PERSONAL VIEW

Reflections of a retiree: 40 years in public service at Chris Hani Baragwanath Academic Hospital

K R L Huddle

Prof. Ken Huddle was chief specialist and head of the Department of Medicine at Chris Hani Baragwanath Academic Hospital and the Faculty of Health Sciences, University of the Witwatersrand, Johannesburg, South Africa, until his recent retirement.

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These reflections on a 40-year career at Chris Hani Baragwanath Academic Hospital, Soweto, Johannesburg, South Africa (SA), provide an insight into the rollercoaster experience of service in the public healthcare sector in SA.

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'Dear Leo,

'It is with sincere and deep regret that I write to you. Following the events of the past several months at Baragwanath, our department's morale has hit rock bottom. We gain some strength from the fact that we are fighting for a just cause, but are deeply saddened by the turn of events with victimisation and intimidation being the order of the day. Your gloomy predictions of a deteriorating situation are now indeed taking place. I am quite sure that this deplorable situation must sadden you immensely, having seen a department grow and develop under your guidance, only to crumble in the face of authoritarianism. Someday, somewhere, someone may appreciate our concern for the welfare of our patients, and not term it a crime.

'After much soul-searching I have decided to withdraw my application for the Chair of Medicine at Baragwanath, as I am unable to see any future prospects for improvement at this hospital. My enthusiasm has disappeared, only to be replaced by disappointment and sadness. I apologise if I have let you down.'

An inauspicious beginning

I wrote this letter to the immediate past-Chairman of the Department of Medicine at Chris Hani Baragwanath Academic Hospital (CHBAH), Prof. Leo Schamroth, on 27 January 1988. My abject despondency was as a result of the vicious and punitive response of the Transvaal Provincial Administration to our letter in the *SAMJ* in 1987, signed by 101 doctors, deploring the appalling conditions our patients had to endure in the medical wards of Baragwanath Hospital. I proceeded to make enquiries regarding the setting up of practice at one of the private clinics in Johannesburg. A meeting with the Chief Executive Officer of this clinic proved decisive in my career pathway. I naively thought that I would like to provide a service to patients, especially those suffering from endocrine/diabetes disorders. This did not particularly impress the CEO, whose next question totally floored me: How much money did I think I would generate for the hospital? The rest of the interview in his wood-panelled office flashed past in a blur. I could not get out of his office soon enough. After reflection and a rethink, I reconsidered my position and decided to reapply for the Chair of Medicine at Baragwanath. Although the interview at the University of the Witwatersrand (Wits) went relatively well (I was told), the provincial administration still had their knives out for me. They refused my appointment on the basis of 'my lack of administrative experience'. I was instructed to take on the Department of Medicine as Acting Head for a year, during which I was to enrol in administrative courses at the Wits Business School. I complied and reapplied for the post. I recall that on this occasion the university was represented by very senior academic staff and also included Helen Suzman. I took up the post on 1 May 1990. Sadly, Prof. Schamroth died after a long illness on 24 May 1988 at the age of 63. Thus began my long and challenging association with South Africa (SA)'s largest hospital.

I started my professional life as an intern at Baragwanath in 1975 and proceeded through the ranks, culminating in 25 years as Chair and Head of Department. I characterise my career at CHBAH as that of a rollercoaster; many ups and downs with substantially more ups than downs: exhilarating, frustrating, satisfying, rewarding. Some of my thoughts and observations follow.

On mentorship

I was very privileged in my career to have the guidance and wisdom of wonderful mentors: Prof. Leo Schamroth, world-renowned electrocardiologist, gifted teacher and orator; Prof. Asher Dubb, doyen of clinical teaching in SA and renowned medical philatelist; and Prof. David Blumsohn, the oracle and moral compass of our hospital, and an expert in ancient languages. They provided me with ongoing support, encouragement and advice, which I valued greatly. Each in his own way was a role model for me, and of course, for other students and staff. I was also fortunate to work with excellent academic heads of our department: Profs Tom Bothwell, John Milne, Patrick MacPhail, Joe Veriava and Sarala Naicker.

