
EDITORIAL

Academic orthopaedics in South Africa – what is the future?

Our teaching hospitals face a number of threats despite assurances of support from national ministries of health and education for our efforts to increase the number of medical graduates and specialists that we train. The actual problems appear to come at Provincial Government level, and details vary between provinces, but the general feeling is that it will be a challenge to maintain our output in most provinces, let alone increase it. Plans to start new medical schools are far-sighted, but given the shortage of suitable teaching staff and lack of support for existing teaching hospitals they appear optimistic. It is possibly more cost-effective to expand and improve the existing schools than found new ones. The frequent and well-publicised decline, indeed collapse, in the standard of State hospitals and their equipment; the poor working conditions; the underfunding; and delays in appointment of key personnel are all factors discouraging an academic or state career.

The need to control medical costs is not limited to our own country; standards of healthcare are under pressure in the developed world including the USA and Euro-zone countries. The fact remains that for a variety of reasons South Africa does not get the same healthcare value for its expenditure as many surrounding African countries.

One of the most basic issues is the need to return to a GP/primary health care level of practice to contain costs and improve the merit of referrals to higher levels of medical care. This is a world-wide tendency which we must respect and incorporate in our training programmes. Nevertheless, primary health care has little impact on orthopaedics; it cannot prevent injuries, deformities or ageing and degeneration, and these conditions usually require specialist evaluation or treatment at some stage. South Africa is seriously under-populated with specialists given our demographics, and it would be wrong to curtail our specialist training programmes to fund primary care. These specialist trainees are an investment and as this country grows it will need their skills in the foreseeable future.

Orthopaedics is one of the surgical disciplines that has moved far beyond the realm of the GP, whose realistic role is limited to diagnosis, the medical management of orthopaedic problems such as osteo-arthritis, and the decision on when to refer. Economics has forced the move to surgical treatment of many fractures and other conditions to relieve pressure on expensive hospital beds and staff and to return patients to a productive life as quickly as possible. It would be impossible to train a GP in the complexities of surgical management of these cases.

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So, if the need to continue training orthopaedic specialists is accepted, the next question is to what level they should be trained. The simplistic approach is that every patient is entitled to the best possible care; even in the developed world this is an unaffordable economic fantasy. The realistic approach is that society, not doctors, should set the basic standard of care the country can afford and expect for its population; if an individual wants more then he must pay for it himself. That basic standard, however, is not good enough for specialist training, which should be up to the highest possible level to allow the specialist to practise with expertise at all levels of technology. At the same time a specialist must be trained to be cost-conscious: to do no more than is necessary, and at the least expense.

At present the NHI is an unknown quantity, but the situation is becoming so critical that we cannot afford to wait to see how it will affect healthcare in the country, and it may come too late to save our training hospitals.

It is pointless criticising without suggesting solutions. I think the following steps are necessary:

1. Increase pressure to accelerate the suggested removal of teaching hospitals from provincial control, and administer them separately as national assets under the Ministries of Education and Health.
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2. Appropriate, dedicated funding is needed from national government.
3. A national standard for infrastructure, equipment and staffing of teaching hospitals should be established, and all hospitals in different regions raised to this level, eliminating present inequalities.
4. Registrar posts must be recognised as primarily training and not service appointments. Registrars need recognition of study and research time and congress attendance as part of their work programme.
5. Specialist appointments in academic units should also be recognised as having substantial non-service components. Teaching and research, congress participation, and examination of students at other centres should all be accepted as a normal part of their duties.
6. Patient access to teaching hospitals must be regulated to prevent their being swamped with trauma, and to provide a representative mix of training cases. Government will need to take responsibility for denying advanced academic level care to the many patients who would like access but cannot be accommodated.
7. This would imply that most State orthopaedics, above all trauma, would be performed in non-academic centres, which would need to be revitalised and adequately staffed. There is no reason why registrars and consultants should not work for defined periods in these hospitals as part of their training and service commitment, keeping them in contact with the harsh realities of non-academic orthopaedics.
8. The single biggest factor threatening our orthopaedic training system is the trauma load; it is time to push hard for professional medical officers to be appointed to do this work, and relieve the pressure on registrars.
9. Despite its many disadvantages, remunerative work outside the Public Service (RWOPS) remains essential at present to maintain and grow specialist skills outside the public sector; however, it needs to be better controlled and exploited for formal registrar training as well to justify its continued existence.
10. Private specialists need to be included in teaching programmes to broaden discussion with their expertise. As this would involve financial loss, it must be decided whether a stick or carrot approach is appropriate, but perhaps the NHI will address this.
11. There is a limited pool of middle-aged State specialists who are not yet ready to become Heads of Departments, but have the potential (if not the desire!) to take leadership posts as they become vacant. The universities have an obligation to identify these invaluable people, and provide opportunities and incentives for management training and research so they can grow academically as well as professionally.
12. Academic orthopaedics cannot be viewed in isolation. We need appropriate back-up by anaesthetic, intensive care, radiology, pathology and other services; they must also be supported and most of my comments apply to them and not only orthopaedics.

The conclusion is that even if the country cannot afford top level orthopaedic care for all, it is essential that the teaching units should be preserved as centres of excellence, with the necessary funding to train to the highest level.

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