Emergency medicine – a new era in South African medicine

The emergency medicine specialist register was opened in April 2005. This broad discipline is well defined and comprises pre-hospital and in-hospital components. It may be regarded as a multidisciplinary 'resuscitation, stabilisation, and appropriate disposition' specialty. The establishment of this new specialty is arguably the most significant development in medicine in this country for decades, providing opportunities for academics, provincial authorities and politicians to make a difference.

The South African emergency physician will be different from most First-World specialists in this discipline. The conditions in our country are certainly more demanding, both in terms of work environments and the pathology profile of patients.

For these reasons the 4-year training programme has been designed to suit our needs, rather than importing established First-World programmes into South Africa. We are confident that our training programmes will withstand international scrutiny and produce world-class graduate emergency physicians.

Will our new graduates be expected to do a 'front room' thoracotomy? Will they be expected to thrombolyse patients in the emergency units? The answer to both is yes.

The Emergency Medicine Society of South Africa (EMSSA) was responsible for establishing the specialty in our country and subsequently for founding the College of Emergency Medicine (CEM) within the Colleges of Medicine of South Africa (CMSA).

The four health science faculties with departments of emergency medicine (University of Cape Town (UCT), Stellenbosch University (SU), the University of the Witwatersrand (Wits), and the University of Pretoria (UP), have registered MMed degrees in emergency medicine. Communication between these departments is healthy and collaboration between UCT and SU has led to a common teaching platform for the MMed programme, as well as a joint Division of Emergency Medicine.

In the short time that emergency medicine registrars have been doing duty in emergency units, an increase in service levels has been acknowledged, while levels of commitment and enthusiasm have surpassed those previously demonstrated by junior staff. No doubt standards of practice and patient care in both the pre-hospital and in-hospital areas of emergency medicine will continue to improve across the country as the specialty is rolled out.

The 'grandfathering' process

What about 'grandfathering' (or to be more politically correct, 'grandparenting') individuals onto the specialist register?

A consensus document has been submitted to the Health Professions Council of South Africa (HPCSA) by the CEM, EMSSA, and the university departments of emergency medicine. The objective is to offer a set of 'guidelines' to be considered when 'grandfathering' in this new discipline. The consensus criteria include postgraduate qualifications relevant to emergency medicine, a minimum of 5 years of relevant experience, recognition by peers, contribution to education and training, and links with a university department related to emergency medicine.

Grandfathering is as old as the term implies, and can be as difficult as a grumpy old man. It is certainly an imperfect process, fraught with emotion. Be this as it may, the so-called grandfather clause remains for a period of 5 years, after which the specialist register is closed to those without a specialist qualification in emergency medicine.

I am sure that the Postgraduate Training and Education Sub-committee (Medical) of the HPCSA will gain the confidence of the profession by dealing with applications in a sensitive and responsible manner.

Career opportunities

New graduate emergency physicians will expect consultant posts to be available on graduating. Some of our provincial governments have been alerted to this, and if such posts are not available the new graduates will be attracted to provinces in which there are such posts. It is anticipated that existing Principal and Chief Medical Officer posts will initially be used and converted into specialist posts.

If sufficient specialist posts are not made available, these valuable people may be lost to South Africa. Are we training emergency physicians for New Zealand, Canada, Ireland and Australia? A timeous warning to the state and private sectors!

South African doctors interested in emergency medicine are being attracted back to our country. These doctors represent two groups, firstly those who have heard that specialist training in emergency medicine is now being offered in South Africa and are applying for registrar posts, and secondly those who left South Africa to specialise in emergency medicine in countries that offered the training and now wish to come home to practise their specialty. We should welcome these doctors with open arms by ensuring that they are accommodated in appropriate posts back in South Africa.

The number of emergency physicians required to meet the service and training needs in South Africa will need to be assessed per province, as there are wide discrepancies in terms of need between provinces. It is estimated that 54 emergency physicians are required in the Western Cape, and between 300 and 400 for the country as a whole.

