A day in the life of a doctor in a rural hospital

Recently over 100 doctors at Baragwanath Hospital protested the conditions endured by patients in the medical wards. The authorities tried to force these doctors to apologise for the stand they had taken. The situation received much coverage in the press and yet hospital authorities have failed to improve the situation to acceptable standards. All this in South Africa's 'showpiece' hospital serving a highly politicised community. How much more vulnerable are the 'quiet' rural hospitals that are hidden away from the public eye. These hospitals, and the rural masses they serve, are badly affected by the inequitable distribution of health care resources in our country.

Below is an outline of the daily experience of rural doctors in many of our rural hospitals.

The hospital where I work

My hospital is a typical rural hospital situated in one of the bantustans. It is situated near a conglomeration of 'little' villages (population about 25,000) and serves a health ward which comprises approximately 200,000 people. The nearest other hospital is about 45km away, a similar hospital, but administered by another bantustan health department. Our hospital has about 230 beds but this is misleading as there are approximately 400 inpatients daily.

We are 'lucky' at this hospital for we have 6 doctors. In some surrounding hospitals there are only one or two doctors and some don't have any at all.

Our nearest regional hospital is 150 km away with specialists in the major medical disciplines. However, we are unable to use this referral hospital as it is not acceptable to transfer black patients to this hospital. Our 'referral' hospital is 500 km away and takes over 6 hours to get a patient to that hospital (if an ambulance is immediately available).

We have an inadequate number of nursing sisters to meet the patient's needs as the posts are based on hospital beds and not on inpatient numbers. There are two theatres, a pharmacy, and a basic x-ray and laboratory facility mainly run by untrained staff.

My day begins

My day begins at 8 o'clock in the morning.

The hospital doctors live on the grounds of the hospital. It is only a 3 - 4 minute walk to the actual hospital buildings. It is Monday morning and I am dreading the day ahead. There are going to be 250 - 400 people attending the outpatients today (depending on the time of the month). Two doctors have been on the weekend call and no doubt there will be a lot of new admissions and work remaining from the weekend. They would only have managed 'problem' ward rounds over the weekend so the wards will be bursting with patient overload and problems.

People have to travel far distances to receive basic health care

The children's ward

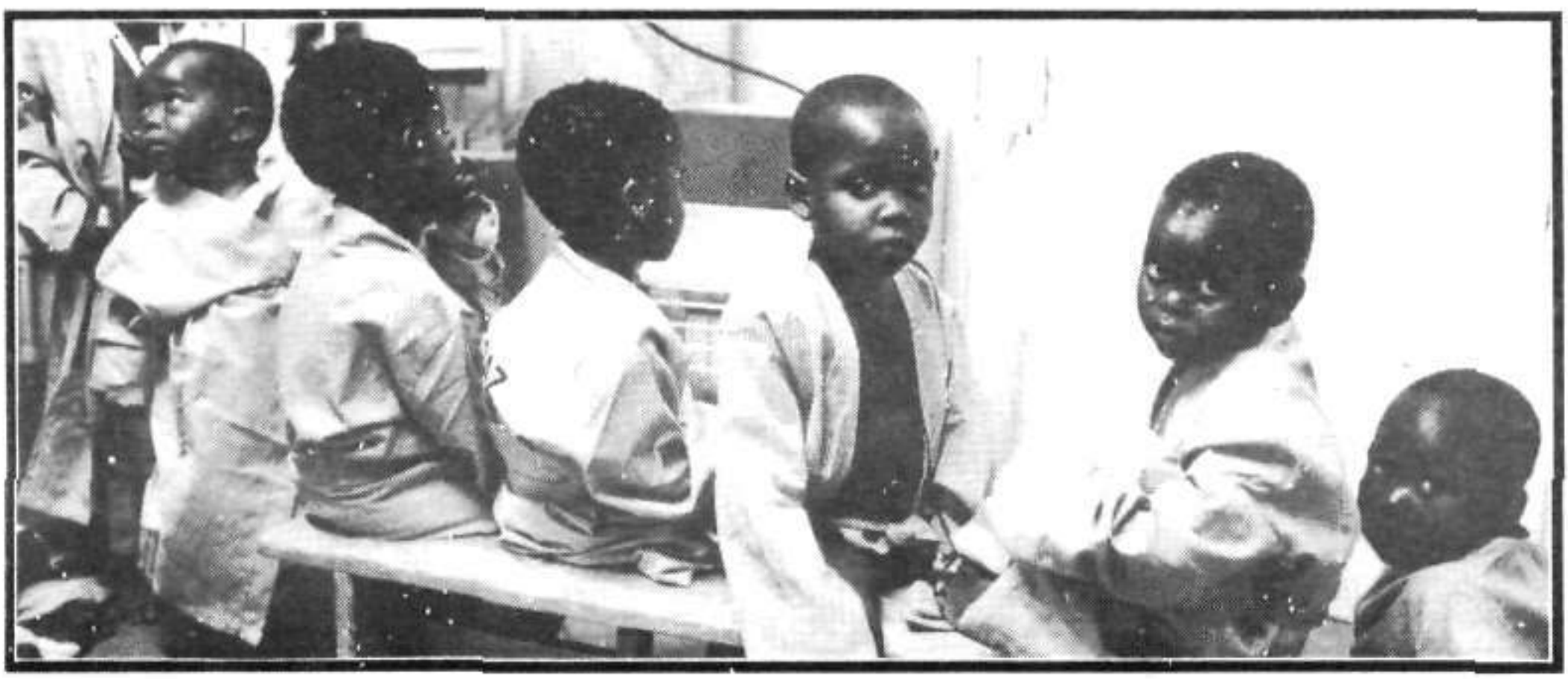
I enter the children's ward with its familiar sights and smells. We have 27 cot beds and we have a daily inpatient load of aproximately 50 - 80 children. A child in this hospital is anyone under 6 years. Any child over 6 years goes to the adult wards. There is the usual disease profile: malnutrition, gastroenteritis, pneunomia, fever, burns, paraffin poisoning, chronic ear infection, neonatal tetanus, fractures, abscesses and so on.

