Complications of tube thoracostomy for chest trauma

To the Editor: In response to the article by Maritz *et al.*,[1] I would like to draw attention to a poster detailing the key steps of an intercostal drain insertion that was presented at the ASSA-SAGES congress in Sun City in August 2007 (*SAMJ*, August 2007). The poster was produced by a trauma surgeon dealing with chest trauma in the Cape Flats in conjunction with a local company. The Xpand drain by Sinapi was found to be equivalent to the conventional underwater drain.[2] The poster can be ordered at no cost from www.sinapi.co.za or by emailing chrisd@sinapi.co.za or phoning +27 (0)83 264 8090; it should be made available in the procedure rooms of trauma units.

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1. Maritz D, Wallis L, Hardcastle T. Complications of tube thoracostomy for chest trauma. *S Afr Med J* 2009; 99: 114-117.
2. Cooper C, Hardcastle T. Xpand chest drain: assessing equivalence to current standard therapy – a randomised controlled trial. *S Afr J Surg* 2006; 44: 132-135.

African traditional medicine

To the Editor: The Draft National Policy on African Traditional Medicine (ATM) for South Africa was published as Notice 906 in Government Gazette No. 31271 of 25 July 2008. Subsequently, the South African Medical Association (SAMA) issued a Position Paper setting out their stance on the matter.

The SAMA Position Paper states *inter alia*: 'It is also impossible to quantify African Traditional Medicine by using "Western" scientific methods. The approach of African Traditional Medicine is holistic and is not, and never will be, quantifiable by empirical scientific methods."

And further: 'There is risk involved in attempting to regulate traditional medicine by means of principles which are applicable to allopathic medicine. The use of the criteria "evidence based medicine" cannot be applied to traditional medicine as the holistic nature of African Traditional Medicine incorporates aspects which are not quantifiable by scientific means.

'It is known that in some cases there are allegations that African Traditional Medicine has resulted in harm to the patients using it. As with any allopathic treatment regime there is always a risk of harm to the patient.'

The Branch Council of the KZN Midlands Branch of SAMA wishes to differ from these positions. The primary goal of any therapeutic contract between a health care provider and a client must be the welfare of the client. This is striven for in 'allopathic' or 'Western' medicine by the rigorous testing of therapeutic interventions by means of clinical trials. It is untrue to say that ATM is somehow special because it espouses a 'holistic' approach to patient care. This is what we should all be doing, whether we are African traditional practitioners or 'allopathic' practitioners; Western medicine also strives to be holistic. The effect and effectiveness of holistic medicine can be studied scientifically – by using methodologies appropriate for the question, such as phenomenology.

The correct method of studying the effect and effectiveness of therapeutic medicinal regimens, however, should be strictly scientific and should not differ according to whether the therapeutic agent is derived from 'allopathic' medical practice or 'traditional African medical practice'. If the remedies and practices applied by ATM are efficacious, they should be codified and their use should be supported and extended to other fields of practice. If they are ineffective or harmful, their use should be prevented. The only way to establish whether they are effective or not is to conduct proper, controlled clinical trials, such as that being conducted at Edendale Hospital at the moment on the traditional remedy, Sutherlandia.

There may be risk of harm to patients in 'allopathic' medicine, but the degree of risk relative to the expected benefit is quantified and taken into account in embarking on a particular therapeutic course. The same standard must be applied to ATM.

The welfare of the patient is paramount and must be protected by all means at our disposal.

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Arbitrary actions

To the Editor: Several recent events at a provincial and local institutional level have raised the issue of arbitrary actions; specifically, the impact of such administrative actions on personnel and, ultimately, service delivery. These events relate to the decision by the MEC of Health in KwaZulu-Natal to suspend and discipline Dr Colin Pfaff (who subsequently left KZN to work in Mpumalanga, and is currently at the University of the Witwatersrand), and the more recent 'suspension/redeployment' of the CEO (Dr Arthur Manning) of Chris Hani Baragwanath Hospital. In both cases, the credibility of a respected member of the medical community was brought into question. In neither case were satisfactory explanations offered for the actions. In the former, a letter was written to the MEC by the Professional and Ethical Standards Committee (Faculty of Health Sciences, University of the Witwatersrand); in the latter, a letter was written to the Gauteng Department of Health by the Dean of this faculty. Neither letter was acknowledged, let alone responded to. It may be that the authorities concerned do not deem it fit to respond to a Committee or a Dean. Potentially, it is simply a

case of actions having been taken, and concerns from interested parties (with vested interests in the outcomes) are irrelevant. Such interests would relate to patient care, professional reputations and the profession in general.

As colleagues of the aforementioned parties, and members of the same public health care system, should our concerns be ignored (one should not forget other incidents of a similar nature involving Drs Blaylock and von Mollendorf)? More specifically, if suggestions of impropriety are the basis of bureaucratic action, then surely it is in the best interests of all if the concerns are addressed rather than ignored. The lack of response is troubling as it seems to imply a lack of accountability or a lack of awareness of the seriousness and implications of such actions.

Clinicians are at the coalface, but to render an effective service it is essential that appropriate administrative structures and processes operate. Arbitrary actions create distrust and uncertainty and ultimately undermine morale. In any system, this is dangerous; in a resource-constrained environment, it is potentially catastrophic. If colleagues have conducted themselves in either an unprofessional or an unethical manner, no-one argues a need for action. So far, there is no convincing or objective evidence that this was the case in either instance. As a committee that deals with issues of professional and ethical standards, we would expect the relevant authorities to respond to concerns raised in a forthright and transparent manner, as a general principle. Certainly in Gauteng Province it is hoped that the recently signed Memorandum of Agreement between the Gauteng Department of Health and the Universities of Limpopo Medunsa Campus, Pretoria and Witwatersrand will ensure a collaborative approach to issues of mutual interest.

While it could be anticipated that the authorities concerned may raise an objection to our approaching the 'media', it should be borne in mind that this communication – such as it is – is one directed at colleagues in the profession based on our choice of publication and, further, that it follows approaches to the respective authorities that appear to have been overlooked.

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Erratum

The editorial entitled 'Bread, baby shoes or blusher? Myths about social grants and "lazy" young mothers' by Marlise Richter (February *SAMJ*) contained several errors due to the working document being inadvertently replaced by an unrevised file close to sign-off. We apologise to the author. Readers are referred to the version on www.samj.org.za, which includes all corrections.