Stories I Never Wrote – 2

Dr Keith Thomson

Edendale Hospital,
Pietermaritzburg, RSA
Dec 1982 - Jan 1984

Introduction

1983 was 5 years after PW Botha was elected president, 6 years after Steve Biko, the leader of the black Conscious Movement, died in police custody in Port Elizabeth and 7 years before the end of Nelson Mandela's '*LONG WALK to FREEDOM*'. South Africa was, and still is, a fascinating country with incredible contrasts of culture, wealth and poverty. Sadly high levels of HIV/AIDS are now having a major impact on the provision of healthcare.

After being an anaesthetic registrar at St. Bartholomew's Hospital in London and an obstetric SHO at Hillingdon, I returned to anaesthetics as a Senior Medical Officer (SR equivalent) at Edendale Hospital situated about 5 miles from Pietermaritzburg. It was a tertiary referral hospital for the black population of Kwa Zulu, Natal. I had turned down an offer from King Edwards in Durban to work with Prof. John Downing, preferring to be a bigger fish in a smaller pond. I persuaded Nick, a Barts colleague, to fill the Durban post.

Pietermaritzburg, named after the famous Voortrekkers Piet Retief and Paul Maritz who arrived in Natal in 1837, is often referred to as the *'sleepy hollow*'. Situated an hour inland from the busy metropolis of Durban, it was an easy drive to the beautiful beaches North and South of Durban and the spectacular Drakensberg resort hotels like Sani Pass, Cathedral Peak and Cavern Berg.

Arrival

I arrived a couple of weeks before my pregnant wife Fiona and fifteen-month-old daughter Rebecca. This gave me time to purchase a second hand car and some basic furniture for our flat. Initially I stayed with the late Jock Findlay, the head of the Anaesthetic Department. He was an amazing character and very accident prone – the second day I was there, while practising his golf swing in his garden, the ball hit a riser on a step and rebounded cutting his eyebrow deep enough to require suturing. During a previous hospital visit after he had fallen off his horse and broken some ribs, a young nurse suddenly noticed smoke coming out of his chest drain and called the emergency team because Dr. Findlay was on fire. He was, in fact, smoking a cigarette under the bedclothes and had a broncho-pleural fistula!

As a family we moved into a ground floor flat in the doctors' residence in Alexandra Road, which was about five miles drive from the hospital. The highlight of our visit to RSA was the birth of our son Duncan in August 1983 at Grey's Hospital which catered only for the local white population. 1983 was still in the apartheid era: everything was separate including townships, bank/ post office queues and hospitals.

The Hospital

Fig 1. Edendale sign

Edendale was a 1000 bed hospital for the black population of Kwa Zulu/Natal, many of the referrals came from mission hospitals. It was a fascinating place with many conflicting social issues, particularly among the staff: for example enmity between ANC and Inkatha supporters and white v black tensions manifest by separate doctors' messes.

Fig 2. Edendale Hospital

Just before I arrived a very popular black house officer had been killed in a SADF raid on an alleged ANC camp in Lesotho. A charming black junior doctor from Swaziland was beaten up by black colleagues for continuing to use '*Easy Riders*' the white doctors' mess after several black colleagues had been expelled for refusing to pay their bar bills.

The junior medical staff were a mixture of white South Africans, Australians and British working alongside black South Africans who were predominantly Zulu with a few Xhosa and other tribes. The white doctors' salary from the Ministry of Health in Pretoria was guaranteed but

the black doctors and nurses were paid, sometimes intermittently, from the Zulu capital, Ulundi which was North of Durban.

My first day in Theatres

The hospital had seven operating theatres in the main block. One of these was reserved for Caesarean sections and another for trauma. I was the senior registrar in the department of anaesthesia with four consultants and eight medical officers (SHOs), with varying degrees of experience who worked a 1 in 4 on call rota often starting after only about two weeks experience. Three of the MOs whom I trained have recently worked as consultant anaesthetic locums for the *Rapid Sequence Agency* (020 7730 4693/ rapidsequence@btinternet.com) at the North Hampshire Hospital, 21 years after we first met. It is gratifying to see that all of them are superbly confident practitioners. The highlights of my first day were initially helping Australian Scottie Wells who was struggling with a Caesarean delivery for twins. He had only one tracheal tube and both twins needed intubating. At the same time the mother was bleeding and to complete the scenario a fly did a terminal nosedive into the operating site!

