African drumbeats: a first conference on emergency medicine

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SUMMARY: Africa's first conference on emergency medicine was held in October 1998 in Johannesburg, South Africa. Attended by 305 delegates from 13 countries, it was an important milestone in the development of Africa, emergency medicine's last frontier. The violence of South Africa's post-apartheid society was portrayed in mock scenario demonstrations of the private sector emergency medical services (EMS) system. Many of the presentations had a distinctly African flavour; they dealt with penetrating trauma and with making the best of extremely limited resources. A session reviewing the activities of traditional healers was not only terrifyingly revealing, it also upset and offended a segment of the African audience. The conference ended positively with the creation of the Emergency Medicine Society of South Africa, a step toward recognition of emergency medicine as a specialty in Africa.

RÉSUMÉ : La première conférence de médecine d'urgence en territoire africain a eu lieu en octobre 1998 à Johannesburg, Afrique du Sud. Trois cent cinq délégués de 13 pays y ont participé. Il s'agissait d'un événement marquant dans le développement de l'Afrique, dernière frontière de la médecine d'urgence. Des simulations de scénarios des services médicaux d'urgence du secteur privé illustrèrent la violence au sein de la société sud-africaine post-apartheid. Plusieurs présentations avaient une couleur nettement africaine; celles-ci traitaient de traumatismes pénétrants et de la nécessité de s'accommoder de ressources extrêmement restreintes. Une démonstration des activités des guérisseurs traditionnels révéla non seulement une réalité terrifiante, mais elle perturba et choqua une partie de l'auditoire africain. La conférence s'est terminée sur une note positive avec la création de la Société de médecine d'urgence de l'Afrique du Sud, un pas vers la reconnaissance de la médecine d'urgence en tant que spécialité en Afrique.

In October 1998, 305 delegates from 13 countries gathered in Johannesburg, South Africa, for this continent's first conference on emergency medicine (EM). Cosponsored by the College of Medicine of South Africa, the Australasian College for Emergency Medicine and the Faculty of Pre-Hospital Care of the Royal College of Surgeons of Edinburgh, this conference was an important step in establishing emergency medicine as a distinct discipline in Africa. Given the primal state of emergency medicine in Africa, it was a significant achievement. There is no shortage of emergencies here, just an absence of organized emergency medical systems and emergency medicine training programs.

Johannesburg, with its gleaming office towers, extensive network of well-maintained freeways, and solid infrastructure, appears very modern and western. Blink and you might think you are in Toronto. Keep your eyes open and drive a little farther, past the miles of densely packed cardboard and corrugated-steel shacks, and you realize this could only be South Africa. The rainbow revolution did not suddenly eliminate disparity between rich and poor, between black and white, or between first world and third.

In South Africa, criminal violence has replaced the political violence of apartheid. This is a country under siege, engaged in an internal guerrilla war.

"Don't walk outside at night! Get in your car, lock the doors and don't stop." Random acts of violence are no

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longer confined to poor black townships; they have invaded rich white suburbs as well. The dismantling of apartheid has also blurred the once clear racial division between have and have-not, creating a new class of impoverished Afrikaners.

At the conference, effective, high-tech, private emergency medical services (EMS) were on display. At the Kyalami Formula One Racetrack, with EM conference delegates in the stands, a typical day in South African EMS was portrayed. To begin, a motorist with engine trouble pulls off to the side of the road and puts up the hood of the car. Four men in a passing pickup truck spot the stranded motorist, stop, shoot him, and steal the vehicle (Fig. 1). A passerby notifies police.

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Moments later, police choppers and squad cars appear on the scene and, after a brief chase, entrap the stolen vehicle. Gunfire erupts, and bodies sprawl everywhere. A hostage is taken. The SWAT team rappels down from a helicopter, frees the hostage and leaves the hostage-taker bleeding from a gunshot wound. At the end of this "mock scenario," six bodies with gaping gunshot wounds lie prostrate in pools of blood. Now it's time for private-sector EMS to save the day. Four helicopters from different ambulance services swoop in from all corners of the sky while land ambulances scream in along the highways. (Do these thugs have insurance?) The bodies are quickly stabilized with back boards and cervical collars and whisked off to hospital (Fig. 2). Although this was undoubtedly meant to represent efficient police and EMS response in a modern society, it seemed more like a version of "Terminator" — live! It was only a display, a game, but still unnerving and offensive to my delicate Canadian sensibilities.

