



A foreign doctor's experiences with the HPCSA

To the Editor: Mr Mkhize's letter¹ in response to the Editor's comments² on the performance of the Health Professions Council of South Africa makes interesting reading. One might have expected the registrar and CEO of our professional registration body to substantiate his defence of the performance of his institution by providing structured evidence, such as a 'customer' satisfaction survey or auditing results. In the absence of such evidence, I have to rely on my personal experiences with the HPCSA. At best these have been frustrating. Never, since I first made contact with this institution in 2003, have I experienced timely, appropriate or well-informed service. I have written a detailed narrative of my experiences during the process of my registration as medical practitioner and family physician, which included visiting the HPCSA premises some 20 times from Rustenburg to 'get things going'. I would honestly love to hear from any medical practitioner who wholeheartedly applauds the HPCSA for its performance.

To use a more recent example, however, I would like to outline the events around my application to have my (German) Master of Public Health (MPH) degree recognised by the HPCSA. I personally submitted an application to this effect at the HPCSA offices in Pretoria in October 2007, at which time I also paid the respective fees. I received a letter dated 29.11.2007, acknowledging receipt of the application and its assessment by a subcommittee. Several further attempts (by telephone, fax and e-mail) to enquire about the matter were futile, until finally a complaint to the 'service@hpcsa.co.za' address was answered in May 2009. Recently I received a letter (dated 11.09.2009) stating that the Executive Committee of the Council in a meeting on 10.07.2009 noted that the same committee in a meeting in February 2008 had considered my application and recommended approval. What this in fact means is that my application lay in some file for 15 months without any further action. I don't want to appear ungrateful: I am glad that the documents were finally rediscovered. Better still, the Council is apparently also busy recovering my application regarding my doctorate (I quote from a recent email: 'I am still trying to find out what happened to your application of the recognition of Dr. Med because the copy of your application is in your file but it does seem like it was served at any of the meetings of the relevant committee').

To summarise, Mr Mkhize seems to have fallen victim to a common fallacy prevalent at management levels in this country: failure to distinguish 'visions' from 'hallucinations'. A 'vision', as far as I am concerned, means that somebody visualises the image of a good situation that he or she wishes to be reality, yet understands well that hard work and focused efforts are needed to get there. A 'hallucination', on the other

hand, means that somebody sees something and wrongfully believes it to be reality. The latter condition should not be accommodated in health care management in this country, but rather treated appropriately by our mental health care teams.

I tried to make Mr Mkhize aware of the realities in the HPCSA a year ago, obviously unsuccessfully. Clinicians often refer to the inability to face harsh realities as 'denial', and it is a common stage in the process of coping with a threatening diagnosis.³ In this country, collective denialism has been an attribute of public policy and governance for far too long. In my view it is because of this legacy of denialism that the new national Minister of Health, Dr Motsoaledi, when talking about the situation of health care in South Africa, has stated that health 'paddled backwards' in this country over the last decade (e.g. when addressing rural doctors at the 2009 RuDASA conference in Broederstroom on 28 August 2009).

An HIV-infected patient will be able to face the dangerous truth once the denial is overcome, and can then make informed choices about lifestyle, nutrition, medication, etc. to improve his health situation. Similarly, an institution needs to be able to critically assess and acknowledge its shortfalls in order to tackle them. The national Minister of Health seems to have taken this first step. It is to be hoped that the HPCSA is on the right track and recognises its dismal failures, to enable it to 'protect the public' and 'guide the professions' in the future.

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1. Mkhize B. HPCSA: A mess in the Health Department's pocket (Correspondence). *S Afr Med J* 2009; 99: 484-488.
2. Van Niekerk JP. HPCSA: A mess in the Health Department's pocket (From the Editor). *S Afr Med J* 2009; 99: 203.
3. Kübler-Ross E. *On Death and Dying*. New York: Simon & Schuster/Touchstone, 1969.

Facebook is smoking

To the Editor: As part of our Family Medicine rotation at a community health centre, we were struck by the number of patients who had started smoking at a very young age, some as young as 5 or 6 years old! These patients present in their late 20s and 30s with significant chronic lung disease. We were motivated to look into this public health tragedy as our group project.