It is apparent to me that in our teaching hospitals in SA we have insufficient role models to inspire, guide and advise junior doctors. This deficit needs to be addressed as a matter of urgency if we are to ensure that our up-and-coming doctors conduct themselves as true professionals and are a credit to the noble profession of medicine.

On life as a physician in a public sector teaching hospital

I am often asked, 'Are you still at Bara?' My standard reply is, 'Yes, of course, where else should I be?'

I have felt very privileged and proud to have been given the opportunity to work at this famous hospital and to head the Department of Medicine for 25 years. I have worked with many wonderful people and experienced the wonderful camaraderie among our staff. I have learned so much from the patients we have

served – the incredibly wide spectrum of pathology, the enduring of illness with dignity and stoicism, the fact that our patients still trust and respect their doctors and are grateful for whatever we are able to do for them. I have enjoyed teaching and mentoring students immensely – they keep me young and invigorated. Making people better and having a positive influence on the career of young professionals are two of my greatest areas of satisfaction. I have enjoyed the excitement of clinical research, especially audit research leading to better clinical practice. All these experiences, collectively, have enriched my life immensely. I feel very strongly that heads of departments should be full-time appointments without the option of private practice. The job, if done properly, is all-consuming and one needs to devote all one's time and energy to the task. Of course, there are downsides to the job. Administration is a very necessary part of the head's job, which would be made much easier in the public sector if hospital administration was more efficient and effective. This area has been a battle for me. During the apartheid era our hospital was a neglected black hospital with all the negative consequences; after 1994, the situation, from an administrative point of view, has sadly not shown the positive change we all so hopefully envisaged.

On the AIDS pandemic

The AIDS pandemic has swept across the globe since the 1980s, leaving a path of devastation and misery, especially for those sufferers from the developing world who have had no or little access to treatment. SA has been the epicentre of this pandemic. We diagnosed our first case of HIV/AIDS at CHBAH in 1987. During the 1990s we began admitting more and more patients with AIDS and its complications, to the extent that this disease accounted for the majority of our medical admissions. We were swamped and overwhelmed. There was little understanding for our plight by hospital administrators – I made numerous representations to our administration pleading for more staff and resources to cope with this crisis. There was little appreciation for the complexity of this disease and its complications, for the fact that it required expensive investigations and treatment, for the fact that it was Internal Medicine that faced the brunt of the epidemic, and for the fact that the disease was associated with a very high mortality in young people, which proved very demoralising for our young doctors. The period of AIDS denialism during the time of President Thabo Mbeki and his Minister of Health, Manto Tshabalala-Msimang, denied patients the effective antiretroviral treatment that had become available. This was immoral and indefensible, and cost the affected population dearly. The response of our department was to take care of the AIDS sufferers as best we could. We initiated the development of a Division of Infectious Diseases under Prof. Alan Karstaedt to do research on HIV/AIDS and to facilitate therapy. The advent of antiretroviral therapy over the past decade provided our patients and us with some hope. It has changed a uniformly fatal disease into a chronic, manageable disease. Our Infectious Diseases Unit has played a major role in the fight against HIV/AIDS. As an aside, our doctors in the Department of Medicine were never distracted in rendering care to these patients despite the ever-present risk to themselves through needlestick injuries – one study performed at two of our academic hospitals found that 70% of interns reported one or more needlestick injuries during their internship year. We take this risk very seriously and developed a 24-hour assistance programme for our staff to provide counselling and immediate prophylactic treatment where indicated. The emotional trauma associated with a needlestick injury is considerable.

The other side of the coin is that we have learned an enormous amount from this epidemic – a new chapter of medicine has been added to our knowledge base. The scientific discoveries regarding HIV/AIDS have been very illuminating; the social and ethical aspects have been equally challenging and humbling.

