present time and should feed into the ongoing debates about health sector restructuring—namely, public health and policy including health economics, epidemiology, health systems research, primary health care development, education and training of health personnel, health promotion, and health services management. A strong public health influence on health sector planning will be necessary, as will be the development of a cadre of skilled health service managers—both totally lacking in South Africa today. Clinical expertise, too, is of extreme value, but it needs to be proffered in the context of improving appropriate levels of care, with an eye kept on cost effectiveness and enhancing quality.

Lastly, individuals travelling to South Africa should make it their objective to learn about what is happening in the country. Whether they are invited to attend a conference or to practise in the health care services, they should make a point of finding out about the population served by that service. Who has access? Where do the people come from? How much do they pay? What service is available to them at home?

Individuals should seek to visit the more peripheral areas and get out of the urban centres, big hospitals, and plush surroundings in order to see something of

the real problems facing the vast majority of South Africans. For most people, life is what it always has been: much more radical change is required before their lot will be improved. Visitors should be cognisant of the real challenge facing health workers in South Africa: transforming the sociopolitical and economic environment into one that is health promoting, and devising a health service that is equitable, of high quality, accessible, and available to all.

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Letter from Kosovo

Coping with Serbian repression in an Albanian population

Lynne Jones

It looks like an ordinary suburban villa—neat, white, two storeys with a garage. In the garden there are fruit trees coming into bloom and green spikes show through the freshly turned earth of the vegetable patch. The garage door is open. Inside, however, instead of a car or the detritus of household goods, are fresh painted walls, noticeboards covered with class lists and timetables, and clusters of young people examining them. These are the offices of the “parallel” Prishtina medical school in Kosovo. The school was established by Albanian staff and their students after Serbian authorities dismissed most of the Albanian medical faculty from the official medical school and ended university teaching in Albanian in late 1990.

Around the corner in an abandoned grocery shop, under dusty adverts for soft drinks, are some wooden benches and a few microscopes that make up the histology laboratory. In the basement of another villa students prepare for an exam in infectious diseases. According to Dr Alush Gashi, sacked dean of the official medical school, some 2000 Kosovo Albanian students study in this way—“Of course, it is far from ideal, but the theoretical teaching is of a very high standard.” Clinical teaching is done in the “parallel” outpatient clinics, run from the homes of some of the sacked physicians. Exams are much more rigorous than before, and the plan is that after qualification students should work as assistant physicians for two years.

those subjects in which Albanian language professors were unavailable, in which case all studied in Serbian. Clinical work, including written notes, was conducted in the language of the patient and doctor, mostly Albanian. However, summaries were written in Serbian, as were any notes needed for communication with doctors, hospitals, or laboratories in other areas. If any Serbian doctor attended a clinical meeting or seminar the meeting would automatically be conducted in Serbian, as most Serbian doctors did not speak Albanian. According to Albanian and Serbian doctors to whom I talked, relations were good. Dr Ferid Agani, a young psychiatrist, explained: “nations were not important—only one’s professional skill.”

Kosovo has specific health problems. With only 42% of the population living in buildings with a water supply and only 28% in buildings connected to the sewerage system there is a high incidence of infectious diseases. Kosovo also has the highest birth rate in Europe—29.5%.¹ The Serbian authorities argue that this “biological surplus... is the result of the planned increase in progenies, as a form of struggle... [and] civilisational backwardness.”² Dr Drita Mekuli, however, points out that infant mortality is 49%, which she believes stems from poor economic and social conditions encouraged by the discriminatory policies of Belgrade in the past 10 years.¹ Albanians claim that it was these poor conditions that resulted in some Serbians leaving Kosovo during this period.

Recent educational and social conditions

It was not always like this. Kosovo, the southernmost province of Serbia, has a population of just over 2 million, of whom roughly 90% are Albanian. The remainder are Serbian, with some other minorities. There has been a university medical school in Prishtina since 1969. Until 1990 medical students could study in their own language—Albanian or Serbian—except in

Brutal measures

Serbian allege that Albanians abused the autonomy granted the province by the 1974 constitution. This had made both Kosovo and the northern province of Vojvodina constituent members of the Yugoslav federation with their own parliaments and almost identical rights with the other sovereign republics. Serbians, however, believed this constitution gave

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Poor economic and social conditions in Kosovo have been encouraged by the discriminatory police of Belgrade

"more power to the provinces than to the legitimate government in Belgrade," and steps had to be taken to "unify" Serbia.³ Thus in 1988 Slobodan Milosevic, newly ascended to power, proposed constitutional amendments to revoke it.

