Letters

The Foundation of a Medical Faculty at the University of Namibia

To the Editor:

The past years have been exciting, interesting and very important for the development of health care programs, palliative medicine, and palliative care in Sub-Saharan Africa. This region reflects all the well-known problems of developing countries. Despite these problems, southern African countries have realized a great deal of growth and development in palliative medicine and palliative care.

To illustrate these phenomena, we briefly review the health care problems and health care systems in Namibia and propose that integration of palliative care within these health care systems is one of the most important aims in the near future.

The history of Namibia began about 25,000 years BCE, when the most ancient drawings of Africa were created in the caves of the Huns Mountains in the south of Namibia. There has been a rich history since then. The founding of The University of Namibia (UNAM) in Windhoek in 1992 is one of our great achievements. At the time, Namibia had been independent for only 3 years.

Namibia is a vast country of approximately 824,268 km^2, located in the southwestern region of Africa. It borders Angola in the north, Zimbabwe and Zambia in the northeast, Botswana in the east, and South Africa in the south. Population is estimated at 1.8 million and the annual population growth rate is approximately 3%. The population is sparsely distributed and 30% are urban.[1] The mainstays of the economy are mineral resources and agriculture, and tourism is gaining in importance.

Namibia has gross regional and social class disparities. Access to health services has been poor due to a number of factors, including distance to facilities, lack of public transport, poor education, lack of primary and community-based health care programs, sparsely distributed populations, and poverty of some groups. Health care is mostly provided by public or private hospitals in large cities. Prevention programs are almost non-existent and hospitals and health care professionals spend most of their time managing severe symptoms, for which there are no treatments available. Most medical care of patients with serious life-threatening illness could be described as palliative. The great majority of the population has no access to social security or private insurance. Patients and their families have extremely limited resources for simple needs, such as transportation back and forth from health care facilities or buying necessary medications.[2]

Tuberculosis (TB) is one of the most important public health problems in Namibia. It ranks second as a cause of mortality.[3] Factors contributing to the seriousness of the disease are poor socioeconomic living conditions in large parts of the society, high unemployment, overpopulation, alcohol abuse, and malnutrition.

Southern Africa is the region most severely affected by HIV/AIDS in the world. The UNAIDS Program estimates that in Namibia, 20–26% of the 15–49-year-old population is already infected with HIV. The AIDS epidemic is, without doubt, a disaster with far-reaching social and economic implications.[4] The fast increasing rate of HIV will worsen the present TB situation, as HIV infection is one of the strongest risk factors for the development of active TB. Additionally, TB is the leading killer of HIV-positive people (more than 30% HIV-positive patients die as a consequence of TB).[3,5,6]

In the years 1995–2000, the Johanniter-Unfall-Hilfe (JUH), a German non-government organization (NGO) that is engaged in the health

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service in Germany and in several African countries, carried out a project to fight against tuberculosis, which was rapidly spreading in Namibia. Dr. Katri Elina Clemens, an anesthesiologist at the hospital of the Malteser Organization in Bonn since 1998, was appointed as the person in charge. The project aimed at allowing the local medical personnel to adopt a plan for autonomous health care administration regarding tuberculosis. The intention was to contribute to an extensive fight against tuberculosis with extremely modest means and especially to cope with compliance problems through regular medication supervised by local medical personnel.

During the initial phase of treatment, patients were placed under Directly Observed Therapy (DOT), in which patients took TB medication under the supervision of health staff, either as inpatients or as outpatients. Patients were motivated to come every day with a warm meal, a strategy called "therapy with a goulash gun." As part of the same program, patients were encouraged to participate in light work by keeping vegetable gardens that were later used for nutrition. This mild exercise also had beneficial effects, including major psychological benefits for patients and families. Patients who improved enough to be able to return to their communities were able to bring this methodology with them and help their neighbors. After several years of continuous development and accomplishments, the administration of the project was handed over to Namibian doctors and medical staff.

However, this project revealed fundamental problems (including the lack of a medical school). As a result, medical students of Namibia were forced to study abroad (for the most part in South Africa, Russia, and Cuba). After finishing their studies, they were not motivated to return to their home country where they are urgently needed as physicians. Medical personnel who stayed in those countries where they had received their medical education resulted in serious deficiencies of medical personnel in the young democratic Republic of Namibia, having great impact on not only the treatment of tuberculosis and HIV/AIDS, but on general medical care.

