

Professor Cyril Karabus

To the Editor: The arrest in August 2012 and subsequent prolonged detention in an Abu Dhabi prison of 78-year-old Emeritus Professor Cyril Karabus has justifiably been met with shock and outrage, both locally and globally. To quote our sister publication the *British Medical Journal*, this is nothing short of a disgrace.

Professor Karabus was arrested while in transit through Dubai *en route* back to South Africa after attending his son's wedding. The charges relate to the death of a child with acute myeloid leukaemia who Professor Karabus looked after while doing a locum in Abu Dhabi in 2002. The child was desperately ill and not responding to chemotherapy, and succumbed to an intracranial haemorrhage as a complication of profound pancytopenia. Unbeknown to him, in 2003, well after his departure, he was convicted of murder *in absentia*. This charge was set aside after his arrest and detention and converted to manslaughter. It took five court appearances and almost 8 weeks in prison before the physically unwell 78-year-old was finally granted bail in October. This followed a significant amount of pressure from groups locally and internationally, and eventual assistance from the Department of International Relations and Cooperation. A 12-person medical panel, which has not yet convened, has been tasked to review the case and make a recommendation; however, Professor Karabus's defence lawyer has still not gained access to the patient's medical file to prepare an adequate defence.

The South African Medical Association, like many others, has lent its support and is appreciative of the assistance from the World Medical Association. At the October 2012 General Assembly of the WMA, an emergency resolution condemning this arrest was unanimously supported by the association's 102 constituent members. Through the WMA, assistance has also been received from Amnesty International, Human Rights Watch, the British Medical Association and the American Medical Association. SAMA will continue to support as and where it can. However, this matter has raised two very important issues.

The first of these is the issue of the vulnerability of doctors who work in foreign countries. The United Arab Emirates depends heavily on foreign doctors to support its healthcare system; allegedly 97% of healthcare workers in the UAE are foreign. The above case lays bare the potential risks attached to working in foreign countries, and SAMA urges its members to consider such risks carefully before embarking on such work – particularly, given the above events, in the UAE. It has also highlighted the fact that despite criticisms, we can feel reassured that the South African justice system affords many immutable rights to individuals, rights that have not been afforded to Professor Karabus by the UAE. Perhaps it is time to consider a global boycott of locum skills in countries that treat health professionals in such a manner?

Second is the very real issue of those who dedicate their lives to the public sector but are left financially challenged upon retirement. Professor Karabus, who like many others had dedicated his life to the public sector, was working in the UAE after his retirement from Red Cross War Memorial Children's Hospital because it was necessary for him to do so. The remuneration policies of the public sector can mean that true retirement is financially not an option, as well as being a major reason for the lack of retention of skilled medical staff. Although remuneration structures have improved with the OSD, the issue remains a very important one and the situation must be improved. If people dedicate their lives to caring for the disadvantaged and poor, the least they should have is a certainty of security in their future.

SAMA remains hopeful that the travesty of justice involving Professor Karabus is swiftly brought to conclusion.

Mzukisi Grootboom

Chairman, SAMA

Mark Sonderup

Vice-Chair, SAMA

msonderup@samedical.co.za

Phophi Ramathuba

Chairperson, Public Sector Doctors Committee

S Afr Med J 2012;102(12):896. DOI:10.7196/SAMJ.6486

Lack of communication kills: Botched circumcisions in the Eastern Cape

To the Editor: Xhosa ritual male circumcision in Eastern Cape Province (ECP) has become a matter of significant concern, following the numerous deaths and injuries resulting from botched circumcisions that occur in this cultural practice. Preventing these adverse events is a priority of the Department of Local Government and Traditional Affairs of the Eastern Cape (DLGTA:ECP).

The DLGTA:ECP joined forces with various arms of government and traditional leaders through the Eastern Cape House of Traditional Leaders (ECHTL) to address the problem. In 2011, the ECHTL compiled the *Do's and Don'ts* of male traditional circumcision for all stakeholders, and then implemented a Monitoring and Intervention Strategy (MIS) on the challenges pertaining to male circumcision.