I begin to make my way through the 'load'. Two and sometimes three children

to a cot. Piles of patient bed records, children crying and many needing a clean nappy. Five children huddle around a gas heater. I cannot even remember half their faces let alone their names. No doubt some children have died since my previous round, but I will only find out after the ward round when it is time to sign the death certificates. There are a number of drips running and it is some wonder to know how the three nursing sisters manage to control all the drips.

I try to order only the very basic tests. The results are likely to arrive too late for decision-making or to get lost along the way. I have to rely on the sisters' impression of the children's progress.

Many of their mothers have to return home to care for their other children. Other mothers sleep on the stone floor of a small side verandah. It is freezing in winter and mosquitoe ridden in summer. We wind our way along and see the children. Many patients are discharged sooner than desirable to make way for the new admissions. The ward sometimes smells and looks like a poor children's zoo. Little somebodies, miserable and frightened peering through steel cots. There are no 'sunshine play ladies' here, no painting and playing with toys or looking at books. This is a rural hospital children's ward.



Children huddle around a gas heater for warmth

Out of stock

Today we are 'O/S' chloramphenicol and ampicillin. O/S is a daily occurence and means 'out of stock'. It is accepted as if there is no alternative. Seldom is the validity of the O/S ever questioned, but on most occasions the drug is genuinely O/S! It would not be a great shame if an odd cough mixture or analgesic was O/S, but we regualrly run out of essential drugs. Last month we were O/S of scoline, intravenous valium, syntocinon and intravenous drips!

Some hospitals issue regular weekly bulletins announcing the latest O/S's and

the new drug arrivals (celebration!). Can you imagine what would happen if the Johannesburg Hospital ran out of scoline and there was an anaesthetic accident!

I will spare you the discomfort of a more detailed description of other problems encountered in the ward.

Rural hospitals regularly run out of essential drugs

Another ward

At 12 o'clock noon, I leave the ward. I feel very sorry for my nursing colleagues who work up to 12 hours in this ward. They try their best and they see the worst, yet they keep their cool, they maintain their dignity and they are always friendly. I move next to the infectious disease ward. This ward is light relief compared to the children's ward. I will have to use the septran to treat the typhoids now, until our stocks return. I see about 30 typhoid patients and a few very sick children with measles.

The outpatients department

I go to the outpatients department. The OPD looks like the Johannesburg station at 5 pm on a weekday. There are literally hundreds of patients to be attended to. There are only four nursing sisters and two doctors. One sister 'screens' the patients into those who need to be seen by the doctors and those to be seen by the nurses. Some of the nurses have not been adequately 'trained' for this, but do the job to the best of their ability. I quickly see some of the more severe or urgent problems.

