enthusiastic and passionate mentoring), student motivation and vacation work. It is suggested that that each district hospital should similarly assume a measure of responsibility in partnership with funders and finding suitable candidates.

This success story is a tribute to the vision and persistence against heavy odds by the team at the Mosvold Hospital and district!

Simple testing of cognitive impairment

Self-management is an important ingredient for the successful management of type 2 diabetes, and cognitive impairment is a barrier to this. Detecting executive cognitive impairment would therefore assist in the appropriate management of such patients, and De Wet, Levitt and Tipping report on the use of a simple bedside screening test.⁵

People with type 2 diabetes have a greater rate of decline in cognitive functioning and risk of future dementia than people without diabetes, but the cognitive impairment is associated with poor diabetes control. It has been clinically linked with functional impairment, poor medication adherence, increased level of care needed and even patient resistance to treatment.

Compared with other tests their bedside battery is effective, takes 5 minutes or less to administer and requires little training.

The facts of death

An editorial⁶ and article⁷ address the errors in the completion of death notification forms that contribute to the poor health statistics in South Africa, something that doctors must take joint responsibility for.

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2. Botha MH. Mechanical bowel preparation in gynaecological surgery – are we doing more harm than good? *S Afr Med J* 2007; 97: 1040-1043.
3. Couper ID, Hugo JFM, Conradie H, Mfenyana K. Influences on the choice of health professionals to practise in rural areas. *S Afr Med J* 2007; 97: 1082-1086.
4. Ross AJ. Success of a scholarship scheme for rural students. *S Afr Med J* 2007; 97: 1087-1090.
5. De Wet H, Levitt N, Tipping B. Executive cognitive impairment detected by simple bedside testing is associated with poor glycaemic control in type 2 diabetes *S Afr Med J* 2007; 97: 1074-1076.
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7. Burger EH, van der Merwe L, Volmink J. Errors in the completion of the death notification form. *S Afr Med J* 2007; 97: 1077-1081.

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