The objectives of the MIS were to restore the dignity and integrity of *ulwaluko* (initiation) in the province, to ensure safe passage of young initiates to manhood, to inform and educate key roleplayers about their responsibilities, and to effectively manage stereotypes and perceptions about the male initiation custom. The MIS also involves the deployment of traditional circumcision teams (TCTs) headed by traditional leaders in all districts. The TCTs are responsible for monitoring circumcision huts daily and providing feedback to the ECHTL. The MIS includes pre-initiation preparation ahead of each circumcision season.

Meetings and training workshops on the correct procedure for traditional initiation nursing skills are held for traditional leaders, *ingcibi* (traditional surgeons) and *amakhankatha* (traditional nurses) in the province to strengthen the MIS initiative. Dialogue and engagement with *ingcibi* and *amakhankatha* are facilitated by the ECHTL and Department of Health to educate the stakeholders.

We undertook a survey to assess whether these initiatives were having an effect. Highlights of our findings were that the MIS, since its inception, has via TCTs rescued 131 illegal initiates who were returned to their home areas in the custody of their parent; identified and reconstructed inadequately built traditional lodges in Bizana, Flagstaff and Lusikisiki; identified initiates in ill-health who subsequently received appropriate clinical intervention; and rescued initiates in Qaukeni and Cofimvaba from natural disasters that took place during the November/December 2011 season, providing alternative lodges and accommodation.

We believe that it is essential for the MIS to not only run seasonally but also to become a proactive and ongoing campaign because, unfortunately, unqualified traditional surgeons, irresponsible parents and inattentive nurses still contribute to the problem of botched

circumcisions. Regular updating of the database of all traditional surgeons should be maintained and circulated to all stakeholders. Community education and workshops should continue to receive priority.

We thank the Durban University of Technology for funding this study, and the Eastern Cape House of Traditional Healers for their time and input.

Lentsu Nchabeleng

Zwakele Ngubane

Renitha Rampersad

Department of Marketing, Retail and Public Relations

Durban University of Technology

nchabeleng@gmail.com

1. Vincent L. Cutting tradition: the political regulation of traditional circumcision rites in South Africa's liberal democratic order. JSAS 2008;34:77-91. [http://dx.doi.org/10.1080/030570701832890]
2. Stinson K. Male circumcision in South Africa: how does it relate to public health? <http://www.africanvoices.co.za/culture/circumcision.htm> (accessed 12 March 2010).
3. Meintjies G. Manhood at a price: socio-medical perspectives on Xhosa traditional circumcision. Grahamstown: Rhodes University, 1998:7-12.
4. Melkote SR, Steeves HL. Development for communication in the third world: theory and practice for empowerment. California: Sage Publishing, 2001.
5. McPhail TL. Development communication. Chichester: Wiley-Blackwell, 2009:3-12.

S Afr Med J 2012;102(12):896-897. DOI:10.7196/SAMJ.6343

Sun protection factor of South African-tested sunscreens

To the Editor: This letter seeks to shed some light and rationality on the recent confusion surrounding the Cancer Association of South Africa (CANSA)-initiated ultraviolet A (UVA) test results on some South African (SA) sunscreens.

In August 2012, media publicity questioned the efficacy and safety of SA-produced sunscreens, suggesting that locally produced sunscreen products 'didn't meet standards'. This controversy originated from a small-scale *in vitro* UVA protection study that was conducted for CANSA on just 10% of products sold in SA.

The *in vivo* sun protection factor (SPF) of the products was never in question, despite suggestions to the contrary in the popular media (and even in *SAMF*). The SA SPF test (SANS 1557), which is conducted on healthy human volunteers, is reliable and has been in line with the International Standards Organisation (ISO) SPF *in vivo* test (ISO 24444) throughout the latter's development. In fact SA played a key role in initiating the ISO standard in 2006.

Take-home point 1: The SPF of tested SA sunscreens is reliable – so use them.

