of MPS indemnity means that doctors only need to be a member of the MPS at the time something goes wrong; after that, assistance can be requested at any time even if the doctor has moved away, taken a career break or retired. This provides comfort and peace of mind for the doctor and his or her patients.

In contrast, insurance contracts are complex and are governed by the wording of the policy conditions. They also are invariably based on the 'claims made' principle, which means that cover ceases at the end of the policy unless the individual doctor purchases 'run-off' cover to meet past incidents that have yet to be reported as claims. It is because we so firmly believe in providing our members with what is best for them and their patients that we remain so committed to our discretionary occurrence-based model of indemnity.

I want to emphasise that the MPS is far more than a provider of professional indemnity against claims of negligence. We also assist with any problem that arises from a doctor or dentist's professional practice. This might include advice on ethical issues or support with disciplinary proceedings, inquests or medical council inquiries.

One of the core benefits of membership is our confidential counselling service, which we fund because the pressures facing those working within health care are such that the consequences of even the smallest error can be personally devastating for the individual doctor.

The MPS has accumulated a vast wealth of experience and expertise in medico-legal issues over many years and from more than 30 countries – we are truly world experts in our field. The MPS is committed to help improve patient safety, and we share our expertise to help prevent future problems occurring. We do this through lectures, seminars, courses and workshops. For doctors our influential publications such as *Casebook* and *Junior Doctor* are core components of continuing education, and we regularly develop materials on important matters such as consent and risk management issues.

We have evolved over the many years we have been in South Africa and, with the support of members and the profession, we want to evolve further in the future. We hope you will support our campaign to persuade the Minister of Health to review the new regulations and to allow us to continue to provide a high-quality service to our members and their patients. As our attempts to secure a solution progress, we will update you on progress regularly via the MPS website. No one should be in any doubt of the intensity of our activity to find a solution that is acceptable to the profession and to government.

South Africa is and will remain of immense importance to the MPS.

A D Mason
Chief Executive
Medical Protection Society
UK
tony.mason@mps.org.uk

Solubility tests and the peripheral blood method for screening for sickle-cell disease

To the Editor: We refer to the paper by Okwi *et al.*[1] Cost benefit analysis of screening for sickle cell disease (SCD) using different methods cannot be done in isolation, and the following are important principles to take into account.

1. Reasons for screening: (*i*) early detection of the disease for timely intervention to minimise morbidity and mortality; (*ii*) patient and family education on SCD; (*iii*) genetic counselling as part of a long-term strategy to prevent live homozygous SCD (SS) births; and (*iv*) short- and long-term cost saving by means of (*i*), (*ii*) and (*iii*) above.
2. The method of detection needs to be very sensitive. Subjects with false-negative results will remain undiagnosed and may well present with an acute crisis or organ damage, with major cost implications.

The sensitivities of the sickling and solubility tests for detection of the sickle cell trait (AS) as reported by the authors were 65% and 45%, respectively, essentially translating to high 35% and 65% false-negative rates, an unacceptable scenario regardless of cost saving.

Clearly the methodologies need to be questioned, since the sickling test is sensitive enough to detect AS.[1,2] In addition, the article advocates that negative sickling tests be regarded as negative for the disease, evidently with no further testing required. This means that 35% of the subjects tested will walk around with undiagnosed AS despite having been tested, which defeats the objectives of screening as stated above.

The recommendation by the group that the sickling test be the preferred and sole method for screening, purely on the basis of economics, is disconcerting, while with its observed shortcomings the proposed screening method would be of short-term benefit.

We conclude that a cost benefit analysis of methods with such low sensitivities is ineffective and futile.

N A Alli
S B Loonat
Department of Molecular Medicine and Haematology
School of Pathology
University of the Witwatersrand/National Health Laboratory Service
Johannesburg
nazeer.alli@nhls.ac.za

1. Okwi AL, Ocaido M, Byarugaba W, Ndugwa CM, Parkes A. Solubility tests and the peripheral blood film method for screening for sickle cell disease: A cost benefit analysis. S Afr Med J 2009;99(12):887-891.
2. Dacie JV, Lewis SM. Practical Haematology. 5th ed. Edinburgh: Churchill Livingstone, 1975.
3. Chanarin J. Laboratory Haematology. 1st ed. Edinburgh: Churchill Livingstone, 1989.

