



## 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 Emergency facilities and equipment are outdated and often not in working order.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?

**Stewart Townley Boyd**

PO Box 99  
Umbogintwini  
4126

**Michael Sydney Morris**

United Kingdom

## 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.<sup>1,2</sup> 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



## BRIEWE

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.

### **John Terblanche**

*Emeritus Professor of Surgery and Member of Council  
University of Cape Town*

*14 Balfour Road  
Rondebosch  
Cape Town*

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