A woman is lying with a pool of blood between her legs. She is aborting a pregnancy and needs an urgent operation to stop the bleeding. The hospital has no blood to replace that which she has lost. I arrange for theatre in 15 minutes. I see another four or five patients. Some need admission so I quickly scribble down the brief history and my findings and order the necessary investigations and medication. I am hopeful that most of it will be carried out by the sister in the ward.

No ambulance available

Another patient is lying on a stretcher for urgent tranfer to our referral hospital. They are waiting for the ambulance to arrive. But the one ambulance is out on a maternity call and the other driver has 'gone to lunch'. The hospital has only two functioning ambulances and no trained paramedical staff. The ambulance man is really only a driver with absolutely no first aid skills.

Possibly the hospital nearby, 50kms away, is also sending someone off to the same referral hospital, but they are from a different homeland health department and as such we cannot co-operate with such hopital transfers. Transport is always a major problem. The hospital has no qualified mechanic, the local roads are atrocious and nearly half the hospital vehicles are out of order. The 'urgent' patient must wait and OPD gets on with its work.

Theatre

It is 13h40 and I rush off to theatre to operate on the woman who is bleeding. I call a colleague to put the patient to sleep while I clean out her womb. My 'anaesthetist' is concerned about the dangers of anaesthetising such a pale and almost shocked woman. We have no alternative, we hope for the best. I clean out her uterus which will stop any further bleeding.

All goes well and at 14h25 I go home for lunch. All is quiet and peaceful at home. I return at 3 o'clock.

The labour ward

I 'pop' into the labour ward. The doctor who normally looks after the ward is on leave. This ward has approximately 350 births a month. It is run almost entirely by midwives. There are four delivery beds. The beds are separated by a small bedside cupboard. The four beds make up the entire width of the room. There is no privacy besides some rundown plastic curtains which are seldom ever drawn. There is no incubator available. There is an old inefficient vacuum extractor and some basic

resuscitation equipment which is taken to theatre for the caesarian sections, during which time there are none left in the labour ward. The labour ward is a very small room when four or five women are in labour at the same time!

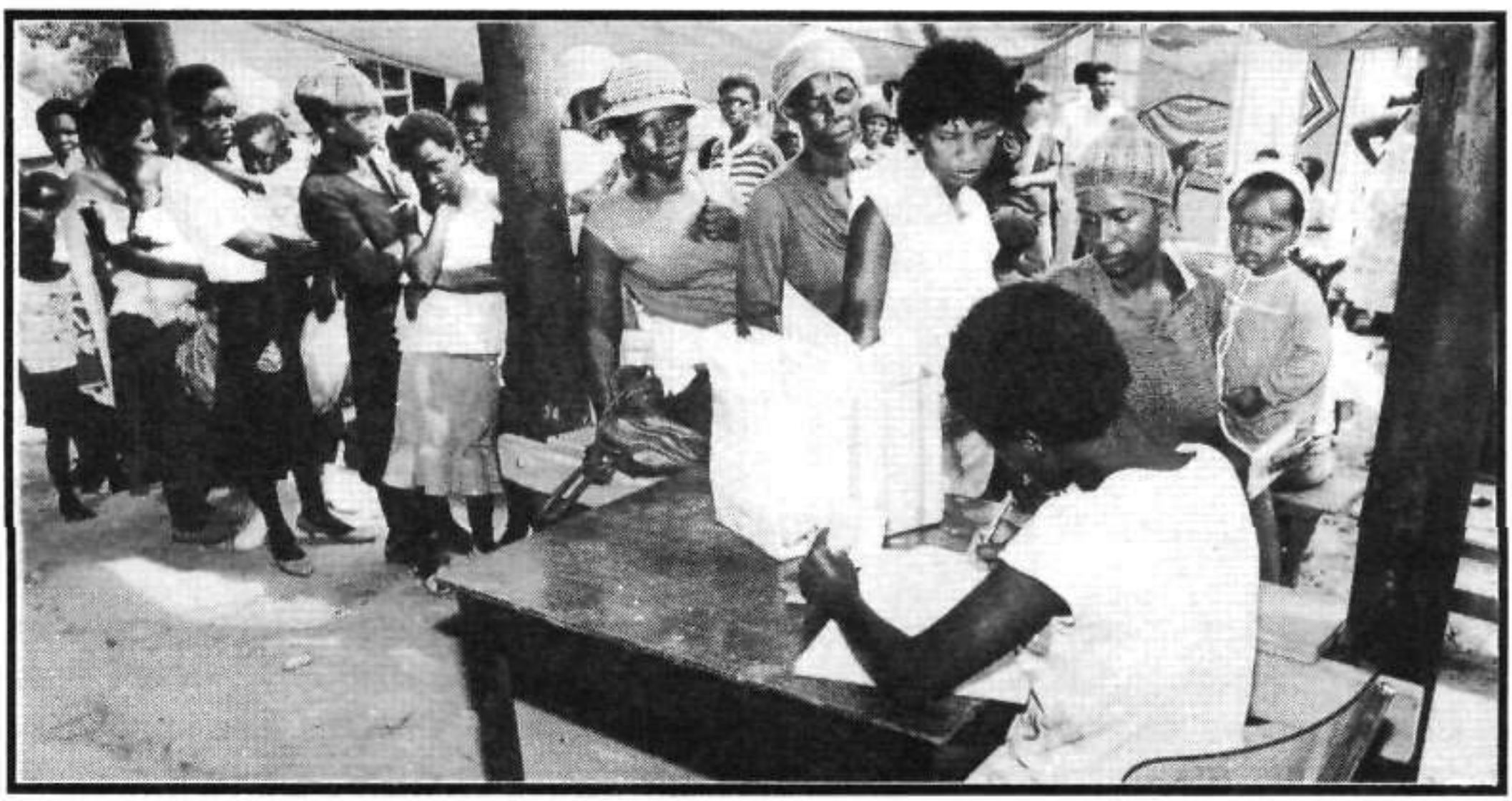
I am asked to do a breech delivery. We cannot get the rusty last third of the bed to dismantle in order to do a breech delivery. We quickly swop the bed with the one belonging to the surprised woman in the next bed. I deliver an uneventful breech. No gloves this time, in the rush of the moment the recycled 'disposable' glove split down the middle whilst I was putting it on.