Later on the same day I was asked to come quickly to the obstetric theatre again by anaesthetic nurse Mary Dlamini because a friend of hers was having a Caesarean section. I asked what the problem was and she said Dr Jock was the anaesthetist. This apparently was enough explanation. Although 'Jock' was reasonable at local anaesthetic techniques his GA's had a reputation of being somewhat risky in these pre-pulse oximetry and capnography days. He was very enthusiastic about epidurals but I had to resuscitate at least three patients with very high blocks during the year one of which did not have an intravenous infusion.

Daily Routine

For me this usually started with the ITU Ward Round run by Surgeon Henri Pickard. The majority of the patients were post-trauma, mostly stabbings or bullet wounds. Deaths were relatively frequent; sadly I had one patient with broken ribs who collapsed and was not resuscitated after a thoracic epidural which I had inserted was topped up. Nurses at night often used to sleep in the store cupboard however busy the unit was. Once I saw a hysterical mother in the PICU whose baby in an incubator had rigor mortis at 8am, regular observations had been filled for the whole night on the chart!

Equipment

The seven theatres had reasonable anaesthetic machines with Nuffield Penlon 200 ventilators and a variety of circuits including Bains, Humphrey ADE and with a soda lime adsorber. Monitoring consisted of NIBP and ECG plus the anaesthetic hand. Anaesthetic drugs included thiopentone, etomidate, ketamine, althesin, halothane, suxamethonium, pancuronium, alcuronium, fentanyl, pethidine and morphine.

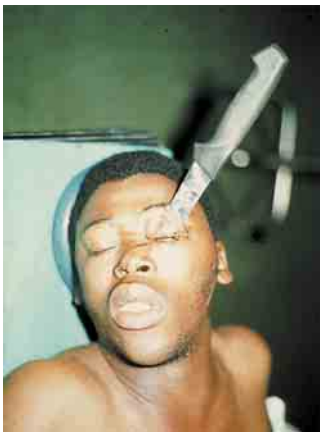

Fig 3. Knife in left eye socket

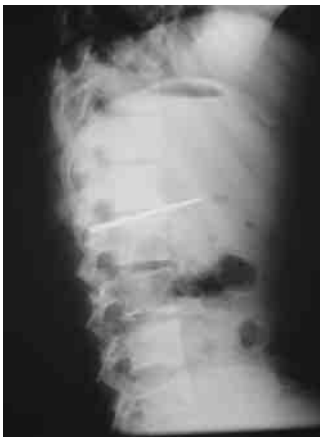

Fig 4. Broken blade in back

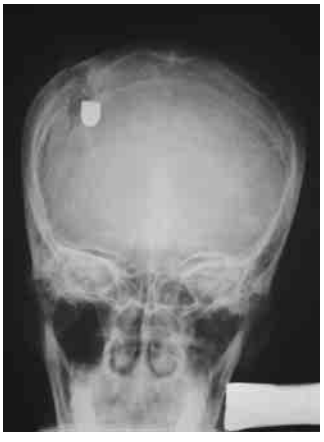

Fig 5 Bullet in head

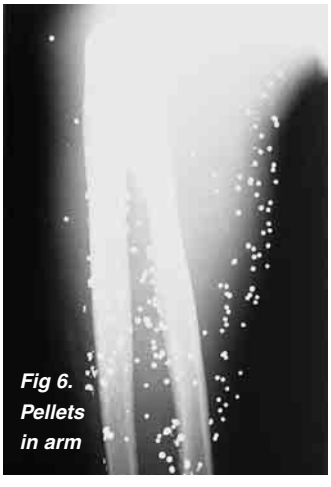

Fig 6. Pellets in arm

Fig 7. Bitten scrotum

Each theatre had an anaesthetic nurse, but there was a wide range of abilities particularly in response to urgent problems. Elective cases included all mainline specialities like general surgery, orthopaedics, ENT, plastics, ophthalmology and gynaecology.

