Disclosing the diagnosis of deceased HIV-positive persons

About a decade ago, the medical profession was rudely reminded of the issues surrounding confidentiality and HIV when a colleague was convicted for disclosing the HIV-positive status of a patient to a golfing partner, a case that received wide public attention. But what is the legal liability on a medical practitioner who divulges about a deceased person?

McQuoid-Mason[1] draws a distinction between the rights of the deceased in terms of the law, and in terms of the HPCSA ethical rules. In terms of the law, 'there is no protection for the personality rights of deceased persons – including protection against disclosures about their HIV status'. Therefore, no civil action for damages attaches to the intentional disclosure of the HIV-positive status of a dead person. The law goes even further and imposes a positive duty on medical practitioners to disclose the medical cause of a person's death in some instances.

On the other hand, the HPCSA ethical rules prohibit such intentional disclosure, and a practitioner is liable to face disciplinary action if he or she discloses the HIV status of a deceased person without the written consent of next-of-kin or executor of the estate of the deceased, except where such disclosure is required in terms of a statute or court order, or the disclosure is justified in the public interest. Matters of public interest include the private lives of public figures 'in the public domain, such as politics …, professional bodies, sports and the arts'. The article further delves into the position of disclosure relative to endangered third parties, and to insurance companies.

Primary care has not reduced emergency diabetes admissions

One of the premier if controversial innovations in the design of health care systems for the new South Africa was the devolution of significant health care resources from hospital-based care to primary care in the expectation that enhancing access and the quality of care at this level would help reduce the burden of preventable hospital admissions through improved prevention strategies, early diagnosis and early interventions.

However, according to Pepper *et al.*[2] these expectations have not materialised in the case of emergency admissions for hyperglycaemic crises – at least not in the greater Cape Town region. The authors conducted a prospective survey of all hyperglycaemic admissions to a Cape Town secondary hospital during a 2-month period, and found that the predominant reasons for admission – sepsis, non-compliance with therapy, and undiagnosed diabetes – could have been prevented by more effective primary care intervention.

Coping with the deluge of ART-eligible AIDS patients

'Of the estimated 5.4 million South Africans currently infected with HIV, 640 000 developed indications for highly active antiretroviral treatment (HAART) in 2006, and a similar number will come on stream for treatment every year for at least the next decade', according to Barker and Venter[3] in their paper on how best to plan for effective future intervention in this nightmarish scenario. The government treatment programme is clearly not coping. In 2006, only 100 000 of the > 600 000 newly eligible clients for HAART were initiated on treatment, and the total number of patients currently on treatment nationally since the inception of government programmes in 2004 is estimated to be just over 200 000. The picture is equally dismal with respect to perinatal and postnatal treatment to prevent mother-to-child transmission, something that would otherwise dramatically reduce the number of children eligible for HAART each year, and help contain infant and child mortality from HIV/AIDS.

The authors believe that the treatment programme would be rendered more effective if it were devolved to district level. This could be achieved by estimating the need for new HAART initiations in each district based on local population and HIV prevalence rates and setting annual targets of numbers of patients to be initiated on treatment at that level. Treatment programmes could then be designed around the existing capacity within primary and secondary health care services in those districts.

Diabetic retinopathy – 'too little too late'

Read and Cook[5] reviewed the histories, carried out corrected visual acuity tests and performed undilated ophthalmic fundoscopy on 248 diabetic patients attending a day hospital in Cape Town, and found that only 5.2% had had regular annual fundoscopy as recommended. The prevalence of diabetic retinopathy was 32.3%, with 4.4% having visual impairment and 8.9% needing urgent referral for sight-threatening retinal abnormalities. There was a massive lack of awareness among the patients with regard to the existence of diabetic eye disease, and an inferred ignorance or negligence on the part of health care givers regarding screening recommendations.

1. McQuoid-Mason D. Disclosing the HIV status of deceased persons – ethical and legal implications. *S Afr Med J* 2007; 95: 920-923.
2. Pepper DJ, Levitt NS, Burch VC. Hyperglycaemic emergency admissions to a secondary-level hospital – an unnecessary financial burden. *S Afr Med J* 2007; 95: 963-967.
3. Barker PM, Venter F. Setting district-based annual targets for HAART and PMTCT – a first step in planning effective intervention for the HIV/AIDS epidemic. *S Afr Med J* 2007; 95: 916-917.
4. Read O, Cook C. Retinopathy in diabetic patients evaluated at a primary care clinic in Cape Town. *S Afr Med J* 2007; 95: 941-944.

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