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MISSION HOSPITALS

Mission hospitals form an important part of South African hospital services. About a quarter of all the hospital beds in the country are still contained in about 85 mission hospitals. Why should this be the case in a country advancing as rapidly as is South Africa? Is it not high time, many will think and ask, for the Province or the State Health Department to take them over and integrate them into the existing hospital services? From a financial point of view this would seem to present little difficulty. Already the State Health Department pays the full patient-day cost for all patients suffering from infectious diseases and the Cape Provincial Administration (for instance) now pays a grant-in-aid to its mission hospitals based on 90% of the cost per non-infectious patient per day; surely the extra 10% would not throw much of a strain on Provincial finances. The present cost per patient-day in most mission hospitals is low—the average in the Transkei, for example, is only a little over R1.00 per day. However, it might well be argued that this would rise fairly sharply if full Provincial or State hospital salaries were paid to all staff, and then the Administration would have to pay considerably more than at present. The Minister for Bantu Affairs has undertaken to make capital grants of up to 100% of the cost for approved new buildings in mission hospitals (provided they were on Bantu Trust land). Thus this major burden, formerly largely borne by the missions themselves, has been removed. Therefore it seems very unlikely that cost has much to do with the continuing presence of mission hospitals in South Africa.

The real reason is the difficulty in providing medical and senior nursing staff, particularly the former, for these hospitals in out-of-the-way, unpopular areas. In the Transkei and Ciskei about 25% of the doctors working full-time in mission hospitals are South African. Further north, particularly in the Transvaal, it seems that a higher percentage is to be found, but nevertheless this hardly gives room for complacency. Many possible causes for this state of affairs come to mind. One perhaps is that the image of the medical missionary has remained unchanged since the days of Doctor David Livingstone. *Then*, a medical missionary was defined by an African native as: 'One who prays over you before killing you!' *Now*, though he may still pray, there is little evidence to suggest that he is any more lethal than his colleagues working in the towns. *Then*, a medical missionary was pictured trekking his way through the bush in search of patients, a pith helmet on his head, a satchel over his shoulder containing a few instruments for amputating limbs and similar emergencies, together with a few simple drugs, and in his hand a Bible! *Now*, he is seen working in a hospital that will bear comparison with a Provincial or State hospital of similar size with a full complement of modern equipment and drugs, and his patients come in to him from the district. It is true that some mission hospitals have outstation clinics in relatively primitive surroundings, but no more primitive than a country district surgeon has to endure. Perhaps a further reason for the small number of doctors willing to work in mission hospitals is the volume of work to be done and the wide range of medicine that must be undertaken without recourse to specialist guidance.

Why should a doctor in this present day and age wish to bury himself in the 'Bundu'? Perhaps the late Dr. Albert Schweitzer was speaking for many more than himself when he described the effect of the parable of Dives and Lazarus on his thinking. He saw the Western world with its wealth of medical science as Dives, and the native African without any such riches, yet in dire need of them, as Lazarus at his gate; he turned and did all he could, as many others have done both before and since.

There is no shortage of work to be done. For example, the newly-formed interdenominational Transkei and Ciskei Association of Mission Hospitals comprises 27 hospitals with over 3,000 beds between them. This group of hospitals admits more than 40,000 patients and treats well over 300,000 outpatients a year. Nearly all the hospitals now have adequate X-ray units, and between them over 30,000 X-rays a year are taken. Likewise, they have satisfactory operating theatres in which are performed about 8,000 operations a year, and some have fully-equipped pathological laboratories. The majority of these hospitals also fulfil the important task of training Bantu auxiliary nurses, while two of them undertake the full training of registered nurses. More than 150 enrolled auxiliary nurses pass their South African Nursing Council examinations each year from this group. Yet there is only a handful of doctors doing this work—about 35 full-time and 15 part-time. Some of the hospitals get help from the local general practitioners, but many of the others have to work in relative isolation from their colleagues.

Until such time as there are sufficient South African doctors and senior nursing personnel of both races coming forward to carry on this important work, reliance must continue to be placed in the mission hospitals, especially for the hospital work in the Bantu homelands. It would seem wise therefore for the Government to continue to expand and develop the existing mission hospital services until such time as there is adequate bed coverage for the population at risk, and for the country to be thankful that there are dedicated doctors and nurses who are ready to devote their energies to this work. Undoubtedly more are needed, particularly from this country: the need is not only for general practitioners—consultants would be of immense benefit particularly in such specialties as pathology, surgery and orthopaedics, not only to practise within their specialty, but also to teach the present staff how to improve their techniques and train technicians. Locums to cover much-needed holidays and study leave are urgently required, if only for two or three weeks, and increased facilities for suitable postgraduate study. An important step in the right direction has been taken recently in

Pretoria, where a most successful week's refresher course has been held for medical missionaries.

We welcome this renewed interest in mission hospitals and hope that it will extend. The missions themselves are always glad to receive visitors, and many of the hospitals have facilities for students or interns should they wish to spend some time looking more closely at this field of medical activity. Medical visitors need never feel that they are likely to be in the way or unwelcome, for one of the great needs of the medical missionary is for increased fellowship with other medical men. Of course, visitors may find themselves asked to give an emergency anaesthetic or assist at a caesarean section, but this is a risk that has to be taken!

MEDIESE WERK IN DIE BUITEWYKE VAN ONS LAND

Die sogenaamde wanverdeling van mediese praktisyns tussen die stedelike en plattelandse gebiede van ons land is 'n onderwerp wat gedurende die laaste aantal jare op haas alle belangrike vlakke bespreek is—deur die Suid-Afrikaanse Geneeskundige en Tandheelkundige Raad, deur liggame en takke van die Mediese Vereniging, deur verteenwoordigers van die Universiteite, deur enkelinge in die mediese professie en ook deur lede van die algemene publiek en lede van die provinsiale en staatsregerings. Nogtans is dit 'n probleem wat by die dag ernstiger afmetings aanneem.