The first 10 registrars should graduate MMedEM/FCEM (SA) in December 2007. Thereafter, it is anticipated that there will be a combined total of approximately 14 graduates annually from the four universities previously mentioned. There is the possibility that other health science faculties will commit to specialist training.

There is no doubt that the private sector will attract new graduates. There are more than 100 emergency units in private hospitals throughout South Africa, functioning at different levels. Approximately half of these units function at a regional level, which implies that they offer a continuous around-the-clock resident doctor emergency service.

Cost- and time-efficient utilisation of space, equipment and staff has been looked at in some detail in the private sector emergency units. In many cases the larger, well-run emergency units in this sector are examples that the state sector could learn from. Options exist for doctors to run their own independent practices or to be employed by the hospital.

The IQ/EQ mismatch and the tripod of clinical duties, teaching, and research

Emergency medicine is forcing academics and administrators to communicate about many new issues. Lack of understanding has been the greatest hurdle to overcome, and emergency medicine has posed several new concepts to provincial governments. The well-worn path of antagonism and territorial power struggles between these groups has to some extent been avoided. The plea to the provincial governments is to take emergency medicine seriously and to budget for adequate funding.

However, opportunities for better understanding and mutual respect have been demonstrated at many of the meetings. Ambulance and rescue services (road, rotary and fixed-wing aircraft), disaster planning, and hospitals at all levels are part of emergency medicine – co-operation and communication is essential.

The unfortunate combination of a high IQ and a poorly developed EQ is well demonstrated by many of our colleagues. Superior attitudes and arrogant displays of power are unacceptable and should not be tolerated if we are to achieve common goals for the benefit of all.

The traditional high regard for 'service' by provincial governments at the expense of teaching and research must be balanced by the right attitudes, understanding of the importance of clinical supervision, and teaching of junior staff.

The three legs of the tripod, namely clinical duties, teaching and research, do not make for a level working surface. Perhaps this should be accepted, and the length of each leg of the tripod could be engaged in such a way that the working surface is workable!

Academics should be good all-rounders who have the ability, energy and enthusiasm for service delivery, teaching, and research. It was suggested at the recent CMSA golden jubilee symposium on academic medicine in Africa that academic medicine should move out of its ivory tower. Perhaps the time is right for this to happen – can emergency medicine lead by example?

Clinical research should focus on South African problems and thereby improve the basic health needs of the country. New knowledge created should update service delivery. Emergency medicine could be categorised as a clinical discipline, and as such relevant research should translate into clinical practice. This has recently been demonstrated by a study done at G F Jooste emergency hospital (Cape Flats), where a new triage system reduced waiting times dramatically and the mortality rate by 50% (S Bruijns – MPhilEM dissertation in progress). As a direct result of this information the provincial government of the Western Cape made R500 000 available for training and implementation of this triage system throughout the province.

The 'publish or perish' attitude of academic institutions lacks perspective, and assumes that there is enough time to write articles. While publication of work remains an integral part of an academic's world, research must be made accessible, understandable and relevant to policy makers. 'Adapt and apply research evidence' will then not be seen by 'service providers' as superfluous, or just an academic theoretical approach. Academic emergency medicine should focus on the above and make a significant contribution to both the pre-hospital and in-hospital emergency management of patients.

Acknowledgement and reward for contributions to developing improved systems, raising clinical standards, designing new courses and advancing service delivery would be as appropriate as recognising publications in peer-reviewed journals.

Conclusion

Significant challenges lie ahead in health care in South Africa. Emergency medicine provides the opportunity for many of these challenges to be met. The university departments, the CEM and EMSSA are prepared to rise to these challenges, and are able and willing to work with the provincial authorities towards improving emergency facilities for all South Africans.

Emergency medicine is a discipline in the public eye – here is an opportunity to demonstrate what can be achieved by academics and policy makers working together to create the greatest benefit for the greatest number of South Africans.

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