Although HIV/AIDS (and its partner, tuberculosis (TB)) have dominated the medical landscape for over two decades, we have not lost sight of the fact that non-communicable diseases, such as diabetes, hypertension, ischaemic heart disease, and cancer, are reaching epidemic proportions in the developing world, including the population of Soweto whom we serve. When I started out as an intern at Baragwanath it was a rarity to find a case of acute myocardial infarction in the wards – in fact, a special ward round was arranged to discuss this rare condition. We now have a coronary care unit dedicated to managing the significant numbers of patients suffering from ischaemic heart disease. There is no doubt that non-communicable diseases deserve the same degree of attention and activism as the communicable ones. There is appreciation for this by the Ministry of Health – Dr Aaron Motsoaledi has made a huge positive impact on stemming the tide of HIV/AIDS, and he is starting to impact on the non-communicable diseases. In my view he has been an outstanding Minister of Health, the best in living memory, and deserves our full support in his quest to provide an equitable healthcare system of good quality for all South Africans. We are a long way from this goal.

On general v. subspecialty medicine

The Department of Medicine at CHBAH is the largest and busiest in SA. We administer over 700 beds with a >90% bed occupancy, an average of 100 patients are admitted per day, and over 157 000 outpatients are seen per year. The medical staffing comprises 30 interns, 20 medical officers, 40 registrars, 15 subspecialty fellows, 27 specialists, 11 principal specialists, and 2 chief specialists. The department is divided into 5 large general medical units and 8 subspecialty divisions (Cardiology, Endocrinology, Gastroenterology, Haematology, Infectious Diseases, Nephrology, Pulmonology and Rheumatology). We are fortunate in having highly qualified and committed specialists on our staff. Despite its size, the department is able to render a quality service to our patients with reasonable efficiency. In my view the functional structure of the department is ideal for the service and teaching needs; the emphasis is on general medicine with subspecialty back-up. The department and its staff fall under one clinical head who holds the post of Chief Specialist and Professor of Medicine. The model has prevented the fragmentation of medicine into 'organ' specialities, a trend which has become pervasive locally and internationally. The patients have the benefit of being exposed to generalists and subspecialists (if required) under one roof with a more holistic approach to care. Trainees also benefit substantially from this comprehensive exposure. There is now a move internationally to strengthen general medicine.

On bedside teaching

There has always been an emphasis on bedside teaching in our department. We have been blessed with some of the great clinical teachers who have inspired others to follow suit. Bedside teaching should not be seen as an anachronism; it is the ideal platform for teaching and training. Our patients are the focus of the encounter. A history is elicited from them, a focused examination follows, a final assessment and diagnosis/differential diagnosis is made, and therapy is planned. I have always thought this akin to sleuth work which provides for much of the excitement and satisfaction in clinical medicine. It allows the teachers to perform as role models for their students in the real-life situation. Through one's interactions with the patients, one is able to influence the future professional conduct of students and young doctors. The art of bedside teaching has virtually been lost in the USA – some of the medical schools have

recognised this deficit and are attempting to resuscitate this mode of teaching. A recent buzz-word in the USA and UK is 'patient-centred' medicine because doctors, as a result of the technological advances in medicine, have moved away from what should be their priority: the care of the patient. We would do well in SA to maintain our focus on bedside teaching, emphasising the centrality of the patient in all our deliberations and interventions. To become a good teacher one needs to be involved in the assessment of students. I participated in examinations throughout our country over many years and this has enriched my own teaching. I have also played a role at various levels in the College of Physicians of SA, a body which plays a valuable role in ensuring that high standards of medicine are maintained.