The Albanians responded with peaceful demonstrations and strikes, demanding republican status within the federation. These were met with increasingly severe repression, including the banning of public meetings, arrests, and detention without charge. Helsinki Watch estimates that between 26 and 100 demonstrators were killed in March 1989 alone and hundreds more injured.⁴ In July 1990 Belgrade suspended the Kosovo parliament and imposed a state of emergency, which included appointing special Serbian commissions to run most public enterprises, including most hospitals. Kosovo medical organisations and institutions were "unified" with Serbian ones. It was shortly afterwards that the dismissals of doctors, along with more than 100 000 other Albanian workers, began (Council for the Defence of Human Rights and Freedoms, Prishtina, Kosovo, personal communication.)

Statistics from the medical branch of Kosovo's independent trade union put the number of sacked health sector workers at 1855, including 263 doctors and 140 medical faculty staff, mostly from the Prishtina municipality. Mr Bosko Drobnjak, secretary of the Prishtina ministry of information, told me that there were no dismissals. "Albanians left their jobs in order to paralyse society." When I cited some specific cases he assured me that "any mistakes could be corrected through the courts" but that Albanians were also boycotting these. Likewise the current dean of the official medical school, Dr Tomislav Djokic, told me that Dr Gashi voluntarily gave up his faculty position and others boycotted work because "they thought people would die here and it would look bad for Serbia, so we had to ask for help and other doctors came from Serbia to help us."

Dr Gashi did not use the word voluntary to describe the severe beating and forcible removal that occurred when he refused to clear his office. None of the dismissed Albanian doctors that I met had voluntarily relinquished their jobs. For example, Dr Shkendija Dobruna, selected from more than 100 applicants as a trainee in anaesthetics, was dismissed because her application papers were not in order. "The man who informed me was the person who had accepted my application papers a year earlier," she said. She took the case to court and was reinstated. (This was before the dismissal of the Albanian judiciary.) However, the hospital returned the case to court, where it is still pending, and used a guard to prevent her from

returning to her office. Paediatric neurologist Dr Vjosa Dobruna was at work examining a 14 day old baby when the police arrived. They gave her a letter stating that because she was not at work when they arrived she was dismissed. She was also forcibly prevented from returning to work.

Medicine a casualty of political correctness

Serbian doctors whom I talked to acknowledged that doctors were dismissed because "of solidarity with the alternative movement of Albanians" and "failing to obey the special measures," such as refusing the new order that all case notes should be in Serbian in Cyrillic script. In particular, they referred to the stance of Albanian doctors over the alleged poisoning of Albanian schoolchildren in March 1990. Most Albanians believe that incident was caused by toxic chemicals being purposely introduced into the ventilation vents of schools, making over 3500 children ill. (Serbian and Albanian children had classes in separate shifts.) But Dr Mustafe Cakaj, former division chief in the department of neuropsychiatry and a lecturer at the university for 14 years, has no opinion on who might have caused the poisoning. He does not regard the matter as his concern. He is convinced, however, that the 21 patients presenting at the department showed signs of physical intoxication, a judgment Serbian colleagues seemed to share but later retracted. Dr Cakaj insisted on standing by his clinical judgment and—despite police interrogations, physical threats, and pressure from a visiting commission from Belgrade—was not prepared to alter it to what he describes as a "political diagnosis" of "psychogenic" illness. Three months later he was dismissed without notice for failing to do his work in the prescribed manner and for maintaining the diagnosis of physical intoxication.

Not all Albanian doctors have been dismissed. But Dr Agani thinks the quality of care has deteriorated. For example, patients with chronic psychiatric illnesses who were previously accepted outside Kosovo were now refused—not simply because of shortage of resources but for the stated reason that "they did not understand Serbian." Meanwhile, qualified Albanian staff were being replaced by more junior staff who could not speak Albanian—and this in a specialty in which communication was the essence of the work.

Psychodynamic work has also suffered. Dr Agani had previously run a group for patients with psychotic illness, in which patients sometimes gave talks to each other. On one occasion a paranoid schizophrenic patient, a former history professor, had chosen to discuss "The League of Prizren" (a people's movement against the Turks in 1878). The group (of Serbians and Albanians) discussed the topic well, but afterwards Dr Agani had been reprimanded and told not to allow such a topic to be discussed again. After this all group work in the department stopped. "How," Dr Agani asked, "can a psychotherapist tell his patients what to say, particularly if they are psychotic? It was impossible to continue under such conditions, with every group vulnerable to accusations of being political. You worry all the time what your patients might say or do." A Serbian colleague had criticised him recently for allowing an Albanian schizophrenic patient to swear at Milosevic in the yard. The colleague, himself a neuropsychiatrist, would not believe that the patient was ill and saw it as Agani's fault. "There is no trust any more," nor "motivation for developing in a scientific and professional way."