The latest Cochrane review on the subject reveals the dismal fact that there is very limited evidence that any interventions up to now have been successful in curbing the long-term smoking habits of young people.

It was clear that something new and fresh was needed. An informal study of a class of Grade 8 learners showed that although most learners knew that smoking was 'bad for you', the learners were less knowledgeable about specific effects and



many were keen to stop smoking but weren't sure how to go about it.

After discussion on a viable intervention strategy, we felt that something 'cool' and innovative was called for. Step forward 'Mr Butt', a Facebook character based on a fictional 14-year-old boy. This champion of quitting smoking is everyone's pal and can be added as a friend on this vastly popular networking tool. Mr Butt's group on Facebook, 'Mr Butt wants everyone to quit smoking', is a source of information to learners about smoking, its dangers, and ideas on quitting the habit. Learners were informed about their new online friend and his group and encouraged to seek further information via him by accessing the web on their cell phones.

Much of the existing literature concludes that social support is a vital component of quitting smoking, and the Facebook interface provides us with the opportunity to give support to adolescents dealing with problems that may not be easy to share with family or face to face with peers. The Internet and its various social networking websites could perhaps be the next step in breaking through to teenagers in terms of health promotion.

Fictional Facebook, Mxit and Twitter characters and their groups could be used by doctors and the health authorities to get through to this traditionally neglected age group, the teenager in the corner playing on his cell phone.

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The costs of a bullet – the true cost of labour

To the Editor: I read with interest the paper by Norberg *et al.*¹ in which they admittedly underestimated the in-patient costs of bullet injuries at Tygerberg Hospital. I note that staff salaries, laboratory and pharmacy costs were unavailable.

The latter two missing items are surprising because the National Health Laboratory Service bills the relevant hospital for services rendered, and the pharmacy manufacturers bill Province for drugs supplied.

Salary costs are more difficult. Some years ago while working on my PhD I looked into the true costs of labour. I had a long conversation with a man from the then Commission for Administration who told me that he had been investigating this same problem. He had identified 54 separate items that contributed to the employment costs of government labour.

Some are immediately obvious such as salary, pension, medical aid, sick and annual leave, and holiday with pay. He included proportionate costs of the office furniture, carpets, heating, salary clerk, tea drunk, telephone, etc. and even toilet paper!

The conclusion was that a civil servant costs the taxpayer salary plus 100%. Therefore if the employee is timed, and the cost of materials added, the true cost of that particular job can be calculated. Unfortunately this was not published because it would have embarrassed the government.

I therefore recommend that when any future researchers try to cost disease management in the government sector they should use this formula.

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1. Norberg J, Nilsson T, Eriksson A, Hardcastle T. The costs of a bullet – inpatient costs of firearm injuries in South Africa. *S Afr Med J* 2009; 99: 442-445.

Dr Norberg *et al.* reply: We thank Dr Craven for his remarks on our recent scientific letter and acknowledge his comments as valuable and relevant. In response we would like to explain that the NHLS data and pharmacy costs were not included because point of care labs are often used and these are difficult to cost – they are used actively in the Trauma Unit. Secondly, at the time of the study the drugs issued by the emergency pharmacy were not linked to the individual patient folder, only to the pharmacy record, and anaesthetic drug costs were not linked to the files, only to the anaesthetic record.

This was an important confounder, as many patients attended after hours. The labour costs were excluded owing to inability to determine for each individual patient exactly how many staff members interacted with him or her during an admission. We wanted to look at the costs we could reflect accurately. We realise that the true costs are far higher.

Linezolid dosing for staphylococcal pneumonia in children

To the Editor: We have noticed that the dose recommendation for linezolid use in our Guideline for VAP in children, recently published in the *SAMJ*,¹ is incorrect.

Results from studies in paediatric patients have demonstrated that there are age-related differences in the pharmacokinetic parameters of linezolid.² Children <12 years old have a smaller area under the Cmax curve (AUC), a faster clearance and a shorter elimination half-life than adults. Newborn infants have clearance values similar to those of adults. However, clearance increases rather markedly