Burnout of junior doctors and skills retention

To the Editor: In response to Professor Max Klein's correspondence,[1] I am flattered that he noticed the research done but take the opportunity to mention a few missed points.

Most significantly, the research was approved by the ethics committees of both the UCT Health Science Faculty and the Business School. I should be most interested to hear on what grounds he infers the research to be unethical.

To assume from the difficulty in gaining responses that dissatisfaction among junior doctors was not great, is poor analytical thinking by Professor Klein. Normal response rates from email surveys are approximately 3%. We achieved 60% (2 were partially completed) – a statistically acceptable response rate. In fact, the dissatisfaction was demonstrated by the doctors themselves – just over 20% of the junior doctors left their rotation before completion of the contract in the previous year. One needs to question an environment in which 20% of the work force leaves.

It may be interesting to Professor Klein to note that, since the study was completed, Red Cross Hospital has employed 4 additional registrars and adopted some management changes, with the result that burnout in a follow-up study dropped by a statistically significant amount. It appears that the study has indeed helped them.

Professor Klein makes a valuable point that I concede – junior doctors are indeed learning skills; it takes time on the job to learn these skills. It would be a disservice (to both the patients of these doctors and to the doctors themselves) not to make the time available to learn these skills. It is due to our skills that South African doctors are sought after worldwide.

We should remember that South Africa is part of a global village. We need to find innovative ways of retaining hard-earned skills in this country, where they are needed. We can no longer simply keep doing the same things because that's what we're used to.

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1. Klein M. Burnout of junior doctors and skills retention. S Afr Med J 2011; 101:604.

Akhenaten's mystery remains

To the Editor: An unsolved mystery in the history of ancient Egypt is whether or not a familial disease was present among royal members of the 18th dynasty of the New Kingdom, which ruled from the mid-16th to the early 11th centuries BC. The notion of a genetic disorder within this royal family originates mainly from sculptures and reliefs of Akhenaten and his family, which depict an elongated head, face and extremities, and undeveloped thorax with gynaecomastia.

I read with interest the paper by Retief and Cilliers[1] that discusses various diagnoses to explain the unusual form of Akhenaten's body. Based on feminine characteristics outlined in sculptures, the authors suggest that either Kallmann's or fertile eunuch syndromes were the underlying disease affecting Akhenaten. They note that the discovery of Akhenaten's mummy would help to solve the puzzle.

I appreciate the authors' reasoning; however, they appear to have been unaware of the discovery of Akhenaten's mummy in the last year. Using a biochemical, radiological and molecular assay of 11 royal mummies from the 18th dynasty, Hawass *et al.* searched for pathological disorders, and inherited and infectious diseases, among the royal family.[2] They could clarify Tutankhamun's lineage: according to their discovery, the KV55 mummy was the father of Tutankhamun and was most likely the enigmatic Akhenaten. Their findings also dispute any feminised appearance in Akhenaten; computed tomography reconstruction of Akhenaten's pelvic bones did not show any feminine features. The presence of gynaecomastia could not be established since the anterior chest wall of Akhenaten's mummy was not available. Similarly, Tutankhamun did not have any prominent feminine features. Therefore, the presence of a feminised body in this family is doubtful, and the peculiar representation of Akhenaten and his family in statues and drawings could have been attributed to an artistic style subsequent to Akhenaten's reforms, involving religious, social and cultural aspects of Egyptian life.

On the other hand, patients affected by Kallmann's or fertile eunuch syndromes have decreased libido secondary to hypogonadism, but Akhenaten had several wives and children. It is also very unlikely that he suffered from hearing loss or blindness, as papyruses have described.

Although the findings of Hawass *et al.* revealed a cleft palate in Akhenaten's mummy, Retief and Cilliers contested its presence. Furthermore, data obtained from these 11 mummies showed several repeated malformations that cannot be accredited to Kallmann's or fertile eunuch syndromes.

Finally, I must confess that despite these interesting findings, there must be another syndrome that can prompt this collection of malformations in the royal family. Further genetic investigations on the remains of mummies seem necessary to make a definitive diagnosis.

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1. Retief FP, Cilliers L. Akhenaten: a unique pharaoh. S Afr Med J 2011;101(9):4459.
2. Hawass Z, Gad YZ, Ismail S et al. Ancestry and pathology in King Tutankhamun's Family. JAMA 2010;303(7):638-647.