In this ward there is no time or atmosphere for caring for anything else but the basic physical needs of the women in labour and even this is difficult. Again the sisters try hard, but the general load and depressing environment make it difficult to maintain a caring and sensitive approach to the women giving childbirth.

Back to the outpatients department

It is now almost 4 o'clock.

I reluctantly trudge back to the outpatient department. There are still patients everywhere. It is difficult to see the window at the end of the room. I find an assistant nurse to interpret for me and begin to see the long line of patients. Two of my colleagues are in theatre with an ectopic pregnancy and two others are 'somewhere in the hospital'. I start to see the patients again. They have been waiting for many hours. Many of them have now missed the last train and cannot afford the taxi-bus fees. Many will need to sleep over on the OPD floor and go home the following day.



Patients have to wait in long queues for many hours

I try to differentiate the 'sick' from the 'non sick'. I try to smile and greet each patient. I try to understand their frustration and I hope they might get a glimpse of mine.

The day never seems to end. There are endless complaints, pelvic inflammatory diseases, body pains, waist aches, headaches, infertility, coughs, skin sores, diarrhoea, abdominal pains, countless disability application forms (desperate people trying their luck), chest pains etc.

It is 6 o'clock in the evening. Finally the background noise seems to be fading. I dare not ask the sister how many patients still need to be seen - it is better not to know the bad news.

Fifty minutes later, I finally walk out of the OPD.

On call

I am also on call tonight. I hope and silently wish for a quiet night. My wishes are seldom granted. I fear there might be some dreadful taxi pile-up or some other horrific surgical problem which is beyond my surgical abilities. The labour ward is sure to steal any peaceful sleep. It is indeed a lonely place in the middle of the night being the doctor on call for a hospital with 400 patients and another 200,000 people not very far away ...

To sum up

I have given you a brief glimpse of a little of the day to day experience of a doctor in a rural hospital in South Africa. This was not an unusual day. Some are much worse and a few are a little better. I have colleagues who work in nearby `bush' hospitals and I am in touch with others in similar hospitals elsewhere. Our experiences are very similar. Naturally some of our rural hospitals may be quieter and better off, but very many exist as described above.

