



## Emerging emergency medicine

South Africa carries a quadruple burden of disease: (i) lifestyle diseases (those most common in developed countries – coronary heart disease, cancers, locomotor problems, etc.); (ii) diseases of poverty (including malnutrition, infectious diseases, high maternal and perinatal mortality rates, etc.); (iii) trauma; and (iv) HIV/AIDS. All of these may present at some time as medical, surgical or other emergencies. Also, because of the overwhelming volume there is a particular need in South Africa for expertise in emergency medicine.

For some time years now the emergency medicine enthusiasts have been honing their skills, developing good teaching programmes and making themselves increasingly valued in their practice roles. They were able to persuade their peers in the Medical Board to open the doors of their discipline as a speciality in April 2005.

In his editorial, Clive Balfour (p. 47) takes us through the development of the discipline of emergency medicine in South Africa. He emphasises that, though broad, it is well defined and has pre-hospital and in-hospital components. It may be regarded as a multidisciplinary 'resuscitation, stabilisation, and appropriate disposition' speciality. In such new specialities there is a 'grandfather' clause that enables leaders in the field who have been recognised as specialist equivalent by their peers through experience, time and other qualifications to be registered as specialists. Previously such decisions have been made because colleagues have 'looked and smelled' like specialists. However, the emergency medicine group have drawn up guidelines to try to define, through more objective criteria, how this should be determined (the occupational medicine speciality also recently went this route).

A group of emergency care doctors has recognised the need to prioritise the emergency care of South African patients (p. 53). Such prioritisation is termed triage – the process of sorting patients according to medical need. They note that the absence of a triage system leads to prolonged waiting times, poor management of clinical risk and increased morbidity and mortality. They developed a triage scoring system that has shown great promise in practice and hope that, with suitable modifications, this may become accepted as the South African triage system.

In the pre-hospital management of emergencies, thrombolysis is often important to improve clinical outcomes. Nicholas, Naidoo and Owen (p. 28) describe the process whereby paramedics may be trained in its use in South Africa.

## Uproar over hospital ratings

A worldwide trend is to develop standards in all manner of activities and to evaluate programmes, organisations, facilities, etc. against such standards for accreditation and other purposes. Medicine is also increasingly moving towards evidence-based practice. Why then the fuss when Discovery Health launched its 'Hospital Rating Index'? Chris Bateman

(p. 14) explores this question, which has raised considerable heat in the South African medical world.

At issue are criticisms of the methodology used to derive these rankings and the lack of consultation before the launch of the system. Discovery Health intends to revise the ratings system and hopes that concerns would be addressed through process and interaction.

## Intracranial endoscopy

Intracranial endoscopy may be far removed from most practitioners' interests. However, the article by Figaji and colleagues (p. 32) provides a fascinating glimpse into the world of medical advances.

Although first considered in the early part of the 20th century, intracranial endoscopy as a treatment and diagnostic procedure came into its own because of technological advances. It offers many advantages over open surgery when used for the appropriate indication. The commonest procedure performed is endoscopic third ventriculostomy for treating hydrocephalus. Other indications include fenestration of various intracranial cysts, intraventricular biopsy, the placement and retrieval of ventricular catheters, the removal of small intraventricular lesions, and the improved visualisation in microsurgical operations.

Fundamental to the success of the procedures are adequate training for the surgeon and the appropriate selection of patients. Although the learning curve is steep, the complications are relatively few.

## Discovery of the ESR

Jarek Kowalczyk has previously contributed papers to the *SAMJ* historical section. One of these drew flack and he was accused of not knowing his geographical boundaries. However, he was quite capable of standing his ground in pointing out the shifting ground of political boundaries!

In this edition (p. 40) Jarek explores the academic life and contributions of Edmund Biernacki and in particular his discovery of the erythrocyte sedimentation rate (ESR).

Biernacki studied medicine at the university of Warsaw, graduating in 1889. In his studies on red blood cell volume he found what he called 'spontaneous blood sedimentation' that set the foundation for the discovery of the ESR. He later proved that the ESR is accelerated in inflammatory diseases such as rheumatoid fever, chronic nephritis, tuberculosis, pneumonia, anaemia and cancer.

Although Biernacki's work was performed between 1893 and 1906, it did not gain popularity until the mid-1920s. The reason for this is that syringes only became commonly used instruments much later. The subsequent publications of Robin Fahreus and Alf Westergren made the ESR one of the most popular and important discoveries in medical practice.

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