



Orthopaedic injuries in state hospitals compromised

The economics of orthopaedic trauma management are simple: early surgery to stabilise fractures and early discharge from hospital reduce hospital costs. The direct expenses of surgery and implants are offset by the reduction in duration of hospitalisation, plaster of Paris casts, follow-up X-rays and so on. The indirect savings of earlier return to work and rapid rehabilitation are equally significant.

Reducing trauma beds but providing adequate surgical facilities saves money, a trade-off that is being ignored in state hospitals. Orthopaedic trauma beds have been reduced but no additional theatre time has been provided, despite an explosive increase in all forms of trauma. This limits the number of orthopaedic trauma cases that can be managed conservatively and surgically, and an increasing number of patients are receiving substandard treatment. Those who must be treated surgically join an ever-lengthening waiting list for 'emergency' procedures, often numbering between 20 and 40 patients, with delays of more than a week, a situation unknown in the past.

This state of affairs is obviously bad for both patient care and economically efficient trauma management. But there are additional considerations.

- With isolated exceptions, public secondary hospitals are understaffed and make only a limited contribution to orthopaedic trauma management. Simple cases are often referred to academic centres, which shoulder most of the burden to the detriment of their training function.
- Unfortunately, efficient service delivery and in-service training are incompatible. Junior surgical, anaesthetic and theatre staff cannot work as rapidly and efficiently as trained specialists and theatre staff.
- Trauma patients are increasingly displacing elective cases from routine theatre lists. Reduced elective surgery seriously threatens the ability of specialists to maintain their own skills and to train registrars adequately. There is no incentive for specialists to remain in the public health service, where they have no opportunity to develop.
- Registrars are often unable to operate on their own trauma admissions when they eventually do get to theatre, and the doctor-patient relationship, so critical to our profession, is destroyed.
- Since orthopaedic operations have a lower priority on emergency lists than general surgical or obstetric patients, they begin when others have finished – often in the early hours of the morning, when fatigue, frustration, and inadequate senior supervision and theatre back-up staff lead to suboptimal surgery. There is also a high risk of accidental injury,

transmissible disease, and use of prophylactic antiretroviral drugs with their side-effects, which further compromises efficiency.

- Stress, frustration and demotivation are often high when staff are expected to cope with an impossible workload under inadequate conditions while maintaining acceptable standards of personal and professional behaviour.
- Failure to replace obsolete equipment, and the shockingly low standards of maintenance of existing equipment, instruments and facilities, combine with the above problems to pose a serious threat to patient care and safety.

We have only two realistic options. The first is to accept a lower standard of care for state patients and loss of our ability to train orthopaedic surgeons to international standards, which is unacceptable. The second is to endeavor to maintain standards in education and service, and we suggest the following:

- Government must recognise the existence and magnitude of the problem, and commit to the allocation of the necessary resources and their effective use.
- Regional hospitals must be revitalised and enabled to provide service at an appropriate level without prejudice to the central teaching hospitals. Failing that, equipment, funding and staff must be redeployed to where they can be used most advantageously.
- The diversion of resources to primary health care at the expense of secondary and tertiary services should be reversed.
- Funds should be used more responsibly – it is not acceptable that administrators work in luxuriously furnished offices while patient services are neglected for lack of funds.
- Provinces must be prepared to motivate and fight for additional funding with Central Government where necessary. The percentage of health funding spent on salaries is often quoted as being in the region of 75%, implying that too much money is spent on manpower and not enough is left for running costs. A more realistic interpretation is that provision for salaries is reasonable, but that other hospital costs are grossly under-funded.
- State hospitals must be better staffed. Better working conditions, elimination of impractical administrative duties and cumbersome appointment procedures and improved salaries should help to retain invaluable staff in the public sector.
- A system of trauma centres at each academic hospital, with dedicated theatres, intensive care units and wards, needs to be considered urgently, with provision for adequate facilities and staff.



- Co-ordinated planning of corrective measures is required, involving clinicians and not only administrators (who often have little understanding of the practical issues).
- Reduction of traffic injuries and interpersonal violence by improved education and policing is essential.

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