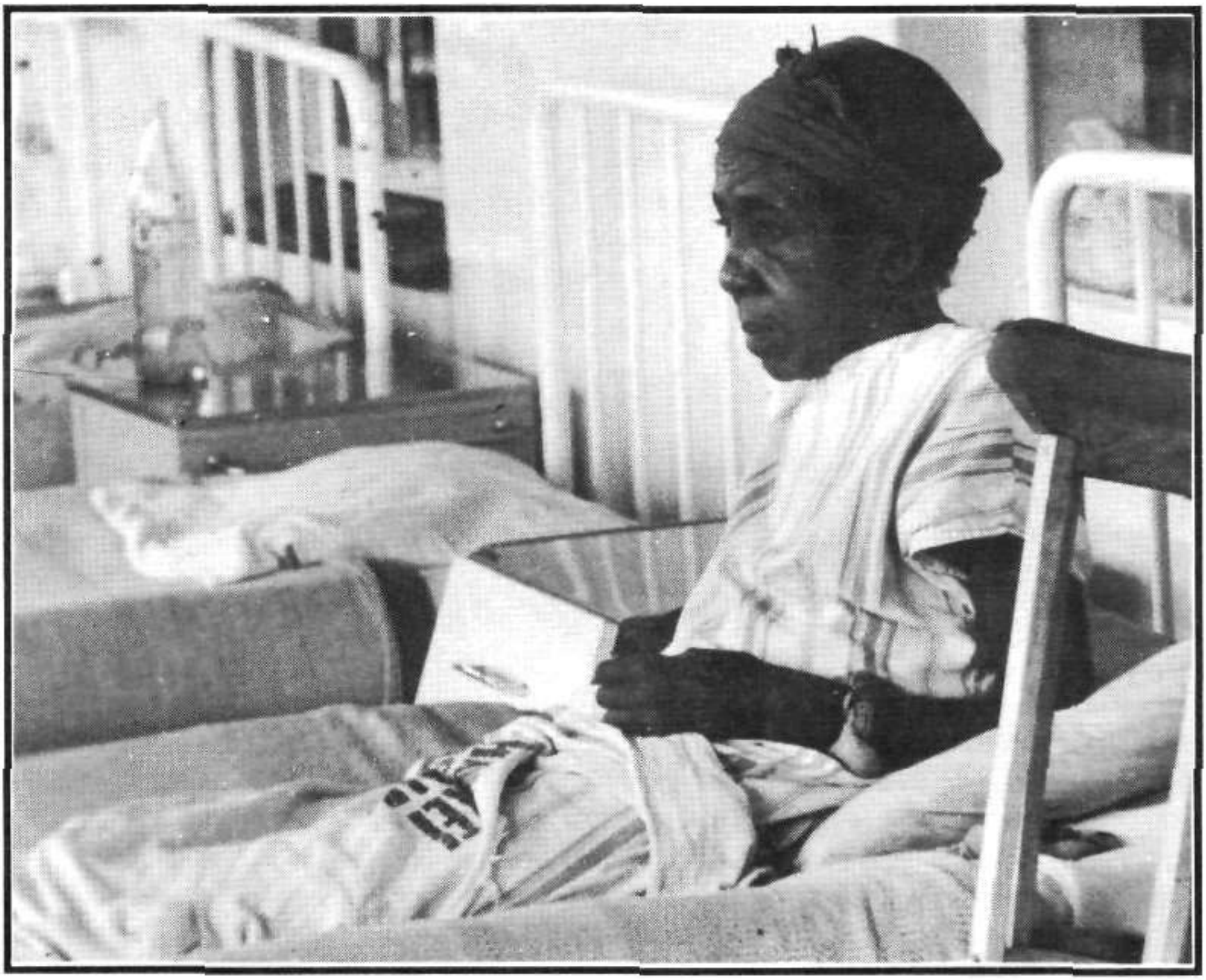
Our rural hospitals are overloaded, overstretched, underequipped and understaffed.