Trauma

This was mainly stabbings (Figs 3, 4) and shootings (Figs 5, 6) although Fig 7 was apparently caused by a female bite! Fig 8 illustrates a remarkable case of a man who had his face sawn through by a band saw (did he fall or was he pushed?) – he came into the casualty department talking and had to have an urgent trachesotomy under LA.

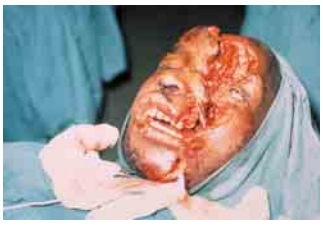

Fig 8. Sawn face

Fig 9. Post-op sawn face

After 4 hours of plastic surgery the result was good (Fig 9).

The most challenging and urgent cases were stabbed hearts which seemed to occur more frequently after pay day at the end of the month. The aiming mark was usually the medial edge of the left breast pocket of the shirt. The patient usually survived if they arrived in theatre with an output, the problem was normally pericardial tamponade, the management of which was not aspiration but urgent sternotomy and removal of the blood in the pericardium.

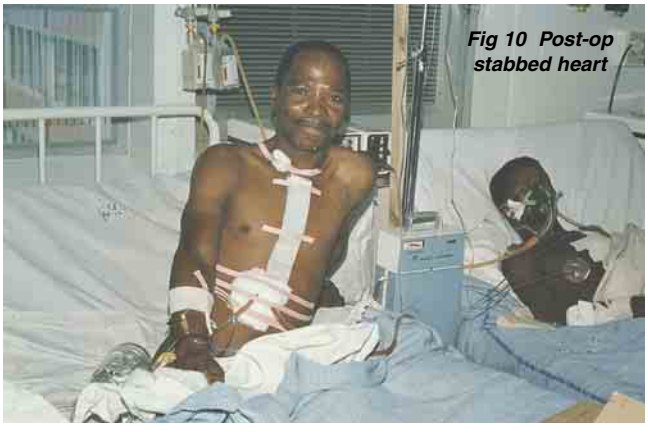

Fig 10 Post-op stabbed heart

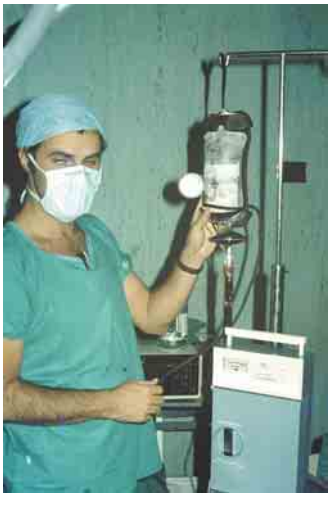

Fig 11. Fenwal blood warmer

It is remarkable how quickly the young Zulus recovered (Fig 10). I anaesthetised one man for his second stabbed heart within three months and a woman who was at least seven months pregnant.

Sadly one patient died during a blood transfusion because the thermostat on the *Fenwal* blood warmer had jammed and he was given overheated blood (Fig 11).

Tumours/Incidents

During my year at Edendale I saw some remarkable malignant growths including in a baby's eye (Fig 12), a nine year old child's femur (Fig 13) and on a woman's buttock (Fig 14).

