

Failing emergency medical services

To the Editor: I refer to the scientific letter entitled 'Emergency centres lack defibrillator knowledge'.¹

I am a recently retired UK accident and emergency consultant who is now attempting to plough back knowledge gained in the discipline of emergency medicine (EM) and trauma to peripheral hospitals in the Western Cape and KwaZulu-Natal (KZN) under the umbrella of Outreach. This includes ward rounds, clinics, shop-floor teaching, checking and demonstrating equipment (defibrillators, ventilators, monitors) pertinent to emergency departments (EDs), and most importantly demonstrating correct drug usage to doctors and nurses. In KZN many doctors are foreign qualified and poorly taught in emergency medicine.

In the Western Cape I have personally taught at 33 central, district and regional hospitals, where most departments are now well equipped and well laid out, with enthusiastic doctors and nurses. This is in sharp contrast to the 26 similar hospitals in KZN where I have taught (the exception is Ngwelezana Hospital, overseen by an accredited EM specialist). The EDs in most KZN peripheral hospitals were failed by the FIFA-accredited doctors, with reports submitted to head office indicating no improvement in equipment or drugs. Non-functioning ECGs, ventilators, monitors or defibrillators were found at 80% of these hospitals.

So how can we improve on this diabolical situation, knowing how poorly Outreach EM is taught in South Africa? This is a fact bemoaned by many of these doctors and nurses.

On completion of these hospital visits a proforma developed by the Western Cape is given to the hospital manager and submitted to head office highlighting deficiencies and making recommendations. At the same time we hand out EM protocols and ACLS, ATLS and PALS updates.

Thirty years ago Professor Coen van der Merwe, Mr Alan White and myself were instrumental in setting up the Dip PEC to address the problem of EM in peripheral areas. At the same time *Trauma*, the EM journal, was started. Little or no help is forthcoming from the very departments that are well established.

The fine line between life and death can often be defined by where an accident or medical event occurs. The more fortunate may be successfully treated at an ED with fully trained medical and nursing staff in a properly equipped unit. Otherwise, living medical problems may become dead certainties if we do not address these problems appropriately.

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Restraint use for child passengers in South Africa

To the Editor: Motor vehicle accidents are a leading cause of death in children of all ages worldwide, and responsible for 32% of all childhood injury deaths.¹ When used correctly, restraint devices such as seat belts and child restraint systems significantly decrease mortality and serious injuries in children.^{2,3} Many studies have been done on the use of seatbelts and car safety seats in America, Asia and Europe; however, none exist for African countries.

Red Cross War Memorial Children's Hospital, Cape Town, annually treats close to 300 children who were involved in motor

vehicle accidents as passengers, of whom 87% were not restrained adequately within the vehicle. In order to correlate the rate of unrestrained children who presented after accidents with the general rate of restraints in children, Childsafe South Africa⁴ conducted an observational study at the main gate of Red Cross Hospital. We observed the use of restraints in all adult drivers, passengers and children passing through the main gate of the hospital from 26 to 30 March 2008.

A total of 1 269 cars entered the premises, with 2 080 people travelling in them; 313 were children. Those restrained were: drivers 50%, front adult passengers 30%, and adults travelling in the rear 10%. A total of 89% of the children observed entering the hospital were unrestrained in the vehicle. Of these 25% were sharing a seat with an adult. Only 8% of the children observed were sitting in a car seat and only 3% were adequately restrained.

As in the rest of the world, trauma related to motor vehicle crashes is a leading cause of childhood injuries and deaths in South Africa.

Our study demonstrates that a large majority of the children observed were not adequately restrained within the vehicles. It shows an alarming trend in restraint use in South Africa and demonstrates the need for promotion of and education in appropriate restraint use for children.

It is now almost 3 decades ago that paediatric trauma was identified as the number one killer of children globally.⁵ Since the efficacy of child restraint systems in preventing serious injuries and deaths in motor vehicle crashes is well established, we urge the medical fraternity to actively promote child safety restraints. It will definitely save many children's lives.

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Maternal and perinatal health

To the Editor: It is encouraging that our very high maternal and perinatal mortality rate has been identified as an important part of South Africa's fourfold national epidemic. I hope that, as the Department of Health sets out to find solutions to the former, it will recognise that some very basic issues need to be acknowledged.

Obstetric care is best delivered by people who have a passion for the care of mothers and the maternal/infant dyad, because success demands the most careful attention to detail, and self-sacrificing work, when attending to obstetric emergencies. Doing such work well consequently imposes a high personal cost on those who engage in it – especially in the public sector. It is very important that their morale is maintained in every way possible, to prevent rapid staff attrition.

However, it is very difficult to maintain high morale when obstetric and midwifery staff are given little control over the patient care

process. Before 1996, for example, the advanced diploma midwives and obstetric doctor team in KZN rural hospitals had full authority to evaluate the care given to mothers in all clinics in their district, provide in-service education to correct defects, improve management protocols, and provide full feed-back on all referrals. After 1996, however, that integrated relational structure was replaced with a complete dichotomy in the vast majority of districts in the province. It has subsequently become difficult to make any impression on district care from the hospital level. And the district midwifery service has too often been administered by cadre deployments, who have little passion or skill for their jobs. This is yet another example of the disempowerment of clinicians as a result of burgeoning bureaucracy that has diminished the primacy of excellence in clinical care in the decision-making process of the whole organisation – simply because bureaucrats are not at the coalface of care, and have none of its sense of urgency. This change has slowly crept up on us since the 1980s.

The great majority of midwives who are passionate about their job are passionate about the rights of the fetus. Therefore, in planning improvements in the service, it is important that they are not pressured in any way to be involved in TOPs.

South Africa has superb in-service training manuals for midwifery and neonatal care. Training is desperately needed by the majority of SRNs who did the new integrated course to deliver a high standard of care. We fall down on the implementation of that training in our hospitals. Our experience in KZN hospitals has been that advanced diploma midwives were the best persons to administer those courses. However, they are generally soon lost to the system because they are excellent personnel and, until recently, there has been no career path for them, so they become managers instead.

Training programmes for advanced diploma midwives should therefore be given more prominence, and distance training programmes resurrected. Careful consideration should also be given to dislocating the training of midwives from the overburdened integrated nursing training, and again making it a hands-on, full-year diploma course.

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‘Off-key’ note speakers

To the Editor: Isn't it disconcerting what some international keynote speakers demand in terms of remuneration, first-class travel and luxury accommodation, whether visiting rich or developing countries? I have just discovered why this may be not just deserved but necessary, as it results in local organisers anxiously awaiting the arrival of keynote speakers at the airport.

I am apparently an 'off-key' note speaker. As a paediatric radiologist working with TB, I was recently invited to talk to paediatricians at an international paediatric congress in South Africa. Excited by the prospect of bringing clinical colleagues up to date on advancements in paediatric radiology and the progress in computer-aided diagnosis of TB in children, I prepared two presentations that I hoped would be informative and entertaining, and deliver a powerful message to a clinical audience. I gave up the long weekend, booked my own flights, thoughtfully opted out of the hotel booking in favour of a friend's couch, and got myself to the congress facility by train and foot.

If I had charged a fortune, someone from the organising committee would surely have bothered to inform me that my session had been changed to the morning, and I would not have been an embarrassing 'no-show'.

So, ironically, the lesson is to talk only to your own specialty, charge a fortune, cost a fortune, accept any and all offers of travel and accommodation, and make the organisers fret about your arrival. If I'd done all that, I might have been considered 'keynote' and not have to resort to ranting here 'off-key'.

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