GROOTE SCHUUR HOSPITAL

80th ANNIVERSARY

THE ANGELS ON DEVIL's PEAK

The history and stories of their experiences.

1938 to 2018

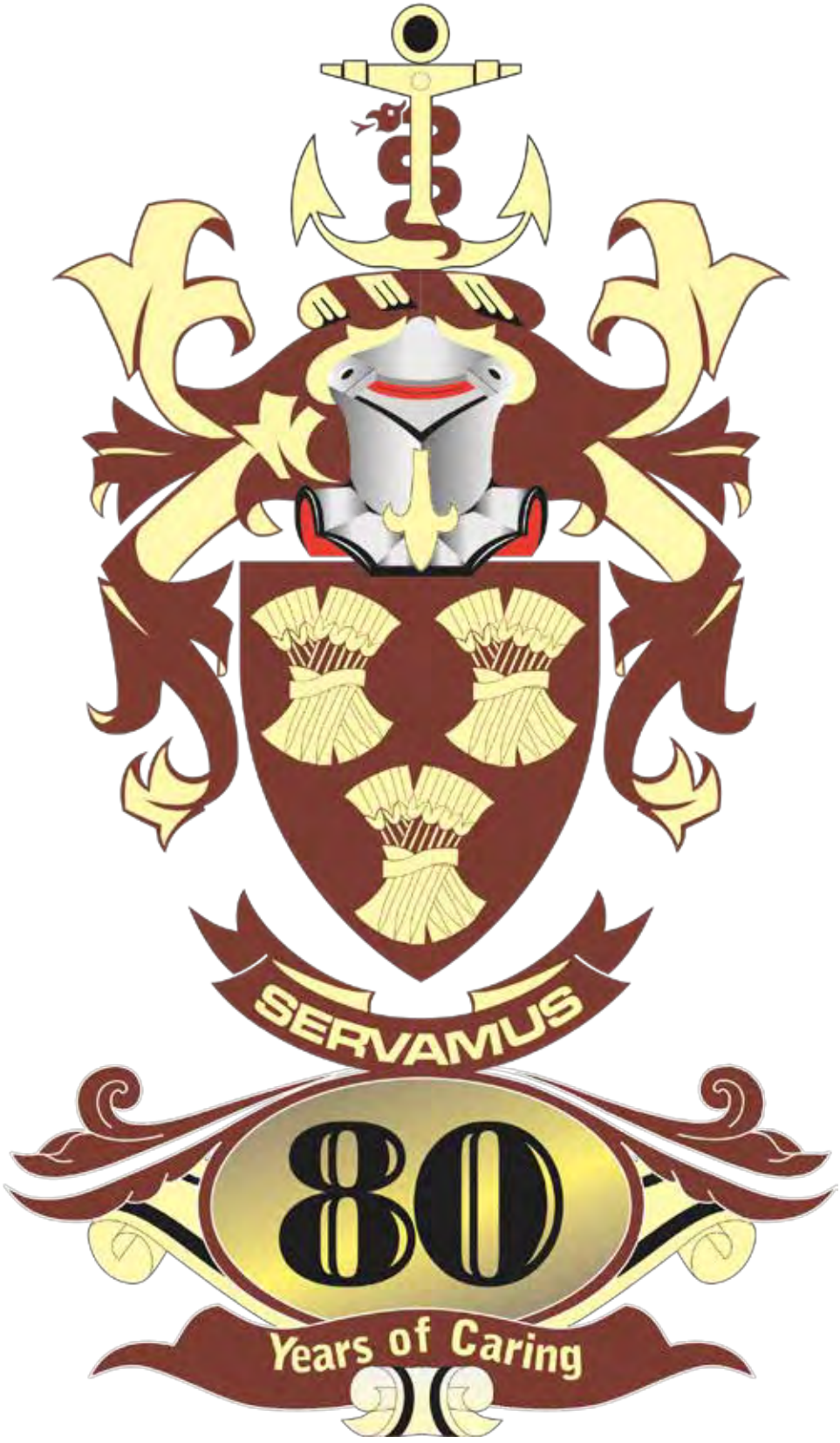
GROOTE SCHUUR HOSPITAL

80th ANNIVERSARY

THE ANGELS ON DEVIL's PEAK

The history and stories of their experiences.

1938 to 2018


SERVAMUS
80
Years of Caring

Written and compiled by
Dr Bhavna Patel
Chief Executive Officer
Groote Schuur Hospital

All the information contained in this commemorative history book has been taken from the Cape Hospital Trust and the Groote Schuur Hospital Annual reports collectively from 1913 to date. Relevant newspaper clippings have been included. All stories have been written by past and present staff and portrays their personal experiences at Groote Schuur Hospital. Statistics and graphs, where quoted have been taken from the same annual reports.

Any errors or inaccuracies are sincerely regretted.
January 2018
Groote Schuur Hospital, Observatory, Cape Town
33°56'28"S18°27'42


Groote Schuur Hospital, Cape Town
Carmen Hall Peterson, 1980.

CONTENTS

ACKNOWLEDGEMENTS AND APOLOGIES

I would like to take this opportunity to thank each and every staff member and patient who has contributed towards making Groote Schuur Hospital the renowned facility that it is today. Every contribution made by the gardener who keeps the hospital green; the porter who collects patients; the messenger who ensures that items needed are delivered to the right place; the Department of Finance staff for managing all the consumable needs and the budget of the hospital; the Department of People Management staff for ensuring that the correct staff with the right skills mix are made available to manage the services of the hospital; all the support services staff who manage the facility, including new building projects, cleaning, catering, clerical, linen and all other hotel services; the Engineering Department staff for maintaining our various buildings and infrastructure, including the yucky plumbing, electricity and painting; the clinical staff, including the medical doctors, nursing staff, pharmacists and all the Allied Health staff for improving the health of the patients.

In particular, I need to note the contributions of the previous managers of the hospital, who have steered this ship through many trying times, but maintained the excellence nevertheless. At the time, the management covered hospitals in the entire region, thereby increasing the complexity of the task. I remain in awe of how they managed to do this and have a huge sense of respect for each of these leaders. At present, I need to acknowledge the important role played by all the current managers/leaders, Heads of Department and Heads of Divisions, who collectively have carried the hospital in serving the increasing patient needs. I am deeply indebted to the competency, stability and commitment that each one offers to managing this facility.

The strength of the relationships and communication with the various higher educational institutions, especially the University of Cape Town (UCT), also contributes and assists in jointly dealing with the challenges and I am grateful for the ongoing support from these organizations, in particular, the Dean and Deputy Deans of UCT.

This book would not have been possible without the information gained from all the annual reports and the diligent collection of newspaper clippings over the years by the Public Relations staff. Some of the wording and pictures have been taken directly from these sources and this highlights the importance for us in the present to ensure that we continue to record all our activities in this detail over the next 80 years. Special thanks to all those who have written the stories about their experiences at our hospital – these go a long way towards our recognition of times past and our path ahead as we transform for the future.

I need to thank Ms Beth Adams, Vincent Rossouw and Alaric Jacobs for assisting me to find this information. To Mrs Ross, Mrs Patton, Mrs Petersen, Mrs Jakavula and Mrs Adams for wading through all the Nursing information, despite all having retired from Groote Schuur Hospital. This reflects the loyalty and pride that our staff have in our hospital, which is a culture that we need to continue to cultivate. Thank you to Amanda Lancaster, Veronica Sasman, Deidre de Kok, Natalie Smit, Hilda Domingo and Mishka Dawood for their continued support in my office and especially with this book. Lastly, we acknowledge and thank the fact that our hospital has such a rich history that constantly needs to be celebrated and as we renew our vision to Leading Innovative Healthcare, we will continue to contribute to this history.

Apologies need to be extended to everyone if there are any omissions or errors in the information provided. Any comments perceived to be directed at a personal, institutional or departmental level are unintended.

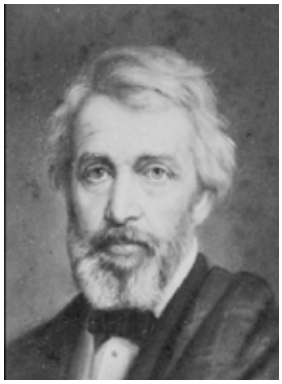
I thank you all for your loyalty to Groote Schuur Hospital and for being proudly GSH!

Dr Bhavna Patel
CEO: Groote Schuur Hospital

QUOTES OF INTEREST

"What counts in life is not the mere fact that we have lived. It is what difference we have made to the lives of others that will determine the significance of the life we lead."

Nelson Mandela



"It is not what you possess but what you do with what you have that determines your true worth"

Thomas Carlyle.

"There is a tide in the affairs of men, which, taken at the flood, leads on to fortune; omitted, all the voyage of their life is bound in shallows and in miseries."

Julius Caesar – William Shakespeare

"The Art of Detachment, the Virtue of Method, and the Quality of Thoroughness may make you students, in the true sense of the word, successful practitioners, or even great investigators: but your characters may still lack that which can alone give permanence to powers – the Grace of Humility."

Sir William Osler

"It is not the pride, pomp and circumstance of an institution which brings honour, not its wealth, not the number of its schools, nor the students who throng its halls, but the men who have trodden in its service the thorny road through toil, even through hate, to the serene abode of fame, climbing like stars to their appointed height."

