

Letter from . . . Soweto

Baragwanath Hospital, 1978

WASILY SAKALO

British Medical Journal, 1979, 1, 739-740

Exactly 11 months ago it was cold and raining in England. Winter had already set in and was promising to be bad. My wife and I sat in Manchester airport waiting to leave, never suspecting what lay ahead. Eleven thousand kilometres later we stepped off the plane in Johannesburg wrapped in our sheepskins and overcoats only to be dealt an almost physical blow by the heat—Africa had welcomed us.

First impressions

Senses reeling, we allowed ourselves to be bundled into a car by a friend who had arrived to meet us. Johannesburg whisked by as we were driven from mansion to mansion. Pools sparkled in almost every garden and eucalyptus trees softly basked in the sun. Then the scenery changed. Gone were the mansions and pools, and 11 kilometres south of Johannesburg a sign pointed down a single-lane highway to Soweto. We passed by what must be one of the busiest crossroads, known as "Uncle Charlie's," and on to Baragwanath Road. We passed Africans selling copper wares and vegetables on the roadside, and the land seemed to take on a barren, unkept look. The black men's hotels and the military base flashed by. A large blue bridge spanned the road ahead of us and we were told we had arrived. On the outskirts of Soweto stands Baragwanath Hospital, flanked on two sides by Soweto and on one side by the police and army. A high wall and barbed wire fence mark the boundaries of the massive, impressive hospital.

European and non-European doctors are housed in separate quarters. We were led to the European quarters and placed in separate rooms. "Mr and Miss Sakalo," said the housekeeper, evidently expecting us. "Sorry, we didn't realise you were married." Recovering somewhat sharply, we rescued a bottle of port from our cases. This situation definitely called for a drink. Trying to get a double room would have to wait until the next day. Right now we had a meal and a couple of parties to attend that had been prepared especially for us. On Friday night we had spent a total of one day in South Africa. Pitch-black night marked the location of our neighbours, pierced at intervals by only a few lights. Though a power station lies practically in the heart of Soweto, the blacks have very little electricity and no street lights.

Sirens blaze yet again and trollies line the casualty department, known affectionately as "the pit." All the patients are seen by doctors, but most of the lacerations are stitched by male orderlies, who work around the clock in an effort to keep up with the influx of patients. Drainage tubes hang out of chests, spilling

their contents into glass bottles, and the whole area is charged with a quiet bustling. A nurse calls me over as a new patient arrives. A seemingly lifeless body is literally thrown on to a stainless-steel trolley thinly covered by a rubber mattress and is wheeled past the casualty clerk, who doesn't even have time to extract the one-rand payment. I rush over and place my stethoscope on his chest and hear distant heart sounds. He is shocked and unconscious with laboured breathing. There is a laceration on the left of his chest. I plunge a needle into his pericardium and extract fresh blood. Stabbed heart! Without further ado I ask for gloves and scalpel, open his chest, and force his ribs apart. The heart is stabbed and blood squirts on to my clothes and shoes. I plunge my finger into the offending hole and race with the trolley and patient across an open corridor to the theatre that is always prepared for such emergencies.

We stitched the hole and left the patient in the care of nurses. He was discharged 10 days later remarkably well. The time was now 11 30 and the night was young. In summer on a warm night anything can happen and the team on duty usually works all through the night. Already we had had four disembowelments and many beatings and stabbings, and this was the second stabbed heart. This was also my first day at work. As I walked out of the casualty department for a much-needed cup of coffee I glanced at the entrance and saw two lines of trollies with patients still waiting to be attended to. This was going to be a long night.

Overcrowding

Baragwanath Hospital was built in 1940 by the British government to treat war casualties from North Africa, and was a military hospital named after John Albert Baragwanath, a Cornish mining speculator who originally owned the land. Eight years later it was transformed into a black hospital, and has since become one of the best teaching hospitals in Africa. It draws patients from a far wider area than it was ever intended to, and, as the patients prefer Baragwanath to other hospitals (the hospital policy is never to turn anybody away), the bed occupancy rate is 105%. At any one time many patients are bedded down on mattresses between the beds. There are 2000 beds and a staff of 700, which includes 450 full-time doctors and 3700 nurses, many of the nurses coming from black-ruled states, some from as far as Kenya, for training. Eleven million outpatients are treated every year, with 85 000 ward cases. This means the hospital has the largest case load of any medical facility in South Africa.

Even with these figures staff shortages are still a problem, but at the moment things are looking better. Medical staffing has improved, especially over the past year, and now all the nursing posts are filled. Some departments are still short-staffed and yet others, such as obstetrics and gynaecology and paediatrics, have a waiting list of applicants. Previously, registrars and consultants had to work in the casualty department as part of paid overtime duty, but recently the staff has increased, so that even in

Mount Lawley, Perth, Western Australia

WASILY SAKALO, MB, FRCS(ED), consultant surgeon

December, when the casualty attendance soars, their services have been practically eliminated. Staff conditions do, however, reflect the government apartheid policies. Of the 450 full-time doctors, 50 are black, and, though they mix easily with their white colleagues on wards and in the theatres, they receive less pay and are segregated for eating and sleeping. A white doctor who is a specialist will receive roughly R 13 450 a year before added overtime, which for him would be about R 6000. An Indian would receive R 11 350 and a black only R 9702. The government has agreed to revise the pay system but, as yet, there is no sign of their good intentions.

