A doctor from an Eastern Cape hospital reports

I am working as a doctor in a black hospital in the Eastern Cape. The hospital serves a very wide area and, like most black hospitals, we are under immense pressure for beds. This, and the pressure from police and hospital authorities, made my position very difficult when it came to treating the victims of the recent unrest in the Eastern Cape.

Call for help

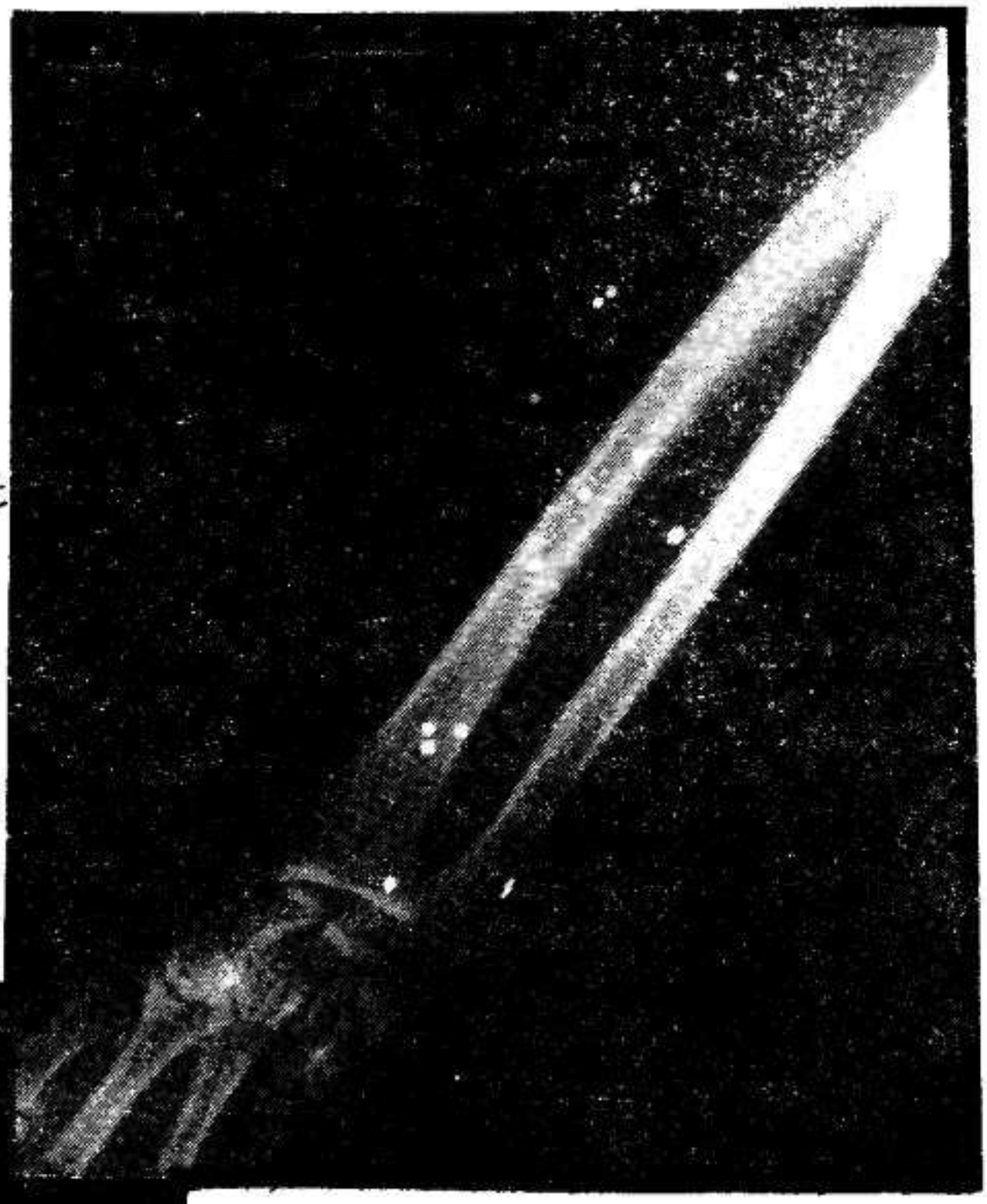
My involvement in the treatment of unrest victims began on the evening of the 21st March. I was working on the fourth and fifth floors of the hospital. The ground, first, and second floors had already been taken over by the police.