Osler, W., Aequanimitas and other addresses

FORWORD

Groote Schuur Hospital opened its doors on 31 January 1938. Dr Patel, current Chief Executive Office of the Hospital, honoured me by requesting a foreword to the 80-year celebratory history book.

In preparation I got embroiled in the amazing stories captured: Stories of people and their endeavours to improve Health over 300 years, when the humble beginnings of health services in the Cape started at Somerset Hospital; the story of the first heart transplant and many other firsts; stories of a hospital standing up for the rights of all people, despite a racially and socially divided community in a past political era.

The statue of Hygeia, the Greek mythology goddess of health, is still prominent as a main feature of the building. This symbolizes the hospital welcoming the sick and suffering with her ever-flaming torch.

The hospital opened with 628 beds. Today, 80 years later, the hospital has 975 beds. The nature of services delivered in these beds as part of the inpatient care delivery has changed dramatically; the nature and role of ambulant care has changed dramatically; the role of the hospital in the health delivery system has changed dramatically. GSH successfully transformed to remain connected to the needs of a health system in a changing environment; from a "Hospital on the Hill" towards being connected to the aspirations of Alma Ata and the purpose of the primary health care philosophy and component part of the health system.

All of the above reflect the achievements of good leaders and academics, of a connectedness of service excellence as well as academic excellence, a connectedness of a service with the community it serves.

Celebrating achievements and capturing these in books like this reflect the loyalty and pride in an establishment such as GSH. The Public Health system is challenged by building trust in the ability to deliver good care to patients and families. The book reflects the continuous pressure on the tertiary care resources towards strengthening PHC in line with the World Health Organization and provincial system needs. Having a hospital and its teams continuing to excel in these difficult circumstances is a testimony of the resilience of teams and team leaders over time.

Today the hospital remains an iconic establishment, possesses the dynamic leadership of Dr Bhavna Patel and team, and continue to have many firsts.

I wish to make use of this opportunity to commend the team for innovation of having this history book, which has a different approach of the one in 2008, "At the Heart of Healing". I thank the contributions of every team leader and team member over time to ensure public confidence in a remarkable public institution.

May you continue to make a difference in the lives of many dependant on our care, and touching the lives of those in need of our response.

Dr Beth Engelbrecht, Head of Health, Western Cape.

MESSAGES OF GOOD WISHES FROM PREVIOUS CHIEF MEDICAL SUPERINTENDENTS AND CEO'S

Dr HANNAH-REEVE SANDERS - MBCHB M.D. (hc) UCT (1976 to 1986)

I have been very privileged to be part of a team at Groote Schuur Hospital for a major part of my professional life; from medical student, through internship and post-graduate general clinical experience here and abroad. Some years later I changed the orientation in my career to include Health Care Planning and Management particularly in regard to Academic Institutions.

I received excellent support from the Graduate School of Business at the University of Cape Town and the Hospitals' Department of the Cape Provincial Administration. I was indeed grateful for the opportunities provided to acquire experience in this field nationally and internationally.

Working together with the members of Joint Staff (UCT and CPA), we made good progress, especially thanks to the existence of the Joint Staff agreement at that time.

So the going was tough, exciting and frustrating but the spirit in this hospital never wavered, hard as the apartheid years challenged us all. We always tried to make decisions based on our professional responsibilities and the code of practice of professionals.

To celebrate now the 80th year in the Hospital "up on the hill" is indeed an achievement for all those implicated in this process – The Western Cape Government: Department of Health, The University of Cape Town and every member of the staff.

I congratulate those currently in the driving seats, all those supporting them and indeed every member of the staff who have kept the motto SERVAMUS – WE SERVE, forever a beacon.

HAPPY 80TH ANNIVERSARY!

Dr JOCE KANE-BERMAN (1986 to 1995)

A retrospective survey of my 30-year association with GSH carries the risk of looking through a rose-coloured rear-view mirror. They were wonderfully rewarding years where I learnt much about hospitals and health care, people, management, systems, technology, planning, building matters, commissioning, research, teaching and friendship inter alia. Those years were filled with joy, frustration, pride, anguish, satisfaction, despair, enthusiasm – indeed passion, irritation - nay fury, fulfillment, loss and many other conflicting emotions.

To select who and what influenced or affected me most is difficult but what has emerged in thinking recently about my time as a medical superintendent at that much loved institution is how important the support staff were and no doubt are. The professional staff - medical, nursing and other categories - were of course absolutely essential to the success of the enterprise and they filled their positions admirably and many were internationally recognized, received multiple awards and high ratings as scientists. I admired and respected them and in general we maintained amiable relationships!

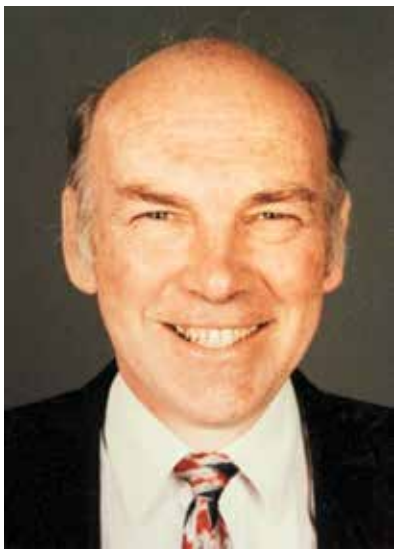
But my memories are focused now on the other staff without whom the hospital could not have functioned or indeed existed – the secretaries, cleaners and housekeepers, messengers, pharmacy assistants, laboratory technicians and assistants, cooks and bottle washers, assistant and staff nurses, records staff, clerks, storekeepers and other administrative people, engineering staff, telephonists, volunteers and more – a veritable army who personified in many ways the GSH maxim in the 80s and early 90s – "I CARE" and the GSH nurses' precept "Servamus" – we serve.

Naming names can be invidious but there are people who endeared themselves to me, cared for and supported me whom I must commemorate by name. Secretarial staff - Debbie Victor, Debbie Peterson and Di Terlien; the housekeepers and sisters Marjorie Traugott and Hilda Domingo. Douglas Ndila - the diligent Admin Block cleaner who managed on a pitiful salary to put 3 sons through tertiary education. Bev May who ran the patients' library in Hospital Street for years and also ran classes for the hospital workers so that they could write and pass Matric. Una Bloch who headed the Public Relations Unit and Sue Henderson who researched and preserved historic items and recorded events in the hospital on her ever present camera. Sue also initiated the Hospital Art Project in the corridors of the new hospital. All exceptional people who truly made a difference.

I thank all the members of that entire army, professional and "non" professional for the exceptional experience of working with you during my time at Groote Schuur – and of course to all those who have filled the positions in the 22 years since I left. You have maintained the reputation of this great institution despite the many difficulties encountered – I know it has not been easy.

On the occasion of the hospital's 80th birthday I wish you all success in the future, joy in what you do, just rewards for the expertise and dedication you bring to caring for patients and each other, opportunities for both personal and shared successes and the determination to constantly extend the boundaries of world-class health care at this remarkable hospital.

Dr PETER MITCHELL (1996 to 2001)



Mention the name of Groote Schuur Hospital to anyone and you are sure to receive a positive response. Everyone has a relative or a friend who has been a patient at this hospital and who will report favourably on the way they were treated by all the staff with whom they came in contact.

For 80 years Groote Schuur Hospital has been a beacon of hope for the sick and suffering, not only for our local population but also for the rest of the country and even farther afield.

May the GSH family continue to provide outstanding patient care, excellent medical training and ground-breaking innovation for the next 80 years.

MESSAGES OF GOOD WISHES FROM PREVIOUS CHIEF MEDICAL SUPERINTENDENTS AND CEO'S

Dr NORMAN MAHARAJ (2001 to 2004)

My association with Groote Schuur Hospital (GSH) comprised three chapters spanning a period of 31 years between 1973 and 2004.

I started my clinical years of medical school in 1973, most of which were spent in the wards of GSH. These were the deep and oppressive apartheid years of separate wards, racially segregated student groups and mostly unsympathetic university lecturers. Our most humiliating experience at that time was to sleep in a make-shift "black" obstetrics ward in order to fulfill our obligation of delivering our quota of babies. Credit has to be given to Professors Olando Meyers (Internal Medicine) and David Dent (Surgery) for their unique support and teaching during this time. There were very few choices where we could serve our internships and many of us opted for Livingstone Hospital in the Eastern Cape.