Okwi *et al*. reply: Our cost benefit analysis was not done in isolation, as suggested above. The paper was published together with others that appeared elsewhere and addressed the issues raised. Sensitisation of communities (patient and family education on SCD) and timely intervention were covered in a publication in the *East African Medical Journal*.[1] Another paper addressing some of these issues was published in *BMC Blood Disorders*.[2]

All the false negatives with the sickling test were cases of AS (carriers), not SS. The sickling test demonstrated all SS cases, as did Hb electrophoresis – i.e. sickling was sensitive in SS detection but not in AS detection. The sickling test would therefore be sensitive enough to detect all the children with SS, who would benefit most since they suffer from crisis, while carriers (AS) do not.

Lastly, the authors state that our article advocated interpreting a negative sickling test as the patient being negative for the disease, with no further testing required. We did not assume or recommend this. Our assumption was that all the children who might accidentally be missed by the sickling test and develop symptoms later would be tested by Hb electrophoresis.

We concluded that although the sickling test was not highly sensitive, it was more sensitive than solubility and the peripheral blood film method.

1. Okwi AL, Byarugaba W, Ndugwa CM, Parkes A, Ocaido M, Tumwine JK. Knowledge gaps, attitude and beliefs of the communities about sickle cell disease in eastern and western Uganda. East Afr Med J 2009;86(9):442-449.
2. Okwi AL, Byarugaba W, Ndugwa CM, Parkes A, Ocaido M, Tumwine JK. An update on the prevalence of sickle cell trait in Eastern and Western Uganda. BMC Blood Disorders 2010;10: 5doi:10.1186/1471-2326-10-5.

Approval of chronic medication

To the Editor: In response to Professor Rayner's letter to the *SAMJ*,[1] I would like to point out that Discovery Health was able to resolve the case before it was published in your journal. Professor Rayner has indicated to us in writing that he would have withdrawn his letter to you, had it not been too late to do so.

Discovery Health formulates its funding policies using evidence-based medicine and in consultation with South Africa's various professional specialist societies and leadership. In the case of diabetes mellitus, current SEMDSA guidelines (published in 2009) do not recommend the use of HbA1c for diagnosis. We are aware of the American Diabetes Association statement referred to by Professor Rayner, which recommends the use of HbA1c as a diagnostic test. This continues to be debated in national forums, and in fact the most recent SEMDSA guidelines released in August 2010 reaffirm the position that HbA1c should not be used alone as a diagnostic criterion for diabetes or pre-diabetes.

We recognise that individual cases do sometimes merit exceptional decisions on clinical grounds. The doctors we employ, some of whom are referred to in Professor Rayner's letter, have the challenging task of applying our funding policies in a way that is fair and consistent, taking into account both the best interests of individual patients and our membership base as a whole. They do so with great care. In this specific case, we failed to recognise up front that a clinical exception could have been made. Going forward we will endeavour to further enhance this aspect of our service.

The sustainability of our members' medical scheme benefits depends on our ability to responsibly apply the principles of evidence-based medicine wherever possible. We will always actively engage with the health care profession and the various representative societies to ensure that our funding decisions are clinically sound, but as noted above, there are often complex cases in 'grey areas' and we acknowledge that we do and will make errors in some of these situations. We always try to correct these as quickly as possible, and we appreciate the feedback we receive, which assists in improving our overall approach. We call on all health care professionals to work with us in a spirit of co-operation, rather than conflict. Finding the balance between what is best for each patient and for our private health care system as a whole is a complex task, and needs an active partnership between responsible funders and practitioners.

Jonathan Broomberg
Chief Executive Officer, Discovery Health
jonathanb@discovery.co.za

1. Rayner B. Approval of chronic medication – Discovery Health hits new lows. S Afr Med J 2010;100:482.