Editorial/Van die Redaksie

Biko revisited

> Those who cannot remember the past are condemned to repeat it.
>
> *The Life of Reason*, George Santayana

It is now just over 10 years since the furore in the South African medical profession over the medical management of Steve Biko before his death in detention reached its height. Many readers may wonder why it is being exhumed this long after the event, but although the memory of the events surrounding Steve Biko's death in detention may have become blurred with time, the damage that they did to the credibility and reputation of the medical profession in South Africa both nationally and internationally is still not far from the surface of consciousness for many people. One of the direct results of the affair, apart from a flurry of resignations from the Medical Association of South Africa, was a split in the profession between the MASA and the then newly formed National Medical and Dental Association (NAMDA). The MASA viewpoint of NAMDA crystallised into regarding it as a radical political rather than a medical professional association, and NAMDA has tended to regard the MASA as a reactionary, conservative organisation with too many apparent ties to the official governmental structure for its own good.

It is not the intention of this editorial to go over the events of that time in great detail, but looking back at the records, and leaving aside the role played by the South African Medical and Dental Council, it is now apparent that neither the MASA nor the *SAMJ* emerged with any great credit from the episode. Much of the correspondence emanating from MASA spokesmen still on record in the *SAMJ* offices displays a defensive, 'total onslaught' type of approach combined with an apparent determination not to think the unthinkable — that authoritarian bodies such as the SAMDC and individuals might have acted wrongly or mistakenly. Letters submitted for publication at the time to the editor of the *SAMJ*, some of them from distinguished academic figures, were not published, the writers being given various reasons ranging from the correspondence being closed to the excuse that no letters were being published until the Federal Council meeting of 12 November 1980. Unfortunately, even after that meeting, the conclusions of which were not positive enough to allay the fears of many doctors that less than justice had been done, the letters were still not published. Worst of all from the point of view of the reputation of the *SAMJ*, an unsigned editorial was published on 16 August 1980 advancing the argument that the SAMDC should not be criticised for its handling of the Biko affair on the grounds that it had been helpful to the MASA in its negotiations with the Minister of Health over the medical scheme tariff structure.[1] A more unfortunate comparison would have been hard to make.

All this is now water under the bridge, although the waves created by these events continue to lap uncomfortably loudly at times. The main point of this editorial is to look at what, if anything, has changed over the past 10 years to make a similar episode less likely in the future.

Anybody who has been following reports on the various MASA activities for the past 2 years should by now have realised that a great deal has changed, much of which was initiated at a series of strategic planning meetings held at Gencor's Conference Centre at Broederstroom in the Transvaal. The purpose of these meetings was to analyse the MASA's function, to formulate a mission statement and to generate a series of aims and objectives for the future. This groundwork has been added to by an evaluation currently being carried out by P-E Consultants, who have interviewed a large number of members and non-members of the MASA, as well as other influential figures and members of the general public, to assess what current perceptions of the MASA are and how it can be reorganised to make it an effective, relevant and credible organisation able to meet the needs of the profession and the public for the future. Considerable changes in its structure have already made the MASA more sensitive to its members' wishes, and more will be implemented when the results of the current investigations are available. Although it would be sanguine to assume that internal reorganisation within a body is in itself enough to ensure that individuals in that body will react rapidly and correctly in response to a crisis, good communications and a streamlined organisational structure should certainly help them to do so. It is also an encouraging sign of the times that the MASA and NAMDA no longer seem to be regarding each other with the mutual hostility and suspicion of a few years ago, and there are indications that the two organisations are at least now willing to talk to each other, and even to co-operate in some areas.

The Publications Division of the MASA has also undergone some radical changes, particularly in internal management structure, which has integrated its activities much more closely with the Head Office in Pretoria. However, this has been done while bearing in mind the vital importance of editorial independence, which enables the editor to remain ultimately responsible for material selected for publication, even though he relies on a great deal of expert advice in making the selection. Present editorial policy is that the *SAMJ* is a forum for all shades of opinion across the medical spectrum.[2] The balance between a journal that is under tight institutional control and one in which the editor has complete freedom of action can be a delicate one, although, as Stephen Lock,

Editor of the *BMJ*, has pointed out, nobody wants to publish in a journal which is a constrained parish magazine.[3] That point of view was also expressed by Arnold Relman, Editor of the *New England Journal of Medicine*, when he wrote, 'an editorially independent journal is more likely to have broad appeal than is a journal under any form of institutional control'.[4] In the same editorial, Relman commented that he was often asked whose views were being represented in controversial articles. His reply was that they represented purely and simply the views of the author. All articles in the *NEJM* are signed by the author, and the same now applies to the *SAMJ*.

Much has changed since the death of Steve Biko, not least being the apparent emergence of a new spirit in South Africa which promotes the recognition of past mistakes and inspires efforts to build a better future, even though the present violence in the country is a tragic indication of just how far away from that better future we still are. However, hope for the future should not blind us to the mistakes of the past, or mislead us into thinking that they can somehow be expunged by declarations of future good intentions, however well meant. What happened to Steve Biko should never be allowed to happen in any country that regards itself as civilised. It is the duty of all of us to learn from the past, and to try to ensure that nothing of the sort can ever happen again.