I returned to GSH in 1981 (my second chapter) to work in the medical emergency unit, having followed Doctor Aziz Aboo who had been appointed as the specialist for the unit. Dr Aboo had taken me under his wing in Kimberley Hospital and taught me every clinical skill I have and which I could effectively apply throughout my clinical years. One could hope for no better teacher, mentor, colleague and friend – a friendship which lasts to this day. On occasion he will still extricate ECGs from his collection to push the boundaries of my knowledge when I visit him at home. These were the most memorable of the years spent at GSH. These were the pinnacle of my years as a clinical practitioner – years of resuscitating moribund patients, solving difficult medical presentations, honing my skills in intubation and ECG analysis and sharing with my nursing colleagues the basics of these. These were also the years when Ambulance men (very few women at the time) were being trained as ambu-medics and having to take them through their paces. I was the senior Medical Officer and mostly in charge of the G2 anteroom, where the daily routine started with clearing the holding area of patients from the night before awaiting blood and x-ray results, and having to make critical decisions whether to discharge or refer for admission. Lasting relationships were forged with (sometimes difficult) registrars, many of whom are successful specialists in their fields today. Lasting relationships were also forged with Senior House Officers (SHOs) who passed through the unit. People such as Lynn Denny, Lucy Linley and many others are remembered with fondness. I sincerely believe that we had the most dedicated and best group of nursing staff - professional, enrolled and staff nurses ably led by Mrs Patton as their sister in charge.

The 80s were also the years of my political activism, inside and outside of the hospital environs. The post 1976 years of student uprising and resistance continued unabated but in the 80s workers started picking up the cudgels which heralded in the formation of COSATU, NACTU and many independent unions. The streets were burning and health workers, my colleagues, were often confronted with difficulties such as getting to work on time or reporting for duty. Many were victimised for these transgressions and such unjust actions could not go unchallenged. Lowly paid general assistants from the townships were mostly affected and the need to organise became an absolute necessity. Lots of my free time was spent organising and in meetings with workers at GSH and often at surrounding hospitals, such as Somerset, Conradie, Victoria and Mowbray Maternity. The E-floor lecture room soon became too small for some of these meetings and we relocated to the bigger Nico Malan Hall and to Gugulethu over the weekends. At the time public servants were represented by 'sweetheart' staff associations, divided along 'racial' lines and having to use the enfranchised Public Service Association as their proxy to extract meagre workplace concessions from the authorities. It was from the Nico Malan Hall that we organised work stoppages and sit-ins in order to get the attention of the powers that be – to no avail.

As a medical doctor, I was at risk of being disbarred by the Health Professions Council at worst, and being dismissed by the health authorities for unauthorised activities at best. The challenge was to avoid either. I served as a dedicated doctor and made sure that I could not be found wanting in terms of my clinical responsibilities while engaging in these "unauthorised activities". These responsibilities were put to the test when I admitted two political detainees from Pollsmoor Prison for complications from a hunger strike. The following week one of them was brought to the emergency unit with serious physical injuries, which were absent the week before. The dilemma was whether to report this to the health authorities or to my political allies outside. Not sure of the response from the authorities, I opted for the latter and we successfully interdicted the respective ministers of Police and Prisons, the first such successful interdict against the apartheid regime at the time.

The Health Workers Association became the Health Workers Union and culminated in what I regard as the first and most successful public service strike in February 1990. There were five demands – Wage increases for general assistants who, at the time, were earning a pittance of R245 per month; Access to the pension fund from Temporary Employees' Pension Fund to the General Employees Pension Fund (GEPF); Maternity benefits; Recognition as a Trade Union; and 'No' to privatisation. These were far-reaching demands and if agreed to, would be applicable, not only to the striking workers, but to the entire public service.

To avoid disbarment for engaging in strike action, I opted to resign and to show full solidarity with my fellow union members. We embarked on two weeks of non-violent disciplined action with lots of vacillation by government offering mediation through a retired magistrate and then a former GSH medical superintendent. Offers which we rejected outright. We finally met with the Directors-General of the Western Cape Administration and the Public Service Administration. We won victories with our wage and maternity benefit demands. The pension rules needed to be amended – a promise granted. That same year, the Public Service Labour Relations Act was promulgated, giving recognition to unionised workers. I returned to the Emergency Unit but was shortly informed that my presence at the hospital was "too intimidatory" and was asked to leave. A soft dismissal as it were.

Out of necessity, I went into private practice until 1996 when again, coerced by Dr Aboo, I joined the newly transformed GF Jooste Hospital. GF Jooste, at the time, was struggling to recruit doctors for a hospital situated on the fringes of Manenberg and Gugulethu. I served as both medical officer and medical superintendent. I was comfortably far enough from the Head Office authorities at the time and avoided the sense of being co-opted.

I finally applied for the newly created post of Chief Director of Groote Schuur and Red Cross Children's Hospitals in 2000 on the advice of some senior colleagues. I remember demanding their full backing – 'covering my back' for whatever changes were envisaged for these institutions.

And so began my third and final chapter at GSH from political activist or agitator as others would say, to being in charge of these hallowed institutions. I arrived on the G-floor with a small office being prepared for me and no secretary. At my inaugural meeting I asked for volunteers amongst the clerical staff present and was most fortunate that Di Terlien put her hand up. She became my right and left hands, a confidant and most able assistant without whom life would have been unbearable. I remember the professors not being sure how to address me, whereas the workers were comfortable with calling me by my first name.

As Chief Director, my time was divided between the two tertiary hospitals and also serving as co-ordinator for the placement of medical interns, community service doctors and pharmacists. At some time during this period, I also acted as the medical superintendent for Conradie Hospital and was tasked with the responsibility of the decommissioning of this hospital into an acute section at Eerste River, the Spinal Unit's relocation to GSH and the creation of a dedicated rehabilitation centre on the grounds of Lentegeur Hospital. All daunting and not very popular responsibilities. It was during this time that I survived a hijacking on the R300 road on returning from an after-hours meeting with Eerste River community members.

MESSAGES OF GOOD WISHES FROM PREVIOUS CHIEF MEDICAL SUPERINTENDENTS AND CEO'S

Under grave suspicion as a former 'agitator', I had to gain the confidence of Heads of Departments, the Deans at Medical School, and the Registrar and Vice-chancellor at UCT. Many of my decisions were questioned, changes were resisted and at times it was a very lonely and thankless experience. Managing two important hospitals with the ever present financial constraints was not easy. These hospitals were world renowned for their excellence and I, at times, had to sacrifice the budget of GSH to protect the funds of RCCH so that the children would not suffer. Clinical heads of Department were co-opted onto the hospital management meetings to encourage joint decision making. Hospital performance management outputs were jointly scrutinised in attempts to bring about efficiencies. A greater emphasis on revenue generation became a necessity and I recall challenging the MEC of Health at the time about choosing between indigent non-paying patients and paying patients.

Mr Salie, the Finance Director appointed at the same time, became my 'go to' man for up to date financial information and together we contrived to split the budget into thirteen parts to guarantee less of an over spend at the end of the financial year. We also attempted to benchmark personnel and non-personnel expenditure and within the various budget divisions. With Mr Salie and Dr Kariem's help, a private revenue generating ward was established but we had to compete with the newly created UCT private hospital. A regrettable missed opportunity occurred at the time when I had suggested to the DoH to purchase this facility when it became available. I had never been happy with the medical staff's divided time between GSH and the private hospital. I had never been happy with some doctors spending an inordinate amount of time and hospital resources on contract research/drug trials. I had never been happy with our poor management of Remunerative Work Outside the Public Service (RWOPS) and regarded this as a betrayal of the needs of indigent patients.

We requested greater decentralised inter and intra hospital management but this was never fully agreed to. Quality of care measures were introduced. I was not pleased with a 95% public satisfactory rating when 5% translated into 2500 dissatisfied members of the public walking our corridors at any one time. I fondly recall calling my first Town Hall meeting with the staff and being questioned by one of the junior managers about having to transport staff to the City Hall. These town hall meetings, held in a lecture hall incidentally, became an important vehicle for gauging the mood of the staff and gaining their confidence. Walk-abouts through all parts of the hospital with respective medical superintendents and nursing heads also helped in assuring staff of our good intentions. An internet café was created to assist staff who had no access to such services. A "back to basics" campaign was started to ensure basic clinical, infrastructural and other needs.

In the interim The Chief Director's position was changed to that of CEO for GSH and life became more bearable but financial constraints remained. The Hospital Board, under the guidance of Dr Barday and then Mr Salwary, were forever friends to rely upon for much needed support, and assistance for basic equipment and other requirements.

In time, I hope and believe that I gained the trust if not the respect of many. Unfortunately, I departed in 2004 and a memorable, life changing experience at GSH came to a premature end when I joined the Public Service Commission.

I cherish the many memories and friendships made and remain grateful for the opportunity to manage such a revered and excellent institution. I am in eternal debt for all the assistance and understanding received from so many during all my time spent at GSH. My sincere good wishes for the next eighty years.

Dr JAPIE du TOIT (2004 to 2007)

I would like to congratulate Groote Schuur Hospital and all its staff, stakeholders and partners on its 80th birthday celebration. In the 8 decades of its existence Groote Schuur Hospital has seen political regimes come and go and policy changes for better or for worse but it stayed true to its purpose and vision of providing excellent service to all those patients arriving on its doorstep, no matter who they were or where they came from. I am sure all of us who were ever associated with this great hospital, have a proud sense of belonging to it and gratitude towards those who came after us for maintaining and growing its service excellence despite the many challenges faced by the healthcare sector in our country. The significance, and important role of Groote Schuur Hospital in the Western Cape, South Africa and the continent has grown with it as a bastion and shining light for healthcare, training of students in the health sciences and research outputs of world class and make this country and all who live in it proud.

