Dispensing doctors disadvantaged by pharmacy clinics and new law on dispensing

To the Editor: The new law promulgated with regard to the dispensing rights of medical practitioners weighs heavily in favour of pharmacies. The very same are carrying out procedures and treatments that rightly belong with the general practitioner, e.g. blood studies, inoculations and primary health care, where there is an adequate presence of medical practitioners

Will nurses and pharmacists also be restricted in carrying out primary health care functions without adequate training and licensing?

The medical profession, traditionally a very divided group, must for once stand united to reclaim our function from the pharmacies as they are now doing to us.

P C H Croucamp

PO Box 1033
Nelspruit
1200

Pitfalls of translation

To the Editor: I refer to an article on the pitfalls of translation in a recent issue of the *Journal*.[1] In dealing with the problem of a cross-cultural questionnaire the authors make it quite clear that this exemplary exercise arose out of the EuroQol group's study design requirements.[1] They recommend that 'more time, effort and funding be invested by researchers to ensure that cross-cultural questionnaire-based outcome measures are indeed valid'. It seems to me that two kinds of validity are involved. One concerns the outcome for each question as originally framed. The other concerns the measuring of quality of life, which must have been the aim of the study. I doubt that quality of life can be meaningfully standardised internationally (and perhaps not intranationally in a multicultural society), because it depends on how quality of life is defined, and by whom. It would be interesting to use the authors' skills in the development of a QOL questionnaire among rural Xhosa and compare results with the translated HRQoL for 'validity'.

Ronald Ingle

Department of Family Medicine
Medical University of Southern Africa

1. Mkoka S, Vaughan J, Wylie T, Yelland H, Jelsma J. The pitfalls of translation — a case study based on the translation of the EQ-5D into Xhosa. *S Afr Med J* 2003; **93:** 265-266.

Misquotation

To the Editor: I refer you to the Izindaba article 'Mechanics overhaul ethics policy' by Chris Bateman that appeared in a recent issue of the *Journal*.[1] I would like to draw your attention to the fact that I have been misquoted.

I am specifically referring to the following paragraph: 'Mkhize said: "We've done far more than just what Jan did (Van der Merwe resigned amid some controversy as a specialist investigator last year)".

The statement I made was: 'We've done quite a lot, including what Jan (Professor Van der Merwe) had done.' I did not make my statement of our achievements in a comparative mode, i.e. versus what Professor Van der Merwe had achieved. I also made no reference to Professor Van der Merwe's resignation. By including this statement in the inverted commas, Bateman creates the impression that those were my words.

I am extremely disappointed about the way in which my comments were altered and would appreciate publication of an erratum in your next publication.

Boyce Mkhize

Registrar's Office
Health Professions Council of South Africa
PO Box 205
Pretoria
0001

1. Bateman C. Mechanics overhaul ethics policy (Izindaba).. *S Afr Med J* 2003; **93:** 483-486.

Chris Bateman replies: It is quite possible that I misquoted Boyce Mkhize. I have not been able to locate my actual verbatim notes to assist me in verifying the facts in the print time available.

On his second point, I have checked the published copy and the parenthesis *was* included in the quote. This was totally counter to what I intended to convey, i.e. to give some background context, not attributable to Boyce Mkhize at all. How it happened is beside the point. I regret the error. You have my apology on both counts.

Extrauterine pregnancy

To the Editor: There has recently been considerable publicity regarding a case of extrauterine pregnancy managed successfully at Groote Schuur Hospital, with both mother and baby in good health after the delivery. As such I thought it of interest to record another case of this rare condition.

On Friday 7 February 1992 Dr Mark Baekeland, a Belgian registrar on an exchange appointment working in the

Department of Obstetrics and Gynaecology at Tembisa Hospital near Pretoria, performed a laparotomy on a patient for an extrauterine pregnancy. Preoperatively the baby was estimated to be at term, and the fetal heart was normal, as was the condition of the mother. At laparotomy the baby lay in the abdominal cavity, a normal uterus was to be seen in the pelvis, and the placenta was attached to the bowel in the left lower abdominal region.

The baby was removed without any problem and was in a completely satisfactory condition. Dr A Haasbroek, senior paediatrician, who was in theatre, cared for the baby. The birth weight was 2 800 kg. The condition of the lungs was normal and there were no postoperative problems.

The placenta was left *in situ*, and the umbilical cord was clamped and tied right against the placenta.

Both mother and baby were discharged from hospital in a healthy condition.

P M Bremer
Formerly Senior Lecturer, Department of Obstetrics and Gynaecology, University of Pretoria

Woodside Village
Norton Way
Rondebosch
Cape Town

Economy class syndrome

To the Editor: On the flight from Accra to Johannesburg a fellow passenger collapsed in the aisle as he passed my seat. It was about 2 hours into the flight, which had left Accra just before midnight, with the aircraft about two-thirds full.

The passenger was unconscious and slightly clammy. He was breathing shallowly and had a pulse of about 120 beats/min, which was difficult to feel. There was no obvious injury or localising signs and his systolic blood pressure was about 80 mmHg. We shifted him into the four middle row seats. He was chubby young man of Chinese origin, and started to wake up soon after he was shifted.

He turned out to be the manager of a fruit juice factory in Accra, on his way to the company's head office in China via Johannesburg. He had been very busy and in the previous 24 hours had had about 2 hours' sleep and very little to eat. Supper was served soon after take-off and he had eaten quite a generous aircraft meal and drank two beers. When the cabin lights were dimmed he had gone to sleep, only to wake up feeling nauseous and sweaty. He had got up to go to the toilet but had only got as far as the row of seats where I was sitting.

After being given some fruit juice he returned to his seat quite cheerfully and completed his journey uneventfully. The purser told me that this kind of fainting incident happened about once a month on the long-haul flights on which he worked.

In trying to work out why this had happened to an apparently healthy young man I wondered if the combination of a few days of stress, little sleep, a mild fast followed by a large meal with alcohol, then falling asleep sitting up with knees at about 80 - 90° had not induced this dramatic drop in blood pressure. Perhaps the same slow-down in lower leg blood flow also plays an important role in the formation of deep-vein thrombosis (DVT)?

If falling asleep after a meal, possibly with alcohol, in a fairly upright sitting position with knees bent close to 90° is the key risk factor, then prophylactic exercise may not be much help. Maybe slightly more leg room, and especially foot rests so that people can place their feet more comfortably with the knees at an angle of 120°, lighter meals and at least a warning about alcohol on long flights, would be a better way to prevent DVTs.

It should not be too difficult to do a randomised controlled trial to investigate this further, perhaps by seeing if adding foot rests to long-haul economy class seats and encouraging passengers to use them makes a difference.

Neil Cameron

Department of Community Health
University of Stellenbosch
Tygerberg, W Cape

National health insurance — friend or foe?

To the Editor: Some brief comments from a GP perspective on the document titled 'The Department of Health Inquiry into the Various Social Security Aspects of the South African Health System'.

National health insurance (NHI) is held as being good for general practice as it is said to bring extra pre-funded patients into the private sector. My concern is that once again pre-funding for general practice will be relegated to what is left in the barrel once provision has been made to cover other costs.

The following are some specific concerns arising out of the document.

1. The concept of prescribed minimum benefits is sound. However, the document calls for 'The expansion of prescribed minimum benefits to include chronic conditions, expanded HIV/AIDS cover and other essential services'. Hospitalisation, HIV/AIDS and the treatment of chronic conditions is expensive. Already medical aids find it difficult to fund these, even before the introduction of expanded coverage! The contributions made to NHI will be swallowed up by these costs, leaving very little for the struggling GP.