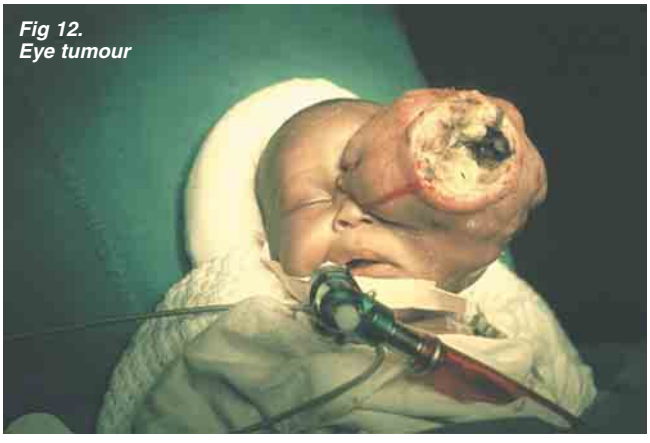

Fig 12. Eye tumour

Fig 13. Osteosarcoma of femur

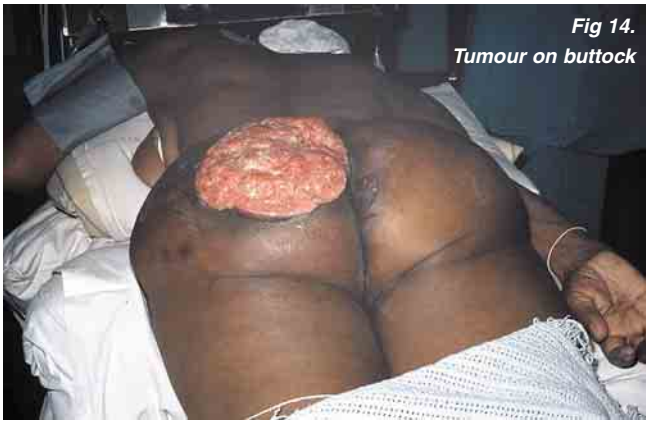

Fig 14. Tumour on buttock

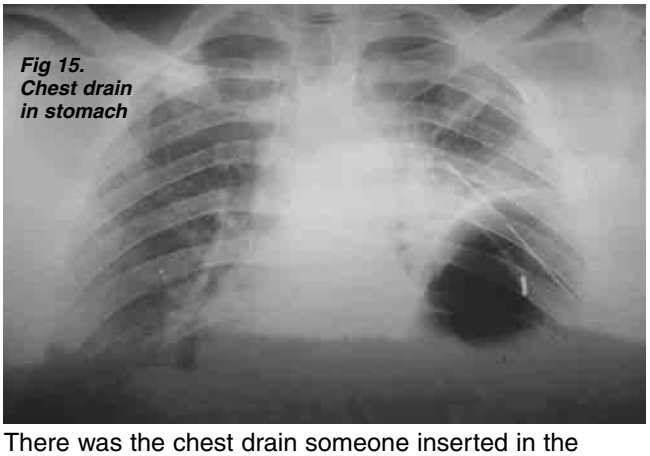

Fig 15. Chest drain in stomach

There was the chest drain someone inserted in the stomach (Fig 15) because they did not realise the patient had a ruptured diaphragm, an electric shock

I received from the operating table because of a frayed diathermy lead, the disconnected inner Bain's circuit tube leading to very high CO_2 (remember 'Adam's Test').

The patient who walked into casualty with a chest drain which had been in for over two years. The patient whom a recently appointed surgeon discovered had been 'dossing' on his ward at night and going to work during the day for the past two years! The 20-year-old having her 4th Caesarean who when it was suggested might have a tubal ligation said '*No, I might get married some day*'. The 'Golden Ovary' award at a mess dinner was given to an Australian obstetric MO who attempted to perform a Caesarean section on a large woman with abdominal pain who turned out not to be pregnant!

Maternity

There were 10,000 deliveries a year at the hospital, with more than 20% Caesarean section rate. Every day there were at least seven Caesareans under general or spinal anaesthesia (we made our own heavy bupivacaine with a mixture of 4.5mls of isobaric 0.5% plus 0.5mls of 50% dextrose and then gave 2.5 to 3mls of the mixture).

The large number of general anaesthetics for Caesareans were useful for training the new SHOs in basic anaesthesia, airway management and rapid sequence induction and in fact it was usually the first anaesthetic they performed on their own. Emergency sections used to have to wait their turn: infusions of beta 2 agonist were used to decrease contractions and for a prolapsed cord the bladder was filled with saline to hold back the presenting part.

On my return to the UK I maintained my enthusiasm for spinal anaesthesia and it has now been my routine technique for Caesarean section for over 20 years. It took some years for the rest of the obstetric anaesthesia fraternity in the UK to follow my lead!

On the Labour Ward there was no epidural service. I occasionally used to perform one or two, particularly on women who were likely to need a Caesarean section. The Labour Ward was usually mayhem with screaming women and midwives yelling "*kanula, kanula*" ('*push, push*' in Zulu), this was proceeded by pinching of thighs and slapping of faces to promote this idea!

Eclamptic fits were relatively common. There were about three a week, some of the obstetricians claimed they could actually sense eclamptic conditions – possibly a combination of humidity and atmospheric pressure. Even though this was over a decade before the 'Collaborative Eclampsia Trial,' magnesium sulphate was used as the initial choice of anticonvulsant.