Dr SAADIQ KARIEM - MBChB, MPhil, FCPHM, EMBA (2007 to 2010)

It is indeed a priviledge to be able to wish the entire Groote Schuur Hospital staff well on the 80th birthday celebrations. Groote Schuur Hospital, or "Grotties" as it is affectionately known amongst staff, has a very special place in the hearts and minds of not only Capetonians, but the world over. The exceptionally high quality of care provided at this venerable institution, by committed and dedicated clinical and non-clinical staff, is in a word, phenomenal.

The very close association with the University of Cape Town as well as other institutions of higher learning, also makes Groote Schuur Hospital a remarkable place of learning and teaching. The combination of exceptionally high quality of care as well as the close association with institutions of higher learning has indeed earned the hospital a place amongst the best hospitals, public and private, in this country and the world over. This is further evidenced by the significant number of foreign nationals who come to Groote Schuur Hospital for advanced training in various clinical disciplines. The hospital is well known as a leader in medical advancement, not only for the first heart transplant, but also in numerous other areas. A further testament to the remarkable achievements at Groote Schuur Hospital.

I am proud to have previously served the hospital as chief operational officer and chief executive officer and wish Dr Patel and her team of managers well for the future. Servamus ! We serve !

MESSAGES OF GOOD WISHES FROM PREVIOUS CHIEF MEDICAL SUPERINTENDENTS AND CEO'S

Dr TERENCE CARTER (2011 to 2013)

Groote Schuur Hospital in partnership with the University of Cape Town continues to build on its proven track record of rendering the highest quality of health care through visionary and strong leadership and dedicated, passionate and committed staff.

With the unity of purpose around the hospital's motto: "We Serve", it was not difficult to ensure the care and well-being of our patients remains the primary concern of all our clinical as well as non-clinical staff. The interest of the patient has always been our primary concern even under the most challenging circumstances.

Innovative highlights that stand out include: improving quality and access to Nuclear Medicine and Oncology services by securing new advanced equipment and extending Oncology services to the Southern Cape/Eden in partnership with the private sector, reducing waiting times for emergency surgery through improved scheduling, psycho-social care for head injury patients, picture archiving communication systems, anti-microbial resistance projects, hospital-based palliative care.

I was encouraged by our ability to ensure improving and strengthening of the partnership and the integral relationship between the Provincial Health Department and the University of Cape Town, as well as the collaboration between Higher Education Institutions on both sides of the Liesbeeck River.

One of the reasons why Groote Schuur Hospital has and continues to excel is because the successes and contributions of its staff are valued, appreciated and celebrated.

Dr BHAVNA PATEL – BSc; MBChB; MFam Med; FCFP; FCPHM; MSc Med (Bioethics and Health Law) (2013 to date)

On 31 January 2018, Groote Schuur Hospital celebrates 80 years of service and caring to the communities of the Western Cape and beyond. The hospital has over the past 80 years built a unique image in the annals of the world medical history and if one has to identify the one factor that goes into making this institution so great, it is undoubtedly the workforce of the hospital. This is aptly captured in the title of this book – 'The Angels on Devil's Peak'. The 80 years have seen numerous personalities, both humble and great, enter and exit the services. It is through their dedication, loyalty, skill, passion, cooperation, planning, management and love for Groote Schuur Hospital that we have such a charismatic image. Each and every staff member maintained our motto 'SERVAMUS' in carrying out their duties and aspired to a vision of greatness through the objectives of providing patient services, teaching, training and research. In the field of Medicine, Groote Schuur Hospital and the University of Cape Town Faculty of Health Sciences remain inseparable, having a symbiotic relationship and the glory of this birthday celebration is shared with the University as a source of strength to both institutions.

Managing such a large hospital means understanding all the considerable changes that occur to keep pace with technological advances, scientific advances, economic fluctuations, skills mix of staff, changes in the patterns of teaching and training and the ability through all of this to address the changing needs of society.

MESSAGES OF GOOD WISHES FROM PREVIOUS CHIEF MEDICAL SUPERINTENDENTS AND CEO'S

The doors of Groote Schuur Hospital opened on 31 January 1938, with 628 beds. Staff included 102 doctors (8 part-time professors ex officio, 72 part-time honorary consultants, one Medical Superintendent and 21 resident medical officers). By the end of that year, the hospital had treated 9 500 inpatients and 77 979 outpatients. Forty-nine years later, on the eve of the 50th anniversary, by December 1987, the hospital had 1473 beds, treated 62 652 inpatients and 1 279 631 outpatients. 80 years later, the end of 2017 shows a hospital with 975 beds, ~75 000 inpatients and ~450 000 outpatients treated annually. Interlinked with the other two functions of the hospital and the University, the number of medical students trained rose from an initial 40 students in 1938 to 180 in 1986 and 202 by the end of 2017. As far as research is concerned, the hospital has developed from an embryo stage to a world renowned academic facility. The number of research papers reviewed have steadily increased in the past five years from 662 in 2012 to 951 in 2016. (30% increase) These achievements make Groote Schuur Hospital a truly unique institution which will continue to strive for the highest standard of productivity and guaranteeing that the investment that the state has made into this hospital is well justified and shows valuable returns.

Our country has seen many injustices to fellow human beings and this extended even to a basic human right such as healthcare. I lived through that injustice and experienced discrimination at the hands of those I now call my colleagues. We had tolerated so much and while we may have forgiven the past, we cannot forget it. My only hope is that future generations will, through reading of these experiences, understand and respect this rich history and be thankful for the opportunities they have today.

I am in absolute awe of the managers and staff who have journeyed through the corridors of this wonderful hospital and am deeply honoured to continue their legacy. The achievements they made in times of severe constraints can only be admired and aspired to and we need to continue to build on that for the future generations that will lead Groote Schuur Hospital into the 21st century. I recently had the privilege of meeting Dr Sanders and Dr Kane-Berman, together with Dr Kirsten, one of Groote Schuur's previous Medical managers. The lessons we can learn from the past are invaluable.

Many upheavals were experienced in the early years of the new millennium. The hospital faced annual budget cuts, staff were emigrating to other parts of the world or leaving to practise in private services and the patient demands continued to increase. Despite this, the passion to work at Groote Schuur Hospital and to provide service excellence prevailed. As stated by Professor Craig Household in an Editorial of the Groote Schuur Hospital Annual Report:

"I recently visited Groote Schuur Hospital and spent the day talking to staff and walking around the current hospital buildings. Despite the changes and setbacks of recent years I was impressed by the goodwill and positive suggestions of those to whom I spoke. There was criticism, but generally, this was constructive. What stood out was that Groote Schuur Hospital as an institution has a 'soul' derived from the service ethic of the many individuals who have worked there and that this is bigger than any single person. As such it is a National asset, and although it may undergo changes, will continue its important role."

This quote was relevant in the past, was relevant at the time it was written and remains relevant up to this day.

MESSAGES OF GOOD WISHES FROM PREVIOUS CHIEF MEDICAL SUPERINTENDENTS AND CEO'S

Groote Schuur Hospital, or `Grotties' as it is affectionately known, is not just a building, but a place of healing; a place of teaching and learning; a place of visionary thinking; a place that embodies the ethos of philanthropy; a place of innovation; a place of idealism; a place where principles carry a huge weight; a place of high ethical and moral standards; a place of selfless dedication and hard work; a place of excellence; a place that the Groote Schuur Family calls `home'. Groote Schuur is not just a building, but the heart and soul of each and every person who has entered its doors.

I congratulate and salute the staff for eighty years of hard work, commitment and dedication to the many millions of patients who have been cared for at the best hospital in Africa and the World.

Chief Medcial Superintendents / CEO's of Groote Schur Hospital. *(taken 12 August 2017)*

Back row (left to right): Dr Saadiq Kariem; Dr Japie du Toit; Dr Terence Carter; Dr Bhavna Patel; Dr Norman Maharaj; Dr Gilbert Lawrence.

Front row (seated): Dr Hannah Reeve Sanders; Prof Abdul Barday (Board member); Dr Joce Kane-Berman.

Absent: Dr Peter Mitchell

THE GROOTE SCHUUR HOSPITAL FACILITIES BOARD

It is indeed a great honour to reflect on the history of Groote Schuur Hospital as it celebrates a glorious 80 years of pioneering world class innovation, delivery high quality care and firmly establishing itself as the 'jewel in the crown' of Cape Town, South Africa and even Africa's public health service. As part of the legacy it has created during these 8 decades, the hospital has enjoyed significant support and guidance by the then Teaching Hospitals Board, having evolved over time in name to the current Hospital Facilities Board. There has been changing of names and legislation that mandated the work of this structure, but the mission of the Board has remained constant and focussed on ensuring that the hospital provides the best possible care for all the patients that attend it and ensuring that staff are supported to do their best in providing this care.

The Hospital Board has a history of well experienced and capacitated leadership, started some 60 years ago by those who have the laid a firm foundation for us to expand upon. The Boards over time have had strong representation from the surrounding communities, the academic partner (UCT) and the hospital establishment itself. Members of the board have all served voluntarily investing their time, expertise and often their own funds to advance the interests of patients and staff alike. The contribution of many individuals has enabled the Board to fulfil its mandate. Simply put, the Board has tried its level best to bridge the gap, step in and support those endeavours that the hospital itself could not afford or was considered out of scope.

