'Formulaic' gender-abuse guidelines seldom followed

The trumpeting by the Health Professions Council (HPCSA) of screening guidelines for emergency care workers handling victims of domestic violence – while welcomed – got a muted response from emergency medicine chiefs in the country's most brutal province last month. The two people heading the Western Cape's clinical protocols and training for emergency medicine and overall emergency medicine services, had reservations as to how practical – or user-friendly – the guidelines are in high-pressure or dangerous situations encountered by their staff.

Prof. Lee Wallis, Head of Clinical Protocols and Training and Dr Cleeve Robertson, Head of Emergency Medicine Services, said the guidelines could not possibly address 'all the variable and dynamic' conflict scenarios. Their province leads the country (and helps put South Africa near the top of the international trauma/injury rankings) with over two million admissions to emergency centres annually, of which 40% (800 000) are trauma and injury – all excluding vehicle-related injuries. Robertson said that although unquantified, personal violence was a 'major cause' of death and injury in the Western Cape. That partner-based violence is a national pandemic is without question. Focused surveys by reputable non-government organisations (NGOs) conducted in Cape Town, Durban and Johannesburg showed that in 58.7% of domestic violence cases, the abuser was the partner, lover or spouse of the victim. A woman is killed by her intimate partner in South Africa every 6 hours, the highest rate (8.8 per 100 000 female population 14 years and older) that has ever been reported in research anywhere in the world.[1] One in four women countrywide is in an abusive relationship.

Dr Cleeve Robertson, Western Cape Head of Emergency Medicine Services (left) and Prof. Lee Wallis, Western Cape Head of Clinical Protocols and Training.

Acting Registrar of the HPCSA (and long-standing former chairperson of SAMA), Dr Kgosi Letlape, spoke stridently about this,

re-emphasising the guidelines (adopted by the council last year) after one of his staff, a temporary call-centre agent, was shot and killed by her policeman husband on 16 April. Ms Tsholanang Kgaladi was shot at the Moot police station in Pretoria while attempting to report her husband having shut her out of their home. He was apparently coming off duty at the time – and she had wanted to collect her clothes from the house. Letlape said that every day 'thousands of women like Tsholanang suffer some form of abuse and the perpetrators are not stopped'. He said emergency care professionals had an 'obligation' to follow the HPCSA guidelines, first published in October last year. These included assessing the risk and identifying imminent danger, providing supportive bio-psycho-social care, documenting diligently any evidence of abuse, informing patients of their rights, services and legal remedies, 'talking through' the implications of domestic violence (including the risk of HIV) and referring responsibility appropriately while identifying their support systems.

Dr Kgosi Letlape, Acting Registrar of the HPCSA (and long-standing former chairperson of SAMA).

Saving lives/treating injuries the priority

Robertson and Wallis said the guidelines were 'welcome and overdue', but doubted what real changes they would make in their contexts. They said their ambulance/emergency rescue staff tended to avoid conflict, concentrating instead on the patient the moment this became possible. Said Robertson, 'They tend to use their normal streetwise savvy to settle people down and then treat the injured patient. These are very generic high-level guidelines.'

Said Wallis, 'It's an issue for emergency medicine in general – if you see a woman that has some injury it's easier to adopt a "don't ask, don't tell" attitude – you don't want to open up a Pandora's box; it's not wilful, it's just the easier way to deal with it. They're already working in a trying situation. The default is to treat the injuries and send them on their way. Their case load is very high.'

Added Robertson, 'They know their duties when it comes to reporting elder or child abuse and we promote the guidelines during ongoing training. The question is whether these (the injunctions) are actually carried out. They'll obviously document the nature of the incident which is handed to the hospital. It all depends on the intensity of the situation; they often don't have the time to transfer the softer information that may be important in the long run. We focus on main-line care – all those softer issues often fall off the bus.' He observed that generally 'everyone's campaigning about alcohol as an issue' but the roots of violence were complex and related to an overwhelming prevalence of violence at all levels of society. The more one was exposed to violence, the more one perpetuated it – and domestic violence was just one component, he added.

