It's virtually impossible to calculate whether South Africa (SA) has a shortage of emergency care doctors and nurses until they are properly deployed to where the greatest needs are – and have sufficient ancillary support to ensure that they don't spend chunks of their time doing 'other people's jobs'.

This is the view of Prof. Lee Wallis, head of the emergency medicine divisions of the universities of Cape Town and Stellenbosch and Western Cape Head of Emergency Medicine. Appointed in 2012 by national health minister Dr Aaron Motsoaledi to chair a committee reviewing emergency care nationally, Wallis spent over a year methodically visiting emergency centres across the length and breadth of the country. This September he also co-led the largest-ever peacetime evacuation of its citizens by an SA Defence Force medical team – the repatriation of the 25 survivors of the tragic Nigerian Pentecostal church hostel collapse in Lagos that claimed 85 of their compatriots among the 115 killed.

Izindaba called Wallis to test our assumption that SA’s lack of emergency doctors and nurses is crippling our ability to deal with our internationally recognised huge burden of violence and trauma. Wallis quickly cautioned against this. He said that SA was actually ‘task-shifting the wrong way’, resulting in emergency care doctors spending up to 40% of their time doing menial tasks such as clerical duties, portaging patients and answering telephones (as one unpublished internal Western Cape government health quality study at three emergency centres in the relatively well-staffed and equipped Cape Town metropole shows). ‘Everybody thinks we need more clinicians, but this [doing inappropriate tasks] is a problem nobody likes to address,’ he stressed. The Cape Town study (which suggests that the situation could be infinitely worse in lesser-resourced and staffed emergency centres) also looked at how many minutes it took for a doctor to assess the different levels of injury severity in patients (triage-coded red, orange and green), enabling a rough estimate of how many doctors were needed. The results suggest that ‘we don’t fully staff our emergency centres’ – but more critically that 40% of their actual workload was ‘non-value-adding’ (the menial tasks referred to earlier). ‘If our doctors were doing what they’re supposed to be doing all the time, we could quantify the gap much better,’ he explained.

Ludicrous deployment

Giving an example of dismally inefficient deployment of emergency care clinicians, Wallis cited two (anonymous) hospitals of roughly the same size, situated cheek-by-jowl, one a district hospital and the other a tertiary. The tertiary hospital had a brand-new emergency centre and four doctors, tending to only about 20 patients daily – because of the strict referral criteria. The doctors and nurses consequently had ‘spare time on their hands’. The other nearby (district) hospital had crumbling infrastructure and a casualty ward typical of those at its sister hospitals countrywide. Here, two doctors handled nearly 200 emergency patients per day. ‘Probably between those two emergency centres they have close to the right number of doctors, but they are inappropriately placed. Granted it’s not this dramatic country wide, but it’s clear that the bigger academic centres have better staffing ratios than district hospitals [90% of emergency patients are seen at district hospitals]. We also need to be putting resources closer to where the communities live,’ Wallis added, citing the already overburdened but hugely successful modern Khayelitsha Hospital (opened in April 2012) in the eponymous sprawling township outside Cape Town. Asked how the imbalance had developed, he speculated that it was ‘probably a throwback to how the balance of power lay and the historical lack of investment in the district health system’.

Mid-level workers will mitigate pressures

Wallis said that because doctors were ‘very expensive’, the 5-year-old clinical associate training programme (3-year hands-on training) was proving invaluable wherever its graduates were being deployed, KwaZulu-Natal being an early example. Although no data were available yet, surveys in that province showed that ‘patients and staff are happier’ wherever mid-level medical workers supplemented healthcare staff. ‘There’s a perception that we can afford doctors, and while that’s partly true, we can’t retain them when other countries are always paying more. Instead of this spiral of retention of
IZINDABA

Loading of survivors begins.

Wallis, a former British naval officer and military medical team were able to resolve. A woman had deteriorated very badly with septic shock and was critical by the day we arrived in Lagos. We brought her to the [airport] hangar and the military team spent a good couple of hours trying to stabilise her. Then a third patient developed a haemothorax which had gone undetected and was intensively treated on the flight home, being admitted to Steve Biko Academic Hospital (along with the others) in a dramatically improved condition.

Asked about his role in September’s evacuation after the Nigerian church hostel collapse, Wallis said that initially he thought that his flying into Lagos 3 days before a specially fitted out Hercules C130 SA air force plane was due to land would put his specialist skills to little practical use. This was because it was well beyond the 72-hour optimal lifesaving window period for seriously injured patients.

However, he was forced to reconsider. The poorly resourced, under-staffed hospitals with limited equipment in Lagos's sprawling shanty towns meant that at least three SA survivors had developed life-threatening complications that he and the military medical team were able to resolve. Wallis, a former British naval officer and battle-hardened medical veteran, said: ‘It was touch and go for a while. One man was on dialysis with a spinal injury and proved a challenge to stabilise. A woman had deteriorated very badly with septic shock and was critical by the day we arrived in Lagos. We brought her to the [airport] hangar and the military team spent a good couple of hours trying to stabilise her. Then a third patient developed a haemothorax which had gone undetected and was intensively treated on the flight home, being admitted to Steve Biko Academic Hospital (along with the others) in a dramatically improved condition.’

Flying all night to Lagos, spending 9 hours on the ground, and flying back to Pretoria (again overnight), Wallis said that the five other doctors, three SA National Defence Force commanders, eight paramedics and eight nurses worked incredibly hard to locate, retrieve via muddy, pot-holed township roads, assess and stabilise their precious cargo. He was full of praise for his military counterparts, who he described as ‘superbly efficient, well-equipped and a pleasure to work with.’ The Hercules C130 aircraft was fitted out with two large intensive care beds and operated as an aerial hospital platform. ‘I actually had goose-bumps, I wouldn’t be surprised to see that level of expertise and equipment on a British military plane dropping into Iraq’ Wallis knows what he’s talking about; he was a medical officer with 40 Commando Royal Marines who secured the Al-Faw Peninsula (Iraq’s land-sea oil-tanker hub) in the 2003 allied invasion of Saddam Hussein’s Iraq. His contingent ‘turned off the oil taps’ before fighting their way to Basra, suffering 40 casualties, all of whom he helped treat.

**Learning from our disaster responses**

Wallis punted the idea of a single SA national emergency response team priori-
tising African medical emergencies, adding that setting up a disaster medicine component at the national health department could play ‘a key role in these situations.’

‘I think there’s value in having a senior disaster management person and a clinician to get to the site quickly, do an assessment and provide good on-the-ground intelligence.’ When called upon to help assemble the Lagos medical evacuation team, he found that many of his colleagues were not up to date with yellow fever injections, effectively ruling them out. ‘We need people available at short notice,’ he stressed. Asked whether his emergency care recommendations to the National Health Committee were being taken up, he said that extending entry-level training from a 4-week course to a year had been accepted in principle (the minimum requirement for ambulance paramedics). Other suggestions such as expanding emergency medical service staff and locating staff correctly were being ‘taken very seriously,’ he added.

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