On the value of quality staff

Over the years I have realised that one of the most important functions of a head of department is to recruit and retain high-quality staff. I recall a statement emanating from a world leaders' forum which indicated that leading entrepreneurs and captains of industry look for three basic qualities when recruiting new staff: intelligence, energy, and integrity. It was also stated that it was of little value having the first two without the last. I also subscribe to this view but would add a fourth quality for doctors: compassion. Once you have selected the appropriate people with these qualities and the requisite training, qualifications and experience, the rest of the job is relatively easy. We are fortunate that in our department we have a large number of these high-quality people who contribute substantially to maintaining high standards of service, teaching and research. It is also essential to have good staff retention strategies. I have found that it is important to thank staff for their contributions, to reward them for significant effort with promotion or various awards, and to value them as people. This creates a positive spiral.

Much of what I have said regarding the recruitment and retention of quality doctors also applies to the nursing staff. I have had the privilege of working with many outstanding nurses during my career; they have reminded me on numerous occasions just how important and integral they are to quality healthcare. However, I feel the standards of nursing have declined in recent times and the ethos of nursing is under threat. Nurses need to be brought back to their primary function, patient care, and freed up from excessive administrative and clerical duties. The nursing curriculum needs to be reviewed and brought in line with patients' needs. The conditions of service for nurses need to be improved, taking into account that the vast majority of nurses are women with particular needs. For example, part-time posts need to be created for women with young children; crèche facilities should be available on site.

On noteworthy projects

There are many sources of satisfaction for heads of departments: watching the growth and professional development of one's staff; enthusing students on a bedside teaching round; making difficult diagnoses and making sick people better; reaping the rewards of providing good leadership in good and bad times; and, ultimately, observing the success of one's department in its three areas of responsibility – teaching, service and research. I am glad to say that I have experienced all of these to a greater or lesser extent. On a more personal level I have derived enormous satisfaction from three projects I have been involved in.

The institution of comprehensive diabetes services at CHBAH

As a young physician starting out at CHBAH in the early 1980s I concluded that the diabetes services at this hospital were rudimentary and totally inadequate, only focusing on acute admissions with little emphasis on preventive strategies and patient education. These findings were supported by a study undertaken at the time showing high rates of morbidity and mortality, many of which were potentially preventable. With this appalling situation in mind, I set out to completely revamp the diabetes services at this hospital. Perhaps the most pivotal intervention we undertook was the introduction of specialised diabetes nurse educators, which revolutionised the care of our patients. I arranged for these nurses to be trained in all aspects of diabetes management both locally and overseas. They are now worth their weight in gold. Most of them have worked in our service for over 15 years. They are all multilingual, are highly motivated and trained, and are able to effectively relate to our patient population. They educate our patients comprehensively on all aspects of diabetes and its management so as to empower them to take good care of themselves. We have been able to show the benefits of a 30-year sustained intervention on the lives of our diabetic patients through audit research. Our service is comprehensive and provides for both inpatients and outpatients, for the young and the old, as well as for pregnant women. It is the largest service for diabetic patients in the public sector in SA. Clearly, these benefits have accrued through a team effort involving specialists, nurse educators, podiatrists and other healthcare personnel. I am indebted to them and to the patients who have taught us so much. It is with a sense of pride that after 35 years, I hand over the baton, with the knowledge that quality care will continue to be available to our patients for the foreseeable future.

The initiation of palliative care services at CHBAH

I lost my wife, Penny, to breast cancer in 2000. This was a devastating blow to my family which took us many years to come to terms with. Dealing with cancer on a personal level prompted me to reflect on how we were dealing with the care of patients suffering from cancer in my department. We were certainly making the diagnoses and instituting appropriate treatment for those who were potentially curable, but we were offering very little to those individuals not amenable to curative therapy. A shameful statistic that I recall is that an audit of the use of morphine at our hospital at the time revealed close to zero use. In response to these serious shortcomings I sent one of my senior consultants, Dr Allison Russell, on a sabbatical to the UK to study the hospice care for which they are renowned. She returned full of enthusiasm and proceeded to establish a nurse-driven palliative care service at our hospital. Patients in need are now appropriately counselled, debilitating symptoms are controlled, and families have become involved in the care of their loved ones. This unit has grown into a fully fledged Palliative Care Centre recognised by the Gauteng Department of Health and the Wits Faculty of Health Sciences. Palliative care now forms part of the undergraduate medical curriculum. Dr Natalya Dinat made significant contributions to this centre on the retirement of Dr Russell. More recently, Dr Charmaine Blanchard has taken over the reins and is extending the influence of palliative care beyond the hospital to the community centres in Soweto. We are grateful to these three individuals and their staff. It is with a deep sense of satisfaction that I reflect on the positive impact that this service has made and continues to make to patients and their families. Sadly, to my knowledge, this palliative care centre is the only one of its kind in the public sector in SA. We need more of the same throughout our country.