Sadly there were several teenagers who died as a result of attempted illegal abortion with intrauterine *Dettol*, this resulted in gangrene of the uterus, severe DIC and death.

Fig 16. Sheep braai with Wally

Social

We lived in a ground floor flat in the doctors' residence in Alexandra Road. The other families were British, South African and Australian, many with young children. It was a very social time with frequent braais and parties. The most memorable of which involved two sheep being spit roasted, turned and basted for several hours by Wally (Fig 16), to celebrate the joint birthdays of surgeon Henri Pickard and myself at his home in Hilton.

Most Thursdays I used to participate in '*Herman's Delight*' which was a timed four mile run around the local park. The only occasion in the whole year I managed to break 25 min was the day my son was born when I did 24min 16 sec. If one wanted a longer distance race there was always the 90 km Comrades Marathon (double marathon + 4 miles!) from Durban to Pietermartizburg. In 1983 this was again won by the remarkable South African athlete Bruce Fordyce but Edendale neurosurgeon, Errol Ackermann also won a gold medal by coming 8th, a great achievement. The hospital medical team put up over 200 intravenous infusions in finishers and non-finishers struggling to achieve a time of less than 10½ hours which was required for a medal.

The hospital social focus was the doctors' mess called Easy Riders which had a bar, squash court, tennis court and a swimming pool. One Sunday while friend Nick and I were playing tennis, our agitated partners arrived at 11am to inform us that there was a dead black male body at the bottom of the swimming pool (Fig 17).

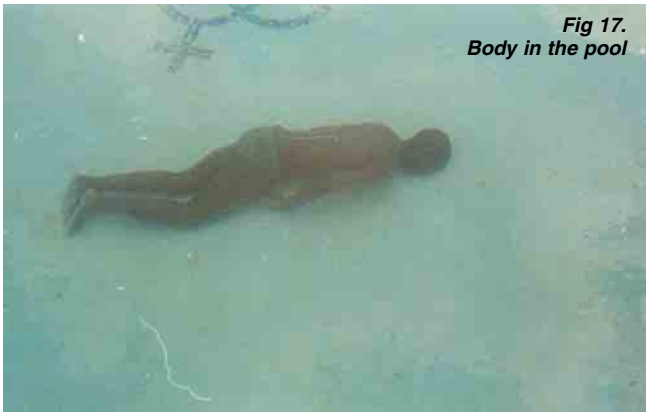

Fig 17. Body in the pool

I had great difficulty trying to get the switchboard operator to take this seriously! A subsequent post mortem showed a high blood alcohol level, a left frontal abrasion and death by drowning.

Easy Riders was also the venue for the annual hospital ball at which the 'rat race' took place. Heavy betting was placed on several different coloured rats and the profits went to a local children's charity.

Historical Interests

I developed a keen interest in Bushman rock art and Zulu history. One weekend I visited *Ndadema* gorge near Cathedral Peak. A group of us back packed into the area and saw hundreds of remarkable 200-year-old rock paintings, in *Eland* and other caves (Fig 18).

Fig 18.
Bushman painting

The expedition was lead by neurosurgical registrar Salti Du Randt, who was 'famous' for shooting his wife's dog in the head after it ate his prize proteas, unfortunately it did not die and she called in the RSA equivalent of the RSPCA!

Fig 19.
Hill over Isandhlwana

Another weekend I travelled round battle sites in Zululand visiting Isandlwana, (Fig 19) (in 1879 the British central column armed with rifles was massacred to a man by Zulus armed only with spears), Rorke's Drift (Fig 20) (Michael Caine starred in the film '*Zulu*' about the heroic defence of the mission station the day after Isandhlwana. Chief Buthelezi, the present Inkatha leader, played Cetsewayo, the Zulu king) and Blood River in 1838 where the Voortrekkers lead by Andries Pretorius, against overwhelming odds, defeated Dingaan's impis without a single Boer death.
I remember reading the accounts of these in an excellent book entitled '*Washing of the Spears*' which chronicled the rise and fall of the Zulu nation in the 19th Century.

