



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

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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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