I and some of the other doctors working with me received a call for help from members of the Black Sash working at the Aid Office in Uitenhage. I and a colleague from the hospital, went to the Aid Office which was on the premises of the Catholic church in Uitenhage. A police casspir was parked directly opposite the church.

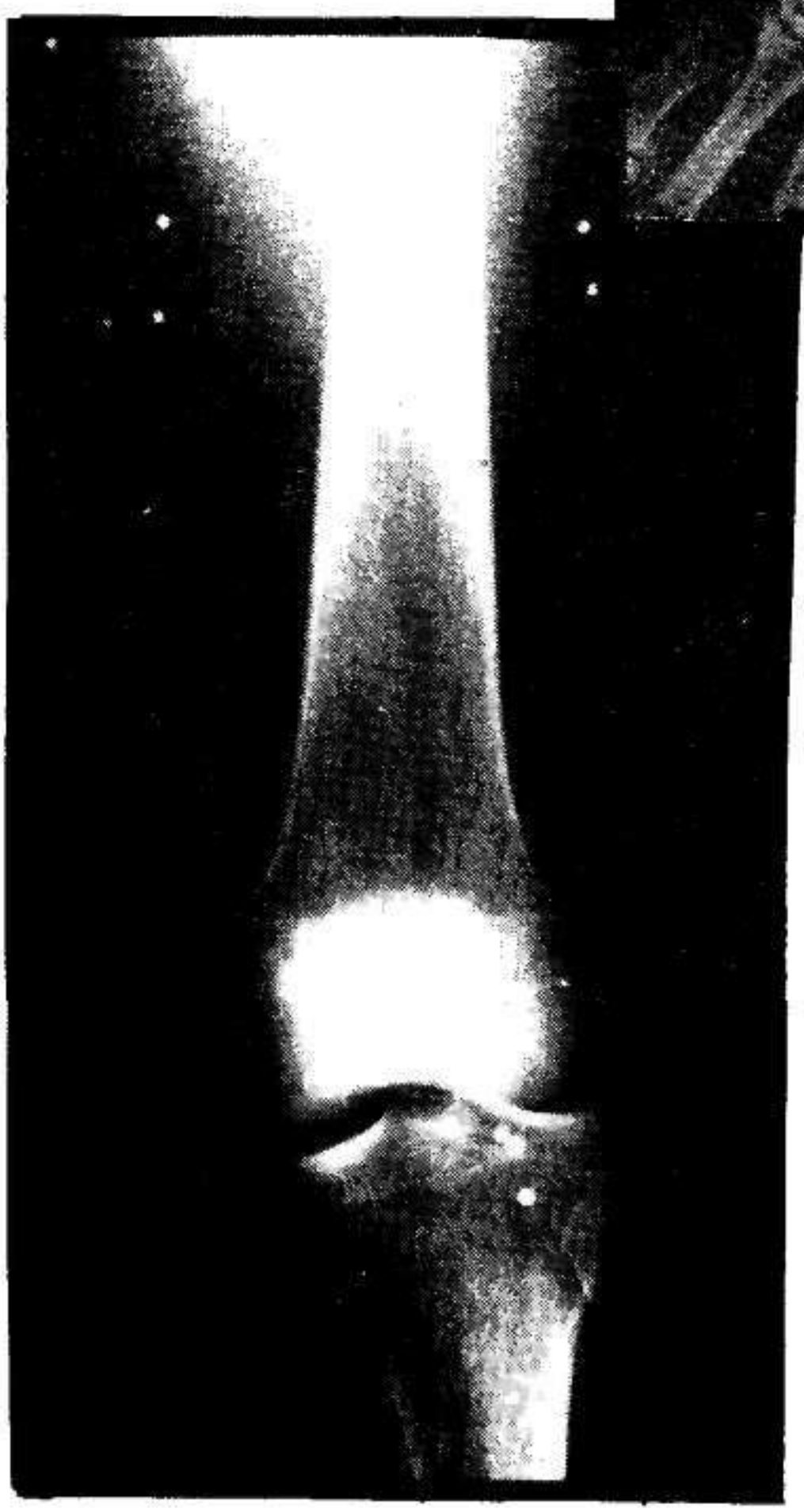
Initial treatment of unrest victims

When we went into the Aid Office, we saw ten to twelve young men with multiple bullet wounds. Most of these young men needed to be examined in hospital, as they had bullet injuries in the areas of the chest, diaphragm and hip. All the patients presented surgical problems. They needed X-rays to find out exactly where the bullets were lodged, and possibly required removal of the bullets.