Daar moet dadelik aangetoon word dat die probleem van die wanverspreiding van geneeshere 'n geweldige groot en ingewikkelde probleem is met baie vertakkinge. Dit is dus nie moontlik om dit hier in al sy fasette te bespreek nie. Wat ons egter wil doen, is om die aandag van ons lesers te vestig op een bepaalde aspek van dié probleem, n.l. die omvang en belang van die werk van sendinggeneeshere.

Toe ons vroeër in die jaar die voorgenome Nagraadse Kursus aangekondig het wat deur die Universiteit van Pretoria vir mediese sendelinge beplan was (die kursus is sedertdien met groot welslae gehou), het ons gewys op die neiging wat daar is vir geneeshere om na die omgewings van die grotere sentrums te gaan omdat die werksomstandighede daar beter is en ook omrede van die bykomstige sosiale en kulturele voordele van die lewe in en om die stedelike gebiede.

Ons het verder aangetoon dat die gevolg van hierdie neiging is dat die plattelandse gebiede, medies gesproke, gaandeweg almeer ontvolk word, en dat dit veral die verafgeleë Bantoegebiede is wat hierdeur getref word. Alhoewel daar, wat die globale bevolkingsyfer betref, 'n gunstige vergelyking is tussen ons land en die meeste van die Westerse lande wat betref die verhouding van geneeshere tot die aantal lede van die bevolking, is die toestand van sake anders in die Bantoetuislande. Daar is betreklik gesproke min geneeshere in die private praktyk in dié gebiede; die grootste deel van die gesondheidsdienste daar word behantig deur geneeshere in provinsiale hospitale en geneeshere wat in die sendinghospitale werk. Eintlik is dit die mediese sendelinge wat in die verskillende Bantoegebiede op die ‚front' staan.

Hoe groot die omvang van die werk is wat deur die mediese sendelinge gedoen word, sal dadelik opval as ons kennis neem van die feit dat die aantal beddens wat deur die sendinghospitale verskaf word volgens skatting nagenoeg een kwart beslaan van alle beskikbare hospitaalbeddens in die land. Aan die ander kant kan ons 'n idee vorm van hoe groot die mate is waarin ons in gebreke bly om hierdie verantwoordelikheid self te dra, as ons daaraan dink dat nagenoeg 75% van die dokters wat in die sendinghospitale orals oor ons land werk, nie Suid-Afrikaners is nie. Ons laat dus 'n belangrike sektor van die gesondheidswerk in ons eie land oor aan vreemdelinge.

Ons kan nie anders nie as om diep dankbaar te voel teenoor diegene wat die werk op hierdie manier vir en ten behoewe van ons onderneem nie. Maar ons kan nie daarmee tevrede wees nie. Beskaafde mense moet hul eie verantwoordelikhede nakom, sover as wat dit moontlik is. Daarom sal ons 'n formule moet vind waarvolgens ons meer van ons jongere geneeshere kan beweeg om mediese sendingwerk te onderneem. En veral sal die bewussyn by ons nie-Blanke kollegas meer en meer moet posvat dat dit ook en veral húlle verantwoordelikheid is om te help om die gesondheidspeil van ons Bantoebevolking te verhoog.

Miskien sal dit help as ons allerweë kan saamspan om 'n nuwe beeld van die sendinggeneesheer op te bou. Hy is nie meer net 'n soort eerstehulpwerker wat in die oerwoud rondtrek nie. Hy is heel dikwels 'n trotse klinikus wat 'n groot taak goed verrig. Trouens, daar is nie minder nie as 85 sendinghospitale in ons land, en sommige van hulle is groot, moderne inrigtings met honderde bedde. Die nuutgevormde Vereniging van Sendinghospitale in die Transkei en die Ciskei sluit, byvoorbeeld, 27 hospitale in met altesaam oor die 3,000 bedde. Hierdie groep hospitale laat jaarliks meer as 40,000 pasiënte toe en behandel meer as 300,000 buitepasiënte.

In die eerste instansie moet ons dus die beeld van 'n belangrike, moderne diensgebied opbou wat betref die sendinghospitale en ons moet soveel Blanke en nie-Blanke geneeshere as wat daartoe beweeg kan word, aanmoedig om dié werk vir 'n korter of langer tydperk te onderneem.

In die tweede plek moet ons egter probeer om waar moontlik self iets aan die saak te doen. Ons is byvoorbeeld bekend met kollegas wat gereeld hulle dienste as locums aanbied in dié gebiede; ook is daar spesialis-kollegas wat gereeld vir 'n paar weke na 'n sendinghospitaal gaan en dan 'n atmosfeer van opknappingswerk rondom hulle skep. Die aantal kollegas wat hierdie soort vrywillige dienste onderneem, is egter maar klein; maar hulle moet sover moontlik aangemoedig word om daarmee voort te gaan. Ook moet soveel andere as wat maar kan, probeer om hul voorbeeld na te volg. En derdens is daar die mooi voorbeeld van die Universiteit van Pretoria wat 'n nagraadse kursus vir mediese sendelinge gereël het.

Op hierdie genoemde, en nog op baie ander ongenoemde maniere, moet ons voortgaan om die agterstand wat daar is te probeer inhaal. Ons moet erkenning betoon vir die groot werk wat daar gedoen word deur ons eie mense, maar veral ook deur werkers van elders. Die stem uit Masedonieë klink nog altyd helder in ons ore: kom oor en help ons. Laat ons nie in hierdie opsig geweeg word en te lig bevind word nie.