“The nationalisation of hospitals in the Eastern Cape”

…appears as the topic I am to address today. In fact I shall move on fairly quickly to talk about the motivation and challenges of rural health care.

For me, the term ‘nationalisation’ refers to the process spanning the years 1960 until ‘76 when the takeovers actually began — not to its consequences. During those years not only the Transkei & Ciskei Association of Mission Hospitals (TCAMH), but also the Natal Medical Missionary Conference, and the Transvaal Association of Mission Hospitals were represented, in dealings with Government, by the Consultative Committee for South African Medical Missions, known as CCSAMM.

I had accumulated more than 600 documents — Minutes, Memos, and Letters — which covered that process. I thought they were as comprehensive as any collection and did not want the way the process unfolded to be lost to history. Nothing came of offering it on CD to UNISA as a basis for research, so I published under the title *An Uneasy Story* in 2010.

I have brought some copies with me today, for sale I’m afraid. In his Foreword Prof JJ Kritzinger, formerly the Director of the Institute for Missiological and Ecumenical Research at Tukkies wrote:

> “Since the late 1950s the government of the time – with its policy of ‘separate development’ for the ‘homelands’ – stepped up its involvement in subsidising and coordinating the medical services in these areas. It became necessary for the medical missions to formulate how they saw the future of their institutions and services, especially in relationship to the relevant government departments. Some missions insisted on an autonomous and independent future for their hospitals, while at the same time welcoming the subsidies the government was willing to give. But there were others who thought differently. With all the misgivings they had about government policy they regarded the provision of adequate medical services as the responsibility of a society and its government.
>
> [Prof Kritzinger wrote that I] belonged to this group who felt that Christians should be willing to also serve in institutions where the churches are not in control, but where loving service can be rendered to the needy people. As time went by [he wrote that I] increasingly found [myself] in the ‘opposition’ but felt supported by, for example, [Professor]David Bosch who maintained that the Christian’s role should be that of servant and not master.”

P.T.O

My Own Motivation

After qualifying in the UK I spent 5 years in the RAF — 2 years of National Service as MO in charge of an RAF flying station in Malaya. Then 3 years in a UK RAF Hospital doing general surgery.

Towards the end of those years I had a big dip in my spiritual life. Helped by the Hospital Chaplain, from having been a Baptist, I was confirmed as an Anglican. I wanted to express my gratitude for all this help by volunteering to the missionary Society for the Propagation of the Gospel society in London. It's title dates from 1795 and not surprisingly has been replaced!

They had two priorities: To establish Jungle clinics in Borneo or to join a single-handed lady doctor at All Saints Hospital in Transkei. We agreed the latter because of my surgical experience. The Bishop of St John's (formerly Kaffraria), under whom I would work, was in London at the time so could interview me. I said I wanted to work as a doctor, not an evangelist. He, with 5 hospitals in his Diocese — more than any diocesan bishop in the world — said "That's just what I need".

So I came by sea to South Africa in 1958.

As for Motivation in General ...

I'ld like to quote a passage from my book, under the heading '*Which entrance to the Stadium?*':

> "When Oxfam, War on Want, … [WHO and other supportive organizations]…get so much media exposure, why do we [the mission hospitals], with all our plant and staff in place, so rarely get a mention? How often one wants to say to the Commonwealth Professorships, *Visit us*; to the Aid and Development agencies, *Use us*; to the Registrar experience-seekers, *Try us*.
>
> Imagine a great stadium, grown from an old club sports field. It still has a stand with a special entrance for foundation Members, not much used now and hardly noticed. In fact that stand is noticeably empty. These days our friends are out there on the terraces, rooting with the crowds. Are our Missionary Societies like the Members Entrance? Not surprisingly, if people don't know about that sort of thing, they don't notice the entrance. 'We are the generation of the terraces'. Can we not say: We are doing the same things so let us link up? There are many who do not think they are the right type for the Members Entrance."

Today, I have tremendous respect for NGOs like Medicins sans Frontieres (MSF), Gift of the Givers, and others, who respond to the plethora of emergency care around the world as well as providing for ordinary health care – if any care can ever be called 'ordinary'.

Whatever the source of your values – be it Christian, Muslim, Humanist or any other – it is those values of compassion, concern and empathy for fellow man, near or far, that motivates.