Chairpersons of the Hospital Board since 1955:

- Mr Hugh M Timoney – serving 7.5 years from 1955 to 1962
- Mr Lionel G Murray – serving 12 years from 1962 to 1974
- Mr Fritz M.Botha – serving 8 years from 1974 to 1982
- Professor David McKenzie – serving 1 year from 1982 to 1983
- Professor J H Louw – serving 2 years from 1983 to 1985
- Professor G K Everingham – serving 7 years from 1986 to 1993
- Professor George Dall – serving 2 years from 1993 to 1995.
- Dr A W Barday – serving 6 years from 1995 to 2001
- Mr Salwary – serving 6 years from 2001 to 2007
- Professor EJ Coetzee – serving 9 years from 2007 to 2016
- Dr Z Brey serving since March 2017 to date.

Some highlights of the Board's contributions over the last 60 years

The Teaching Hospitals Board was entrusted with the care of special funds donated for Groote Schuur Hospital and any other hospitals associated with the University of Cape Town. The Board was empowered to receive donations and bequests from the public to be used for special equipment, patient and staff amenities, buildings and other authorized purposes. When these funds were expended, the amount was subsidised by the Provincial Administration in a manner that every pound received from the public was matched by an equal amount from the Administration. As at 31 December 1961, the amount available to the Board was £60,682.

In 1962, the Board committed R51 000 towards the building of an Assembly hall for 280 people. Due to delays with the building it was only completed in 1968 at a cost of R75 000. Over the following two years, the board purchased piano's and sound equipment for the hall. The piano is still being used at the staff residence today.

In 1968, the Board payed for the services of an Afrikaans teacher for nurses to obtain their Junior Certificate. The training of nursing staff in hospitals ensured a deeply contextualised curriculum with nurses confident to move into service delivery rapidly after qualifying.

With the establishment of the Nico Malan College of Nursing for 'non-White' nurses, the accommodation was lacking in general amenities, which the board then provided.

By 1970, the crèche, which the board had been motivating for in the previous two years, was established. The crèche is one example of an important and much valued asset for the staff of Groote Schuur to ensure the safety and education of their children.

Given that Groote Schuur Hospital is based at the pinnacle point of a tiered health system, it recognised its responsibility to ensure that referring institutions were also strengthened and supported. As part of supporting the referral system to Groote schuur, the Board provided a similar crèche at Red Cross Children's Hospital and Mowbray Maternity Hospital.

Over these early years, the board received many bequest ranging in total from R30 000 to R60 000 over the five years after 1970.

Under the leadership of Mr Fritz Botha in 1976, the Board continued to advocate for 'non-White' staff to have a crèche for their children and live-in accommodation on the GSH site. This was realised with the assistance of the board.

In 1982, the board provided a swimming pool at the Peninsula Maternity Hospital and also sponsored Afrikaans and Xhosa classes; background music for waiting patients; barbering services for indigent patients and newspapers for the wards. While many of these seemingly small provisions seem insignificant, to the patients they meant the difference between boredom and some excitement for the day. As the Board, we continue to try our level best to provide some relief during the times of suffering, for our patients through basic entertainment, access to the canteen, activities and educational sessions to empower our patients.

Recognizing the value and importance of the building, the board submitted a request to the National Monuments Council in 1983, to recognise the front façade and palm trees of the main entrance to the hospital as a National Monument. On the occasion of the 50th anniversary of the hospital, a stained glass window was donated to the chapel. For fundraising, two film premiers were organised, and commemorative glassware and first day covers were sold.

By 1991 – because of funding constraints at the hospital, the Board was asked to fund more activities, such as the shelving in GIT, a Doppler machine, vending machines (50% with the Hospital Benevolent Association); expenses on the gardens and library books. The late Mabel Entwisle bequeathed the largest amount ever to the board: R276 160 in cash and R543 000 in shares. The condition was that the funds be used for Brain, Throat and Stomach cancer research. Fundraising was also successful with a Soiree and banquet at the Mount Nelson Hotel gaining R74 000.

In 1992/3, the board hosted the 25th anniversary of the first heart transplant and also had a charity ball and golf day to raise funds. Professor Barday was appointed as vice Chair of the board. The cancer appeal, started in 1990 with the Cape Argus and a Women's club resulted in the board raising R3.4M, with which various Radiotherapy equipment was purchased.

1996 – Another large donation of shares was received from the Schonnberg trust to the value of R3.5M for Psychiatry and Neurology services.

In the following year, two further substantial bequests were received, to the value of R688 278 and R500 000 from the estates of Late Zweigenhaft and Braam respectively.

1998/9 – the board prioritised R1M for much needed equipment at the hospital and also refurbished the D-floor after the closure and subsequent move of the Princess Alice Hospital to GSH.

1999/2000 – The Radiotherapy fund drive again raised R2.8M and purchased the Linac machine from this. Additional funding of R1M was again allocated by the board for hospital equipment. The board also assisted with the improvements to the Museum.

2001-2005 – the Teaching Hospitals Board was dissolved and replaced by the Health Facilities Board. Dr Barday remained chairperson and on the 2nd April 2013, was elected as the 1st chairperson under the new Hospital Facilities Board Act.

New conditions were set to make the Boards more representative of the community. The Western Cape Health department invited the public to nominate members onto the board with 50% of the membership being community members and the other half being staff representatives - clinical, academic and non-clinical. Experts in law, finances, etc could be co-opted onto the board. Donations from the mail appeal raised more than R1.3M.

In 2003, the Christoffel Blinden Mission(CBM) started contributing towards cataract operations at GSH, which was a great success in creating much needed access to this procedure for indigent patients.

In preparation for the 70th anniversary of the hospital, Prof Howard Phillips started researching and writing the History of GSH in 2003 and completed it over a 5-year period. The book was funded by Mr Gangrekar and was launched in 2008.

In 2004, the GSH Hospital Facilities Board is awarded 18A Tax status, enabling donors to receive tax exemptions for their contributions.

From 2005-2009 the board successfully hosted a number of Chairman's Golf Days to raise funds for much needed equipment, amongst other things.

In 2007, in keeping with the Boards function of enabling staff to perform at their best, the internal telephone directories were converted into braille so that our visually impaired staff could navigate their way around it. The year also saw the receipt of a large perpetual bequest of R23million for cardiology and the Edith Sorrel Cardiac Fellowship was established.

In 2010, Mr Gangrekar, of the Wembley Group in Athlone, a long standing board member of more than 20 years, donated two golf carts to the hospital to transport patients and visitors down the long corridors of the hospital.

In 2011, the Board received a donation of R525 000 towards the renal unit to increase capacity for a much over loaded service. Two longstanding employees of the board, the Office Manager Ms Joey Jauch and the Board secretary, Ms Debbie James retired. Mrs Shanaaz Dove was then appointed – initially in an interim capacity and then as the full time office manager overseeing the Hospital Board and the Benevolent Association's functions.

In March 2013, 50% of the Fewster property was bequeathed as well as cash to the value of R200 000. Both Mr Gangrekar and Prof Barday were acknowledged for offering the hospital 10 year terms on the 'new board' structure but also another 10 years on the previous board structure, more than 2 decades of commitment and service to Groote Schuur Hospital. We remain deeply grateful to them and all other board members who have served and continue to serve the hospital.

In 2014, the Board was alerted to the severe pressures on the surgical waiting lists and made R1.7m available to ease the congestion and allow additional slates for these much needed operations. That year saw the start of an annual tradition of distributing food and toiletry hampers during the festive period to patients admitted to the hospital, rather than being with family or friends. The initiative is made possible with the help of a local NGO, *Mustdaafin* and several local businesses, most notably the JIVE Cooldrink company led by Mr Sharief Parker, who also serves on the hospital board. He made the annual hampers one of his personal commitments to the hospital, for which the patients are immensely appreciative.

THE GROOTE SCHUUR HOSPITAL FACILITIES BOARD

In 2015, the Board funded the Innovation Challenges to stimulate and support staff to develop new ideas on how to improve patient care and staff well-being. A total of R1.6m was made available and the Board partnered with the UCT Faculty of Health Sciences, the UCT Graduate School of Business and several other organisations to assist the staff in taking their ideas from concept to implementation. The project has leap-frogged the innovation process and rendered some ideas ready for hospital wide diffusion, while another has reached near commercialisation.

The Hospital Board, upon request from the CEO, has chosen to further their investment in innovation by part funding the Innovation Hub and funding a second round of Innovation Challenges in 2017.

In 2015, the Board hosted an `Eat n Treat' co-ordinated by Mrs Mia (a board member) to raise funds for the Neonatal Unit. While proceeds from the actual event were modest, we were completely bowled over by the magnanimity of local businessmen and community based organisations who made significant donations following the event.

In 2016, MEC Nomafrench Mbombo attended the Board meeting; we received a donation of 10 wheelchairs from *Muslim Hands* and we hosted a second successful `Eat n Treat' in aid of the Liver Clinic.

