



Department of Health statistics challenged again

The paper by Rob Dorrington and David Bourne,¹ again challenging the National Department of Health's statistics, was originally published on-line on 4 November 2008. The research subcommittee of the South African National AIDS Council (SANAC) discussed the matters raised in this paper on 14 November, and the Department of Health has convened its workshop on the matter.

Ownership of professional turf

Some of the characteristics of professions are mastery of theoretical knowledge which is advanced and esoteric, the capacity to solve problems, and the use of practical knowledge. Typically, this takes a long time and the formal training is an adult socialisation process whereby they become part of the profession. This is recognised by licensing and legal enforcement that also places responsibilities on its practitioners. From a handful of professions at the beginning of last century, there are now large numbers of groups that claim to be professionals, many that would not qualify by generally accepted criteria. Most professions have fairly clear boundaries but when professions that have traditionally co-operated start competing for turf, the sparks are likely to fly. The editorial² and three papers in this journal³⁻⁵ address aspects of this matter.

Apffelstaedt and colleagues³ report on their mammography series from a dedicated breast unit. Their results compare favourably with reported series from elsewhere though the readers are not radiologists. Emergency medicine practitioners make a bid for their (non-radiologist) practitioners to use diagnostic ultrasound in their work, having had suitable training.⁴ Neurosurgeons Le Feuvre and Taylor report on the long-term outcomes of endovascular cerebral aneurysm treatment,⁵ noting that they, and not radiologists, are the primary interventionalists.

While it happens that these papers relate largely to radiology, the question of turf acquisition and turf protection relates to all the health professions. Psychologists have tried to make inroads into the domain of psychiatrists; optometrists are making a bid for territory claimed by ophthalmologists; orthopaedic surgeons are concerned about the extending areas of practice by physiotherapists etc. (My wife, who owns a specialised shoe shop, is incensed at the inroads that departmental stores are making into her territory). And claiming all knowledge and skills are the flourishing alternate and indigenous 'health' practitioners against whose unproven belief systems all the scientific health professions have made little headway.

Defining boundaries or agreeing to share turf should not be an impossible task – but continuing conflict over ownership can be expected, especially where cash is at stake.

Peripheral arterial disease: Predicting walking intolerance

A common belief is that a compromised circulation with exercise increases anaerobic metabolism, resulting in an increase in lactic acid production and a depletion of ATP and creatinine phosphate, leading to pain. The findings of the study by Parr, Noakes and Derman⁶ challenge existing views on the factors causing claudication.

The ankle brachial index (ABI), a commonly used clinical measure to predict the functional capacity of patients with PAD, did not predict pain-free walking distance (PFWD) or the maximum walking distance (MWD). Peak post-exercise venous lactate concentrations also did not correlate with PFWD and MWD. There was no correlation between total pain perceived on the graded treadmill exercise test.

Since traditional measurements used to predict exercise performance in healthy subjects or in patients with PAD could not explain perceived discomfort and factors determining the walking distance of their subjects, alternative explanations should be considered in future research.

Fair payment for trial participants

Koen and colleagues⁷ challenge the South African Medicines Control Council (MCC) policy that trial participants be paid a flat rate of R150 per visit in clinical trials. The main problem is that the MCC policy violates the ethical principle of justice in that participants are paid the same amount but do not do the same things or incur the same expenses.

The authors conclude that participants should be paid for their actual expense and time outlays at a rate that approximates national unskilled labour rates, with additional payment for inconvenient procedures. If this is implemented, trial payments will differ and may involve logistical challenges and complex administration, but it would reflect a payment policy underpinned by thoughtful, ethical reflection.

Recommendations to stakeholders include that the MCC should revoke its payment policy, the National Health Research Ethics Committee should adopt the recommended form of payment, and regional ethics committees should implement this form of payment.

JPvN

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3. Apffelstaedt JP, Steenkamp V, Baatjes K. Performance data of screening mammography at a dedicated breast health clinic. *S Afr Med J* 2008; 98: 950-953.
4. Bruijns SR, Engelbrecht D, Lubinga W, Wells M, Wallis LA. Penetrating the acoustic shadows: Emergency ultrasound in South African emergency departments. *S Afr Med J* 2008; 98: 932-934.
5. Le Feuvre DE, Taylor AG. Endovascular cerebral aneurysm treatment: Long-term outcomes. *S Afr Med J* 2008; 98: 954-957.
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