Gauteng belt tightening chokes tertiary hospital efficacy

The life-threatening lack of reliable CT scanners at Chris Hani Baragwanath Hospital and the state of disrepair of vital equipment there and at Johannesburg General Hospital come under Chris Bateman's scrutiny. These two tertiary hospitals epitomise an almost country-wide malady. We describe the problem, make a diagnosis and suggest a cure – all straightforward enough, except that the way the system has been set up makes an escape from their dilemma nigh impossible for the highly frustrated clinicians who, year after year, remain unable do their jobs properly. Chris Hani Baragwanath's CEO, stung by doctor implications of management incompetence, spills the beans on what she sees as wrong, inadvertently siding with her clinicians to put Gauteng province in the dock. Austerity measures at 'head office' put a R25 000 ceiling on autonomous tertiary hospital equipment procurement. Fulfilling the hospitals' core mission and containing costs this way (resulting in longer patient stays) seems absurd, even given the endemic corruption and mismanagement in Gauteng's health department (currently unable to account for R19 billion).

Belt tightening is obviously indicated – but choking the life out of doctor morale and service delivery will surely only result in total failure of these vital organs of state![1]

Trauma – and more trauma

Trauma is a major contributor to the burden of disease in South Africa. The National Injury Mortality Surveillance System (NIMSS) report estimated that 60 000 non-natural deaths occurred in 2004, accounting for 12% of all deaths. The most common non-natural cause of death in South Africa was accidental/unintentional injuries, accounting for 39.8% of fatal injuries; violence and homicide accounted for 39.3%. This issue of the *SAMJ* has no fewer than 8 items on trauma or trauma-related issues.

Direct admission to a level I trauma unit improves survival. The level I trauma unit at Inkosi Albert Luthuli Central Hospital was commissioned in March 2007. Since such units are expensive to run, are their costs warranted? Cheddie and colleagues[2] studied admissions to the trauma unit and the intensive care unit at the hospital from March 2007 to December 2008. They concluded that trauma is a major cause of premature death in the young and that direct admission to a dedicated trauma unit improves outcome in the critically injured.

The 11 P's of an Afrocentric trauma system for South Africa. Trauma systems improve survival and decrease morbidity – but can only do so after universal acceptance and sustained application. A trauma system involves the interaction of prehospital care, emergency care and definitive care (including prevention and rehabilitation services), providing an organised approach to acutely injured patients. Timothy Hardcastle[3] outlines the requirements for cost-efficient, patient-centred trauma systems relevant to South Africa. He groups and discusses the items, each commencing with a P, namely: Political will, Public pressure, Participants from multiple sectors, Professional compliance, Provincial restructuring, Private sector participation, Professional society accreditation, Proper data management, Purpose-driven governance – improved outcomes, and Practise the theory in a financially sound model.

Pre-hospital rapid sequence intubation. Rapid sequence intubation (RSI) has become widespread as the procedure of choice for definitive airway management by pre- and in-hospital emergency care worldwide. The Professional Board for Emergency Care at the Health Professions Council of South Africa has approved pre-hospital RSI as part of the scope of practice for emergency care practitioners. Stein *et al.*[4] provide a position statement regarding the training, system requirements, and the clinical governance system within which RSI should be practised.

Safe endotracheal tube cuff pressures. Endotracheal intubation is performed in pre-hospital and emergency department environments by advanced life support paramedics and emergency doctors. Over-inflation of endotracheal tubes (ETTs) may result in serious complications including tracheal stenosis, tracheal rupture and tracheo-oesophageal fistula. Stein and colleagues[5] found that qualitative assessment of ETT cuff pressure by practitioners who regularly perform emergency endotracheal intubation is inadequate. This means making the use of ETT cuff pressure manometers mandatory throughout the continuum of emergency and critical care.

Procedural sedation in the emergency centre. A proportion of patients presenting to emergency centres need to undergo procedures that can be unpleasant and painful. The Emergency Medicine Society of South Africa recognised that there was a lack of uniformity in the provision of safe and effective analgesia and procedural safety. On behalf of the society, Stander and Wallace[6] provide guidelines for emergency medicine specialists and all medical practitioners involved in the provision of emergency procedural sedation in emergency centres in South Africa.

Assessment of trauma centres. On behalf of the Executive Committee of the Trauma Society of South Africa, Hardcastle *et al.*[7] provide guidelines for the assessment of trauma centres for South Africa.

In a letter to the editor, Michael Morris[8] laments the **failing medical services** in much of South Africa, and suggests that if these are not addressed 'living medical problems may become dead certainties'.

A call to arms for trauma care. In his editorial Lee Wallis[9] notes that trauma is the second-commonest cause of death in the region. The only sensible health service response is through the development of an integrated trauma system, which is long overdue in South Africa and should be made a national government priority.

1. Bateman C. 'Fix the damn system!' – Johannesburg's tertiary hospital doctors. S Afr Med J 2011;101:152-156.
2. Cheddie S, Muckart DJJ, Hardcastle TC, Den Hollander D, Cassimjee H, Moodley S. Direct admission versus inter-hospital transfer to a level 1 trauma unit improves survival. S Afr Med J 2011;101:176-178.
3. Hardcastle T. The 11 P's of an Afrocentric trauma system for South Africa – time for action! S Afr Med J 2011;101:160-162.
4. Stein C, Botha M, Kramer E, et al. Pre-hospital rapid sequence intubation. S Afr Med J 2011;101:163.
5. Stein C, Berkowitz G, Kramer E. Assessment of safe endotracheal tube cuff pressures in emergency care: Time for change? S Afr Med J 2011;101:172-173.
6. Stander M, Wallis LA, on behalf of the Emergency Medicine Society of South Africa (EMSSA). Procedural sedation in the emergency centre. S Afr Med J 2011;101:195-201.
7. Hardcastle TC, Steyn E, Boffard K, et al. Guideline for the assessment of trauma centres for South Africa. S Afr Med J 2011;101:189-194.
8. Morris M. Failing emergency medical services. S Afr Med J 2011;101:146.
9. Wallis L. Trauma care in South Africa – a call to arms. S Afr Med J 2011;101:171.