Maldistribution of health workers and facilities

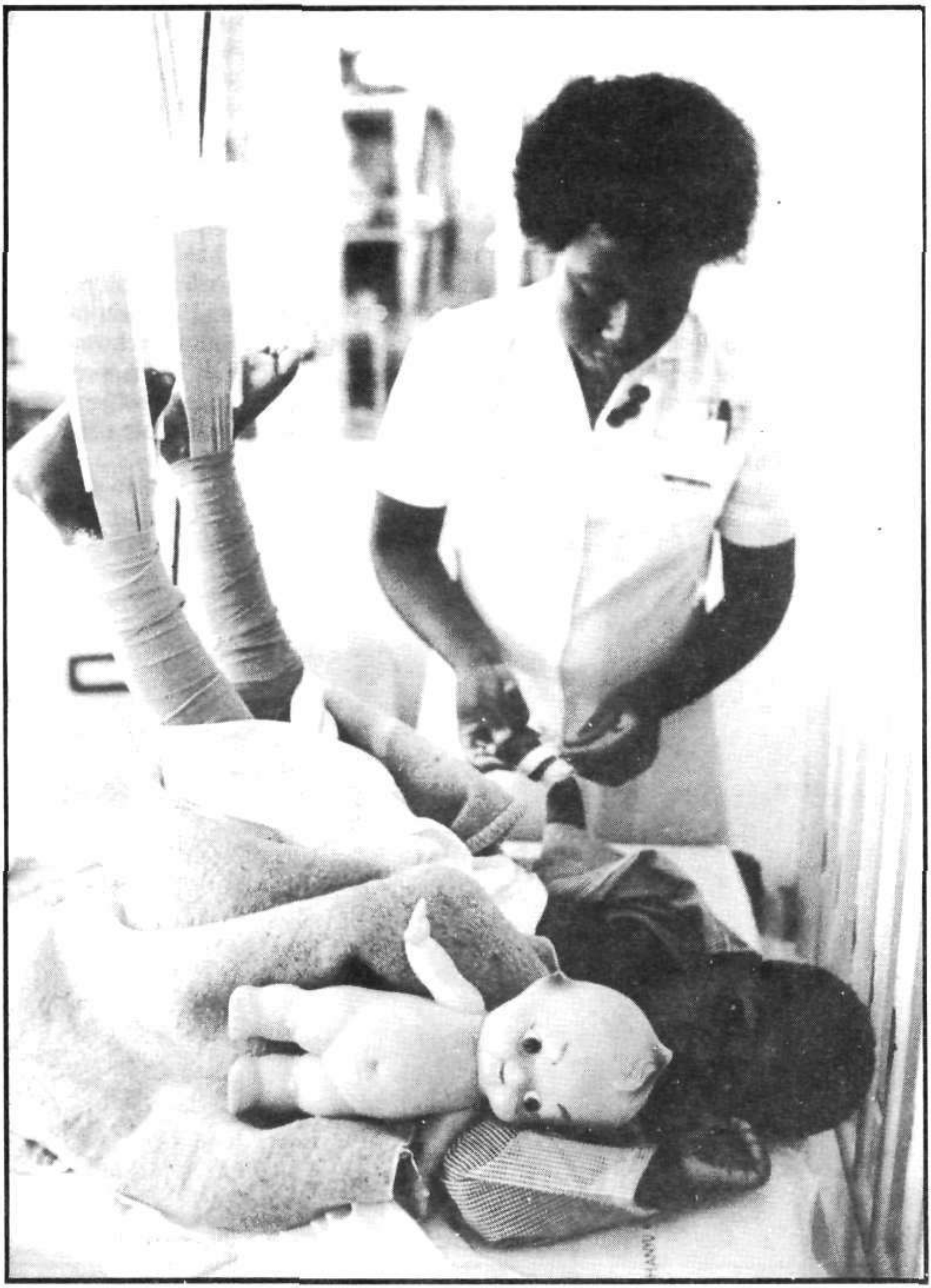
The shortage of doctors is critical in many hospitals. The previous supply of European, British and American doctors is drying up fast. The government does not seem to have the political will to streamline overseas applicants. The long delay in processing their applications often results in losing the services of such doctors. South African doctors are reluctant to work in these hospitals. There is no meaningful incentive in the form of better salaries or perks for health workers who

choose to work in these areas. There is no major effort by the central government to encourage young doctors to go to rural hospitals or even to make a rural hospital spell compulsory for all graduating doctors. The problem is not confined only to doctors - *in terms of health personnel, it also involves nurses and other* supplementary health service professions, administrators and skilled maintenance personnel.

The health budget for our hospital is clearly inadequate and in real terms it has been getting less each year (the situation and fate of our district clinics is even worse!). Many decisions such as the siting of new clinics, health centres and hospitals are made by politicians and not by informed health administrators and planners. We know of an extravagant new hospital recently built in a homeland (Lebowa) only 3 km from an adequate new hospital in another homeland (Gazankulu). Other expensive health centres and clinics are built in inappropriate places. It is all very frustrating and disillusioning. There are many problems and inadequacies in our rural hospitals and health services in general. This outline is only the tip of the iceberg.



Rural hospitals serve 10 - 20 million of South Africa's people: They are entitled to better health services



One of the causes of the crisis is that not enough money is allocated to health.