Death with integrity

To the Editor: Dignity SA was launched on 25 September. Its stated intention is to lobby for legal doctor-assisted suicide in South Africa, to allow individuals with terminal illnesses this choice. The debate, which will follow in our profession, should be undertaken in the correct ethical framework.

The ethical debate about doctor-assisted suicide assumes an ethic of radical individualism: rationalising the use of medical 'care' to relieve suffering by taking life. The contractual model of care (which refers to 'clients', not 'patients') is based on this ethic, and emphasises the right to self-determination as paramount in decision-making. Thus, the caregiver holds correlative duties, such as confidentiality and informed consent, to guarantee the free exercise of the right to self-determination.

However, the contractual model of care has serious deficiencies in tending to people who suffer at the end of their lives, as the notion of informed consent becomes very difficult to apply in practice. Dying individuals are extremely vulnerable; their problem-solving skills are frequently impaired, and it is very difficult for an observer to assess them accurately.

It is easy for doctors who are granted permission to take life to become ambivalent in their work. Value judgements may be made on patients' lives, and their lives may be taken without their consent, as

is happening in the Netherlands.[1] Doctors risk being drawn into acts of maleficence, which involve the worst forms of paternalism.

Rather than needing an emotionally distant caregiver with a contractual relationship, suffering terminal patients require an empathetic presence from a team of individuals who are willing and trained to challenge despair and build hope.

'Suffering is not a question that demands an answer; it is not a problem that demands a solution; it is a mystery which demands a presence' (Anonymous).

It is certainly never true to say that 'There is nothing that can be done for you' (except perhaps to kill you!); there is always something that can be done for terminal patients, by those who are prepared to be present compassionately, and to enter into the suffering of another, without being drawn into their despair. Caring is the essential requisite for the ability of the patient and their family to cope; it helps a person to recover a sense of worth, and to appropriate meaning.

Death with dignity is only possible if the relational, existential and spiritual issues at the end of life are addressed – including offering and receiving forgiveness, and dedicating time for a family to gather around a dying member, to celebrate their life, and affirm their worth. Good hospice care is death with this kind of integrity that allows the patient to reach for wholeness, and brings dignity. Encouraging a rapid escape from these issues by doctor-assisted suicide implies defeat, and not dignity.

The almost unopposed concept of autonomous individuality as a basis for decision-making in end-of-life decisions is further flawed: we must fully embrace the ethical principle of 'do no harm' to other family members. Decisions for voluntary euthanasia will inevitably draw others into them; spouses, siblings, children, grandchildren and friends must be allowed to grieve a death freely and healthily, without subverting their grief by deciding on doctor-assisted suicide. This is particularly important in the case of adolescents and young adults; subverted grief can manifest as emotions of denial, diffuse anger, self-contempt and depression, which can be destructive to others and to self.

The incidence of suicide, especially among adolescents, is a significant public health issue in our country. With active euthanasia, we risk adding deaths by 'suicide contagion'[2] – suicides that follow the previous incidence of a suicide in a family or peer group. This is well documented in relation to abortion, and is likely to occur in the case of doctor-assisted suicide. Young individuals, in particular, have an intuitive, God-given sense of the sanctity of human life. Collectively, this evidence suggests that introducing doctor-assisted suicides, even in 'havens', will lead to additional suicides, resulting in compounded grief for their families.

Doctors should take an active stance in this debate, as its outcome will involve all of us. Health care ethics must not be subverted by people who will never have to break their oaths, and deliberately give someone a lethal prescription or injection.

We must be honest about our fallibility as diagnosticians and prognosticators. We must refuse to allow society to give health care professionals the power that it refuses to give to the legal system, which has more checks and balances in place to prevent wrongful deaths.

As health care professionals, we must ensure public sector support for the hospice movement. We should also ensure that training in terminal care is an effective part of our undergraduate and postgraduate instruction.

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1. van der Wal G, van der Maas PJ, Bosma JM, et al. Evaluation of the notification procedure for physician-assisted death in the Netherlands. N Engl J Med 1996;335(22):1706-1711.
2. Canterbury Suicide Project. Suicide Clusters and Suicide Contagion. Bulletin No. 10, February 1997. New Zealand: Canterbury Suicide Project, 2007.

Butterfly season:
Piercing morning sunshine, and
Sugarbirds frantic.

Haiku: Peter Folb