



the disciplines of paediatrics, medicine, surgery and mental health to bring about a successful interdisciplinary service. Furthermore, there is much that paediatricians, physicians and surgeons need to learn in order to promote optimal transition care. Pseudo-parental infantilising and poor understanding of the needs of adolescents with longer-term health conditions are recognised faults of well-meaning child health practitioners.

In the 1990s, a survey of staff at Red Cross War Memorial Children's Hospital (RCH) and Groote Schuur Hospital (GSH) in Cape Town showed that, in general, paediatricians felt inclined to take on the care of adolescents, while physicians preferred to take over care of the more mature (A Westwood and L Henley, unpublished data). Specialised surgeons (such as neurosurgeons) found it relatively easy to span the transition to adult-orientated care for the few adolescents in their services, largely because the same staff served the child and adult services. At the time of the survey, formal transition services existed for adolescents with diabetes mellitus and cystic fibrosis.³ The survey found that significant numbers of teenagers received care at RCH, varying from yearly follow-up of young people who had survived cancer, through intensive management of those who had had renal transplants, to end-of-life care for young adults with genetic muscular disorders.

From the survey, a policy on the care of adolescents with long-term health conditions was developed at RCH to 'regularise' the continuing attendance at the hospital of children over the age of 13 years. The policy also encouraged transition plans in all services. The establishment of an inpatient adolescent ward at GSH was mooted, was supported by most people surveyed and, within a few years, had become part of the GSH strategic planning process.

Plans for a 15 - 18-bed adolescent inpatient unit (which is due to open in 2009) include:

- appointment of a specialist with a special interest in adolescent health to oversee the ward (in this case, a paediatrician)
- promotion of shared care between paediatricians and physicians for adolescents with long-term health conditions
- access for most adolescents with an acute non-psychiatric disorder who require specialised care
- nurses with skills in adolescent care
- admission rights for paediatricians, physicians and surgeons from RCH and GSH
- support from mental health professionals such as social workers
- an associated outpatient service
- space for schooling
- space for relaxation.

It will be important to audit and evaluate this pioneer project to further develop the service and to provide a blueprint for

similar units in other hospitals (not only public ones) in South Africa. The authors undertake to do this.

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Medical responsibility at inquests

To the Editor: One of the duties of a forensic pathologist is to give expert testimony during an inquest or trial regarding the cause of death and/or the mechanism of death. At an inquest, nobody is on trial; its purpose is to elucidate to the inquest magistrate who the deceased is; where, when, why and how the death occurred; and whether or not someone may be held responsible by virtue of an act of commission or omission.

When patient management is the issue at stake, doctor(s), nurse(s) and even the hospital involved often have excellent legal representation. The Medical Protection Society (MPS) legal team consists of well-prepared, experienced lawyers. They have access to medical records and specialists in different fields of medicine who are paid well to give expert testimony and assist the MPS in defending their clients.

In contrast, the inquest prosecutor is often inexperienced, has poor insight into the important medical issues involved, and is unprepared.

Since the inquest is not a trial but an 'inquiry', the inquest magistrate must hear testimony from all sides and is only then able to give an objective ruling. The court case *Castell v. de Greef* set a precedent by which the code of conduct of a doctor is evaluated - '... the conduct of a doctor in both medical diagnosis and treatment should be tested against the standard of the reasonable doctor faced with the same problem'.¹

A forensic pathologist performing an autopsy, where the possibility of negligence on the part of a health care worker(s)



exists, is expected to determine a cause for death, review hospital records and statements from medical personnel concerning treatment, and recommend whether or not an open inquest should be held. When recommending an open inquest, a frustrating and discouraging aspect is finding medical personnel who are willing to give expert testimony in their specialty at an inquest on behalf of the inquest prosecutor and also to act as assessors.

If health care workers are unwilling to assist, the forensic pathologist is often the sole witness to give the prosecutor necessary insight. Pathologists are unable to, and at times even prohibited from, expressing opinions on matters outside their expertise, e.g. radiology, obstetrics, surgery, pharmacology, etc. Given these constraints, how effectively can medical inquest cases be evaluated by magistrates?

Court proceedings are generally unpleasant for health care workers. However, does the medical profession not have an ethical responsibility to assist the court, given that the standard by which conduct is tested at an inquest is based on what the reasonable doctor would do?

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Training an old-timer as a GP in Britain

To the Editor: I was born in England and have always hankered to work in Britain. In 1972, I was set to train in community medicine in Britain but accepted a post in the USA instead. In 2002, on turning 60, after 17 years as a lecturer in primary care and 5 years working in municipal clinics in Cape Town, I renewed a lapsed application to the British Joint Committee on Postgraduate Training for General Practice. I had to complete 6 months as a GP registrar and pass a summative assessment before becoming eligible for the Certificate of Equivalent Experience entitling me to work as a GP in Britain. The Merseyside (Liverpool) Postgraduate Deanery offered me a GP registrar training post with an outstanding solo dispensing practice in rural Cheshire. In September 2003, after completing the requirements, I received a Certificate of Equivalent Experience.

The summative assessment comprised a trainer's report, an audit of epilepsy care in the practice, a multiple-choice examination, and – by far the most testing – 2 hours of technically perfect video consultations. Counterbalancing the stress-inducing assessment was the support that British GP training affords trainees. I was generously supported by my trainer and the practice staff, while the dean encouraged registrars to attend conferences and training courses. Of course, the patients made the exposure ultimately worth while, by challenging, amusing, teaching, frustrating and professionally affirming one as patients generally do.

Despite misgivings about being a trainee at the age of 60, and notwithstanding the taxing assessments, I found this training worth while for adapting to British GP culture and being assimilated into the Local Primary Care Trust. My transition from municipal clinic work, with patients with TB and AIDS in South Africa, to 'normal' GP work in Britain has felt more like a complete clinical and psychological rehabilitation than an update of my knowledge and skills.

The extent of the damage I had sustained during prolonged work in public-sector primary care only came home to me fully when I spoke on AIDS to my fellow registrars at our weekly half-day release course. I was surprised to learn that I had become bruised, disillusioned and weary – burned-out – by working with predominantly young South Africans who should have been able to look forward to rewarding lives but, because they were denied antiretroviral drugs, faced early death heralded by TB, shingles or meningitis. It has taken me most of the year to recover and once again feel the professional fulfilment and personal satisfaction that general practice brings.

I also had the opportunity to drive through glorious countryside, visiting remarkable patients in their homes and learning something of English country life. Despite decided differences between public-sector clinic work in Cape Town and rural general practice in England, the fundamentals of family medicine apply as much in Cheshire as they do in South Africa; namely, close attention to the patient's expectations and needs. Above all, I have been gratified to learn that one can teach an old dog one or two new tricks.

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