on the biopsychosocial approach in a PHC context in the first 3 years [of the curriculum] is undermined by the traditional biomedical approach of the latter years.’

The penultimate chapter (chapter 6) is a rich summary of the processes, which took place over two years, that put ‘flesh’ on the ‘bones’ of the curriculum blueprint, and of the shifts in control of the educational strategies from heads of departments to within the Education Development Unit.

The successes are highlighted: the multidisciplinary and multiprofessional faculty foundation courses that embed, and are strongly aligned with, the PHC approach; and the basic sciences courses (running over 2½ years), characterised by a (UCT-specific) hybrid of problem-based learning applied to commonly occurring illnesses that are representative of SA’s disease burden, along with clinical skills training that begins in year 2 and continues through year 3.

So also are the failures, the basis of which is multifactorial but the consequences of which are clinical. Years 4 - 6, characterised by biomedical, silo-based disciplinary teaching and experiential learning in secondary and tertiary hospital settings, are unlikely to ‘fit’ a graduate for ‘real-world’ SA practice (sometimes) unsupervised internships and community service – and encourage subspecialist rather than general practice/general specialty career choices after graduation.

In the words of one of the curriculum design team conveners: ‘we [referring to UCT’s FHS] started a curriculum change process to produce generalists and did not invest in strengthening our small Primary Care Department’ . Equally sobering, all these years later, is to hear another state: ‘there is ignorance around the Department of Health’s policy document on health systems transformation (underpinned by the PHC approach) and the HPCSA’s 1997 Training Guidelines (that mandate the PHC educational approach) … the MB ChB has never been subject to a major revision, so the tendency to specialise has been unchecked and it is a foreign concept that their practice could be guided by anyone other than themselves … autonomous behavior that is (now) being challenged by the HPCSA Accreditation process’.

In the context, the Guest Editorial that opens this issue of SAMJ deserves noting.

Hartman’s book will interest those who are (medical) educationists, and those medical colleagues who choose medical education as a subspecialty interest.

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The AIDS Conspiracy: Science Fights Back
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Prof. Nicoli Natrass is an economist who has contributed substantially to the understanding of health issues in South Africa (SA). In this important book she addresses the background factors that contributed to the dark AIDS denialism period in SA’s healthcare history. Although the book deals primarily with the AIDS pandemic, many of the insights contribute to a better understanding of the way in which all conspiracy beliefs function.

Conspiracy beliefs included that the human immunodeficiency virus (HIV) may have been created in a laboratory, and that the pharmaceutical industry invented AIDS to sell more toxic drugs. Swallowing this belief from the denialists, President Mbeki and the then Minister of Health delayed the provision of treatment, resulting in hundreds of thousands of deaths, increasing the spread of the virus, and marginalising our medical professionals and scientists.

Natrass identifies players who contribute to the development and maintenance of conspiracies: the hero scientists, dissidents who lend credibility to the movement; the cultopreneurs, alternative therapists who exploit this for their own benefit; the living icons, who claim to be living proof of the legitimacy of the denialism; and the praise singers, media people who broadcast the false messages to the public.

Science and evidence-based medicine have fought back by their evidence and political credibility. However, this is not a single battle. It requires ongoing vigilance.

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