The current controversy surrounds the UVA/ultraviolet B (UVB) balance of protection of the sunscreens. In late May the ISO 24443 *in vitro* UVA test was published and is due to be incorporated into the SANS, but is not yet in any SA National Standard. The ISO 24443 is an instrumental test – not an *in vivo* test – that seeks to test for UV filter photodegradation. Products are irradiated with a full UVA and UVB spectrum equivalent to the *in vivo* SPF of the sunscreen (e.g. SPF 30 or 50) to 'stress' the sunscreen product and test for potential photodegradation. Thereafter, the UVA/UVB protection spectrum is tested. The new ISO standard (24443) for *in vitro* UVA tests requires the post-irradiation UVB/UVA *in vitro* ratio to be greater than 1:0.3.

The SANS 1557 states only that the UVB/UVA protection ratio must exceed 1:0.4. There is currently no SANS for *in vitro* UVA, although a process was included in earlier editions of SANS 1557.

All the CANSA-tested products complied with the existing SPF, UVA and irritancy requirements at the time of going to market. The

test that was conducted (and incorrectly reported in the media as the 'COLIPA' test) produced post-irradiation results for some of the tested products below the ISO-stated 1:0.3 UVB/UVA ratio. For an SPF 30 product, the UVA protection factor (UVAPF) was therefore less than 9, or for an SPF 50, less than 15.

Take-home point 2: All products tested had SPF and UVA test data that complied with existing standards.

The most effective and widely used UVA filter (butylmethoxydibenzoylmethane) is prone to some photodegradation, as is also the case for one of the most commonly used UVB filters, (octyl methoxycinnamate), albeit to a lesser extent. These two filters can be photostabilised with the addition of any of three other ultraviolet (UV) filters (octocrylene, methylbenzylidene camphor or diethylhexyl naphthalate). The organic pigments, such as zinc oxide and titanium dioxide, are not known to photodegrade.

Take-home point 3: Products can be stabilised against photodegradation, and photodegradation does not occur with the inorganic sunscreen pigments.

Dermatologists agree that the link between UVA exposure and melanoma is tenuous. Melanoma is genetically linked, and while UV exposure certainly plays a role in its causation, evidence is conflicting in respect of the significance of UVA exposure. Moreover, the daily UVAPF protection factor requirement is unknown. However, UVA levels in SA are not thought to typically exceed 7 minimal erythema doses (MEDs) a day.

Take-home point 4: The UVA protection factor required to protect against skin damage is not known. While UVA levels in SA are not thought to exceed 7 UVAPFs a day, an SPF 30 product would have to have UVAPF of >7.5 to pass the ISO test.

High SPFs cannot be achieved without some UVA protection, as the SPF *in vivo* test is inherently a UVA and UVB protection test. The products tested did provide protection against both UVA and UVB. The maximum UV exposure possible, dawn to dusk, on a clear sunny summer's day in SA is 35 MEDs. It is surely unlikely that any sun-conscious individual would stay out the whole day and fail to reapply sunscreen regularly as recommended!

Take-home point 5: The *in vivo* sun protection factor (SPF) of the sample of products tested on healthy human volunteers is reliable, but they must be re-applied regularly as recommended ... sunscreens are designed to be used regularly and often.

The CANSA seal of recognition remains a trustworthy guide to quality and reliability. It is safer to use sunscreens than not to do so!

Beverley Summers

Photobiology Laboratory, Department of Pharmacy, University of Limpopo (Medunsa Campus), North-West

S Afr Med J 2012;102(12):897. DOI:10.7196/SAMJ.6428

Speaking freely about our private health system

To the Editor: I would like to comment on a recent editorial.¹

Freedom of speech is greatly appreciated, especially by the previously under-privileged. Since we are going through a transformation, I would like to see an accurate, informative and constructive approach to restructuring and progress. As Editor, you have the right and duty to express your general opinion, including on issues related to the South African Medical Association and its members.

My family was decimated by World War II. My father is a labour camp survivor (Mauthausen), the sole survivor of a family cremated in Auschwitz. He joined the communist party and the struggle. I was part of the youth league, received military training and graduated as an officer in the popular liberation army. When I defected to the West in 1980, he was disgracefully fired from the Party and forced to retire from work and politics. I graduated in Romania and did 2 years' community service, internship in Israel and South Africa, and specialist training locally. I believe that I am truly part of the previously disadvantaged, and never compensated. I believe we both have the right and the duty to critically appraise and criticise.