Presently, the University of Namibia has been unable to raise the necessary financial means to fund a medical faculty and it will not be in such a position in the near future. This is mainly due to the considerable costs of preclinical training. Based on this background and the importance of founding a medical faculty at the local university, the German supporting organization decided to provide the initial support and funding to start a medical degree program.

Due to the costs, the project of a medical faculty at the State University of Namibia will not include funding for pre-clinical training with expensive laboratories and equipment, but rather will focus on clinical education (after the preliminary examination in medicine), paired with practice until graduation. This seems best suitable to keep Namibian-educated doctors in their country. The foundation of a Medical faculty at the University of Namibia (UNAMED) gained general acclaim and interest from the individuals responsible in the University and in the government. Both the president of the Republic of Namibia, Dr. Sam Nujoma, and Dr. Klaus Kinkel, former Foreign Minister of Germany, support the project.

The agreement to create a medical faculty was signed on 6 September 2001 between the University of Namibia and Dr. Clemens, representing the German supporting association. The Medical Faculty for the education of physicians as medical specialists for the young state of Namibia was established with the belief it will contribute to the economic and democratic development of the country.

In Germany, an association for the support of the faculty was founded a few months ago (Verein zur Förderung der medizinischen Forschung und Lehre an der Medizinischen Fakultät der Universität Namibia). The Friends of UNAMED is a Bonn-based association, which is, according to German law, exclusively dedicated to the promotion of the Faculty of Medicine at the University of Namibia. We will contribute to the Foundation of a Faculty of Medicine at the University of Namibia by raising funds in Europe for equipment, staff, and the organizational needs of the new faculty. We will establish connections with universities and medical schools all over the world that are ready to share their experience with the Faculty of Medicine at University of Namibia concerning academic, organizational, and scientific matters. We will also foster connections with companies engaged in medical services,

drug manufacturing, and the manufacture of medical equipment. The founding of this association, which is largely based on Dr. Clemens's personal experience, also recognizes the importance of education and professional training in the development process. We all agree on the insight that Namibia needs qualified and well-educated young people to proceed and protect the democratic way.

There is need for more medical care, especially good community-based palliative care. Palliative care will play an important role in the curriculum for medical students, as a method to integrate the traditional viewpoints of medical responsibilities with new development of science to improve the quality of life in patients with incurable, far advanced, progressive diseases. Palliative medicine has shown, for a long time now, that it is possible to reduce pain and other physical symptoms to a bearable level, avoid unnecessary suffering, and restore human dignity. Palliative medicine is a cost effective and ethically justified practice with the potential for large public health impact. In countries with a high prevalence of diseases in which cure is less likely to be achieved, palliative education and care becomes even more important.

The aim for this project is to ensure its success so that it can become a model for other African countries. The fight against HIV/AIDS and TB cannot be won without cooperation with well-trained doctors, nurses, and other members of the multiprofessional team, along with the cooperation from interested faculties and pharmaceutical companies from around the world.

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Myocardial Infarction Associated with Diffuse Pain

To the Editor:

A 67-year-old man with a history of coronary artery disease, type II diabetes, and metastatic prostate cancer to bone presented to the emergency room of a cancer center complaining of severe diffuse body pain for 10 hours. He had been using transdermal fentanyl patches (150 μg/hour) with hydromorphone 4 mg tabs as needed for low back pain secondary to metastases in the lumbar spine. He typically would use one or two tablets of hydromorphone per day with good pain control. On the day of presentation, he developed the sudden onset of severe pain starting at 10 AM. He was carrying out his normal schedule of activities when he suddenly experienced excruciating diffuse total body pain. When he arrived at the hospital, he received 12 mg of hydromorphone IV over three hours divided in four doses, without relief. He was then given dexamethesone 24 mg once and an additional 5 mg of IV hydromorphone with only minimal improvement. He ultimately was given a total of 42 mg of IV hydromorphone before his pain improved. Given the unusual amount of opioid needed relative to his prior regimen and the history of coronary artery disease and diabetes, 10 hours after arrival to the hospital we performed an electrocardiogram (EKG). The EKG showed ST elevation of V2-V4. The CPK (333 U/L, normal 0–120) and troponin (2.64 ng/ml, normal <0.31 ng/ml) were both elevated. A diagnosis of acute myocardial infarction (MI) was made. The patient never localized the pain to the chest, arm, or jaw. Anticoagulation was not administered because of heme positive stool. The pain subsided completely 19 hours after its onset and recurred 29 hours thereafter, at which time the patient was transferred to the cardiac unit of the nearby university hospital. Catheterization revealed a culprit lesion of the obtuse