Editor's Choice

Alien justice – the pitfalls of foreign work

The legal vulnerability of healthcare workers in foreign countries where justice operates in unfamiliar ways has never been better illustrated than by the shocking case of one of the doyens of haematology and oncology in the South African state sector, Professor Cyril Karabus.

As of 13 December 2012 he was still on trial for manslaughter and forgery, his sudden arrest having taken place at Dubai Airport's passport control on 18 August – a decade after the incident. (He was about to board a connecting flight to Cape Town after attending his son's wedding in Canada.) Karabus did a 5-week locum at the Sheikh Khalifa Medical Centre in Abu Dhabi in 2002, during which a 3-year-old Yemeni girl he was caring for, suffering from acute myeloid leukaemia, succumbed to an intracranial haemorrhage as a complication of profound pancytopenia. Unbeknown to him or (supposedly) the Canadian agency that hired him, he'd been tried *in absentia* in 2003 and found guilty of murder, a verdict set aside on appeal. A fresh manslaughter charge claimed that he failed to give his patient vital platelets and then 'doctored' the files *post mortem* to show that he had done so. Vital supporting documents from the time went missing and he was out on R240 000 bail (*sans* passport), having spent 57 days in prison. He lives with a pacemaker and stent, putting him at risk in what seemed an interminable trial. Izindaba profiles the case.[1,2]

For South African practitioners the whole sorry saga represents a 'cautionary tale'. Think twice about risking reputation and freedom before committing to a foreign locum post.

Nineteenth-century mortality rates?

Medical inpatient mortality rates at Groote Schuur Hospital of 12 - 17% are comparable to rates observed in North America in the mid-19th century (down to 2% in the modern era), say Myer *et al*.[3] These high rates reflect South Africa's shifting burden of disease due to HIV and tuberculosis, paralleling increases in chronic disease of lifestyle and increased access to higher hospital-based levels of care as primary healthcare access improves. The sobering reality is that the majority of deaths occur shortly after admission, which speaks volumes about the severity of illness at admission and deficiencies in pre-hospital care.

Deliberate self-harm by ingestion of agricultural insecticides burdens limited critical care facilities

A community service medical officer[4] reports on the burden such patients place on the limited critical care facilities at Cecelia Makiwane Hospital, costing the Eastern Cape fiscus, at a conservative estimate, R1.3 million a year. Fortunately there has been a fall in these admissions, for which several reasons are advanced, the most hopeful being that potential victims are receiving improved social support.

HTLV-associated myelopathy

Tropical spastic paraparesis reflecting atrophy of the spinal cord following infection with the human T-cell lymphotropic virus type 1 (HTLV-1) virus is reported by Schutte *et al.* as just one of the neurological complications to which HIV-infected persons are prone.[5] HTLV-1-linked myelopathy is rare enough (developing in 0.25 - 2% of virus carriers), but in co-infected HTLV-1 and HIV patients it presents earlier and takes a more rapid course, which may reflect virus interaction and can occur at any stage of HIV-induced immunosuppression.

Late termination of pregnancy by intracardiac KCl injection

Experience with late termination of pregnancy (TOP) by intracardiac injection of potassium chloride is described by Govender and Moodley.[6] The South African Choice on Termination of Pregnancy Act, No. 92 of 1996, permits TOP at any gestational age for severe fetal abnormalities, to prevent the birth of a severely mentally or physically handicapped child. The authors report on their 5-year experience and the relative safety of injection of KCl into the fetal heart under ultrasound guidance, to ensure stillbirth of a fetus with severe congenital abnormalities – typically picked up only after 24 weeks' gestation, when the fetus is viable.

Lymphoma or tuberculosis?

Lymphoma is easily misdiagnosed as TB in HIV-positive patients because the presenting symptoms (fever, weight loss and night sweats) and signs (lymphadenopathy) are so similar. The lymphoma is typically an aggressive, diffuse B-cell variety of non-Hodgkin's lymphoma. Puvaneswaran and Shoba[7] warn us how easily doctors in primary health care settings, burdened with large numbers of patients, can fall into the trap of calling the illness TB, by failing to order TB cultures or follow up patients to appraise results of investigations and check on response to TB treatment.

The intimate examination – chaperone or not?

A survey of gynaecologists and GPs by Guidozzi *et al*.[8] reveals that a majority of practitioners wisely opt for the presence of a chaperone when undertaking intimate examinations. Given that the Medical Protection Society reports that practitioners are rarely accused of sexual impropriety if a chaperone has been present, it is surely foolish of a third of doctors to deem this unnecessary. And the gender of the patient should not offer any false sense of security, as complaints are received by the MPS against practitioners of the same gender as the patient. While the Health Professions Council of South Africa and international ethics codes and guidelines clearly prohibit sexual relationships between doctors and patients, this has not prevented complaints against practitioners in South Africa. The authors suggest that the time has come for a stipulation regarding use of chaperones to be included in the HPCSA Guidelines for Reproductive Health, and widely publicised, to bring this country's ethical standards in line with international clinical standards such as those of the UK and USA.

An update on office spirometry

Koegelenberg, Swart and Irusen[9] of the Division of Pulmonology, Stellenbosch University and Tygerberg Hospital, present an updated guideline for office spirometry in adults (2012).

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