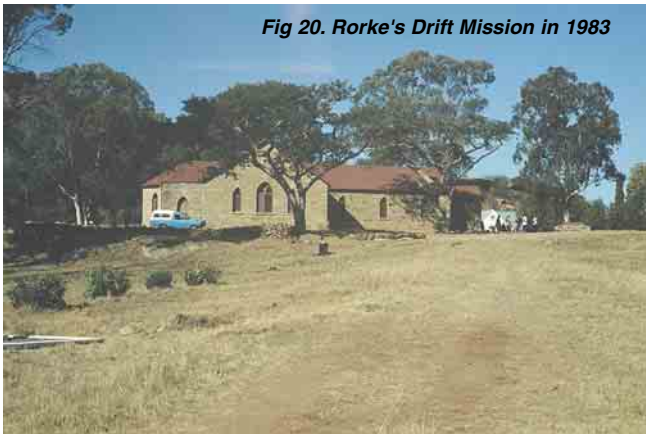

Fig 20. Rorke's Drift Mission in 1983

It was founded by King Shaka whose name derives from ushaka, a beetle reputed to give women menstrual irregularities. Shaka's dad got rather too friendly with a beautiful young maiden called Nandi. When representatives from her kraal came some months later to say that her periods had ceased he said it must just be ushaka. A few months later they returned with a bouncing baby and said here is your uShaka!

He became a remarkable general who won some extraordinary victories against overwhelming odds. He redesigned the Zulu spear to be a weapon for stabbing rather than hurling at the enemy. He also toughened his warriors' feet by compelling them, on pain of death, to walk barefoot on thorn bushes, so they could march/run up to 50 miles per day. He invented an attacking formation using initially the central body or 'chest' and then the encircling 'horns' coming from both sides.

Final Comments

All in all we spent a remarkable year in South Africa. The experience I gained of many different aspects of anaesthesia was fantastic. I personally performed 1049 anaesthetic procedures including over 106 spinals and 30 brachial plexus blocks. I anaesthetised 62 children of one year old or younger, 19 of whom were less than one month.

Fig 21.
Choanal atresia

Particular cases I remember were choanal atresia (Fig 21), a bronchoscopy for a metal 'rawl plug' down the right main bronchus in an eight-year-old (Fig 22), a ranula (Fig 23), exomphalos (Fig 24), a mega urethra

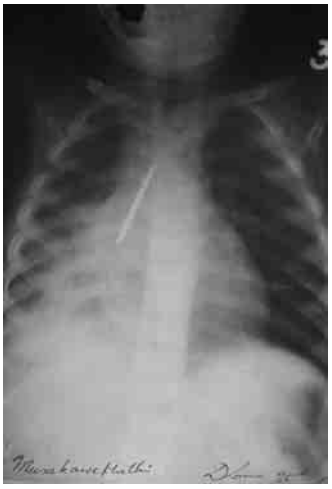

Fig 22.
'Rawl plug' down R. main bronchus

(Fig 25) and a case of neonatal tetanus possibly caused by a local custom of sealing the umbilical cord with cow dung after delivery (Fig 26). A copy of the book *Neonatal Anaesthesia* by Hatch and Sumner on the anaesthetic machine was essential equipment!