We are currently part of one of the most exciting times in the life of Groote Schuur Hospital. Dec 3rd 2017 will mark the 50th anniversary of the most monumental occasion in modern medicine, the success of the first human to human heart transplant and a symbol of our thirst to push all current boundaries (perceived or real) through innovation. Groote Schuur can fairly comfortably hold the title in South Africa's public health system, as the bastion of innovation, having pioneered several world firsts and first of its kind in South Africa. Being able to offer our indigent population the very best care is what keeps some of the world's most reputable staff working here and leaving each day with a sense of fulfillment. Additionally, 2018 represents 80 years since the establishment of Groote Schuur Hospital and represents a unique opportunity to showcase the phenomenal work of the staff and acknowledge their many, many hours days, weeks, months, years and even decades of contributions. Most recently I stood in awe of a general worker and nurse, who both retired after 48 years of service at one place of work, that was Groote Schuur!

As the Hospital Board, we have set ourselves an ambitious target to raise R50m in 2 years to enable Groote Schuur to stay at the very forefront of medical technology and offer this to the poorest patients in Cape Town and beyond. To do this, we have engaged the professional services of the former Dean of UCT Health Sciences, Professor Marian Jacobs. We look forward to re-establishing Groote Schuur in the hearts and minds of Capetonians and South Africans as their preferred institution of healing! To do this, we have a string of events, activities and opportunities for involvement and participation. We are inviting all those interested, those who have crossed paths with the institution as patient, visitor, staff member or related party to contact us and find out more about how you can help us expand the legacy of Groote Schuur Hospital.

Servamus: We Serve

Dr Zameer Brey
Chairperson Groote Schuur Hospital Facility Board

MESSAGE FROM THE DEAN: FACULTY OF HEALTH SCIENCES, UNIVERSITY OF CAPE TOWN

Groote Schuur Hospital at 80 Years: Congratulations from the University of Cape Town

The Faculty of Health Sciences at the University of Cape Town (UCT) congratulates Groote Schuur Hospital (GSH) on achieving the milestone of their 80th anniversary in January 2018. The history of GSH is inextricably bound with that of the UCT Faculty of Health Sciences. The idea of establishing GSH was first mooted in 1913 by the Cape Hospital Board (CHB) who proposed the construction of a central hospital to replace the ageing Somerset Hospital (founded in 1859). In 1916, the CHB further recommended that a teaching hospital be built on Cecil John Rhodes' Groote Schuur Estate to serve the medical school of the UCT. Although it was to take another 22 years before the hospital was built, the two core roles of GSH were established just over 100 years ago: to be a general hospital for the people of the Western Cape, and a clinical teaching hospital to train UCT health sciences students.

In 1920, legislation was passed in Parliament granting UCT use of the land on the Groote Schuur Estate to build a medical school and a teaching hospital adjacent to it. By the same law, UCT was authorised to lease the land for the teaching hospital to the CHB for 99 years at £1 per annum; in return, the CHB had to allow UCT's medical staff and students access to the new hospital's patients for teaching purposes. When the hospital was eventually built by the Cape Provincial Administration in 1938, all the clinical departments of UCT (such as Medicine and Surgery) relocated from Somerset Hospital to GSH.

The collaboration between GSH and UCT has set a high standard of clinical care, teaching and research to meet the overwhelming health needs of the people of South Africa. As a result, remarkable medical advances have occurred at GSH, such as the invention of the CT scan by Cormack and the first human heart transplant by Barnard, making the institution to be one of the iconic hospitals of the world. These were engendered by the foresight and vision of the Joint Agreement between UCT and the Cape Provincial Administration, which provided mutually beneficial funding and governance arrangements for clinical care, teaching and research in the 1960s. The Joint Agreement between the higher education institutions and the provincial department of health is being re-negotiated through the multi-lateral and bilateral agreements. There is hope that the new leadership in the university and health service will propel GSH into a prosperous future.

The ethos of GSH is service, innovation and leadership. A commitment to these values, together with the enduring partnership between GSH and UCT, promise to take the hospital to even greater heights over the next 80 years.

Professor Bongani Mayosi

References

1. Digby A, Phillips H, Deacon H, Thomson K. At the Heart of Healing: Groote Schuur Hospital 1938-2008. Auckland Park: Jacana; 2008.
2. Benatar SR. Changes, Challenges and Choices in Medicine. Cape Town: University of Cape Town, 1981.

VISION, MISSION AND VALUES

OUR VISION

LEADING INNOVATIVE HEALTHCARE

OUR MISSION

Groote Schuur Hospital will remain a beacon of service excellence by striving to develop leaders who will build a culture of continuous improvement through problem solving in order to improve person centred quality health care

OUR VALUES

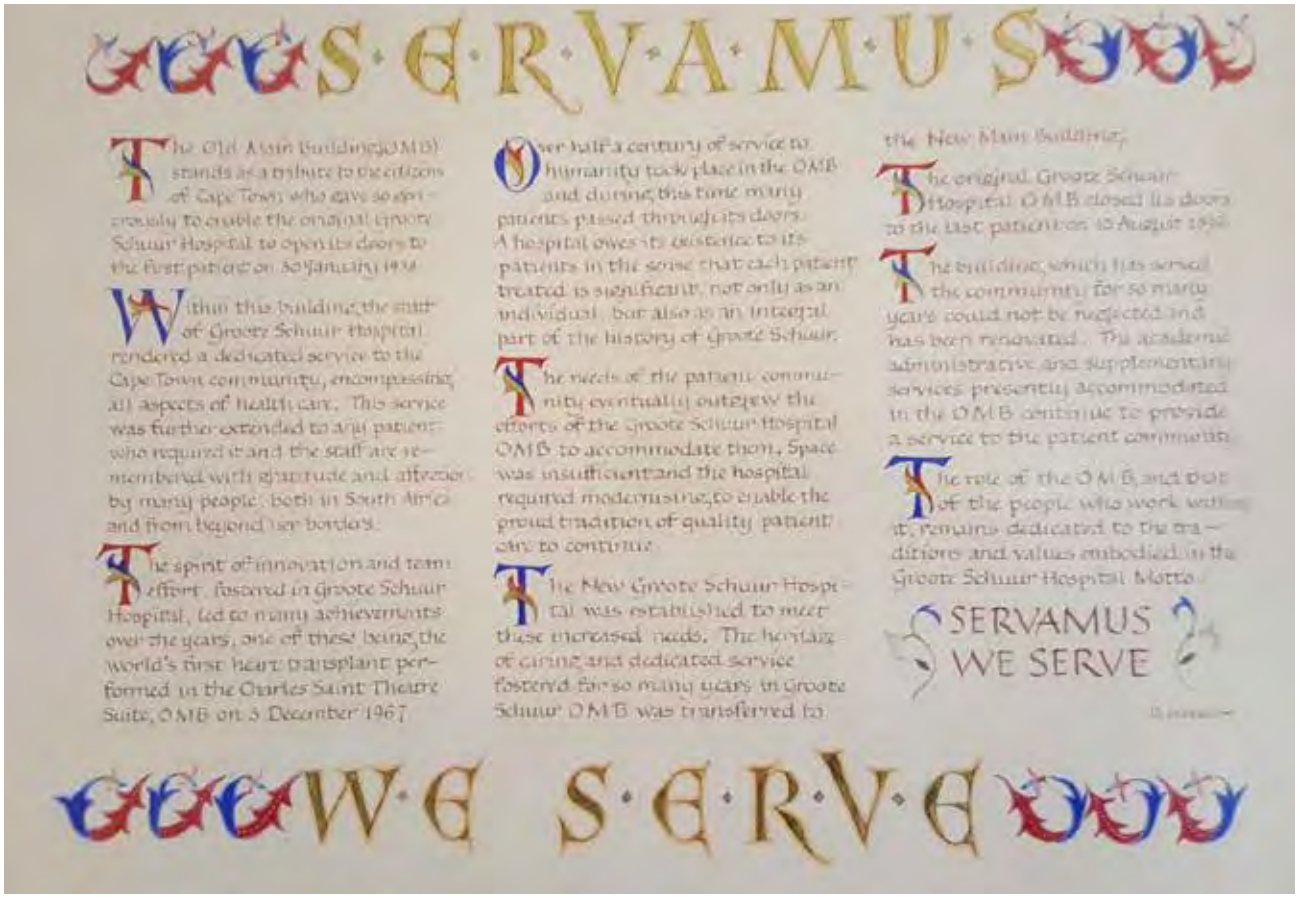
Caring; Competence; Accountability; Integrity; Innovation; Responsiveness and Respect.

OUR BEHAVIOURAL PRINCIPLE

`I will respect you and you will respect me'

OUR MOTTO

SERVAMUS – `We Serve'



CREST

GROOTE SCHUUR HOSPITAL REGION

Description	Arms:	Murrey, three garbs Or.
	Crest:	An anchor erect Or, the shank entwined of a serpent Murrey Wreath and Mantling Or and Murrey
Interpretation	Anchor:	Representational of Brittannia and a seaport
	Serpent:	A caduceus or staff of Asclepius
	Sheaves of Corn:	Relates to Groote Schuur or Big Barn

Hospital motto *Servamus*, which means *We Serve*.

GROOTE SCHUUR HOSPITAL NURSING BADGE

Badge designed by Miss Hester Whitney
(an American Student Nurse) in 1936.