The breakdown of trust is not just between professional colleagues but also between patients and the hospital. Immediately after the dismissal of all 41 Albanian doctors from the department of obstetrics and gynaecology deliveries dropped from 30 per day to

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fewer than two per day.⁵ Many Albanian women feel threatened by Serbian concerns about their high birth rate and prefer the risks of no prenatal care and home delivery. Moreover, dismissed workers and their families have no social security and thus are not entitled to free health care, so they are dependent on charities such as the Mother Theresa clinic.

I visited the clinic, housed in a small shop in an unpaved street. In an upstairs corridor Dr Myrvete Pagarada was seeing gynaecology outpatients. The queue extended into the road. "Everything comes too late—when it's severe. There's no possibility for basic prevention like cervical smears. We are back to the seventeenth century." Albanians believe that the complete disruption of the health care system has done more damage than sanctions. For example, vaccination rates have fallen in some communities from around 80% to as low as 30% in those health sectors under "special measures" (University of Prishtina medical faculty, unpublished data, March 1993).

Prospects for reconciliation

The problems in health care must be seen in the context of continuing repression of the Albanian population. While Serbian men are recruited into the local police and armed, "weapons searches" of unarmed Albanians become the excuse for further beatings and detentions. Two searches took place in the three days that I was there. Evictions of dismissed workers from tied accommodation continue. The refusal of Albanian teachers to teach the new unified Serbian school curriculum has resulted in their dismissal and the closure of schools to Albanian children. Reportedly, three parents were killed and others wounded while accompanying their children to an unofficial Albanian school.⁶ And when I asked a class of forty 17 year olds, sitting on mattresses studying Ovid in a private house, what they would do when they graduated the boys uniformly replied that they would leave Kosovo or hide, to avoid being drafted into the Yugoslav army. A total of 300 000 Albanians have left in the past three years.

Albanians regard the creation of parallel systems of

education and health care as a way of maintaining the human, social, and ethnic rights they enjoyed before 1989 and of non-violently defending themselves against what they see as a "quiet form of ethnic cleansing." Working Albanians and many abroad provide the financial support. And regardless of the dispute over the province's political status they would like dialogue with the Serbian authorities to resolve these practical issues. However, concerns over human rights abuses and calls for dialogue are perceived by the Serbian authorities as "a mask...to get time until wanted separatist goals are achieved,"⁷ and little dialogue has occurred.

Dr Stevan Baljosevic, director of Prishtina hospital, told me his only concern was his patients' wellbeing. Yet it is hard to see how the best patient care can be achieved in a setting where large numbers of skilled staff are dismissed because of ethnic and political affiliations, where medicine cannot be taught in the language of most of the population, and where doctors must monitor their clinical opinions, their therapeutic interventions, and their patients' behaviour for political correctness.

A brutal war is raging in Bosnia 200 km away. The hope of avoiding it in Kosovo lies ultimately with Serbia finding a way to address its own needs in a manner that also addresses the needs of others. The reinstatement of unfairly dismissed health workers and the reopening of the Albanian medical school would benefit both Serbians and Albanians in the province. It might be a good way to begin. Throughout this article Kosovo is spelt in the conventional way. Albanians refer to the region as Kosova.

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Guidelines for the management of spontaneous pneumothorax

A C Miller, J E Harvey on behalf of Standards of Care Committee, British Thoracic Society

Simple flow diagrams, with explanatory notes, have been devised to assist in the immediate and subsequent management of patients presenting to casualty departments with spontaneous pneumothorax. They cover decision making about which patients require admission; whether a drainage procedure is necessary; if so, the appropriate method, including technical details; inpatient treatment; referral of inpatients to a respiratory specialist; and follow up arrangements. The guidelines, designed for incorporation into casualty and ward handbooks, have already proved valuable in several district general hospitals, and can be used as a basis for audit.

Spontaneous pneumothorax is common in two groups of patients: otherwise healthy young adults, who can tolerate a large air leak, and older patients with emphysema, in whom even a small pneumothorax may cause severe respiratory failure. A district general hospital with a catchment population of 200 000 may expect to treat 25 such patients a year, so all casualty

doctors and general physicians need to be familiar with the management of this condition.

Although intercostal drainage has been standard treatment for pneumothorax, it is common for intercostal tubes to be inserted by inexperienced junior doctors, fit poorly, leak, and become dislodged or infected; there is continuing confusion about suction, clamping, management of surgical emphysema, and when to seek specialist advice. Moreover, many patients find indwelling tubes uncomfortable and sometimes very painful.

Awareness has been increasing of the simplicity, effectiveness, and acceptability to patients of simple aspiration,^{1,2} and these advantages over tube drainage have been confirmed in a recent multicentre study.³ It is recognised that many patients with pneumothorax require no intervention at all.⁴ National guidelines for management of spontaneous pneumothorax now seem appropriate. The following plan has been drawn up on behalf of the British Thoracic Society after consultation with over 150 British respiratory physicians and thoracic surgeons.

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