



TRANSFORMATION TRAUMA IN BUFFALO CITY



Alterations to Cecilia Makiwane Hospital in Mdantsane outside East London.

Specialists at the coalface of health care delivery in the East London Hospital complex have convinced new senior managers to moderate a plan that would put vital services either at Frere Hospital or at Cecilia Makiwane in Mdantsane, claiming such exclusivity would debilitate the overall health care system. The doctors bluntly challenged the wisdom of having the bulk of essential health services exclusively at one or the other hospital, situated 25 km apart. The ambitious rationalisation, only recently implemented, is aimed at moving services to where most people live (Mdantsane). However the 'collateral damage' to accessibility, care and value for money – especially for a burgeoning, underestimated, low-income urban population around East London/Gonubie is predicted to be severe. These urban areas outside of Mdantsane include Duncan Village, Nomphumelelo, Mzamuhle, Ducats and several other 'West Bank' settlements.

Total outpatient visits to Frere Hospital over nine months last year (between April and December) stand at 145 491, while the tally over the same period for Cecilia Makiwane comes to 119 426. The Buffalo City hospital complex managers began listening to their senior physicians and consultants and making adjustments only recently – after years of questioning and probing of the plan's rationale by most heads of

departments at both hospitals. Mdantsane is one of the largest townships in the country and has a population that exceeds that of the East London/Gonubie area, a major reason cited for the new 'transformation and equity' plan.

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Planning 'lacked pragmatism'

Doctors say they have no problem with cost-saving rationalisation but believe the pragmatic detail of how this affects all patients, especially the poor outside Mdantsane, was shabbily thought out. Many believe that 'the political agenda' of being seen to redress apartheid imbalances has skewed the balance in the opposite direction and could prove disastrous.

'There's not a lot wrong with the present system in terms of health care delivery – apart from the smell of the apartheid system,' claimed one senior specialist, who declined to be named. The jury will remain out for at least a

year because only the orthopaedic department had begun moving (its inpatients out of Cecilia to Frere) at the time of going to press – with the Department of Medicine due to move from Frere to Cecilia by the end of August.

The orthopaedic move is regarded as the 'pilot project' and is being watched with eagle eyes. Medicine, paediatrics, obstetrics and gynaecology, and ophthalmology are earmarked for moving to Cecilia, while surgery, orthopaedics and oncology will be housed at Frere. Each discipline will have an outpatient department at each hospital, while management has also agreed to retain casualty, trauma, high care and intensive care at each hospital – a shift from the original and highly contentious blueprint.

The beds for each discipline will however be based exclusively at the hospital housing that discipline. Referred patients will be ferried from one hospital to another in two dedicated ambulances (one still on order) plus two 'patient transport' minibuses that are currently averaging 10 return trips daily. The grace for the battle-weary specialists lies in the softening of what was for a long time a hard-line 'exclusivist' management approach – one that had some at their wits' end. A new Department of Family Medicine is currently being aimed at Cecilia, although many consultants strongly believe it would serve overall patient care best at Frere. The hospital complex is applying to the Health Professions Council of South Africa for accreditation for family medicine and anaesthetics – both necessary to retain its status as an accredited intern training institution next year.

One veteran said housing a family medicine department at Frere would 'help solve 80% of the problems' that the indigent and poor patients might otherwise experience. Said Dr Alan Atherstone, Head of the Department of Surgery for both hospitals, 'Initially they wouldn't listen to a thing we said, but now we are seeing some flexibility'. Atherstone said he doubted that half of



Cecilia's 11 recently upgraded operating theatres would be used. In terms of current rationalisation plans, surgery and orthopaedics will be based at Frere Hospital which has eight theatres. Atherstone added, 'We'll be under pressure (at Frere) to cope with all surgical conditions. It might work if all eight theatres operate at 100% efficiency but it will still be difficult, especially for orthopaedics.'

'Guinea pig' department speaks

Norrie Gibson, one of three principal specialists in the orthopaedic department (Frere), confirmed this, saying the bottleneck in his department was directly attributable to the shortage of operating theatres. Gibson revealed that there had been a 21% increase in outpatient workload between October last year (before rationalisation of his department) and January this year (after rationalisation began), with the patient load having leapt from 488 per week to 591.

Yet the number of professional and enrolled nurses had remained constant (five and one), they were given just one more enrolled nurse assistant (up from five) while one clerk and two porters were taken away. 'So we have the same number of nurses doing 21% more work – meaning that by the time referred upcountry patients get near the front of the queue, the ambulances from referring hospitals have returned home, leaving behind patients who have not yet been seen in our clinic.' Instead of 'booked patient files' being drawn by clerks the previous day, patients now had to walk down to filing and draw their files or get X-rays after filling in forms – creating long queues in administration and a mere 'trickle' of patients arriving for actual treatment.

'When they've all been processed we get swamped with patients,' he said, adding that management was aware of and had promised to address the shortage of clerks. Gibson said the number of orthopaedic operations had increased by 17% since amalgamation, while the cancellation rate had risen from 20% to 31%. Yet theatre staffing levels had remained constant since January last year. 'There should be a step down facility at Cecilia and our

operating capacity must be increased. I know it's quite complicated, but you can't just move people around like pawns. It has to actually work.' Gibson emphasised that 90% of their overall orthopaedic workload was trauma.

