



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 DNA samples, 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



number of trauma survivors who either do not develop or recover from PTSD, knowledge of vulnerability and risk have become essential in understanding the nature of the disorder. Biological studies have also provided empirical validation for conceptualising PTSD as a medical condition mediated by a cascade of physiological and psychological events. In particular, neuroendocrine findings have revealed a hormonal profile distinct from that of chronic stress and other psychiatric disorders.¹ While studies of risk factors (biological, environmental, personality, psychiatric, genetic, familial and cognitive) have become increasingly popular, relatively little is understood about the mechanisms that mediate resilience in the face of trauma.²

Firefighters are exposed to different types of risk for PTSD, either directly as victims or indirectly as helpers. A recent study reminded us of how resilient high-risk occupational groups can be. We were consulted by a local metropolitan fire department in Cape Town that was concerned about the potential psychological impact of multiple duty-related trauma exposures (e.g. gang-related violence, motor vehicle accidents and shack fires) on their personnel. We evaluated 34 active-duty firefighters (31 male, 3 female) using two diagnostic interviews, the SCID (Structured Diagnostic Interview for Axis I *DSM-IV* disorders) and the CAPS (Clinician Administered PTSD Scale). The mean age of the firefighters was 29.3 years (standard deviation (SD) = 7.3 years) and the median duration of employment in emergency service was 8 years (range 0.7 - 22 years). Contrary to expectation, only 3 firefighters (9%) had fulfilled diagnostic criteria for PTSD (2 had current PTSD and 1 had past PTSD) and another 6% had partial

symptoms of PTSD (insufficient symptoms to make a diagnosis). In addition, while 38% qualified for a lifetime diagnosis of alcohol abuse or dependence, none with a diagnosis of PTSD reported coexisting alcohol-related problems.

Surveys on the psychological effects of disaster among firefighters have noted high rates of PTSD (in the range of 13 - 32%).^{3,4} Similar rates have been documented in studies of



other high-risk populations in South Africa, e.g. active-duty police and military personnel. Further, high rates of alcohol-related disorders in firefighters (up to 47%), independent of disaster, have also been previously described.^{5,6}

More recently, several studies have argued that high levels of resilience in rescue workers may be protective against PTSD. For example, a recent study of psychiatric disorders in rescue firefighters following the Oklahoma City bombing found significantly lower rates of PTSD in firefighters (13%) compared with direct bomb blast survivors (23%).⁵

Although repeated stress exposure may contribute to the erosion of resilience, it has been suggested that chronic controlled exposure to adversity may in fact be necessary for its development. Moreover, the resilience seen in firefighters may relate to career selection, job mastery and preparedness for repeated stress exposure during emergency missions. Considering that an important determinant of PTSD is the level of social support post-trauma,⁷ strong morale in the work setting and support from superiors and the public may help to mitigate the effects of such exposure. We need to advocate that such systems are in place to support the many South African emergency workers who, in trying to save the lives of victims, are exposed to death and suffering on a daily basis.

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A note on confidentiality of death notification forms

238

To the Editor: The reporting of deaths due to HIV/AIDS continues to pose a serious challenge to physicians. In this regard, Dhai and colleagues¹ made the following observation about the older BI-12 death notification form: 'Physicians found themselves in a dilemma when completing medical

certificates, especially where individuals had died from an AIDS-related illness. Many physicians felt that their duty in terms of confidentiality precluded them from reporting HIV/AIDS on the death certificate, and hence underreported HIV/AIDS as a cause of death. This led to inaccurate epidemiological data.' In their opinion the new BI-1663 form (attached in a previous article published in *SAMJ*),² which was designed to increase confidentiality, failed to ensure this. As such, medical practitioners still found themselves in a dilemma when completing the new death certificate.

Experience on the development of cause-of-death registration in the Netherlands has shown that it is only when the confidentiality concerns of physicians have been sufficiently addressed, that more reliable cause-of-death statistics can be obtained. As van Poppel and van Dijk³ put it, 'The Central Statistical Committee as well as the Minister realized that only a system that would guarantee doctors confidential handling of cause-of-death information could encourage them to cooperate with the NCBS [the Netherlands Central Bureau of Statistics]'. Once confidential registration had been put in place in the Netherlands (through anonymous linkage), stigmatised diseases such as syphilis suddenly appeared to be more widespread than in previous years. Confidentiality is therefore the crux of the matter for improving the quality of cause-of-death statistics.

In the case of the BI-1663 form, the anonymous linkage proposed by Dhai and colleagues¹ is only a partial solution. The issue of the 'independence' of page one has yet to be addressed. In registering the death, it is required that the immediate cause of death be entered onto the population register. When the registrar does not see the cause of death (no matter how vaguely put) on page one, he or she is forced to look for it on page two (by opening it up and hence violating confidentiality). In the Netherlands there are also two forms, Form A (equivalent to page one) and Form B (the page two equivalent). Unlike in South Africa, Form A does have room for the cause of death. The trick is that 'Form A was the less accurate; doctors were not allowed to give false information to the registrar, but at the same time they were not required to state the absolute truth'. South Africa has in the Netherlands a good precedent on how poor quality of cause-of-death statistics improved considerably once confidentiality issues had been successfully addressed.

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