The co-occurrence of filarial infection of the pleura and breast is uncommon, although cases of breast involvement have been reported.[4-7] Scanning the literature we found only 1 report on microfilarial pleural involvement.[2] The atypicality of our case is also noteworthy because the patient did not give any history of acute filarial attacks characterised by fever, lymphangitis or breast inflammation, and there was no lymphatic obstruction or lymph node involvement. Our report therefore describes the first case of simultaneous microfilarial pleural and breast involvement.

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Should doctors charge doctors?

To the Editor: Dent and Strauss could find no rules about medical practitioners charging their colleagues.[1] I am delighted, because I would like pro-amico charity to reflect the relationship of one individual to another without the interposition of inflexible law, rule or directive. Even etiquette implies ritualisation. More pleasing is that there are no statutory directives, or even SAMA rules, because the decisional autonomy of medical practitioners is shackled enough by busybody inclinations.

Charging doctors covered by health insurance should present no quandary, since subsidising insurance companies is not the realm of health care. 'Shortfalls' could be abandoned, since they are notional concepts, just as the 'appropriate fee' is arbitrary.

Pro-amico treatment evolved when small communities depended for help on those close by; before the division into specialties, a sick doctor was reliant on fewer individuals within his community. There were pragmatic reasons for helping colleagues. Today, the variety of specialists involved and appreciation for past referrals challenge how much charity any individual can offer. Selection therefore becomes determined by context.

I suggest a 'proximity index' to guide the 'closeness' of context, such as:

1. Time. Long association brings compassionate and charitable affinity.

2. Place. A doctor from a distant area, encountered for the first time, will have fewer claims to charity.

3. Affordability. A local but wealthier doctor might have less 'proximity claim' than a poorer colleague from further afield.

4. Cultural bondage, a common cause, or common obstacles overcome. Afrikaans- and Zulu-speaking doctors in South Africa might have little in common, but a great deal when they both find themselves in similar circumstances in Canada.

Should the 'proximity index' for compassionate treatment extend beyond doctors? Nurses often struggle financially, and we have all been assisted (or salvaged) by that extraordinarily close professional relationship. By my count the proximity index here is high, and pro-amico treatment warranted.

The shoe can lie on another foot. Doctors who have generated millions of rands for a fee-paying hospital warrant subsidised or free treatment there, particularly in their age of decay.

The SAMA Benevolent Fund, however, is different and needs rule-driven decisions. This fund is an expression of the finest qualities of human altruism and organisational capacities. In our affluent age I hope this charity will prosper, benefiting from donations made in lieu of paying colleagues.

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