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1. Anonymous. Comment on the Biko case (Editorial). *S Afr Med J* 1980; **58:** 265.
2. Lee NC. Serving the truth (Editorial). *S Afr Med J* 1987; **72:** 371.
3. Lock S. Editorial freedom: a modest proposal to Dublin (Editorial). *Br Med J* 1988; **296:** 733-734.
4. Relman AS. The journal as an open forum (Editorial). *N Engl J Med* 1985; **312:** 1384-1385.

Syncope

Syncope is a term that is misunderstood and frequently misquoted. No matter what the cause, syncope is defined as sudden, temporary loss of consciousness due to an abrupt fall in blood pressure to such low levels that cerebral autoregulatory mechanisms are no longer effective and cerebral blood flow becomes impaired.

Certain forms of syncope are readily recognised as being vasovagal in origin, when they occur in association with, for example, severe pain, venepuncture, standing on a parade ground or at a school assembly, or following any acute emotional stress — including social commitments, public speaking and air travel. This type of fainting spell is benign, and common in young patients. It invariably occurs in the upright position and is often preceded by presyncopal symptoms such as blurred vision, dizziness and perspiration. Loss of consciousness will supervene unless the subject immediately lies down so that the heart and head are at the same level. The patient is extremely pale, usually sweating and has cold extremities. The pulse is weak but, importantly, not always slow. Irrespective of where a vasovagal syncopal episode occurs, the crucial contribution to management is to place the patient in the supine position and, if necessary, to elevate the legs.

Syncope is frequently confused with vertebrobasilar transient ischaemic attacks (TIAs) and epilepsy, resulting in incorrect investigations and therapy.[1] Vertebrobasilar TIAs are focal events; the patient may 'blackout but will always have at least two vertebrobasilar territory abnormalities such as double vision, speech loss, cerebellar dysfunction, etc.'[1] Some epileptic seizures may also resemble syncope. However, the presence of an aura, focal jerking movements, incontinence, lack of pallor during the event and confusion after the event will make a diagnosis of syncope unlikely. An electro-encephalogram is required to confirm this diagnosis.[2]

Syncope is a global event, with a sudden transient loss of consciousness. The patient is usually alert immediately upon awakening and there should be no organic brain disease present. The patient is unable to maintain postural tone during the event, which would not be compatible with a seizure disorder, vertigo, dizziness, coma or other states of altered consciousness.

Diagnostic criteria were well described by Kapoor *et al*.[3] The major categories described range from benign problems to severe life-threatening disorders. The major groups are those related to carotid sinus pressure, and those due to cardiac abnormalities and drugs. Syncope is a result of a decrease in cardiac output or blood pressure, or both. It is not a primary brain disorder.

Vasovagal syncope has been mentioned and can usually be easily recognised after a relevant precipitating event has been identified. Cough syncope, micturition syncope and defaecation syncope can only be diagnosed if no other causes are found and the syncopal event occurred during or immediately after a paroxysm of coughing, micturition or defaecation. Frequently these patients have another abnormality such as aortic stenosis, postural hypotension, SA nodal disease or autonomic disability and the 'Valsalva' effect of micturition, defaecation or severe coughing is sufficient to significantly decrease blood pressure and cardiac output and impair cerebral blood flow.

Drug-induced syncope should be diagnosed only if clinical anaphylaxis occurred, if drug overdose was present or, most important, if orthostatic hypotension resulted from the use of diuretic, antihypertensive or anti-arrhythmic medications.[4] It is important to remember that patients with hypertension are more prone to orthostatic hypotension than normotensive patients because of an increased sensitivity to cerebral autoregulatory failure at higher systolic blood pressures than normal.[1,5] Orthostatic hypotension should be diagnosed if there is a decrease in systolic blood pressure on standing up (from the lying position) of more than 20 - 25 mmHg associated with dizziness or syncope. The blood pressure should be measured during the first 25 seconds after standing and again after 1 minute. In normal subjects the blood pressure normally drops about 10 mmHg in the first 25 seconds after standing, but tachycardia develops and this again raises the blood pressure. If no tachycardia or diminished tachycardia is noted (poorly reacting sinus node) this blood pressure drop is likely to be more symptomatic. Autonomic neuropathy such as that caused by diabetes can also cause orthostatic hypotension.

Mechanical and functional cardiac abnormalities causing syncope should be sought. These include valve (especially aortic valve) stenosis, hypertrophic obstructive cardiomyopathy, myocardial dysfunction, cardiac myxomas or thrombi, pulmonary embolism and pulmonary hypertension of other cause. Irrespective of whether the heart is otherwise normal, near-normal or significantly abnormal, a prevalent and important reason for syncope is cardiac arrhythmia.[6] This includes bradyarrhythmia, especially sick sinus syndrome, slow atrial fibrillation (R-R interval greater than 2 seconds) and other manifestations of atrioventricular heart block (types 2 and 3). Paroxysmal tachyarrhythmias such as supraventricular tachycardia, ventricular tachycardia and even intermittent ventricular fibrillation may all cause syncope.

