

Ambulatory care of paediatric and adolescent diabetic patients in the Western Cape

To the Editor: It has been proposed that routine care of paediatric and adolescent patients with type 1 diabetes (T1DM) in the Western Cape should be devolved from centres of excellence to centres at secondary or even primary level. Experience with adults with type 2 diabetes (T2DM) in another African country is cited to support this notion.¹ However, these two conditions have completely different aetiologies. While T2DM is entirely preventable and treatable by simple measures, this is not the case with T1DM. T1DM usually starts in childhood, and children can by no means be considered 'little adults'. They vary in size, growth phase and pubertal stage. Their manipulative skills can catch many a health worker off-guard. Maintaining optimal blood glucose control in order to prevent both acute (diabetic keto-acidosis and hypoglycaemia) as well as chronic (microvascular and macrovascular) complications is therefore far more difficult in this age group than in any other. The International Society for Paediatric and Adolescent Diabetes (ISPAD) in the latest Clinical Practice Consensus Guideline (supported by delegates from Africa) therefore recommends that children and adolescents with diabetes 'should be cared for ... by members of a team of specialists, all of whom should have training, expertise, and understanding of both diabetes and paediatrics, including child and adolescent development'.² Such a team would consist of a paediatric endocrinologist or an experienced paediatrician, a diabetic nurse educator, a dietician, a social worker, a psychologist and an ophthalmologist.

Randomised controlled trials in children with T1DM to support ISPAD's recommendation are not available, and for ethical reasons may never be done. In certain African countries where there are no or few paediatric endocrinologists or diabetologists, children with T1DM have a shortened life expectancy (0.96 years in Mali, 3.5 years in Mozambique, 11.2 years in Zambia).³ This suggests that lack of expertise is indeed associated with significant mortality among diabetic patients. In adult ambulatory diabetic care, adherence, monitoring of blood sugar and detection of complications is significantly better when patients are looked after by endocrinologists as opposed to generalists.⁴ These patients usually also have a better HbA_{1c} level, and significantly fewer develop end-stage renal disease. Furthermore, a multidisciplinary diabetes management team has been shown to impact on the cost of diabetic keto-acidosis, duration of hospital stay, number of emergency room visits and hospitalisations, hypoglycaemia and foot infections.⁴

Given the above, a secondary hospital geographically distant from a centre of excellence should only consider duplicating a diabetic ambulatory service if a multidisciplinary diabetes management team is available. An appropriately stocked dispensary, run by a motivated pharmacist, is also essential to prevent some of the problems frequently encountered at primary care centres.⁵ If these requirements cannot be met, it would not be in the interests of children and adolescents with T1DM to devolve their care to secondary or primary level.

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Termination of pregnancy and children

To the Editor: Recent articles^{1,2} addressed the duty of health care professionals and researchers to report sexual activity involving children. They discuss the interpretation and practical implications of section 54 of the Criminal Law (Sexual Offences and Related Matters) Amendment Act No. 32 of 2007 (Sexual Offences Act), which requires that 'a person who has knowledge that a sexual offence has been committed against a child must immediately report such knowledge to a police official'. The articles give guidance on the circumstances under which health care professionals and researchers, respectively, should report child abuse and who to report it to. However, it is of concern that some of their arguments seem to be based on a misinterpretation of section 56(2) of the Sexual Offences Act.

McQuoid-Mason¹ highlights *inter alia* the conflict between medical confidentiality and the mandatory reporting of consensual sexual acts with certain children which is criminalised under the Sexual Offences Act (sections 15, 16). He suggests that it may be justifiable for a medical practitioner not to report a pregnancy of a child resulting from a statutory rape (i.e. consensual sexual penetration) in cases where the defence of section 56(2)(b) of the Sexual Offences Act is applicable. Under section 56(2)(b) of the Sexual Offences Act it is a valid defence 'to contend that both the accused persons were children and the age difference between them was not more than two years at the time of the alleged commission of the offence'. His argument seems to be that if the court would not find the children guilty of statutory rape because of a valid defence, then there is no basis for asking the medical practitioner to report such an offence (and breach his patient's confidentiality) in the first place. However, the defence of section 56(2)(b) of the Sexual Offences Act does not apply to statutory rape; it only applies to the offence of statutory sexual assault (section 16 of the Sexual Offences Act), which deals with non-penetrative sexual acts with certain children. The argument of section 56(2)(b) of the Sexual Offences Act serving as a defence for statutory rape and thereby obliterating the doctor's duty to report is therefore of no avail.

Similar thoughts seem to guide Bhana *et al.*² in discussing standards for researchers for the reporting of sexual activity and abuse of minors. They argue that no formal reporting action needs to be taken by researchers when receiving reports of consensual sex between minors where the parties involved are no more than 2 years apart in age. They emphasise that the age difference of 2 years is a crucial factor for a decision about reporting sexual activity. However, in the light of section 56(2)(b) of the Sexual Offences Act, the age difference can only be a guide in deciding about reporting cases of consensual sexual violation with children (i.e. non-penetrative sex), because the provision does not apply to statutory rape.

The authors' suggestion that the Sexual Offences Act 'replaces previous legislation where reporting could be done to a social worker or the police' ignores the fact that the Sexual Offences Act does not repeal or amend the mandatory reporting provisions created under