

Indemnity hikes – suck it up or risk serious money?

Just when doctors were heaving a sigh of relief at not having to cast around for a solid indemnifier with the track record and reserves of the briefly government-threatened Medical Protection Society (MPS),¹ a hefty subscription hike kicks in, reports Chris Bateman.²

Unavoidable, says the MPS, given local patient claims, litigators becoming smarter, fast-evolving (and expensive) medical technology and growing patient awareness, which boosted the cost of reported local negligence claims by 132% over the past 2 years. Paediatricians who recently moved into the neonatology field suffer most – with a 182% subscription hike, pushing them to R26 230 per annum, the result of a spike in payouts for catastrophic injuries in their bailiwick. Yet obstetricians and spinal surgeons won't exactly be happy either; they face 43.9% and 65.2% increases, which take their annual subs to a hefty R187 830 and R174 700, respectively.

The bigger hikes reflect the increase in the cost of compensation awards made to young children harmed by negligent treatment, and specifically the heavy cost of funding lifetime care packages. If this is thought outrageous, consider the patient who last year won R17 million for catastrophic damage following a spinal/neurosurgical procedure.

Race in research

The *SAMJ* author guidelines advise that 'Work that is based on or contains reference to ethnic classification must indicate the rationale for this.' Although authors may provide a rationale, it is sometimes far from clear that such classification is appropriate. Anton van Niekerk investigated race as a variable in research ethics.³

Race as a variable in research needs rational and democratic deliberation, as its admissibility can seldom be settled by alleged 'hard scientific facts'. Deliberation may be defined in terms of outcomes: 'the endogenous change of preferences resulting from communication'. Secondly, the democratic process of deliberation is public. Thirdly, deliberation occurs in a group that agrees to the procedural assumptions of the process. Decision-making ought to be the outcome of a transformation of views, rather than simply the aggregation (and possible misrepresentation) of preferences.

The structure and context of a research ethics committee support our efforts to overcome prejudice and to engage in superior rational argument. Deliberation about a controversial notion such as race is arduous, and will probably remain inconclusive. Our challenge is to make it manageable and no longer feared or concealed. If continued deliberation cannot achieve that, nothing short of violence will.

Hope for cryptococcal meningitis

Adult meningitis in areas of high HIV prevalence in southern Africa is most commonly caused by *Cryptococcus neoformans*.

Lessells and colleagues⁴ report on cryptococcal meningitis (CM) at Hlabisa Hospital, a district hospital in rural northern KwaZulu-Natal. They investigated outcomes 2 years after an episode of cryptococcal meningitis. Inpatient mortality was high (40.5%) and was significantly associated with a reduced level of consciousness and absence of headache. They conclude that long-term outcomes of CM are poor in routine practice and that interventions to strengthen linkage to HIV treatment and care and continuation of secondary fluconazole prophylaxis are critical.

A case is made for routine cryptococcal antigen screening for HIV-infected patients with low CD4+ T-lymphocyte counts by Jarvis and colleagues.⁵ They note that CM is a major cause of death among HIV-

infected individuals. Even with optimal treatment in study settings, 10-week mortality rates are between 24% and 37%. The incidence of CM should fall with the scale-up of antiretroviral treatment (ART) programmes as CM primarily infects patients with low CD4 T-cell counts.

Fortunately nearly all patients at risk of developing CM during ART can be identified on entry into ART programmes by screening for sub-clinical infection using cheap, simple and highly sensitive cryptococcal antigen (CRAG) blood tests. Evidence for the utility of CRAG screening to identify patients at risk of CM is compelling, but key questions remain of how best to implement a screening policy and how to manage the asymptomatic CRAG-positive patients identified.

Jarvis and Meintjes⁶ note that, despite the poor outcomes of CM reported, a series of straightforward steps could markedly improve outcomes, even with the available treatment options, including a low threshold for suspecting CM, having amphotericin B available to all clinicians treating such patients, and other established clinical interventions.

HIV-associated tuberculosis and provider-initiated HIV testing

The traditional model for HIV testing is that of voluntary counselling and testing (in which the decision to test is left with the patient). Lawn and colleagues⁷ sought to determine the impact of the introduction of provider-initiated HIV testing in TB clinics at a community-based clinic in Cape Town.

They found that the introduction of provider-initiated HIV testing by the TB control programme was temporally associated with a major increase in referrals of patients with HIV-associated TB to this service, a progressive decline in referral delay, improvements in baseline CD4 cell counts, and fewer recurrent TB episodes. Such trends are likely to be associated with improved survival, and these data strongly support this HIV testing strategy.

Rift Valley fever – an occupational hazard

Rift Valley fever (RVF) is a viral zoonosis endemic to Africa that re-emerged in South Africa in 2008, and Archer and colleagues⁸ investigated the effects on cattle farmers and farm workers, and the staff and students of a veterinary school.

They conclude that the epizootic highlights the need for renewed vaccination of ruminants against RVF in South Africa. The defined occupational group should also be considered as a primary target for future immunisation against RVF once human vaccines become available.

JpVN

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