Opinion Piece, Dr Karl Le Roux, Chairperson RuDASA, 17 June 2010

At the end of last year, I was privileged - in my capacity as chairperson of the Rural Doctors' Association of South Africa (RuDASA) - to be part of a panel talking about "rural success stories" on the After-Eight Debate with Time Modise. He quoted Clem Sunter, who feels that there are many South Africans who are doing remarkable, world-leading work in all kinds of fields, but who do not get celebrated by us as country, nor consulted for their expertise as we grapple with the many challenges we face as a country. And so, as Modise was presenting his last show of the year, he felt that he wanted do exactly that – to recognize people who have done incredible work in the rural parts of South Africa.

As I prepared for the debate, emailed and phoned around and spoke to people in the know, it was easy to find the stories of many remarkable, dedicated visionary doctors: black and white, English/Zulu/ Xhosa/Afrikaans/ Sotho speaking, South Africans and foreigners– Dutch/Nigerian/Welsh/Belgian/ Cuban/Congolese/ Indian, all who were working way beyond the call of duty, doing exceptional work and delivering healthcare to the poorest of the poor against the odds of a broken public health care system. It is true that many of these extraordinary doctors have not received any recognition for the work they have done and so it was great that Modise was dedicating a whole hour on national radio to try do this.

But as I put the phone down after the "debate", a thought struck me – why are we relying on exceptional people to keep the rural health system afloat? Would it not be much wiser to design a health system that draws the "ordinary" medical graduate (still competent, hardworking and committed to his/her patients – but who isn't a masochist, missionary or madman) to spend some time in rural medicine? If we continue to rely on exceptional doctors to man our rural hospitals they are always going to be understaffed (even in a country like South Africa, which is blessed with an remarkably high percentage of extra-ordinary doctors!)

This thought has come to mind again as the Occupational Specific Dispensation (OSD) negotiations for doctors re-opened last month, after the first round of OSD for doctors last year largely bypassed career medical officers, who form the backbone (and, in fact the muscles and skin too) of professional medical care at rural hospitals. The original OSD improved the situation significantly for interns, registrars and specialists (who are mostly based in cities), but failed to provide a career path for non-specialists who run hospitals in rural areas. To illustrate: a Community Service Doctor just out of internship, will earn only R10 000 less than the Principal Medical Officer 8 years their senior who supervises them and has significant responsibility for patients, administration, training nurses and oversight and planning of clinical services. (Incidentally, OSD for Allied Health professions has been even more dismal disappointment.)

This is not going to draw or retain your "ordinary" doctor to work in rural medicine – instead OSD as it stands is pushing even committed rural doctors to specialize in the cities if they want to further their career and/or improve their financial situation.

The glimmer of hope RuDASA held onto, that the second round of OSD negotiations (specifically aimed at reviewing the situation of career medical officers) would address such anomalies was quickly extinguished by the government's offer (paltry increases of 1.5 to 4%) and the unwillingness of the largest unions in the bargaining chamber like Nehawu and Cosatu to contest it.

The offer (and it's apparent acceptance by the unions) is foolish, shortsighted and profoundly anti-rural. Of course, money isn't everything and decent salaries and a reasonable career path alone are not going to solve the crisis in the recruitment of rural (and other public sector) doctors. Working conditions, poor management, stock-outs of drugs and poor accommodation options all need to be addressed if we want to keep "ordinary" doctors in the pubic sector.

Yet the unwillingness of the government to offer the doctors who form the backbone of the rural public health system decent increases (which in the scheme of things is fairly easy to do), has lowered morale and created the impression that the government doesn't have the stomach to deal with the bigger systems' challenges that are crippling our public health system.

Despite all this, the exceptional doctors I mentioned earlier will probably stay on in their rural hospitals and clinics, where they'll continue to work against the odds, but now with even less hope for reinforcements. Yet, unlike interns, who were rewarded by government for striking with 50% increases in their salaries, these are the kind of doctors who would never think of striking against their patients for money. And so, they will continue doing remarkable work, propping up a broken public health system (ironically making things look better to health officials than they really are), some of them burning out in time, others continuing heroically without expecting or receiving any accolades.

Ultimately, however, the failure to attract larger numbers of "ordinary" doctors to work in rural hospitals to join the extra-ordinary ones already there, will mean that voiceless rural poor will continue to receive sub-standard healthcare, and children and women will continue to die unnecessarily in the same country that can wow the world with remarkable, beautiful stadiums built for a month of soccer.

The group of doctors who, in RuDASA's opinion, should have been the number one priority of the Occupational Specific Dispensation has been passed over completely. Go figure.

Note to the editors:
Contact details: Please communicate with karlleroux@gmail.com and cc to Marije@rhap.org.za as Karl may not check his emails regularly during working hours. Cell Marije: 0741063800, Karl: 0728589751, 0475750322