Dr Ivan Toms – a true hero

To the Editor: I was shocked to read in the *SAMJ* of the unexpected death of Dr Ivan Toms,[1,2] who served as a doctor in 3 Medical Battalion Group (3 Med Bn Gp), a citizen force unit, during the time that I was the officer commanding (OC).

I made an appointment to see him, since I was aware of rumours originating from the state security hierarchy that he was to be made an example of because of his well-known stance against any form of military duty. I was also aware of his sterling work at the SA Christian Leadership Assembly (SACLA) clinic in Crossroads – he was at that time the only doctor taking responsibility for the health of more than 40 000 people.

I was immediately struck by his ready smile and friendliness. We had a long discussion, during which he informed me that he was not willing to do any form of military duty, not even in a medical unit or in the unit for conscientious objectors (whose members did gardening work, without being required to wear a uniform). He was clearly committed to serving poor people. Although not a religious devotee, he was a true believer in the principles taught by Jesus Christ.

My response was that I truly believed that he would serve South Africa best by continuing with his work in Crossroads. However, the limits of my authority extended to preventing 3 Med Bn Gp from calling him up for camps or border duty.

We got away with this for three years, during which time I stayed in contact with him. In April 1987, I resigned as OC 3 Med Bn Gp. In July 1987, the state security hierarchy charged and tried Dr Toms under compulsory conscription legislation. At his trial, I testified that he was truly committed to his work in Crossroads and that I believed that he served South Africa best in that capacity. The judge expressed the same sentiments before sentencing him.

The appalling experiences which he suffered in prison would have broken a lesser man. His subsequent appointment as Cape Town's Health Director and receipt of the Presidential Award of the Order of the Baobab were well deserved. I salute one of the most courageous men that I have had the privilege of knowing.

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The child rape epidemic

To the Editor: We wish to comment on the clinical review of 294 cases of child sexual abuse.[1]

A bias towards significant surgical injury may exist as the Department of Surgery at Red Cross Children's Hospital (RCH), which is a referral centre for managing child sexual abuse of all types, has the more severe cases referred.

A case is made for examination under anaesthesia (EUA). Paediatric anaesthesia is highly specialised and best performed in centres of excellence; its unnecessary use should be avoided as it carries its own morbidity and mortality. Many clinicians, supported by protocols in other centres, hold that most children do not require EUA. Difficult cases or uncertainty and examiner inexperience are indications for referral and possible EUA. The use of EUA is perhaps contradictory to the authors' suggestion that it is '… perhaps time to encourage nursing staff to become qualified sexual assault nurse examiners to perform most of the examination'.

Most sexually abused children presenting to health services have been chronically abused, therefore indications for EUA are less as they are often pathologically co-operative with clinical examination.

It is traumatic for children to be taken from place to place, waiting for transport, etc. The provincial guidelines for management of child sexual abuse suggest that children should be seen and managed close to their communities, with support from the local police and social services. Primary and secondary level health care workers have provided positive feedback on this point, and it is supported by the Women and Children's Directorate of the Provincial Government. We acknowledge the services that social service agencies render within our communities. With inadequate resources, organisations such as Cape Town Child Welfare, the Department of Social Services and the Afrikaanse Christelike Vroue Vereniging use innovative methods with community involvement, and carry huge workloads.

RCH is the *only* designated children's hospital in the country, and would be overwhelmed if all the approximately 18 000 raped children (the annual number of sexually abused children *reported*, according to the South African Police Service) were seen there. It would be greatly preferable to decentralise the management of sexually abused children and to equip all health centres to deal with them adequately and effectively.

Problems with implementing the provincial guidelines require ongoing training and education of junior doctors, improved referral processes to avoid delay, better links with Police Family Services and the prosecution process, and improved community social worker networks. Success in providing facilities for EUAs outside of RCH would depend on the competence and knowledge of the examiners.

Motivations to increase the number of child abuse referrals to RCH do not take into account the Department of Health's Comprehensive Service Plan for Health Care to reduce to four (!!) the number of social work posts at this hospital. This means that there will be only about two social workers available to see a small portion of the child abuse cases. (Social workers do not work with abused children exclusively; they have many other duties.)

Our Multidisciplinary Child Abuse Management team (including nurses, paediatric surgeons, social workers, child psychiatrists, paediatricians, and members of the South African Police Service) represents an excellent model for services elsewhere in the country.

The total reported number of sexual abuse cases (rape and indecent assault) in South Africa in 2005 was 65 737; the overall conviction rate for rape is approximately 7%.[2] Usually, inadequate policing, inefficient evidence collection and an inefficient justice system are blamed. In the UK (with a substantially bigger population than South Africa's) 62 081 sexual offences were reported in 2005. However, despite an arguably better police force, their conviction rate for rape remains persistently lower: under 6% in England and Wales, and only 4% in Scotland.[3]

It would be putting the cart before the horse to suggest that developing a strategy for effective management of these cases would '… curtail the incidence of sexual assault'. The solution to this social ill lies in dealing with 'upstream' rather than 'downstream' factors, as previously indicated.[4]

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2. Van As AB, Whithers M, Millar AJW, Rode H. Child rape – patterns of injury, management and outcome. *S Afr Med J* 2001; 91(12): 1035-1038.
3. Cybulska B. Sexual assault: key issues. *J R Soc Med* 2007; 100(7): 321-324.
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Sharon Cox and Heinz Rode reply: We thank van As *et al*. for their comments, and accept that RCH, as a referral centre, sees more severe injuries than any other unit. Both the incidence and the severity of injuries are increasing.

Paediatric anaesthesia is far safer in experienced hands. We feel that an anaesthetic is necessary in most cases and mandatory for injury delineation and evidence collection in any first-, second- or third-degree tear. Sexual assault nurse examiners (SANEs) would be trained to perform most of the protocol and follow-up – supported by anaesthetic and surgical staff. We submit that a well-trained nurse would render better service than an inexperienced doctor.

Although our study deals specifically with acute presentations, both acute and chronically sexually abused children will benefit from a dedicated unit. When examination needs to be performed on a sexually abused, awake, terrified child in pain, the need for EUA or examination under sedation arises. The trauma of being 'taken from place to place' or 'waiting for transport' is less than that of reliving the assault.

RCH would indeed be overwhelmed if all cases were referred there, but whether a single or multiple units are set up, more resources need to be allocated to this problem to create a functional service. Providing anaesthetic capability or facilities for sedation in community centres would dramatically improve care. We agree that ongoing training of doctors is of paramount importance. Suggesting that '… there may well be a place for providing facilities for EUA outside of RCH' contradicts the authors' earlier point.

This letter motivates the '… capability to provide holistic care to be extended to all rape centres or a comprehensive effective referral system to a dedicated unit' to be developed. Now is the time to connect with policymakers to discuss these issues before 2010 implementation.

We did not suggest that appropriate medical management would curtail the incidence of rape. The role of the health sector is to ensure diagnosis and treatment in a non-threatening and secure environment.

Although disagreeing on management details of child rape victims, we appear to agree on most aspects:

- The incidence of child rape is unacceptably high.
- Apart from implementation problems, the provincial guidelines have been generally well accepted.
- We acknowledge community-based services and their workload.
- The ideal would be to equip all centres adequately. There may be a place for providing facilities for EUA outside of RCH, but its success depends on the competence and experience of examiners.
- Each centre needs a holistic management plan similar to RCH. Well-trained practitioners, whether doctors or nurses, should be able to offer comprehensive management including all aspects of care and evidence collection.