Needless to say, there were plenty of papers on penetrating trauma — a year's cumulative Canadian experience collected in 3 months at a single hospital. There were also other uniquely African presentations. For example, a paramedic, Mr. Eduard Bezuidenhout, demonstrated why the concept of a "golden hour" for trauma resuscitation remains entirely conceptual in the reality of the vast distances, sparse population and severely limited medical resources of Namibia. Dr. Paul Davis, of Medical Rescue International in South Africa, gave a moving overview of the effects of imperialism and colonialism in sub-Saharan Africa. The rape of the land and peoples, the artificial political boundaries, and the sudden retreat of colonial powers have left these new political creations in chaos. The difficulty of providing quality health care in the face of desperate poverty and political and social upheaval is enormous. Dr. Davis also noted that the health and educational status of a nation is inversely related to its police and military spending.

The "alternative" medical system of traditional healers was also examined. In 1977 the World Health Organization adopted a resolution supporting inclusion of African traditional healers as part of the primary health care team. Africans clearly concur. A 1993 South African study found that 80% of people consult a traditional healer before going to see a nurse, a doctor or visiting a hospital.

An individual becomes a traditional healer through spiritual endowment rather than a course of study. The belief system of African traditional healers revolves around magic and the presumed value system of one's deceased ancestors. Disease is an indication that the patient has been hexed by someone or has offended an ancestor. Therefore, in assessing causation, the traditional healer's first priority is to identify who is responsible for the disease. If the patient has been bewitched, then vengeance is necessary to prevent progression and eliminate the cause. The "prescription" may involve injury or even death of the offending party. If the illness is thought to be due to an ancestor's wrath, the traditional healer performs supernatural divination to determine whether the patient has violated any pre-established order, and to seek the ancestor's forgiveness through sacrifices and rituals, which appease the anger of the dead.

In many cases it is necessary to take *muti*, a concoction that contains various herbs, but which may also contain animal or human body parts. This secret elixir is the perfect pharmaceutical. If the patient dies after taking it, the cause is ancestral wrath. If there is no improvement, it is because

Fig. 1: The shoot-out

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Fig. 2: EMS in action

the patient failed to take it in the proper kneeling position or perhaps faced the wrong direction when taking it. If the disease abates, then the *muti* was clearly effective. Of course, since most illnesses spontaneously improve, *muti* is often very effective. Alarmingly, some "*muti* prescriptions" involve violence toward, or mutilation of others, and some notorious traditional healers are known to personally administer *muti* by performing sexual acts with the patient.

Mr. Sipho Kunene, an "ethnomedicine practitioner" and graduate of the African Herbal College, spoke of his research on the practice of traditional healers in South Africa. He warned emergency practitioners that many, if not most, of their patients would have consulted a traditional healer and been prescribed a treatment prior to their medical visit. In Africa, it is particularly important to inquire about these treatments because they may cause ill health rather than cure it.

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Kunene went on to condemn the interpersonal violence that is perpetrated in the name of traditional healing. He stated that, in its current form, traditional healing has no role to play in emergency and prehospital medicine. He called for regulation of traditional healers, a formal course of training, pharmacological assessment of *muti* preparations, and scientific evaluation of their effectiveness. This blatant political incorrectness created an uproar among a segment of the African audience. A special session was hastily added at the end of the conference to allow for a rebuttal to his views.

The role of traditional healers in African health care is a controversial and emotionally charged issue. These healers have been around for thousands of years and are an established component of many African cultures. They have and will continue to have an important supportive role in the community health care system. Perhaps some of their *muti* prescriptions even contain appropriate pharmacologically active ingredients. However, with their reliance on myths and magic, are they not simply exploiting an ignorant population? Worse, *muti* prescriptions for violence or mutilation are contrary to basic human rights and social order. The WHO endorsement of traditional healers suggests that the desire to be culturally sensitive and politically correct has over-ridden the basic scientific principles of modern medicine.

This historic EM conference concluded with the distribution of application forms for the newly created Emergency Medicine Society of South Africa. As Africa is the last continent without any recognized specialty of emergency medicine, it was a step out of the darkness.

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