In investigating the cause of syncope it becomes clear that a good history including (if possible) an eyewitness account of the event and careful clinical examination are of utmost importance.[4] An electrocardiogram is mandatory. Ambulatory 24-hour Holter electrocardiographic monitoring and echocardiographic evaluation are indicated only after a careful drug history has been taken and the blood pressure monitored in the standing and lying positions.

The sole neurological test that is of any real value is an electro-encephalogram to exclude a seizure if the history is not clear.[2] Brain scanning is seldom indicated and magnetic resonance imaging probably has no place at all in investigating syncope. Invasive or provocative procedures (e.g. electrophysiological studies) of any kind should be reserved for selected patients with specific indications.

Syncope is not a neurological disorder. When associated with sudden death the cause is invariably a cardiac conduction defect, arrhythmia or important structural abnormality. Expensive tests such as brain scans are often performed in patients with syncope but are rarely contributory. In this day and age, when cost is becoming more and more important in patient care, the vast majority of patients with syncope will be diagnosed by a good history and careful physical examination. An electrocardiogram may indeed be important but most other tests will add little to elucidating the cause of this common symptom.

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1. Fritz VU. The role of the extracranial vessels in acute cerebral ischaemia: a clinical and laboratory study. Ph D thesis, University of the Witwatersrand, Johannesburg, June 1986.
2. Wee AS. Is electroencephalography necessary in the evaluation of syncope? *Arch Intern Med* 1990; **150:** 2007-2008.
3. Kapoor WN, Karpf M, Wieand S, Peterson JR, Levey GS. A prospective evaluation and follow-up of patients with syncope. *N Engl J Med* 1983; **309:** 197-204.
4. Critchley EMR, Wright JS. Evaluation of syncope. *Br Med J* 1983; **286:** 500-501.
5. Manolis AS, Linzer M, Salem D, Mark Estes III NA. Syncope: current diagnostic evaluation and management. *Ann Intern Med* 1990; **112:** 850-863.
6. Klein GJ, Gulamhusein SS. Undiagnosed syncope: search for an arrhythmic etiology. *Stroke* 1982; **13:** 746-748.

An integrated healing approach

The South African medical profession has over the years been preoccupied with the notion of the African view of disease and the best way in which to relate to traditional healers in the best interest of their patients. These concerns, laudable as they are, ignore some fundamental realities of explanatory models of disease causation and health-seeking behaviour of their patients.

All over the world human beings utilise information and symbols accessible to them in their daily environments to construct an explanatory model of disease causation. Models so constructed change over time as more information becomes available.[1] The same applies to Africans. The quest for healing is also a universal human pursuit and stops only when satisfaction is attained or hope for cure dies.[2] It seems from international publications and work done locally[3-5] that patients are rational beings in their health-seeking behaviour. These studies also document that the biomedical healing system is the first choice for the majority of respondents.

The quest for healing by patients also illustrates their ability to select and integrate what they perceive as the best out of all possible healing systems. The article by Simon in this issue of the *SAMJ* (p. xxx) documents how an African healer has adapted to the needs of his patients by integrating biomedical and African healing idioms and symbols.

The challenge for biomedical healers is to improve their health care delivery system to make it accessible, in all aspects, to black patients. Fundamental to this accessibility is the issue of language and the ability to respond to the human needs of patients. The impersonal environments of biomedical health services are largely responsible for the continuing need for patients to seek help from other healers. 'Alternative healers' are seen as being more willing to recognise and address fear associated with the experienced disease and death, as well as the need for reassurance and warmth in patient/healer relationships.

It would thus seem that dualist analyses of disease causation and health care strategies, as consisting of mutually exclusive 'systems', hinder rather than enhance appropriate responses by the medical profession.[6,7] Patients seem to be ahead of the profession in this respect. It would seem that the best contribution the South African medical profession could make to the development of a comprehensive integrated health care service would be to put its own house in order. A biomedical system that is responsive to human needs in a holistic manner will face fewer challenges from traditional and other healing systems. The temptation to focus only on the physical aspect of illness and leave the psychological and spiritual side to other healers should be strenuously resisted.

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1. Kleinman A. Concepts and a model for the comparison of medical systems as cultural systems. *Soc Sci Med* 1978; **12B:** 85-93.
2. Janzen JM. *A Quest for Therapy: Medical Pluralism in Lower Zaïre*. Los Angeles: University of California Press, 1978.
3. West ME. *Bishops and Prophets in a Black City — African Independent Churches in Soweto, Johannesburg*. Cape Town: David Philip, 1975.
4. Heap M. *Health and Disease in South-Eastern Lesotho: A Social Anthropological Perspective of Two Villages*. Cape Town: Centre for African Studies, University of Cape Town, 1989.
5. Ramphele MA, Heap M. Health status of hostel dwellers, parts I-VI. *S Afr Med J* 1991 (in press).
6. Bührman MV. *Living in Two Worlds*. Cape Town: Human & Rousseau, 1984.
7. Hammond-Tooke D. *Rituals and Medicines*. Johannesburg: AD Donker, 1989.