No man is an island

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Department of Surgery, University of Pretoria

All Mankind is of one author, and is one volume ...
No man is an Island, entire of itself ...
Any man’s death diminishes me, because I am involved in Mankind.

John Donne (1572 - 1631) Meditations XVII

Mr Chairman, distinguished invited guests, ladies and gentlemen, welcome to the ASSA Conference of 2004. Professor Krige, Dr Panieri and the local organising committee, thank you for all the trouble, energy and effort that have gone into years of planning the scientific programme, poster sessions, banquets and social events, accommodation, air tickets and other details of the conference. We also know that much time has been spent weighing up ideas, negotiating, mediating and bargaining over tariffs, sponsors’ space and so forth — the list is endless. Thank you for doing a very challenging job so exceptionally well.

In South Africa we are in a very privileged and interesting position — living where the First and Third Worlds meet. The ‘haves’ and ‘have nots’ rub shoulders on a daily basis. In many places there are too many doctors who over-service, and in other areas many doctors are forced to under-service a majority of the population, as a result of the milieu in which they work. In most instances it is the specialists who are responsible for the over-serving of patients.

The government has a duty to deliver a health care service that is advantageous to all sectors of the population. At the moment health care is enjoying tremendous prominence in the media and in politics at large, and there is legislation in place or being designed that will:
• reduce profit margins for pharmacists
• regulate dispensing by doctors
• restrict the freedom with which practitioners can ‘open shop’ by means of the required certificate of need
• ensure that there are doctors in government service, through community service and imported doctors, who are inadequately equipped for South African circumstances.

Legislation concerning the inclusion and exclusion criteria for admission to intensive care has been published.

At the heart of all this is the fact that there is not enough money in the Department of Health to go round. There is a maldistribution of services. With the over-serving of some and the under-serving of others, Government is obliged to reorganise and plan to make services available in the periphery. At present Government has not yet clamped down on specialists, but this will come. If we do not work and plan well to determine our own destiny, the Government, politicians and the state auditors certainly will. We have to have the answers, and implement them, or else others will supply the answers — and they will not always be to our advantage or to the advantage of our patients. I will illustrate four scenarios.

Fig. 1 shows the situation when the ‘haves’ and ‘have-nots’ are two forces in the country. They will move apart, and the ‘have-nots’ will become poorer. A further danger is that the ‘have-not’ arrow will become larger and the ‘have’ arrow will move off the map, leaving us with a situation like that in Zimbabwe — a retrogressive step to the ox-wagon ambulances of 150 years ago.

In Fig. 2 the two arrows are superimposed upon each
other. The colours of the arrows mix, illustrating how the ‘have-nots’ dilute the ‘haves’, resulting in a mean that is below acceptable 21st-century surgical norms and standards. This scenario will be untenable for surgeons who are worth their salt; they will leave the country to practise their profession elsewhere, and the depleted surgery corps remaining will result in a further downward spiral of surgical services.

In Fig. 3 the two arrows are in close proximity, but next to each other. The ‘haves’ and ‘have-nots’ are side by side, with ultra-modern private hospitals alongside battling overcrowded, understaffed state hospitals. This will cause a widening of the rift between the two sectors, with professional jealousies, patient and staff dissatisfaction and poor morale in state hospitals exacerbating the existing situation to a point of no return.

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Mr Chairman, the surgeons of South Africa have a major role to play in designing the future of affordable surgical health care, without compromising standards. Surgery needs to be available to all who require it at a good level of quality. Surgeons have to be represented where decisions are made; we need to offer practical advice to Government and other regional health ministries.

In South Africa, ultra-modern First-World medicine must also exist within the ‘have-not’ circumstances (Fig. 4). It is possible to have fully equipped theatres and to have qualified surgeons and sisters working in all theatres. But the staff must be paid competitively. I postulate that money will be saved because the theatres will be run in a super-efficient way. Quicker throughput by dedicated staff, with top-class amenities, will save money in the long run.

The four scenarios are relevant to the discussions that take place at this congress in Africa, where there are First-World speakers who work in First-World, state-of-the-art conditions. I would like to recommend that the papers presented be made relevant to Africa in order to answer the question ‘How do we take state-of-the-art conditions to Africa?’

The days of the mission doctor and nature simply being allies — the days of the patient being fit and able to recover while the mission doctor facilitated this in simple surroundings — are over. When recovery did not take place, it was put down to the survival of the fittest, and the high mortality rate was accepted.

The best facilities should be taken to the patient. Gone should be the days of patients presenting with terminal cancers, massive goitres, and advanced disease that needs major and costly therapeutic effort to try to ensure one patient’s survival. If diagnosis and treatment could take place sooner, there would be a better prognosis at a much lower cost.

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There is no point in cutting-edge First-World discussions that pay no regard to our role in South Africa. There is no point if the two ends of the spectrum move in opposite directions, the one forward and the other lagging behind. Movement should not be the moving away from each other of opposing poles, but should be movement in tandem, not a dilution or a dragging down of what is good. It should not be a case of the Third World pulling down the First World with a mean somewhere in between, but rather First-World principles making inroads, unaffected and undiluted by Third-World conditions. There should be, for example, telemedicine, telediagnostics, cellular and satellite linking, computerised record systems, and telecommunication of pathology results, X-rays, CT scans and MR scans.

Can the surgeon be replaced within the African context? No, and neither can good surgical practice be compromised. We need surgeons where the people are. Surgeons are practical people, they are in the vanguard of medicine — we must make sure that our position of leadership is not taken from us.

A First-World surgical facility in a small country town might be an expensive investment, but if well managed it can save money. For example, earlier diagnosis will lead to fewer investigations, which will be cheaper in the long run while delivering an excellent service. A surgical team with a well-paid surgeon and complementary staff, in well-equipped, First-World conditions in the depths of the country may seem like wishful thinking to some, but this is my vision for supplying surgery where the need is. In our discussions let us be practical and keep in mind how we can ensure that all the sophistication and knowledge of modern surgery can work in the peripheral areas that so desperately need a larger share of the medical cake.

I have often said that I believe in the destiny of people. My opinion is that if God had wanted us to be born at any other time in the history of the world, either in the past or the future, He would have planned it so, but He didn’t. He chose to bring this specific group of surgeons together at this particular point in time and for a particular reason. Each era of people has a calling, and what they do with it determines their future and has an effect far beyond their own time. It is a case of ‘cometh the hour, cometh [the people needed for that hour].’

Mr Chairman, let us use this congress to recognise the role we have to play in order to be relevant to the needs of South Africa.