



## An 'amnesty' for health professionals?

**To the Editor:** The Health Professions Council of South Africa has acknowledged the large exodus of health professionals from South Africa, and has consequently embarked on a campaign to attract emigrant health professionals back to the country.

This campaign seems to have devolved upon changes in the costs of re-registering in South Africa. Previously, a 'penalty' had been imposed on medical practitioners who had not 'terminated' their registration after having left South Africa. (Is there any reason why they should have?) The penalty amounted to 10 times the annual registration fee, plus the registration fee for the year of re-registration. Subsequently this was reduced to 5 times the annual fee, but on condition that returning practitioners performed 100 hours of community service, as a form of 'amnesty'.

Has this campaign worked?

I conducted a poll of a number of health professionals who had emigrated from South Africa and established themselves successfully elsewhere in the world. They are all highly competent, well trained and in every way desirable contributors to society. Twenty-two subjects were questioned informally in an open-ended fashion. Some requested anonymity. While there was some variation in response, as one would expect, their overall views were remarkably consistent, as follows:

They all showed interest in and a surprising degree of familiarity with events in South Africa. This may be interpreted as their sustaining an interest in possibly returning to the country.

They all felt that the term 'penalty' for leaving South Africa without deregistering was entirely inappropriate. They commented repeatedly that there was no legal obligation upon them to do so. There was an emphatically negative attitude to the 'penalty' of 10 times the annual registration fee. They all felt that this was entirely inappropriate and demonstrated an unpalatable aspect of the HPCSA, which appeared to be motivated primarily by financial benefit to itself. It was noted that the administrative costs of re-registering were likely to be relatively small.

The use of the term, and the policy, of 'community service' was heavily criticised; it held all the implications of a sentence for a criminal transgression. Most people felt that 100 hours of community service, as an alternative to the fee, was insulting. It was generally agreed that they could earn far more in the 100 hours than relief from the fee penalty. They questioned the capacity of the HPCSA to objectively understand these relative values.

There was considerable knowledge about, and dissatisfaction with, the structure of the HPCSA, and almost all the subjects interviewed felt that nepotistic appointments, which were totally inappropriate for a body of its nature, had been made.

The reasons offered for not returning to South Africa were diverse, but many respondents felt that there was a universal degradation of infrastructure. In particular, a number of persons commented on their unwillingness to become subject to the authority of the HPCSA which, in their view, had shown itself to be insensitive, authoritarian, lacking in insight and perspective, unapproachable and rigid, as well as not adequately assuring the medical profession of freedom from corruption.

All the interviewees said they would not be prepared to return to South Africa if they had to register with the HPCSA as it is currently run.

### Personal comment

Medical practitioners are generally capable, intelligent and versatile individuals with high ambitions and aspirations. They do not take kindly to gratuitous authoritarianism, or perceptions of mismanagement and corruption. They are wary about subjecting themselves to the authority of groups for which they have no respect. The activities of the HPCSA in recent years give no reason for them to respect that organisation. They believe that the Council would not support their aspirations to achieve an income comparable to that which they could make internationally, and in fact suspect that there is an active policy of the Council, in alliance with the government, to further reduce the income of health professionals.

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## QF-PCR for prenatal diagnosis of common aneuploidies in women of advanced maternal age

**To the Editor:** The policy of the Division of Human Genetics (National Health Laboratory Service (NHLS) and University of the Witwatersrand) in respect of prenatal testing for chromosome abnormalities in women of advanced maternal age has changed. The purpose is to accommodate the limited human and financial resources available in South African public health services for such testing.

Advanced maternal age (AMA) screening is undertaken on pregnant women of 35 years or older because of their increased risk of bearing children with the more common autosomal trisomies, namely trisomy 13, 18 and, particularly, 21 (Down syndrome). Once identified, these women should be offered counselling to inform them of their increased risk and the options for its reduction. The options include prenatal testing for trisomies 13, 18 and 21 using fetal material usually obtained by amniocentesis.



Prenatal AMA diagnosis has traditionally been performed by cytogenetic analysis of cultured fetal cells, which is time-consuming (7 - 21 days) and expensive (R2 400, NHLS rate). Quantitative fluorescent polymerase chain reaction (QF-PCR) analysis is now recognised as a viable alternative to cytogenetic analysis for the rapid detection of autosomal aneuploidies.<sup>1</sup>

QF-PCR is a molecular (DNA)-based test performed on uncultured fetal cells. Used in the Laboratory of the Division of Human Genetics it is able to detect the common numerical chromosomal abnormalities of chromosomes 21, 18, 13, X and Y. Trisomies 13, 18 and 21 are detected with about 99% accuracy, usually within 48 - 72 hours and at a cost of R1 197 (NHLS rate).

QF-PCR has limitations. It cannot yield accurate results when there is maternal contamination of amniotic fluid or, less commonly, when chromosomal imbalances such as low-level mosaicism (<30%), some types of polyploidy, and structural chromosomal abnormalities (deletions, translocations and ring chromosomes) are present. It detects extra chromosome 21 material present in cells with unbalanced translocations of chromosome 21, but does not identify the problem as a translocation. These shortcomings are, however, put into perspective by a multi-centre audit of 23 genetic laboratories, which found that, in over 98 000 amniocenteses performed after Down syndrome screening, only about 1% of autosomal chromosome abnormalities were not detectable by QF-PCR.<sup>2</sup>

In industrialised countries, newer technologies such as QF-PCR are considered as optional extras to routine cytogenetic analysis for prenatal diagnosis.<sup>1</sup> However, in resource-limited developing nations such as South Africa, we believe that QF-PCR can be the standard diagnostic technique.

Therefore, at the Division of Human Genetics, QF-PCR will now be done instead of conventional cytogenetic analysis in cases where AMA is the only indication. Should abnormalities be detected on sonar or other specific indications, full karyotyping can still be requested and performed. Pretest counselling of AMA women should take this policy change into consideration; a *pro forma* consent form for amniocentesis that does so, is available from the Division of Human Genetics.

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## Of HIV, grief and TOP

**To the Editor:** People living with HIV are frequently people living with very high levels of grief. They grieve over the loss of life expectancy and of their own dreams for the future. They are often grieving over the loss of a spouse or a child. In our practice, they are frequently grieving over the loss of other close relatives. This makes them emotionally very vulnerable people.

At first sight, the offer of TOP to such people in early pregnancy may seem to be a compassionate way to avoid further grief from infant losses, and to avoid increasing the number of orphans in our nation. Yet there is strong evidence that a decision for TOP may precipitate a severe grief reaction of its own. Such grief has been associated with a 7-fold increase in suicide and homicide,<sup>1</sup> and a 180% increase in psychiatric illness, in the year following TOP in first-world countries with excellent access to health care.<sup>2,3</sup> In South Africa, with the generally poor access to psychiatric care and high levels of violence, the effects can be expected to be far greater. The effects of maternal depression, of resorting to substance abuse or of the development of self-destructive behaviour, may completely negate the advantages to the family of not having another baby to nurture.

This question raises the need for very skilled and careful counselling of women with HIV before TOP is offered, and very careful follow-up and emotional support following TOP, should they choose that option. It also makes even stronger the case for ready access to HAART.

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