



A standard of care?

To the Editor: As accident and emergency medicine consultants, we provide voluntary medical supervision to aeromedical services in KwaZulu-Natal. We have visited 70% of rural hospitals here, and have noticed a disquieting deterioration in medical management of trauma and emergency patients. These hospitals are staffed by community service doctors with little or no senior supervision. Emergency facilities and equipment are outdated and often not in working order. Despite reassurances from national and provincial health authorities, very little has been done to alter the status quo. A recent case transported from northern Eastern Cape indicates the seriousness of the situation.

A 48-year-old man had chest and head injuries sustained in a motor vehicle accident the previous night. Air transfer to a central hospital in Durban had been requested. On arrival of the aircraft, the patient was found in a general ward on a soft bed with the spinal collar on back to front. He had been orally intubated (secured with paper tape, no bite block in place), with oxygen being piped directly into the endotracheal tube. Two IV lines had been placed to keep the vein open. It was clear that he had abdominal breathing with motor and sensory neurological fallout from C6 level. There was no monitoring. No history was available other than that he had been given furosemide (dose unknown) and steroids during the night for the head injury according to the local protocol. Intubation had been very difficult with 50 mg suxamethonium intravenously and no sedation. No cervical spine or pelvic X-rays had been done. The treating staff included the community service doctor (apparently with no supervision) and two nurses at the time of handover. Overnight, one nurse had been on duty looking after a ward of 40 patients.

In this case stabilisation and transport was successfully accomplished after yet another prolonged turnaround time (time spent on the ground stabilising the patient). Over the past 2 - 3 years this has increased to an average of about 1 hour. Numerous other cases have featured problems such as:

- Hospital oxygen running out (pressure too low to run the transport ventilator).
- No equipment or malfunctioning equipment.
- Good equipment, but no one who knows how to use it.
- Inability to activate the aeromedical service quickly.
- No integration between pre- and in-hospital services, resulting in poor communication and inappropriate care.
- Responsible person/treating doctor very difficult to get hold of by telephone.
- Treating doctor almost never present at the time of arrival of the aeromedical crew.
- Under-qualified medical personnel (staff nurses) treating the patient.

- Poor standards of hygiene (equipment used on numerous patients).
- Specialist receiving units unaware of aeromedical transport considerations, resulting in inappropriate decisions.
- District referral system not geared to fast-track a critically ill patient to definitive care (e.g. the patient is rushed to the CT scan, not to the surgeon).
- Inappropriate/outdated patient management.
- Ineffective monitoring resulting in critically ill patients being left for a prolonged period before being managed.
- No clear-cut policies for the use of aeromedical services as a means to upgrade the level of care and transport patients rapidly to definitive care – i.e. the aircraft is used as just another ambulance if an ambulance is not available. There do not appear to be any clinical guidelines (we have made repeated requests to see the guidelines).

Trauma, South Africa's silent killer epidemic, is compounding the tragedy of our HIV/AIDS pandemic. Our reason for writing this letter was to highlight the fact that in many rural state hospitals, young inexperienced community service doctors are working unsupervised in very difficult circumstances through no fault of their own, as senior more experienced colleagues have 'voted with their feet'. A recent newspaper article indicated that 65% of professional posts in Natal are unfilled.

Having created this problem through the restructuring of the various health departments, what is the government doing about restoring the standard of care our population is entitled to?

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Mr Hamilton Naki

To the Editor: I write to document my extreme distress about seriously false allegations and misinformation contained in the obituaries on the late Mr Hamilton Naki that appeared in the *Economist* [see also subsequent article, 14 July, in which this account is retracted] and the *BMJ* recently.^{1,2} The scurrilous claims made in these obituaries belittle the very special person Hamilton Naki was, and also the memory of Chris Barnard and the heart transplant team of December 1967. It will also be distressing for Denise Darvall's surviving family, and unacceptable for the University of Cape Town.

Many who worked with Hami recently attended a very moving special gathering to remember Hamilton Naki in the



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J S Marais Laboratory, which we were able to share with his family. Reflecting on this event, I concluded that I had to object to the misinformation and correct the record. Hamilton Naki was a remarkable man, as evidenced by the citation for his honorary degree and many obituaries in the South African media.

I was Chris Barnard's Research Fellow in the Marais Laboratory in 1960. The skilled senior operating assistant in the laboratory was Victor Pick. Hamilton helped with the animals and at the operating table in the role of a scrub nurse – not as the surgical assistant. Returning to the laboratory as a Fellow in 1964, I helped Barnard start an experimental kidney transplant programme. In the laboratory, the roles of Mr Pick and Mr Naki remained as before.

