Roadblocks ahead on gilt-edged RWOPS highway?

The longstanding abuse of a system crafted to supplement poor public sector doctor salaries, broaden up-skilling prospects and deepen our research pool may soon be halted as too many specialists continue to cynically cruise down what has become a gilt-edged highway.

Gilt-edged because, since a now thoroughly 'disappointed' Health Minister Dr Aaron Motsoaledi took office, public sector health worker salaries (especially at the top and bottom ends of the scale) continue to climb, thanks to the new Occupation-Specific Dispensation. In Izindaba Chris Bateman takes a multi-dimensional look at the Remuneration for Work Outside the Public Sector (RWOPS) abuse, uncovering specific examples and lifting the collegial 'veil of silence' to plumb sentiment.[1] What emerges is seemingly universal agreement that the policy must at least be revised to address the now inappropriate and crumbling remuneration/retention pillar while preserving the up-skilling and research struts.

As Motsoaledi bluntly puts it, those hardly ever seen at their posts (in breach of contract) are 'welcome to resign' when their dishonest income stream is denied. He can then 'properly fill' what was a virtually vacant post anyway. Given our huge specialist skills shortages, an official clampdown may seem unwise – but efficacy (with integrity) must surely beat filled posts?

Women and girls welcome NHI

Research carried out by Evans and Shisana[2] reveals that while both males and females are supporters of National Health Insurance (NHI), females supported the potential services at higher rates, particularly if they had enjoyed some primary or secondary education. There was, moreover, greater support for NHI among females compared with males across all employment categories. The majority of the population would prefer to support NHI than hold down taxes, a signal that Government can move forward with its implementation.

We doctors are still getting it wrong ...

by assuming that women endurance athletes who present with vomiting and disorientation/confusion are dehydrated. Take a history and these women will tell you that they have achieved a high fluid intake (Coke and water before and during the race or marathon). What they have is dilutional hyponatraemia and cerebral oedema, and are in need of a blood test – to confirm their hyponatraemia – followed by intravenous hypertonic saline. Assuming dehydration and treating with Ringer's lactate may kill.

Two graphic case reports from the MRC/UCT Research Unit for Sports Medicine[3] serve as a timely reminder of this potentially lethal complication, which particularly afflicts young menstruant females.

'Reflex' screening for cryptococcal disease

Since cryptococcal meningitis is now the most commonly encountered meningitis in South Africa, 'reflex' screening for cryptococcal disease is to be phased in across the country.[4] Essentially, the remnant blood specimen of any HIV-positive patient showing <100 CD4 cells/µl will be tested for cryptococcal antigen and the result reported to the clinician along with the CD4 result. Cryptococcal disease will be detected and treated before full-blown meningitis develops, with obvious benefits to patients and the fiscus.

ART for HIV-associated TB – so far we are failing such patients

Two research papers[5,6] tackle the importance of getting these patients, among whom there is a high toll in terms of both morbidity and mortality, onto antiretroviral therapy (ART) early in the course of their disease. The South African national guideline calls for starting ART within 2 - 8 weeks of commencing antituberculosis therapy. There are concerns about overlapping drug toxicity, and of hepatotoxicity in particular, but the advice is to use an efavirenz-based rather than nevirapine-based ART regimen.[4] Success is all about integrating management of these patients so that those facilities doling out the anti-TB meds are responsible also for commencing patients on their ART as soon as the TB medications are being tolerated.

High prevalence of antenatal depression in HIV-infected women

Research from KZN[7] alerts us to this reality, and to the fact that a third of such women contemplate deliberate self-harm. None of this will seem surprising: these women typically face socio-economic deprivation, are ill-nourished and have high-risk pregnancies, and the pregnancy is often unplanned. However, doctors should be on the lookout for antenatal depression in their patients.

Seeking 'cognitive enhancement' ... doctors should be warned

We are familiar with the concept of biomedical enhancement to achieve the appearance of youth, slimmer bodies, or 'immortality' in general. The 'Forum' article by Verster and Van Niekerk[8] informs us of a new phenomenon, particularly among students – seeking to improve intellectual prowess and academic success by resorting to use of the drug methylphenidate (Ritalin), typically prescribed for treatment of attention deficit hyperactivity disorder (ADHD) in children and for narcolepsy.

The drug is closely related to amphetamine, and it should be noted that the US Food and Drug Administration (FDA) requires that it carry a 'black box' warning arising out of the evidence that methyphenidate carries a significant risk of serious, even life-threatening, adverse effects. While its prescription other than for ADHD in South Africa is not illegal, and is becoming common practice, practitioners should heed the warning that there are cardiac complications associated with the drug including cardiac arrhythmia, tachycardia, hypertension, stroke and chest pain. Psychiatric side-effects include suicidal thoughts, aggression, psychotic behavior and hallucinations. There have also been sudden (mainly cardiovascular) deaths in children. See http://ritalinsideeffects.net

JS

1. Bateman C. RWOPS abuse – Government's had enough. S Afr Med J 2012;102(12):899-901. [http://dx.doi.org/10.7196/SAMJ.6481]
2. Evans M, Shisana O. Gender differences in public perceptions on National Health Insurance. S Afr Med J 2012;102(12):918-924. [http://dx.doi.org/10.7196/SAMJ.6397]
3. Hew-Butler T, Boulter J, Bhorat R, Noakes TD. Avoid adding insult to injury – correct management of sick female endurance athletes. S Afr Med J 2012;102(12):927-930. [http://dx.doi.org/10.7196/SAMJ.6156]
4. Govender NP, Chetty V, Roy M, et al. Phased implementation of screening for cryptococcal disease in South Africa. S Afr Med J 2012;102(12):914-917. [http://dx.doi.org/10.7196/SAMJ.6228]
5. Kendon M, Knight SE, Ross A, Giddy J. Timing of antiretroviral therapy initiation in adults with HIV-associated tuberculosis: Outcomes of therapy in an urban hospital in KwaZulu-Natal. S Afr Med J 2012;102(12):931-935. [http://dx.doi.org/10.7196/SAMJ.5574]
6. Nglazi MD, Kaplan R, Caldwell J, et al. Antiretroviral treatment uptake in patients with HIV-associated TB attending co-located TB and ART services. S Afr Med J 2012;102(12):936-939. [http://dx.doi.org/10.7196/SAMJ.6024]
7. Manikkam L, Burns JK. Antenatal depression and its risk factors: An urban prevalence study in KawZulu-Natal. S Afr Med J 2012;102(12):940-944. [http://dx.doi.org/10.7196/SAMJ.6009]
8. Verster C, Van Niekerk AA. Moral perspectives on stimulant use by healthy students. S Afr Med J 2012:102(12):909-911. [http://dx.doi.org/10.7196/SAMJ.6090]