UNIVERSITY OF CAPE TOWN MEDICAL SCHOOL

Description	Argent:	a caduceus Azure
	Chief gules:	three annulets Or
Interpretation	Gold annulets:	emphasize the proximity to Cape Town
	Carduceus:	winged staff of Hermes entwined by two serpents, symbolic of the medical profession
Design	1936 – Dr M du Preez (Urologist)	
University motto	*Spes Bona*, which means *Good Hope*	

GROOTE SCHUUR HOSPITAL

INTRODUTION

At the foot of Table Mountain stands a mammoth building overlooking Cape Town from Muizenberg to Atlantis. Perched high upon the hill in the shadow of Devil's Peak, this building functions as a hospital, providing a public healthcare service to the population of the Western Cape and beyond.

Opened on 31 January 1938, the hospital boasts a proud 80-year history of service excellence. Sir Patrick Duncan, the Governor General of South Africa at the time, officially opened the facility and at the event, expressed the hope that the hospital's doors should never close. This hope has been honoured despite numerous adversities faced in the past and those still to come in the future.

The facility was named ***Groote Schuur Hospital*** after the Big Barn (de Groote Schuur), which was erected by the Dutch on the estate about 400 years ago when they colonised the land from the San and Khoi people. The history further reflects that the entire estate was acquired by Cecil John Rhodes in 1893, where he built a large park, and his home with all its furniture became the home for future Prime Ministers, and now Presidents of the country. Upon his death, the rest of the estate was bequeathed to the Government for the people of South Africa. One of his dreams was to see a National Teaching University on his estate, which was realised in 1910 and called The University of Cape Town. The need for a hospital to provide for the increasing demands on healthcare resulted in the building of Groote Schuur Hospital. It was located on the extreme northern side of the Groote Schuur estate and became the principal teaching hospital of the University of Cape Town Medical Faculty, based adjacent to the hospital, but about 2.2km from the main University Campus. Both the hospital and the University occupy unrivalled sites on the slopes of the mountain, commanding magnificent views of the mountains, the sea and the suburbs of Cape Town.

History of Hospitals in the Cape

The story about how hospitals came about in the Cape starts in 1656, with the Dutch settlers erecting a facility that lasted for forty years until a larger one was built in the late 1690's. A third and bigger hospital was built in 1772, designed for 1442 beds, with quarters for medical officers, attendants and storehouses. The war between England and Holland resulted in the hospital being used as barracks for the troops arriving from France and remained as such until the early 1900's. It was only in the 19th century that a philanthropist and medical practitioner built and established at his own expense the first hospital that served the civil population of Cape Town. Dr Samuel Silverthorne Bailey wanted to erect a facility where merchant seamen, slaves and paupers could receive medical attention. Lord Charles Somerset, the governor at the time, gave him a site off Somerset Road and Dr Bailey opened his hospital in 1818, called Somerset Hospital and Lunatic Asylum. This hospital functioned to treat the sick people of Cape Town until 1859, when the foundation was laid for the New Somerset Hospital. The Old Somerset Hospital remained the town's infirmary and pauper establishment and was known as the Cape Town Infirmary until it was closed in 1938. Dr Bailey remains the founder of hospitals in the Cape and aptly has the 'Bailey ward' named after him at the New Somerset Hospital.

Elsewhere in the Cape, the King William's Town's Grey Hospital and the Provincial Hospital in Port Elizabeth were opened in 1856; Grahamstown's Albany Hospital was established in 1858 and by 1905, the number of hospitals had increased to 24. In the Cape Peninsula, the following hospitals were erected: Victoria Cottage Hospital – 1888; Woodstock Hospital – 1893; Eaton Convalescent Home – 1905; Rondebosch and Mowbray Cottage Hospitals – 1901; Simonstown Cottage Hospital – 1905. Through the collection of private funds, 1860 saw the first free Dispensary in Cape Town, to provide relief to the poor, so that they need not travel all the way to the New Somerset Hospital. By 1887, out-door maternity cases became a reality. General Nurse training was offered at 4 of the 13 hospitals in the Cape Peninsula, while midwifery training happened at the Cape Town Free dispensary unit and the Bree Street Maternity Hospital, which later became Booth Memorial Hospital.

The Cape Hospital Board

Changes in the hospital administration came with the advent of the Union of South Africa in 1910, when the four colonies became Provinces, each with a Provincial administration, hence hospitals were governed by their respective Provinces. The Province of the Cape of Good Hope passed the Cape Hospitals and Charitable Institutions Ordinance No 5 of 1912, resulting in hospital boards being in control of the management and finances of the institutions. The Cape Hospital Board was established in 1913 and managed New Somerset, Woodstock, Victoria Cottage, Rondebosch and Mowbray Cottage, Simonstown Cottage Hospitals, the Eaton Convalescent Home and the Cape Town Free Dispensary.

The functioning of the Cape Hospital Board was significantly hampered by many adverse criticisms levelled against their creation as well as the many difficult problems they faced, having centralized previously independent bodies. They therefore chose to offer the hospital committees a fair amount of self-government until a thorough enquiry could be held with regard to the betterment of hospital patient accommodation in the Cape Peninsula. One of the recommendations of the enquiry was that there was a need for a suitable General Hospital to serve the city. The project was unfortunately abandoned when the Board was unable to secure a loan for the project. The board hence had no alternative, but to consider expanding existing institutions for both free and paying patients.

The New Somerset Hospital was selected to be the free hospital to serve the municipalities of Cape Town and Sea Point; Woodstock Hospital served free patients between Woodstock and Newlands and the Rondebosch and Mowbray cottage hospitals were demarcated for paying patients. Serving the area between Claremont and Muizenberg, it was decided to develop the Victoria Cottage Hospital as a free hospital, with another building for paying patients alongside the structure. With further pressure to provide services for Maternity patients, the Board resolved to provide for Maternity departments in all free and paying hospitals as well as outpatient departments. This broad view taken by the Board in establishing services to benefit all communities resulted in the opposition to their creation being dissipated and all committees started working loyally and harmoniously.

Many challenges were faced since its inception, but the Board resolved to continue to address these, including the further need for more patient beds, the need for a nurses' home, the need for a 'sanatorium' and the many financial demands that went with the expansion of services. Some of the needs were managed by expanding the New Somerset Hospital by building three storey pavilions to accommodate ophthalmic and ENT care. By 1914, the Shipley Pavilion was built in memory of Joseph Shipley from whose estate the bequest had been made. Mr and Mrs Brown Lawrence donated £1,000 to equip and furnish the building. This allowed the board to concentrate on building accommodation for the nurses, who had been sleeping in empty patient beds or the top floor store rooms. Over the following years up to 1919, Nurses' homes were built at all hospitals and slowly expanded as funds became available.

Building projects were funding-dependent and prioritised in terms of need. Some expansions to patient services and nurses' homes occurred because of the many bequests that the Board received during this time, including the facility for nurses at False Bay Hospital in 1931, the expansion to the nurses' home at Woodstock Hospital in 1932, two new wards for `non-European' patients at Mowbray and Rondebosch Hospitals in 1925, a three-storey block for `non-European' patients at Victoria Hospital in 1930 and an extension to the Free Dispensary Building in 1928 allowing dental work to be expanded. In 1918, the Board leased premises for the Peninsula Maternity Hospital in Woodstock, which later moved to a larger space and was opened in 1932 by Lady Clarendon as a Maternity Hospital and Children's Home. The Princess Alice home for children in Retreat, officially opened in 1933, mainly due to funds raised by the Women's Hospital Auxiliary. Similarly, the Lady Michaelis Orthopaedic Home in Plumstead was developed and run by the woman who bore her name and was gifted to the Union Government who passed it on to the Provincial Administration and they in turn offered it to the Cape Hospital Board.

Financially, the Board struggled year on year, being dependent on the Provincial Administration as well as the generous support from the public. 1928 saw the first Hospital Association take shape at False Bay Hospital and similarly at Victoria Hospital two years later. As further hospitals opened their doors, hospital associations assisted them to raise funds. The year 1932 was seen to be the darkest year of all, with financial stringencies being imposed in order to ensure that services did not suffer. Certain employees had to endure a cut in their salaries until the end of March 1934.

The Cape Hospital Board started out with seven institutions and when it ceased to exist in 1949, the number had increased to fifteen. Apart from the hospitals, convalescent homes were also developed, mainly due to donations of property, houses and huge sums of money to run the facilities. District Nursing services formed the cornerstone of care directly to the communities managed by the District Nursing Organization. The Cape Hospital Board had led the way among Hospital Boards to expand District Nursing care throughout the country. At its commencement in the Cape, the organization had two nurses and by 1949, had 17 branches, 28 nurses and a Superintendent, serving 29 662 patients at 154 406 attendances.