The Aid Office was just a room, and we examined the patients in the kitchen. We did not have any equipment. The only thing we had with us were penicillin and syringes. So all we could do for these people was to give injections of penicillin in order to prevent secondary infection.



X-Ray of forearm and
wrist showing birdshot



X-Ray of leg at knee
showing birdshot

Problems with hospitalising unrest victims

The question was how to get these patients into hospital and avoid them being found and arrested by the police. I decided to get some of these patients admitted to one of the hospital wards, and treat their injuries with the help of surgeons.

This involved an element of risk and secrecy. Firstly, these patients had to be admitted to a ward with a false diagnosis. Then it was a matter of getting the nurses to keep quiet about it. That meant talking to the day and night nursing staff. It was not to be expected that the nurses or the medical staff would betray this trust. But it is possible that there is an information link between the nurses and the police. Also, there may be some degree of liaison between matrons and the police. Matrons may sometimes inform the police about patients in the wards, or vice versa. In the wards, there were lists hanging out, on which the names of patients with bullet wounds had to be entered. In some wards, however, some patients with bullet wounds were present, and these were not recorded.

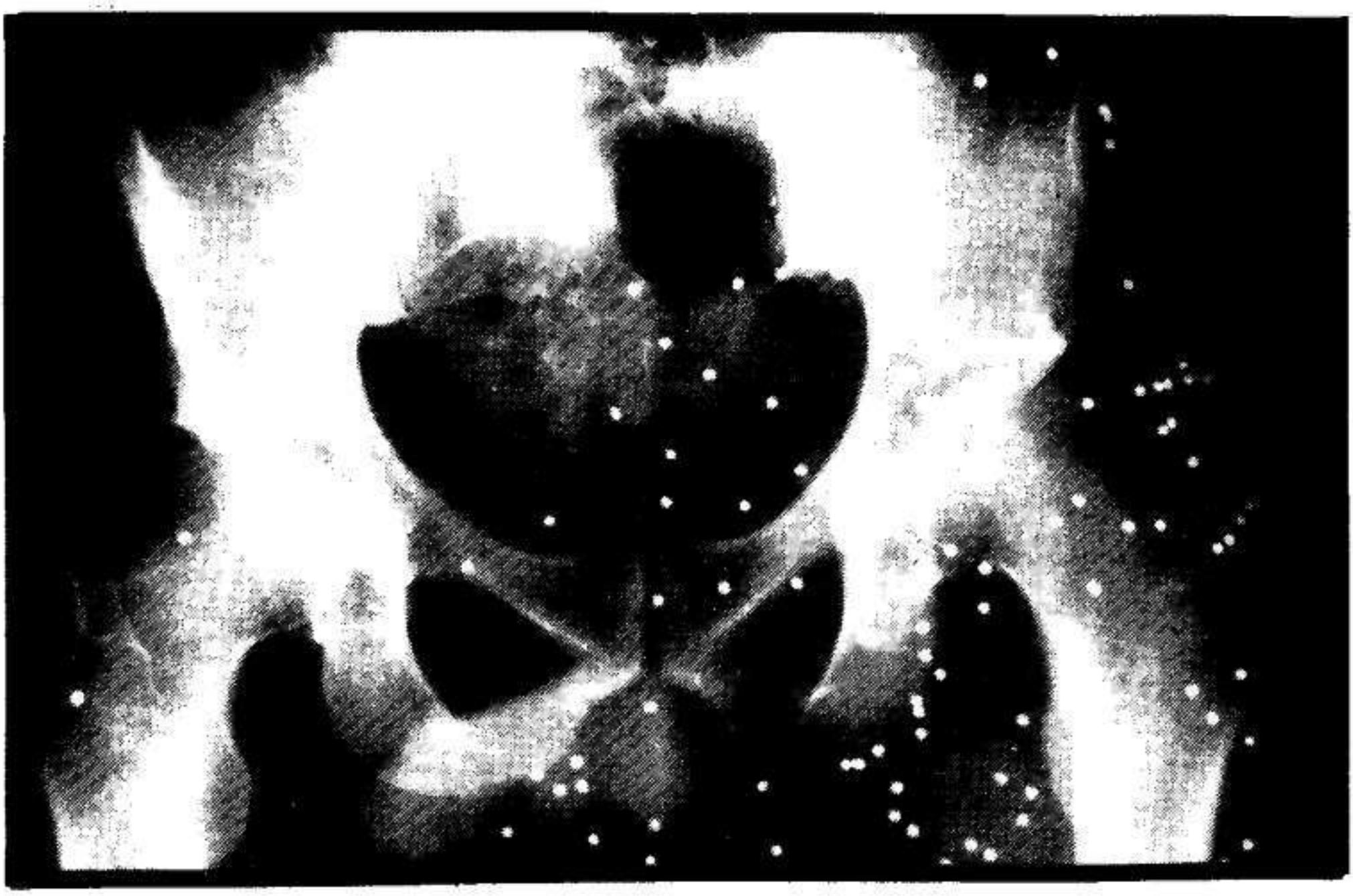
Once the patients were admitted, they had to be treated as quickly as possible, so that thet could be discharged from hospital before the news travelled around.