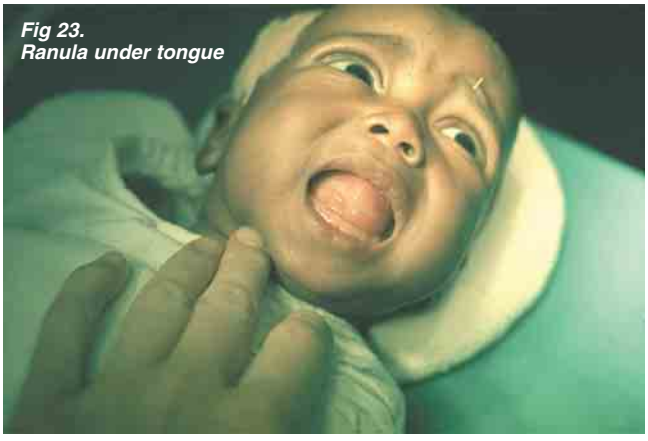

Fig 23.
Ranula under tongue

Fig 24
Exomphalous

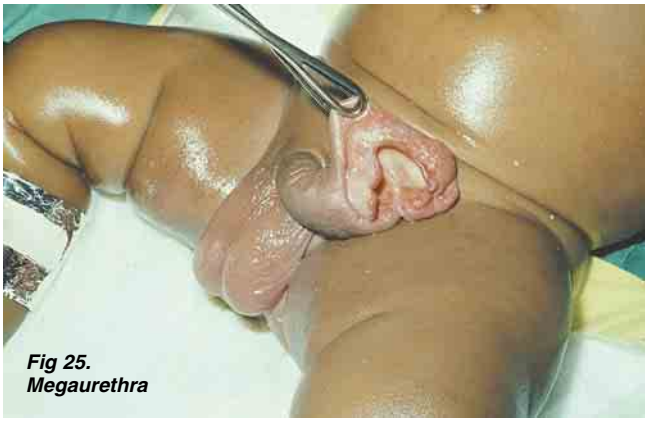

Fig 25.
Megaurethra

Fig 26.
Neonatal tetanus

As a family we had some great weekends in the children friendly beautiful Drakensberg resort hotels; we also drove the 'Garden Route' from East London stopping to ride ostriches in Oouteshorn and staying a night at a famous watering hole, the Lord Milner in Matjiesfontein before arriving in Capetown, which must surely be one of the World's most beautiful cities.

We made many medical friends, some of whom we are still in contact with even after over twenty years. In 2003 we had the pleasure of meeting Canadian Ron Jarvis, a GP, and his family in Vancouver, while Kevin Camden-Smith is currently doing my locum while I am on sick leave.

Epilogue

After we left, violence increased between ANC and Inkatha supporters. There was a reported incident in 1984 during which the ITU was machine gunned during the 'rescue' of an ANC activist, several nurses sadly were killed.

Henri Pickard, the brusque but excellent Africaans Surgeon died of mesthelioma a few years later, Prof Richard Johanson, a British obstetrician who was an MO in 1983 died of melanoma in 2001 and neurosurgeon Errol Ackermann died in Pietermaritzburg in 2004 under mysterious circumstances. It is gratifying to hear that Jenny King has continued to run the department for the past 20 years and that Edendale now enjoys an excellent reputation in South Africa for training in anaesthesia.

Postscript

By ***Dr Charlotte Johanson*** *(Howell),*
Consultant Anaesthetist,
North Staffordshire Hospitals Trust

I have some very good memories of my time at Edendale in 1983. One of my favourites is when I was anaesthetising for a Caesarean section when the inevitable stabbed heart case was wheeled in through the door fully dressed including boots.

The third theatre had been emptied as usual so I was looking for and setting up an anaesthetic machine leaving the other anaesthetist in the laparotomy theatre to manage both cases. The housemen had wheeled the patient up to theatre but as one of them was very drunk, he tripped as he moved the man across onto the table, fortunately not dropping him but both litre bottles of saline crashed to the floor. At this point there was a moaning patient, surgeons running to get scrubbed, nurses running to get instruments, 2 litres of saline on the floor, a drunk houseman and then a cat walked into theatre! Where this cat came from I have no idea but we then had nurses chasing the cat to add to the fun. I never saw it again but the patient survived his sternotomy to be wheeled into the ITU with his boots on.

Another fond memory was of the night calls. I was second on and had been busy but we only had one bed in theatre. There were various other options for sleeping as you will remember which included going up to the labour wards and sneaking into one of their doctors beds! However on this occasion I had found a spare theatre trolley and wheeled it into the room where they kept the clean instruments. I found some green towels and pulled them over me including my head probably because there was a mosquito about. In the morning I was woken by the wonderful singing of the nursing staff, then some nurses must have come into the room because I could hear muttered voices. After a few minutes I sat up to be greeted by horrified shrieks. They had thought I was a dead body from theatre that had been left from the night! To see me coming back to life was a bit of a shock. You would need to understand the way the place worked to appreciate that dead bodies might well be left about, a bit like the one in the swimming pool. Richard often remembered asking the nurses to get the person out of the gynae clinic doctors' toilet, as he himself was ill and kept having to run back to the doctors mess to use the loo. Needless to say the body was dead by the time it was removed!

I learnt such a lot during my time there, and for that matter in all my other attachments abroad where using your initiative was a major part of practice.