The initiation of an outreach programme

One of the problems bedevilling our public sector regional hospitals is staffing, especially the filling of specialist posts. Just over 5 years ago, we in the Department of Medicine realised that we had insufficient subspecialty training posts for the increasing number

of newly qualified physicians. We met with the Chief of Operations at the Gauteng Department of Health and came up with a win-win solution: the regional hospitals in our area would give us their unfilled specialist posts to fill in return for a continuous specialist service run by us at these hospitals. I initiated such an outreach programme to Sebokeng Hospital, an 800-bed regional hospital approximately 60 km south of CHBAH with a catchment population of over 1.1 million. Currently, two to three young physicians rotate through the Department of Medicine at Sebokeng Hospital every 3 months. This has ensured a continuous specialist service at this hospital with the following benefits: better administration, better structure and supervision of junior staff, better discipline, an ongoing teaching programme, and ultimately, more effective patient care. This department is now highly rated by interns and is attracting staff. Recently, one of our senior physicians, Dr Arjuna Dissanayake, has taken up the full-time Head of Department post at this hospital. I have no doubt that this appointment came about as a result of the positive spiral created by the outreach programme. We, in turn, have benefited from the expanded pool of subspecialty training posts. There is potential for this type of outreach programme to be extrapolated to other areas of our country.

On the changing demographics of students and staff

When I first started out at CHBAH in 1975 the students and staff were predominantly white and male. Today, we have a far more cosmopolitan mix, much more representative of the SA population. I really appreciate the diversity of our staff which has been an enriching experience for us all – we continually learn from one another and learn to respect and value the views of people from different racial and cultural backgrounds. Our female colleagues have also added great value to our perspectives and have been a very welcome addition to our staff. I feel very strongly that we need to provide a more supportive working environment for female doctors who are starting families. We need more part-time posts with more flexible working hours to allow young women to contribute to their profession at the same time as taking care of their children. These female doctors often feel conflicted; on the one hand they are not doing enough professionally, and, on the other hand, they feel they are neglecting their children. Most of, if not all, the medical classes at our medical schools are now at least 50% female. We should do everything possible to retain these valuable doctors in their profession.

On patient advocacy

Rudolf Virchow (1821 - 1902), the famous German pathologist who is considered 'the father of modern pathology', stated that 'physicians are the natural attorneys of the poor'. I and many of my colleagues subscribe to this viewpoint. During the apartheid era most of our patients from Soweto were poor, socioeconomically deprived, suffering from the ravages of malnutrition, TB and, more recently, HIV/AIDS. Twenty years post democracy, the living conditions of the Sowetan population have improved somewhat, yet the ravages of TB and AIDS persist. This is compounded by the burgeoning epidemic of non-communicable diseases such as hypertension, heart disease, diabetes, respiratory disease and cancer. Throughout my 40-year tenure at Bara I have been struck by the enormous burden of disease experienced by our patients, and humbled by their dignified and courageous response to devastating illness. I have also been struck by the inadequate facilities available to such patients in the public sector, including Bara. Rather than just accepting the status quo, we have fought on behalf of our patients for better facilities and services. For example, four of our senior physicians, Drs Blumsohn, Huddle, Krut and Marinopoulos, penned a strong letter to the *SAMJ* in 1987 protesting the appalling conditions which existed for ward patients at the time. The letter was signed by 101 concerned doctors. This led to the unleashing of a vicious and vindictive response from the hospital authorities. Instead of focusing on the very real and serious problems at Bara, they proceeded to victimise and intimidate the medical staff. A court case ensued in which one of the signatories to the letter, Dr Traub, instituted legal action against the hospital authorities who had refused her further employment. She won her case which was a watershed moment for all those concerned. The Vice-Chancellor, Prof. D J du Plessis, undertook to raise funds from the private sector to provide an extra 320 beds for the Bara patients. The project took a mere year to complete – patients could then be comfortably accommodated.