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'I can live with the amalgamation but we must be provided with the services to be able to put the increased patient load through. There are just not enough nurses for the patients to get a good deal. One of Gibson's main concerns is that the sepsis rate appears to have gone up substantially and he and his colleagues are considering stopping joint replacement surgery until this is fully probed. 'I'm aware of four septic total knee replacements in the last six to twelve months, which is just unacceptable – we had to amputate one lady's leg.' Requests for a laminar flow theatre and to convert a third theatre into a dedicated septic theatre were turned down because of 'budgetary constraints'. While he was aware that

money was scarce, Gibson said that to enforce transformation without counting the cost was 'window dressing, and one has to ask who it is serving'. If it was *batho phele* (people first) then management needed to demonstrate that services would actually improve matters instead of imposing a preconceived plan.

Improvements on other fronts

Head of the Department of Paediatric Surgery, Dr Colin Lazarus, said that since the new management team came in about a year ago, proper financial controls had been introduced, staff appointments were done professionally, salaries were paid and community service doctors were electing to stay on. 'But heads of department are, without exception, extremely concerned by the particulars of the management proposals – the actual plan for rationalisation.' The principle of *batho phele* was in danger of being violated. 'Obviously we accept that high tech and expensive equipment should not be duplicated but it's absolutely essential to have services at both hospitals,' he asserted. No account seemed to have been taken of the 'enormous amount of inter-dependence between various specialties (e.g. the separation of medicine and surgery).

'You can't have the bulk of adult surgical disciplines in one hospital because among them will be ill and infirm patients with medical conditions who need help,' he said. As originally proposed, the plan was 'wholly inappropriate'.



New entrance at Cecilia Makiwane Hospital.



Service level drop 'inevitable'

Most senior specialists interviewed said it was 'too early' to say what the human cost of the eventual rationalisation would be, although several believed that a drop in service levels was inevitable. Lazarus doubted that the current rationalisation was sustainable, adding that in a decade's time, 'we'll be back to duplicated services'. 'Fundamentally what we've been fussing about is that there are very large numbers of ordinary people who are not critically ill but need help and care and will no longer get it in their environment,' he added. He and many of the other specialists rejected accusations from Bisho (the seat of the Eastern Cape government) that they were 'old guard and anti-transformation'. 'One cannot deny many of us have comfort zones, but that's not where we are coming from,' he emphasised. The oldest serving specialist, Dr Peter Swift (28 years in the Department of Medicine), and currently Head of Medicine for both hospitals, said transformation should not cause any harm to patients or 'be significantly for the worse'. 'It needs to be for the better and not be transformation for transformation's sake,' he said. Several longer serving specialists said that, on ethical grounds, they would have refused to participate in closing down entire departments in East London.

CEO vows to 'continue consulting'

The CEO of the East London Hospital Complex, Mr Derek Pryce, promised that every consultant/specialist involved would be thoroughly consulted and partnered with before any recommendation on the evolving plan was put to Bisho. Clinical Head of the complex, Dr Narad Pandey, based with Pryce at the new hospital administrative centre on East London's beachfront, said the rationalisation was aimed at creating 'optimum utilisation'. Both he and Pryce rejected claims of any current deterioration in health care quality or delivery and denied that there was inadequate transport to ferry patients to the requisite hospital. They pointed to a 'good public transport system operating in the Buffalo City region', as supplementing their transport arrangements. 'It's all working, but if you want to find a negative person, they will obviously tell you otherwise,' Pandey said.

Public 'happy and well informed'

He had not heard 'a single complaint from the public' or of any patient deaths or additional suffering. Pryce said the public had been informed through 'numerous press statements', newspaper advertisements and posters and pamphlets at all clinics and customer service points in the region. Bill boards were erected at entrances to both institutions while regular

'stakeholder' briefings took place. He admitted however that radio campaigns were needed for the illiterate. Of the specialists' complaints, Pandey said, 'In the South African system you'll still be talking to the beneficiaries of apartheid – and the system is not good for them – but as a community member or patient, I see this as very positive – I want what is right for society'.

Specialists see at least two alternative solutions. The first is to build a specialist level hospital between Frere and Cecilia near the N2 highway and turn the existing hospitals into level-one district general hospitals. However with hundreds of millions of rands of the health budget having gone into building the Nelson Mandela Academic Hospital at Umtata, this is probably a pipe dream.

The second is to turn one hospital into a primary specialist hospital and the other into a district general hospital, both with functionality at all three levels. Pryce acknowledged the need for a district hospital and said planning was underway for the completion of a day hospital in Mdantsane next year.

Current trends indicate that management may pay more attention to doctors as the plan meets harsh health care realities on the ground. 'Hearing one another has never been more important,' observed one veteran physician.

Chris Bateman

WORKPLACE-ACQUIRED HIV – IGNORANCE PERVASIVE



Dr Joe Shikwane, principal medical officer responsible for the Compensation Fund in the Department of Labour.

Only one of 158 known claims for occupational exposure to HIV over the past 25 years received a 100% permanent disability and a monthly pension from the South Africa's Department of Labour, it emerged last month. A second case in which the victim died has been settled with a monthly payout to the dependants.

January was the deadline for comment on a definitive set of HIV claims procedures but it was reliably learnt that the department was considering input from as recent as late February.

Officials are battling with dysfunctional and scattered data systems and the absence of a central data collection mechanism in order to track, budget for and appropriately address what is believed to be a seriously underestimated workplace problem.

Dr Joe Shikwane, the principal medical officer responsible for the Compensation Fund in the Department of Labour, admitted to *Izindaba* that there were 'no proper or reliable national statistics' on workplace-acquired HIV/AIDS.