Increasing stresses in O & G units in district hospitals

To the Editor: It is time to express our mounting concern about a number of issues that combine to make work in O & G units in district hospitals increasingly difficult and stressful, particularly for senior medical staff. Our unit in Eshowe Hospital is a good example.

1. Four of the 6 medical staff in the unit are replaced by new trainees (interns and community service doctors) every 4 months. A heavy clinical load has been mitigated, but largely replaced by a heavy teaching load. I am fortunate in that I have a senior medical officer (SMO) as part of my team. Many other units do not have that luxury. The need to begin again with a new team every few months is demoralising and exhausting, especially if you are the only senior person in the unit and you are trying to maintain a high standard.

2. There is a steady attrition in the number of experienced midwives, especially advanced midwives, as a result of foreign recruitment and the drift of personnel into city hospitals and the private sector. One result of this is that no clinics in our area now do deliveries, and all deliveries done in the public sector must be done in hospital. A second result is that this loss of personnel also increases the amount of personal patient surveillance required of the permanent medical staff.

3. The redirection of the care of rape survivors from district surgeons to district hospital medical staff has placed a considerable load on permanent medical staff because of the huge escalation in the number of rapes. These cases take about 2 years to get to the courts in our area, so it defeats the ends of justice if the community service doctors see them.

A high proportion are juveniles, and their accurate assessment requires considerable experience. Therefore the majority must be seen by senior doctors. The primary assessment of a rape victim takes about 1 hour (providing emotional support, collecting DNAsamples, filling the J88 form, prescribing anti-retrovirals and other prophylaxis, etc). We follow them up for 6 months if adults, 1 year if children. For the past year I have had 2 - 3 court subpoenas per month, and one of the courts is 50 km away. In 2002, we looked after 158 rape survivors (106 children aged 15 years and under), compared with 70 (48 juveniles) in the first 10 months of 2001, so we expect this court work to increase.

4. There is considerable complication in having about 35% of our O & G cases HIV-positive. This means additional counselling and care is needed to ensure that mothers and babies get their Nevirapine, etc. As the epidemic matures, we are looking after increasing number of very ill women in our antenatal, postnatal and gynaecology wards, and even having to provide terminal care in each of these sites.

The first three sources of stress listed here are unfortunate spin-offs of medico-political decisions, and solutions are possible. I record them here in the hope that those with the power and responsibility to address them will be able to find solutions. Useful first steps could be:

- To ensure that every unit that trains interns and community service personnel has at least a post for a head of unit and another for a SMO.
- To speed up the process of training forensic nurses to take on much of the care of rape victims.
- To recruit and train midwives in numbers that take cognisance of the attrition rate in the profession.

It is clear that quite urgent action is required if these stresses are not to add to the continuing loss (from burn-out) of experienced medical personnel from our hospitals as their tasks become more and more difficult.

The epidemics of rape and AIDS should be put together. It is time that we, as a profession, stopped pretending that a condom morality will make any contribution to solving these problems. We must also stop pretending that the profession can continue to cope with steadily escalating numbers of patients who have been overwhelmed by these disasters. We really must state unequivocally that a return to traditional biblical morality is a *sine qua non* for national survival. Three immediate steps would seem to be desirable:

- The will and legislation to reduce access to pornography in the nation.
- Strong moral leadership promoting family values from our political and ecclesiastical leaders.
- The redirection of resources currently poured into organisations that promote hedonism in the guise of sex education toward programmes that encourage norms such as premarital chastity, marital faithfulness and the sanctity of the individual.

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Stress and resilience in South African firefighters

To the Editor: Post-traumatic stress disorder (PTSD) was once considered a normal response to an abnormal event. Implicit in this idea was the presumption that most individuals exposed to a traumatic experience would develop symptoms regardless of pre-trauma considerations. However, given the substantial