'If we could reduce the levels of violence in our society we'd make a significant amount of money available to treating the chronic illnesses that people have to bear,' he added, estimating the financial cost of interpersonal violence in his province at close to R5 billion per annum.

Challenge culturally acceptable violence – EM chief

'We have to change the culture and values of our society … the way we do things … to have cultural symbols of violence like spears and knobkerries borne by praise singers of politicians at major events is a problem to me. We need to create the space to have conversations about horrific things like "corrective rape" without treading on toes,' he added. Wallis revealed that the Metro Emergency Rescue Services in Cape Town had begun a pilot project tracking exact geographical locations of all assaults so that police could identify hotspots and respond pro-actively. Given the link between alcohol and violence, identifying a particular public bar or shebeen and its urban precincts with a high incidence of violence would have a far-reaching preventive impact.

Meanwhile an Alexander Bay GP, forensic psychiatrist and lawyer, Dr Michael Pravetz, has taken on Dr Norman Mabasa, the immediate past chairman of SAMA (and now Health MEC for Limpopo Province), for effectively calling for the reinstatement of the death penalty.

These included assessing the risk and identifying imminent danger, providing supportive bio-psycho-social care, documenting diligently any evidence of abuse, informing patients of their rights, services and legal remedies, 'talking through' the implications of domestic violence (including the risk of HIV) and referring responsibility appropriately, while identifying their support systems.

Mabasa, speaking at an emotionally charged Pretoria memorial service after the murder of internationally renowned South African dermatologist, Dr John 'Oupa' Moche earlier this year, said the ongoing tide of killings had to be stopped, adding, 'We cannot allow this killing with impunity to continue. Kill and you will be killed. This is the message that needs to be sent out.' Pravetz said he was 'appalled, outraged and chagrined to learn that the SAMA chairperson abused his position to espouse what I sincerely hope is his personal view on the desirability of "bringing back the death penalty". The funeral service of a beloved physician, himself brutally executed, should not have been the forum to raise this issue.' China, Iran, Yemen and the USA led the world in capital punishment. The South African Constitutional Court put to rest the argument legitimising executions in South Africa when, in 1995, it held that the death penalty was inconsistent with the commitment to human rights as expressed in the South African (Interim) Constitution *(State v. Makwanyane)*. 'No scientific

Dr Norman Mabasa, former chairperson of SAMA, now Health MEC for Limpopo.

evidence exists that the death penalty is, or ever was, any deterrent to crime. Physicians in most societies practising capital punishment are banned by their professional ethics to participate in this act. While SAMA's (now ex) chairperson can behave (or misbehave, as the case might be) in his personal capacity, and is certainly free to have his own opinion, his speech at this funeral service gave the appearance that he was speaking on behalf of all of those doctors he purports to be representing (or in this case, misrepresenting). I personally wish to distance myself from these ill-reasoned ideals which violate every sense of civility. To send the message "kill and you will be killed" to me is all the more barbarically outrageous when it is spoken from the mouth of the chairperson of SAMA.' Moche, head of the Steve Biko Academic Hospital's dermatology department and one of South Africa's 166 dermatologists, was gunned down in late January in a hijacking in Riviera. The doctor and a nurse he was dropping off at home were sitting in his new Range Rover when two attackers shot Moche in the heart before speeding off in his vehicle.

Dr Robert Weiss, SA Dermatology Society President, said the murder had caused irreparable damage to the country. 'South Africa had up until now only 166 dermatologists, of which 100 are in private practice, with a large number either having retired or left the country, leaving a minority to treat over 50 million people.'

Mabasa did not return voice and text messages left on his cell phone before the *SAMJ* deadline.

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1. Mathews S, Abrahams N, Martin L, et al. A national study of female homicide in South Africa. MRC Policy Brief No 5, June 2004. www.mrc.ac.za/policybriefs/woman.pdf (accessed 9 May 2012).