Improved surgical output in district hospitals relies more on softer ingredients than on formal postgraduate training time

To the Editor: Mash *et al.*[1] have suggested that part of the solution to improving surgical and other services at the district hospital may lie in an approach that places full-time specialist family physicians and associate clinicians at district hospitals with periodic outreach from surgical specialists. However, I submit that a solution to district healthcare already exists in the example of Kokstad Medical Centre (KMC), and that it is less reliant on formal specialist family physician training and surgical outreach than on the softer ingredients required to assemble a team of inspired rural practitioners committed to delivering optimal healthcare outcomes.

KMC currently has five full-time general practitioners (GPs) and two assistant GPs of varying ages (29 - 56 years) along with support staff. We operate as rural generalists in Kokstad, Sisonke Health District (SHD), KwaZulu-Natal, in South Africa's private health sector. None of the practitioners has spent time in postgraduate specialist family physician posts, although two have MFGP qualifications that have not been granted specialist status.

I believe that KMC effectively addresses surgical need in SHD. For example, during the 5 years ending 31 December 2013, we performed and provided anaesthesia for 280 appendicectomies in addition to performing and/or providing anaesthesia for 868 caesarean sections

(other generalists also use KMC to provide anaesthesia) and the majority of procedures that should be performed by specialist family physicians according to expert consensus.[2] Note that this is the same district in which Kong *et al.*[3,4] reported alarming morbidity (mean total hospital stay 8 days, re-laparotomy rate 60.5%, mortality 3.5%) and associated cost escalation for patients presenting to public sector facilities with acute appendicitis, largely the result of delayed time to surgical source control, as access to appropriate surgical care in the district was nil. Proof of volume does not prove quality or cost-effectiveness of a service, particularly in a fee-for-service environment; an audit will therefore be undertaken.

Longmore and Ronnie[5] bravely pointed out what local practitioners know to be a significant part of the public health problem: poor human resource management (HRM). I believe good HRM to be a critical part of the solution to district surgical output.

In the near future, I shall expand on the surgical output of KMC and attempt to expound on the 'softer ingredients' in order to assess the applicability of this model to the public health domain. For unless these issues are identified, acknowledged and upheld, it is with some degree of scepticism that I await to see how many specialist family practitioners will enter the district healthcare system and indeed deliver their surgical promise, despite being specifically prepared for these challenges.

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