My son emigrated to the USA. He has a Master's in aerospace engineering and works for Space X, with a good medical aid. He needed a root canal treatment. After the initial \$400 visit and X-rays (R3 500), 80% of which was covered by the insurance, he was quoted \$2 500 (R20 000) for the treatment in the rooms, i.e. \$800 (R6 400) was not covered as the cap was considered a cosmetic procedure. My private dentist quoted R2 000 per root (R8 000 inclusive of the cap!). I told my son to book a flight, a dental visit and provisional filling and one week in a lodge at the Kruger National Park, with a final filling and cap before leaving – I would pay the difference in price. I hope this puts your costing to rest. A decent medical aid system has been derailed after 1994. We eagerly adapted plans and schemes from the free world. The national schemes in Western Europe, the UK, Spain, France, Ireland and Portugal, which worked well 20 years ago, are now defunct or in a deep coma. We have a National Health Insurance, we pay taxes and have inherited a healthy (I would like to rephrase, living) public health system. It is crumbling and needs funds, nurses, doctors, technicians, equipment and medicines, and not management, economic directors, 5-year plans, and cost-containment and job-cutting 'efficiency'.

Transport, education and healthcare are the duty of a social democratic state and are not cost-effective or private obligations. That is why we pay taxes, which we do not mind provided they do not

only pay for fighter jets and politicians' salaries. The tax system, VAT, the petrol levy and the toll system should be improved to equalise taxation and benefits for all. There is public transport (not taxis and private cars), public education and grants for the needy in primary and secondary schools, and in tertiary, technical and vocational institutions (not private schools, private universities and private colleges), and finally a healthy, strong public health system, well run at primary, secondary and tertiary care levels (not the private insurance, RAMS and private medical aids). In democratic societies, the state should care for all, and the privileged (the American dream) can contribute towards their own better transport, education and healthcare. Only oppressive, unjust, dictatorial systems, such as the communist system I defected from 32 years ago, deny people the right to better themselves. Communism, with its beautiful and idealistic ideas, died because of its inhuman exploitation, terror and dictatorship and lack of competition, initiative, motivation and incentives.

Criticising, finding fault and leading towards destroying a system 'well regarded for its quality of care', to quote you, not wondering why medical aid contributions have increased and benefits decreased, seems short-sighted. Calling private healthcare self-destructive is an outrage. What guidance is it when leaders like yourself say that we are outrageously expensive and look at ownership instead of quality, despite your saying that the public health system is crumbling? You criticise monopolies, pharmaceuticals and fee for service, see medical aids as scapegoats and private doctors as over-servicing. This kind of thinking forced me to resign from SAMA. How can we negotiate with the powers to be with this kind of thinking from within?

Emeric P Frohlich
drfrohlich@yourbaby.info

1. Ncayiyana DJ. The self-destructing private sector is no less a blot on our health system than the crumbling public health system. *S Afr Med J* 2012;102(10):772. [<http://dx.doi.org/10.7196/SAMJ.6442>]

S Afr Med J 2012;102(12):897-898. DOI:10.7196/SAMJ.6322

Corrections

In the article by Bera and Mia entitled 'Safety of nevirapine in HIV-infected pregnant women initiating antiretroviral therapy at higher CD4 counts: A systematic review and meta-analysis', which appeared on p. 855 - 859 of the November 2012 *SAMJ*, the text in the EMBASE box in Fig. 1 should have read '446 citations: 23 articles retrieved' (i.e. '46 466 citations' should have been deleted). We apologise to the authors for this oversight. The online article has been corrected.

We further regret that an editing error occurred in the antepenultimate paragraph of the letter entitled 'Some South African universities provide good specialist otorhinolaryngology training' that appeared on page 774 of the October 2012 *SAMJ*. The online letter has been corrected. We apologise to the author for the error.



*Rushing mountain streams,
Stately pines and deep quiet -
A place of solace.*

Haiku: Peter Folb