I left for England in February 1965 and initiated a successful liver transplant programme in a new experimental model, the pig, at the University of Bristol. In 1967 I returned to the University of Cape Town as Senior Lecturer in Surgery and was employed by the then Cape Provincial Administration. Having taken over control of the Marais Laboratory, Hamilton Naki, who had worked for Barnard previously, reported to me until years later when Rosemary Hickman took over control of the laboratory, and more recently Del Kahn.

Victor Pick remained the senior assistant until his tragic death in a motor accident in the early 1970s. Because his increasing skills were already evident, Hamilton Naki's remarkable work at the experimental surgical operating table as a surgical assistant commenced after that time.

Thus, the claims that he was an integral part of the first human heart transplant team and performed the operation on the donor are fictitious, mischievous and false. Like me, Hamilton's first knowledge of this great event would have been after the event, in the newspapers or from the wireless.

I trust this will correct the false information in the two obituaries.

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1. Hamilton Naki. *Economist*, 11 June 2005.
2. Richmond C. Hamilton Naki. *BMJ* 2005; 330: 1511.



***Ehrlichia ruminantium* – an emerging human pathogen**

To the Editor: *Ehrlichia ruminantium*, transmitted by ticks of the genus *Amblyomma*, causes heartwater in ruminants in sub-Saharan Africa, Madagascar and some Caribbean islands, but there are no authenticated reports that the organism can cause disease in non-ruminants or humans. No reliable vaccine is available and infected animals frequently die before treatment with tetracyclines can be initiated. Serological tests for *E. ruminantium* lack specificity and the most reliable and sensitive test for the organism involves polymerase chain reaction (PCR) amplification and probing for a section of the organism genome.

We report here on 3 fatal cases of suspected ehrlichiosis involving unrelated individuals who were not overtly immunocompromised but for whom strong probe-positive results were obtained. The first of these, for whom few clinical details are available, died approximately 3 weeks after her dog died of 'biliary fever'.

The second, a 6-year-old child, died a week after hospital admission, with the clinical picture of encephalitis with complaints of severe headache, sleepiness and an unsteady gait. The child deteriorated rapidly. A brain computed tomography (CT) scan revealed echo-dense lesions in the

cerebral hemispheres. After the child died a postmortem examination was performed. Results were unremarkable, other than for the brain, where severe vasculitis affecting the midbrain and pons regions was demonstrated. Prominent pulmonary oedema was reported.

The third case was also a child, who died after a short illness. The clinical features resembled those of the second case.

Molecular evidence based on small subunit ribosomal (srRNA) and pcS20 gene sequences indicates that *E. ruminantium* was present in DNA from all 3 individuals although the aetiological origin of the infections differed.

The possibility that these deaths resulted from ehrlichiosis must be considered and investigated.

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Employment contracts for South African doctors

To the Editor: There has been concern about the loss of health care professionals from South Africa, and while there are multiple factors contributing to this, one of them, in my opinion, is that health care professionals work under poor employment terms and conditions.

My brief experience with South African employment after a period of time in the UK led to an unfair dismissal (Commission for Conciliation, Mediation and Arbitration (CCMA) case reference WE3402-04) because I refused to sign a contract that among other issues, included a clause in breach of South African labour law (notice period in violation of the basic Conditions of Employment Act). To illustrate the scenario, a selection of my points of objection follow.

A set of clauses covered hours of service. These were not consistent between the employment contract and the conditions of employment document. Further, a separate clause dealing with out-of-hours work was not specific and did not refer to the clause on total hours of service. I wanted the contract to be consistent and clear about what was expected of my time. Another clause indicated that any submission for publication must be made through the librarian of the organisation. I can see the benefit in having all publications centrally recorded but do not see why the submission should be made through a central service. The contract as a whole had the appearance of a document that had been compiled from a number of other contracts without proper thought or organisation. It had clearly not been reviewed by any person with knowledge of the basic Conditions of Employment Act. While I was in the UK contracts between doctors and the National Health Service were extensively debated and negotiated between the British Medical Association and employers. Accepted understanding of a contract between an employer and an employee is that it clarifies the conditions of service of the employer and helps define the individual's position. The contents of the contract should be discussed and negotiated. In South African health care, contracts are presented to employees and are not negotiable. South African doctors sign these contracts and implicitly consent to poor labour practice.

Apart from employment contracts for doctors, South African health care has many other issues to deal with. However, when health care professionals with access to international positions look at South Africa and find non-negotiable contracts that are poor in quality and incorrect in content they may choose to seek employment elsewhere. In my case I was forced to look for work outside the country as my only potential employer dismissed me.

There is a solution if the South African Medical Association takes up the issue of employment contracts and negotiates

these properly with the different employers. Alternatively, SAMA could challenge the contracts that breach South African labour law in labour court. I would encourage South African doctors to stand up against poor labour practice and challenge their employers. My case took many months to be heard at the CCMA and eventually they found that I had been unfairly dismissed. The CCMA will not allow another case like mine to wait so long before it gets heard. The chances are that doctors will win and employers will have to concede to contract negotiation.

