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 Africa[4] 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