The Challenges

I can only speak of the challenges as I experienced them 50 years ago. I cannot address whatever may be the scene today.

For me it was like being thrown into the sea and struggling to swim. How different this was from the context in which, you might even say *for* which, I had been trained. In many walks of life we behave self-centredly — This is me, this is what I know, this is how I do things.

Here is an early, ground breaking example of what I am calling my 're-education' – from what I had been equipped (or rather not equipped) with. Malnutrition and Kwashiorkor — an entirely new clinical problem, admitted to a children's ward, fed until appropriate weight gained, discharged — only to relapse. What 'cause' did I think I had treated?

This challenge led to establishing Kwazondle Uphile — a Nutrition Rehab Unit (NRU) — away from hospital wards, and admitting there mothers-for-learning rather than babies-for-treating.

There was the challenge of culture

Living within another culture was the big challenge — a privilege, I now call it. Coming from the insular UK of those days, I had not even been taught what the term 'culture' meant! To me, the way I lived, worked and thought was 'normal' – was a universal baseline. Living and working within another culture means re-thinking yourself as much as 'them'.

This broadening of outlook was reflected in our transition from *didactic* health education to *interactive* health education. Start with the people themselves, where they, as they are. Learn their beliefs to gain their confidence. If they have confidence in you, and know you respect them, they are more likely to be influenced by your new ideas.

You could look at my website www.healtheducation.co.za.

Travelling this road also led to interacting with traditional healers and traditional rituals. Maybe you saw my Letter about male circumcision in a recent Mail & Guardian? I wrote:

> "Forty years ago, before the current high levels of debate, but through interaction between hospital and the community, abakhwetha (initiates) were brought to the hospital by their amakhankatha (nurse-instructor). Still clad in their white blankets, they waited on the grass outside Outpatients, apart from other people. After being safely circumcised under local anaesthetic in theatre, they would return to their mkhwetha hut."

P.T.O

Supportive Teamwork

What kind of stamina did I rely on during my 18 years at All Saints? For many years I felt very aware that I had been sent by the same society as the other missionary staff that I worked with, not only the medics. So this sense of solidarity, of 'not letting the side down', was important for me.

But as years went by 'team work' became the strongest support.

When called for a second time during the night for yet another head injury due to stick fighting, it would be the professional reliability of the theatre nursing staff and their expectations of me, that I lived up to.

As our ideas and commitment to expanding health care broadened, that rather personal theatre-dependence, grew into really organic teamwork. It was no longer "Can I cope". It became "We are doing this together".

Leadership

It was during my 5 years in the Mthatha Head Office that I rethought my rather 'welfare society' upbringing and 'top-down' planning. I now believe that, whether its politics, environmentalism, or health care, its local leadership that counts most. As it was with some of the mission hospitals, it still shows with certain hospitals today. Just look at Mosveld's Umthombo Youth Development Foundation!

Clinical Skills

Within the context of all those challenges there are clinical skills.

In those days, although we connected well with the Frere Hospital, Umtata General, and even Groote Schuur via air ambulance, we did as much as possible ourselves.

Because the consequence of referring whatever you have not been specifically trained or qualified to do, overloads limited transport, overloads tertiary capacities, can lead to poor clinical outcomes and always drains the resources of poor communities.

Resourcefulness

Surgery is often the problem. So I believe we should add a special kind of resourcefulness to our training and practice. This way by which I increased my range of operative skills is described in an article: ***Preparing for rural surgery: Procedures or Skills?*** in ***SA Fam Pract 2003;45(9):8-9***.

It will be the unusual, rather than the common, procedures that throw you. You need confidence in the basics of cutting, closing, control of bleeding etc — the 'knife fork and spoon' of surgery. Then be equipped with good books of operative surgery. Learn to sit quietly and prepare yourself for an operation by mentally, or even in writing, converting what

you read into the ordered steps you need to perform – and, if you want to, take your notes or textbook into the theatre.

Generalism

To meet as many clinical challenges as possible involves crossing the boundaries of many specialities. There are several procedures that could be learnt in advance that help to cross such boundaries. Just as examples:

- Giving a general anaesthetic – and intubation
- Regional blocks – brachial plexus block and epidurals
- Intercostal drainage.
- Managing fractures by conservative methods - in these days of so much open reduction!
- Rehydration – scalp vein drips for kids

Ronald Ingle

16 October 2013