

EDITOR'S COMMENT

Medicine by numbers



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I am writing this from Scotland, where my mother and stepfather live. I brought forward a planned trip because my stepfather, Murray, was in hospital – again. He developed pneumonia earlier this year and has been in and out of hospital ever since. At his initial admission he was discharged in florid cardiac failure and it took some time for the local GP to work out what was going on because GPs no longer look after their own patients after hours, so he was never able to respond to the nocturnal attacks of PND. As a result poor Murray eventually landed up in hospital again – and was again discharged without the correct medication for cardiac failure. The remainder of the year has been a round of constant follow-up visits to a variety of GPs in the village and one cardiology consult – and several hospital admissions. Lack of continuity of care and poor follow-up eventually saw him going back into cardiac failure in the past couple of weeks, this time almost certainly because of verapamil, which disagreed with him violently, but which the GP would not stop ‘until she had seen the result of the investigations’ that were ordered by the cardiologist in September. He now seems to be on the correct medication – although the GP still carries on trying to interfere – which he was put on by a South African-trained doctor at the local hospital!

Sound confusing? It is meant to. I have long been an admirer of the NHS in principle. I was a recipient of its facilities for a large chunk of my life and I have worked in it as well, although not for about 20 years. When

I was working in the NHS it was very much GP led, with good follow-up by specialists where necessary and a rational approach to management, prescribing and investigations. Over the past 20 years or so that has changed radically. Medicine in the UK is now ‘target-driven’ – from the number of over-70 annual checks a GP does, to the number of admissions for stroke and other vascular diseases in smaller hospitals. GPs now do numerous investigations because they need to meet the targets for managing renal disease in diabetics and hypertensives, make sure that the elderly are placed in diagnostic categories and ‘appropriately’ treated and so on and so on.

In hospitals the continuity of care has gone because the junior staff are no longer attached to firms, but flit around from department to department, taking over patients as their shifts change, in the name of keeping to the hours required by the European Union Directive on working hours in hospital. This was evident when my stepfather was in hospital – he never saw the same doctor twice and the specialist who was looking after him never did so much as place a stethoscope on his chest. He was discharged with different medications after each admission and his GP seldom seems to have any idea what happened in hospital, even though all results are now on a central electronic database.

GPs no longer look after their own patients after hours. I know how this happened –

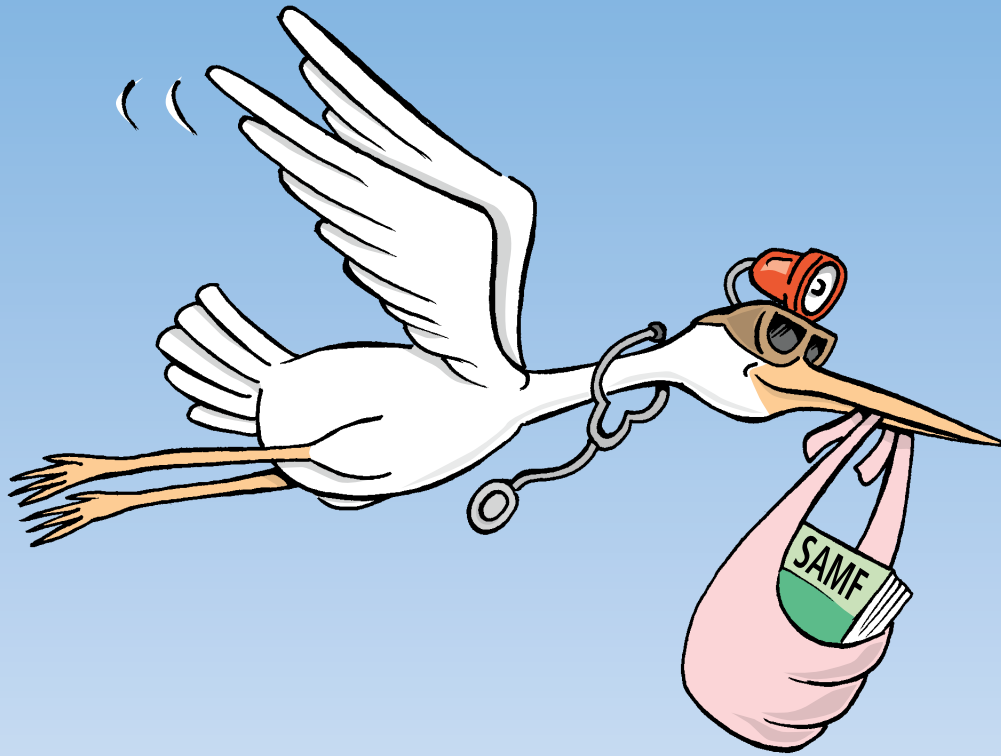
through major abuse by patients my nights and weekends on call as a GP in Scotland 20 years ago were ridiculous. But what is now in its place isn’t working. Over a weekend or at night the easiest doctor for my mother to talk to is in Cape Town – me! And this is the main reason that Murray was not sorted out properly earlier – you need to listen to the chest in the acute situation in cardiac failure – not several hours later when the patient is walking around.

My real concern with all this is not so much the deterioration in care provided by the NHS – I will never need it and my mother and stepfather are nearing the end of their lives – but the way in which it happened. The current approach is government- and administrator-driven, and this is what concerns me. When the NHI in South Africa is finally implemented I suspect that similar ‘targets’ and approaches will be implemented. We have a government that is keen on micro-management and that is so against the independent approach of the private sector that they are likely to massively over-regulate the way in which medicine is delivered in the public sector. Add to this the rampant corruption that is part of all our public structures and the parlous state of public health infrastructure and we have a recipe for disaster before we even start. There are serious lessons to be learnt from what has happened to the British NHS over the past couple of decades. I just hope someone will take the time to look for them.

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