South African doctors are a precious resource to the country. I would urge you to stop allowing poor labour practice to continue unabated in the health care sector.

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Medical negligence – what is SAMA's position?

To the Editor: One sincerely hopes that comments from SAMA chairman Kgosi Letlape quoted in the *Sunday Times* on 5 June 2005 do not represent SAMA's consensus view on medical risk and the rise in number of professional conduct enquiries conducted by the Health Professions Council of South Africa (HPCSA).

In the report entitled 'Dodgy docs need insurance', Dr Letlape commented on the apparent inability of certain doctors to pay fines when found guilty of professional misconduct. In what appeared to be direct quotes, he blamed the 'unbecoming behaviour of doctors on the appalling conditions in which some of them worked', slow payment or non-payment by medical aid companies, and 'refusal of hospital administrators eager to blame doctors for errors, to assume responsibility'.

Even if we accept that medical practice is compromised to variable degrees by the issues highlighted by Dr Letlape, I question whether such factors adequately explain the wide range of misconduct allegations reported to the HPCSA. I am more concerned that the tendency to blame medico-legal disputes primarily on extrinsic factors ignores both the principles and the challenges of safe, ethical practice. In turn, such dismissal denies medical practitioners any opportunity to constructively address the fundamental issues underlying medical error, lawsuits and HPCSA enquiries.

Modern risk-management philosophy rejects both the Just World Hypothesis ('bad things happen to bad people') and the knee-jerk tendency to shame and blame either ourselves or others when mistakes happen.¹ The Bristol Inquiry which shook the British medical establishment, arose from an investigation into the deaths of paediatric cardiac surgery



patients, but the findings published in 2001 emphasised the importance of professional accountability at all levels of any system that provides health care.^{2,3} As long as doctors, nurses and hospital managers are human (and long may they continue to be so), the eternal risk of human error will prevail, and the challenge will be to constantly examine, modify and sometimes even re-invent medical practice and behaviour, so as to compensate for the inherent risks that threaten every interaction between provider and patient. If we instead opt for scapegoats, we will never achieve true accountability. If we hide our heads in the sand, the litigators and the HPCSA will both draw a bead on our butts, and relish kicking them black and blue.

The SAMA chairman's words may well be what the Association's members want to hear. But tough love in the form of accepting medical fallibility, and providing clear, meaningful guidance towards individual and collective accountability, may be far more effective in the long term if SAMA truly wishes to keep the medico-legal demons at bay.

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1. Reason J. Human error: models and management. *BMJ* 2000; **320**: 768-770.
2. Bristol Royal Infirmary Inquiry. *Learning from Bristol: The Report of the Public Inquiry Into Children's Heart Surgery at the Bristol Royal Infirmary 1984 - 1995*. London: HMSO, 2001.
3. Coulter A. After Bristol: putting patients at the centre. *BMJ* 2002; **324**: 648-651.

Holy Communion – chalice or challices?

To the Editor: Holy Communion is practised globally as a symbol of holy communication with one's maker. In many congregations a communal chalice is used to serve wine/water/juice to participants. In other congregations a choice exists between a chalice and a chalice (small individual glass).

As we enter the age of immune-deficiency diseases we need to be aware that certain diseases may be transferred via lip sputum, with far-reaching consequences to immune-compromised patients such as those with diabetes, cancer patients on chemotherapy, HIV patients or those who are ill and debilitated. Transferable diseases include: (i) herpes simplex (winter sore); (ii) herpes zoster (shingles); (iii) diarrhoea (viral); (iv) cholera; (v) *Salmonella* (typhoid diarrhoea); (vi) *Shigella* (dysentery); (vii) hepatitis A (infective jaundice); (viii) flu and other respiratory (lung) viruses; (ix) viral encephalitis; (x) bacterial meningitis; (xi) *Streptococcus* group A (sore throat); (xii) *Staphylococcus aureus* (diarrhoea and food poisoning); and (xiii) TB (sputum transfer – all organs may be infected).

A sputum-contaminated chalice requires medical sterilisation in an autoclave to eradicate the possibility of disease transfer.

If individuals feel strongly that they should use the common chalice, they should be made aware of the above possibilities. The church has a moral and ethical obligation to inform participants of the potential risks involved in using the communal chalice.

To be on the safe side, an individual chalice should be used by each participant.

J B Janeke

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Erratum

In the Childhood Atopic Eczema Consensus Document (part 2, June *SAMJ*), there was an error on p. 439 (first line, right-hand column). Trials have shown that pimecrolimus can be used safely in infants as young as 3 months of age (not 3 years as stated).

The corresponding author has however pointed out that pimecrolimus is only approved by the Medicines Control Council for use from 2 years of age.