The South African government's racist policies are again clear, in that the white hospitals have monetary preference over the black. Baragwanath Hospital is undeniably overcrowded, and, though the government plans to build a new 2000-bed black hospital, almost a decade of talks have failed to finalise it; yet a new white hospital with 2000 beds has recently been opened. The new hospital cost R 140 000 000 to build, yet there are already white hospitals with a bed occupancy rate of only 60%. Baragwanath had a 1978 budget of R 22.5m, of which R 1.1m came from patients. The rest came from the tax payers. The last computed figures in 1970 show that one bed was available for every 68 whites, while only one bed was available for every 179 blacks. The gap is closing, but very slowly.

Government showpiece

Treatment and medical facilities at Baragwanath are excellent. There are 17 departments that have facilities for anything from neurosurgery and plastic surgery to open-heart surgery. Gunshot wounds, stab wounds, and measles are dealt with, as is kidney dialysis, and even the most super-specialist procedures are done. In fact, practically anything except nuclear medicine is available. Baragwanath may be described as a showpiece designed for the South African government to show the rest of the world what they are doing for the black population. Many of the patients are treated for afflictions and diseases resulting from poverty and overcrowding. These include tuberculosis, malnutrition, diabetes, infectious kidney disease, hypertension, epilepsy, scabies, diarrhoea, eye afflictions, trachoma, and glaucoma. These cases present a particularly heavy case load and draw patients from as far afield as Zululand. Malnutrition, in particular, is endemic among the black population and a study by the University of Pretoria has shown that 75 black children die of malnutrition every day.

Patients visiting the hospital pay one rand a visit to the admissions clerk, unless they are unemployed, when treatment is free. The maximum charge is R 5 a month. This fee covers the consultations, prescriptions, operations, ward care, and

ambulance transport. Maternity care is also very cheap for the black population. A fee of R 10 covers an initial inspection by an obstetrician, confinement, and postnatal care. The same service would cost a white mother R 500. The maternity wards sprawl over 50 hectares of land and cope with a 2.7% birth rate, which is a rate higher than India's. There are 600 beds and it is one of the busiest departments in the hospital. They have roughly 2100 births a month, and 250 caesarean sections and 300 epidural blocks are performed every month.

The intensive care unit at the hospital is the biggest of its kind in the country. It comprises two, 18-bed wards, though at the moment only one ward is in use. All the nurses are black and many of them are students from black-ruled countries. Even in this modern day, in one of the most advanced black societies, witch doctors still retain a strong hold on the people. There are over 100 registered witch doctors practising in Soweto and this is one of the main reasons why many patients present at a late stage in their illness.

Need for recognition

The largest bone of contention in Baragwanath is the lack of research facilities. The hospital is a major teaching hospital that draws doctors and students from the University of Witwatersrand, yet academic facilities, such as libraries and laboratories, are in Johannesburg at the medical school with the white general hospital, and there are few facilities at Baragwanath. Recently, many doctors, including senior specialists, have left Baragwanath, especially to go to the USA. The main reason is the lack of research facilities and conditions of service and the prospects of better pay. The patient load is so great at Baragwanath that doctors find that they have inadequate time to study. Baragwanath needs recognition as an important academic hospital and should have research facilities, the lack of which is causing them to lose doctors. Funds for research in South Africa have recently been cut, and the hospital administrators seem to concentrate only on treating patients, not finding new and better ways of treating them.

Overall, the work is hard but stimulating and hours are long. Recreation is limited, but a pool and tennis and squash courts are provided. Recommendations for this hospital are excellent, and for doctors wanting to put medicine and experience first it is second to none. Nevertheless, I do wish to add that one would gain more working at Baragwanath at postmembership or post-fellowship stage and it would certainly be worth a 12-month stopover for medical graduates travelling between Australia, New Zealand, and England.

(Accepted 2 January 1979)

As an alternative to the expensive CAT scanners, can electroencephalography be used to differentiate tumours from vascular disease in the diagnosis of stroke?

A focal EEG abnormality may be detected at the appropriate site in a patient presenting with "stroke," but the finding does not distinguish vascular disease from an underlying tumour. The character, distribution, and evolution of an EEG disturbance on serial recordings may offer support for a vascular lesion or raise suspicions about a tumour, but the distinction cannot be made with certainty. CAT scans provide an anatomical picture of structural intracranial disease, and it is usually possible to differentiate a tumour from vascular lesions with a single examination. Infrequently the CAT-scan appearances after cerebral haemorrhage or infarction are difficult to distinguish from a tumour, but follow-up scanning after one or two weeks nearly always resolves the diagnosis. In my view CAT scan is the investigation of first choice for patients with strokes and it is unfortunate that availability is limited by high cost, since alternative non-invasive methods of investigation are less informative in this context. Extracerebral haemorrhage, intracerebral bleeding, infarction, and the non-vascular

causes of stroke can be distinguished by CAT scanning, and complications—for example, hydrocephalus—are recognisable. Information of this type, gathered without risk to the patient, is valuable in planning further investigation or deciding about treatment. It is hoped that improved diagnosis from CAT scanning will contribute to better management of cerebrovascular disorders; an area in which the efficacy of almost all presently available treatment is debated.

Many years ago a patient had an upper canine apical abscess causing sinusitis. He has since been taking fluoride and calcium tablets. Are these likely to help his condition or harm him?

Sinusitis resulting from an apical abscess is a finite condition. When the correct treatment has been instituted, both for the teeth and for the sinuses, resolution is the rule. Fluoride is added to the water to prevent dental decay, and calcium tablets are sometimes given when it is thought that the patient is deficient in calcium. Fluoride has a definite effect in reducing dental decay. Neither fluoride or calcium would either help or harm the sinusitis.