The other problem was to get help from specialists in other disciplines. It was uncertain how much co-operation could be expected from other medical practitioners, now that these patients were in the ward. How would the admission of these patients be explained to the consultant on the ward-round? One cannot leave these patients in one corner of the ward and forget about them. One cannot pretend that they are no-one's patients.

Injuries and treatment of unrest victims

One of the patients who had been admitted had been seen at the Aid Office in Uitenhage. A bullet had gone through his maxilla (upper jaw bone) and had shattered

his mandible (lower jaw). His face was swollen on one side. He was admitted as a facial palsy. This person had to be treated by a maxillo-facial surgeon. The maxillo-facial surgeon, who was a part-time staff member, came to the hospital about once a week. After about three days, the maxillo-facial surgeon came and saw the patient. It turned out that an anaesthetist and a theatre had to be booked for surgery. Surgery was done a week later. The maxillo-facial surgeon advised to keep the patient in the ward for three days after surgery. For all this time, the patient was occupying a bed in the ward. I grew more and more anxious as time went by, given the need for secrecy and the pressure for hospital beds in the ward.



X-Ray of hip showing birdshot embedded in skin around pelvic area

Other patients with bullet wounds were brought to me. One of them was a young boy - he must have been about 14 years old. When he came into Casualty, he could hardly walk; he had to be supported. When I examined this patient in the ward, he was pyrexial (feverish), had low blood pressure, a fast heart-beat, and had a

pericardial (heart lining) friction rub. On listening to his heart, he had two definite metallic sounds clicking with each heart beat. He was stable for the first two days. After that, he became septicaemic (infected). At this stage, I started getting anxious that this patient would die, and die on my hands. He was a patient with bullet wounds, and was in the ward for a long time. He was a very ill patient - the most critically ill patient in the ward - and the entire nursing staff knew about him. He had been admitted as a case of pericarditis (inflammation of the heart lining).

This patient needed to be seen by a thoracic (chest) surgeon. We do not have a thoracic surgeon at the hospital. There is only one thoracic surgeon for the whole of the Eastern Cape, and he is based at another hospital. He only comes to our hospital twice a week. The question was how to get him to come out and see this patient when it was not his day to come out.

Apart from chest problems, this patient had several other bullet wounds in his chest and around his hips. Later on, I discovered that he also had a bullet in his skull. We treated the patient for shock, for a small haemothorax (bleeding inside the chest cavity) with an intercostal (between the ribs) drain. We treated him for septicaemia with antibiotics, and he seemed to stabilise. But later on, he still complained of headache. I asked him whether he got hurt on the head. But he was not aware of having got hit with a bullet in the head. When I examined his head, I felt a small depression in his occiput (back of his head) that could just take the tip of my finger. An X-ray and a cat-scan revealed thay he had a bullet just below the vertex.

This patient stabilised, and we were able to discharge him.

I saw another patient who was brought to the hospital by the police from Algoa Police Station. He was a young boy of about 13. He was walking abnormally. He was admitted for paraperesis (weakness). On the ward-round the next day, it became obvious that this boy had hys-

terical paraperesis. I was thinking of discharging him. He told me that he had been arrested for public violence. We had reports that this young boy, together with others, had been subjected to homosexual rape, sodomy, etc. in the cells.