In 2009 I played a role in averting strike action by junior doctors at Bara. This strike was part of a countrywide protest against the slow implementation of the Occupational Specific Dispensation (OSD) – an improved salary structure – for doctors. I felt very strongly that vulnerable patients should never be used as 'footballs' in protest action; their trust in the profession should never be betrayed. The senior doctors prevailed – no doctors went on strike at Bara. More recently, I participated as a member of the Concerned Clinicians Coalition at Wits which protested the deficiencies in supply and delivery of drugs, consumables, and equipment to our hospitals in Gauteng. We, together with the Centre for Applied Legal Studies (CALS) at Wits and Section 27, were instrumental in precipitating the signing of an accord between the National Department of Health, the Gauteng Department of Health, and the University of the Witwatersrand in July 2013, in which a turnaround strategy was proposed. Progress thus far has been slow. My colleagues and I also protested the privatisation of public sector beds – Folateng private wards – in several of our public hospitals in southern Gauteng in the face of overwhelming numbers of public sector patients. This is unacceptable and, besides reducing the number of available public sector beds, it leads to a two-tier system of healthcare in the same institution, favouring the private patients. There are many other examples of patient advocacy at our hospital – this has contributed to the 'soul' of our institution of which we are very proud. Much remains to be done – *a luta continua*.

One of my pet hates is the use of certain terms which are either demeaning to patients or undermining of the true philosophy of medicine. For example, I frequently overhear junior doctors on the ward using the word 'turf' when referring to the transfer of patients between wards. This is unacceptable and unprofessional. Another example is the use of two expressions which are frequently bandied about: 'client' for patient, and 'healthcare industry' for the profession. Medicine should not be perceived as a business with a contractual relationship between caregiver and patient, but rather as a noble profession dedicated to serving the needs of people who are ill or in distress, thereby honouring the trust that is so fundamental to our profession.

On the importance of self-audit

Over the years I have encouraged young doctors to follow a career which is characterised by continuous growth and development so as to ensure that they provide the best possible care for their patients. It is, of course, just as important for more senior physicians to follow suit. I have found that for my own personal growth and development, self-audit and reflection has been essential. I recall a talk on how physicians think, which likened an experienced physician's approach to diagnosis to that of the grand masters

playing 12 games of chess simultaneously. How do they manage to do this so effectively? By pattern recognition. This is the same for the experienced physician who can often make the diagnosis on a post-intake ward round after only hearing a few of the patient's details. This is different from a 'spot' diagnosis and takes many years of hard work, practice and self-audit to achieve. I personally found that the pieces of the puzzle fell more readily into place 10 years after becoming a physician.

On the importance of family and friends

I am blessed with wonderful family and friends. My wife, Linda, our children, Justine, Natalie and Gregory, our son-in-law, Guy, and our grandchild, Liam, have added immeasurable value and joy to my life. My good friends within and without the profession have done likewise. Collectively, they have provided me with a superb supportive framework for my professional and personal life. I am indebted to them.

Conclusion

I am grateful for the opportunity I have had to play a meaningful role in providing healthcare to the community of Soweto and beyond, for the opportunity to teach and mentor students of this noble profession, and for the opportunity to lead a large department of committed and expert specialists in their pursuit of excellence. Ultimately, as doctors, our main focus is on patient care. In this regard, I wish to thank our patients who have taught us so much about medicine and humanity, and who continue to show trust in their caregivers.

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