I tried to arrange bail for him. This took some time. Two weeks went past before I got a reply from the attorney concerned. For this time, I had to keep this boy in the ward. After two or three weeks, I could discharge him and send him home, after I had heard that charges had been dropped.

People brought other patients to the hospital from the Aid Office. They were terrified and had to be assured that they would not be arrested. This involved getting

Waiting to see injured relatives at the Provincial Hospital

them through the Admissions Office undetected by the police. Casualty was surrounded by police waiting to arrest any patients with bullet injuries.

Most of those patients were treated as outpatients. But even so, this was quite difficult. It involved getting in touch with people from the Aid Office to arrange a time to meet. It also involved getting in touch with other medical practitioners, and keeping the patient concerned overnight in Casualty.

There were some people who came to the hospital three weeks after the massacre with gangrenous legs. This shows how scared they were to come to a hospital.

Shortly after the massacre on March 21, I went around the hospital and took down the names of the injured, and some brief notes on their injuries.

Here are a few examples:

- Moses. Age 14. Abdominal operation. Kidney removed. Colic artery tied off. Duodenum sutured.

- Simon. Age 44. Bowel resection. Laceration of stomach.

- Name unknown. Head injury. Bullet in skull. Fixed dilated pupils. Patient died after 24 hours.

- Sipho. Lacerated colon. Kidney damaged. Severe fracture of the skull. Patient paraplegic. Developed kidney failure and died.

- Name unknown. Removal of kidney. Colostomy. Three pellets and cartridge in abdomen.

- Nel. Gunshot in hip and lower back. Fracture of zygoma (facial bones). Bullet under base of skull. Spinal fluid leaking from right ear. Hearing impaired. Bullet under right shoulder blade.

- Young girl. Depressed fracture of skull. Right sided paralysis. Damaged left eye to be removed.

Death from teargas exposure

One of the patients in my care, a young woman aged 20, died of teargas exposure.

One Wednesday morning, on her way to school, she got exposed to teargas. She was not in a closed space at the time. Immediately after exposure, she became ill. She was taken to a day hospital in one of the black townships near Port Elizabeth where she was treated. But the vomiting and headache continued on Thursday and Friday. She was taken to hospital on Saturday. The main problems were acute respiratory distress and coma. She had been breathing rapidly for the past twelve hours. She showed no neck stiffness, and no response to painful stimuli. The pupils were equal in reacting. She had a pulse rate of 130 per minute, and a blood pressure of 120/80. The respiratory rate was 48 per minute. The patient had bilateral rhonchi (abnormal breath sounds). The chest X-ray was clear.

We admitted this patient to the Intensive Care Unit. We put a tube into her, and connected it to a ventilator, so she could breathe. We contacted the Poisons Centre in Cape Town to find out the contents of teargas. We did get some information on the clinical features. Among other things, we were told that some cyanide was used in the teargas.

The patient had become pyrexial for the next 14 to 20 hours. She died early the next morning.

Police presence in the hospital

The hospital was taken over by the police. There was a prominent police booth outside Casualty. At the time of the crisis, it was like a military camp. Police trucks were moving into the hospital compound as frequently as ambulances.

Most of the policemen were walking around the hospital in military gear, with guns and rifles. This created a feeling of tension and fear. The policemen were walking in and out of the wards and Intensive Care Units without as much as asking permission from the sisters and doctors. Policemen were at the bedside of patients. They were smoking freely in the wards, which are "no smoking" zones. They were also playing cards in the wards.

The superintendent of the hospital received complaints about the behaviour of the policemen. He said that the police were not supposed to shackle the patients, that they were not supposed to be in the wards, but only at the entrance of the wards. The superintendent phoned the police chief. But this did not do much to change the behaviour of the police.

The situation in the hospital was still the same, except that the number of policemen in the hospital went down.

This matter was raised at the meetings of the heads of departments. But there was not much discussion on the issue. That makes me question whether the medical profession is at all concerned about guarding doctors' and patients' rights.

What can be done?

People working in the community need to liaise with members of hospital staff. Civic associations should be geared to handle such a situation; people should know where to go to and to whom to go.

Also, doctors and health workers need to be mobilised to give sympathetic and appropriate treatment to victims of unrest.

Thirdly, a venue needs to be organised where the injured can be seen and treated by medical practitioners.