Nursing services at the hospitals

The Cape Hospital Board remained mindful that while they struggled to provide accommodation for the many patients seeking care, they also had to accommodate those who took care of the sick, the doctors and nurses. The hospitals would not be able to provide any service without the support of the nursing staff, who to this day remain the backbone and heart line of any health service. The minutes of the Chairman of the Board for 1922-1923 read, "A great advance has been made during the period under review in the conditions under which the members of the nursing staff are housed and rewarded for their services. It has been a settled policy of the Board from the first to improve the housing conditions of their nurses, and a large sum of money has been spent in providing Nurses' Homes at several hospitals. The pay, leave and conditions of service of the nurses generally have been very considerably enhanced under the Nurses' Salaries and Pensions Ordinance of 1918 and its amendments, which have been enacted almost annually since that year." Nursing as a profession has a long history over many centuries and had emerged from a period of darkness to enlightened days around the 19th century, when Florence Nightingale changed the concept of Nursing and started offering systematized training. To the present day, Nursing is a profession of calling, requiring a person with compassion who is prepared to work long hours, under difficult working conditions, including nights and weekends and for a small wage. In the 1870's, the Matron of Somerset Hospital earned £60 per annum. Her successor received £70.10s. At the turn of the century, the salary had risen to £120 per annum. Their duties started at 07h00 and only ended at 20h30. Prior to 1913, nurses worked every day and only received 2 hours off per day, half a day per month and three months' night duty with no night off. Education was over two years under the supervision of a medical person and around the early 1900's, it became a three-year course. In 1914, the South African Trained Nurses' Association was established, which in 1944, became the statutory body, the South African Nursing Association. Their purpose was to foster a spirit of unity among the nurses of South Africa and to deal with matters affecting the interests of the profession, the conditions under which they worked and to provide a trained and qualified nursing service for the benefit and protection of the public.

An acute shortage of nurses was felt during the First World War, necessitating the employment of uncertified assistants. In 1922, the committee of the New Somerset Hospital reorganised the training course for nurses which involved four years instead of three under the supervision of a Sister Tutor, but the idea was later scrapped because of non-interest from other training institutions and hospital boards. Discussions however remained ongoing because of the need for obtaining nurses who provided a higher standard of care. Eventually, in 1927, the revised Nursing regulations were published, adopting the training period for Class 1 at three and half years

and that for Class 2, at four and a half years. Many other changes ensued, for example, in 1929, the Board allowed for the substitution of the stiff collars, cuffs and belts of the old regime, with White overalls. Hours of duty were improved and salary scales were adjusted.

Although the training of 'non-European' nurses was considered at an early stage, the idea was never carried into effect because of a lack of separate accommodation. In a letter from the Honorary secretary of the Conference of Women Missionaries of the Church of the Province of South Africa, which was presented to the Board at the meeting of 23 March 1921, it was stated: "…facilities should be given for the full training of `native' and `coloured' women as nurses in some of the larger training schools in the Union which have `native' and `coloured' wards, in order that such nurses may be available to attend upon their own people in case of sickness…"

With the planning of the Groote Schuur Hospital in 1932, space was again not made available to accommodate `non-European' nurses, but with further pressure from organizations interested in the welfare of these populations, `non-European' nurses were accepted for training once Groote Schuur Hospital was built and funds were then made available for this. However, the accommodation was not completed by 1938 when the hospital opened and it was decided the `non-European' nurses would use the Somerset Hospital facility for training purposes. On this matter, it is recorded that there was agreement between the Medical Association of South Africa (MASA) Cape Western Branch, the South African Trained Nurses' Association and the Cape Hospital Board.

Throughout the many annual reports, a common thread is noted to be a shortage of skilled nurses, as quoted in 1916, "…The scarcity of nurses is general throughout South Africa and has been shown by the complete lack of response to the many advertisements placed by the Board".

Other hospital and patient services

- Early in 1938, a Blood Transfusion Service was carried out in Johannesburg, by a voluntary organisation. The same organization established the service in September 1938 in the Cape Peninsula, called the Cape Peninsula Blood Transfusion Service. They officially started on 1 December 1938 and are now known as the Western Cape Blood Transfusion Service.
- The first motor ambulance was put into commission in July 1915 and operated by the Fire Brigade. By 1948, due to increased demands on the service, the fleet had been expanded to eight ambulances and one station wagon with a staff complement of 28. The Board also used the services offered by the St John's Ambulance Brigade and the South African Red Cross Society.
- All facilities had access to well-equipped workshops staffed by skilled technicians and artisans available day and night. A Central Laundry had also been established.
- After many discussions, the Board meeting on 24 January 1923 adopted a regulation requiring a form of consent to be signed by every patient admitted to hospital for an operation.
- On 28 July 1920, the Board considered the advisability of arranging a policy of hospital public liability insurance under which they would be relieved of their liability to the public for alleged neglect, mismanagement, wrong treatment or professional malpractice on the part of any of the hospital staff. It was decided however not to effect such insurance.

Figure1: Ambulance arriving at Groote Schuur Hospital

Funding arrangements of the Cape Hospital Board

The Cape Hospital Board received funding for its activities from Provincial subsidies, revenue derived from patient's fees, voluntary contributions and bequests. This system of funding hospitals is thus a century old. Prior to 1912, there was the voluntary system, which relied on charitable contributions and fees, with the assistance of casual grants from Government. The Ordinance of 1912, allowed for the voluntary system to continue, thereby allowing for hospitals to rely on additional support from donors, while receiving a government subsidy proportionate to the amount donated and not exceeding £500. Later, in 1916, this process was discontinued and only the difference between the cost of maintenance and revenue received was subsidised. By 1921, there was a further ordinance limiting the amount of funds provided by the Provincial Administration to the actual amounts given to them in the previous year. Despite huge financial constraints in the early 1930's, the Board managed to sustain its essential services through the assistance of staff and members of the board to reduce costs and function stringently during the trying times.

As stated before, hospitals relied heavily on the generosity of the public who had the interests of their local hospital at heart. Others donated annually, while some gave freely of their time to assist patient care. Various committees, such as the Women's Hospital Auxiliary, the Rotary, the Rag Committee of the University of Cape Town, the Ladies' Clothing Guild, Moslem Hospital Welfare Committee, Jewish Ladies Society, Church Committees, among many others, assisted by raising funds or volunteering at the facilities. The Mayoress held an annual Ball to augment the funds required. The establishment of Hospital Associations attached to specific hospitals and served by spirited men and women, assisted the hospitals with minor improvement work as well as dealing with certain humane aspects of the care of patients.

Groote Schuur Hospital

The Medical School was established during 1902 and used the Hiddingh Campus as its first teaching facility when it started in 1912 and later moved to the Groote Schuur estate.

At the start of 1913, a School of Medicine had occupied the attention of both the Committee and the Board from time to time and they never lost sight of this need. Having build a post mortem room at Somerset Hospital, it was equipped for the convenience of medical students. Somerset Hospital thus became destined to become the teaching hospital attached to the South African College as the medical academic facility.

Figure 2: Hidding Campus - the first medical teaching facility inaugurated on 6 June 1912

The Groote Schuur estate had been bequeathed to the Department of Education for the development of a National University, which was built and opened in 1928 as the University of Cape Town. The University initially functioned as the South African College, a high school for boys, founded in 1829 and situated in the heart of the City. The College included a small tertiary education facility and developed into a fully-fledged university between 1889 and 1900 with an injection of funding from private sources and the government. The need for a Medical Faculty had been agitated for some time, but needed to find a hospital suited for the clinical training of students. It was only in 1928 that the University was able to move its activities to the Groote Schuur estate at the foot of Devil's Peak, the land originally intended for it.

Figure 3: South African college

Figure 4: Somerset Hospital

The Medical Faculty used the New Somerset Hospital as its teaching platform, but with only 267 beds, the hospital was clearly overcrowded and unsuitable for the training of the many medical students. The need for a large General Hospital in the City became more imminent after the worldwide Influenza epidemic from the latter part of September and throughout the month of October in 1918. The proposal was mooted several years before, but had to be abandoned due to a lack of funds and the First World War of 1914 to 1918, which declared other priorities. The initial proposal of such a general hospital site was to use Alexandra Hospital, at a cost of £25 000 to £30 000. Somerset Hospital would remain the site for `European' chronic cases and the Old Somerset Hospital would be restricted for `non-Europeans'. The matter was put forward to the University and after much deliberation, noted that the use of Alexandra Hospital with 458 beds, would actually cost £85 000. The idea was then no longer considered to be viable.

The realisation of the acute shortage of beds in the Peninsula maintained the pressure of the need for a hospital closer to the medical campus, which assisted in procuring the site for a hospital. The University of Cape Town (Medical School) Act No 36 of 1920, allowed for authority to be given that a portion of the site of the Medical School could be used "for the purpose of building a fully equipped hospital for the sick".

During the initial stages, the acquisition of the land as a site for the hospital was delayed because of legal difficulties, with the then Minister of Education being required to develop and introduce Union legislation to overcome this. The Cape Hospital Board persisted with enthusiasm and early in 1919, suggested that the hospital be named "The Peace Memorial Hospital", in commemoration of the soldiers who participated in the First World War. In the early 1920's, there was little progress. Additionally, the public objected to the closure of the main drive at the Observatory end of the estate. Pressure on the accommodation needs for patients was mounting with the hospitals not only serving the population of the Cape Peninsula, but also those from the country districts. In addition, Alexandra Hospital, which served as a convalescent home, kept patients in beds long after they had ceased to benefit from any treatment, resulting in more chronic patients being kept at the hospitals.

Once the need for the hospital was agreed, it was decided that the hospital would be named "The Somerset Hospital". The Board took the advice of Colonel D.J.Mackintosh of the Western Infirmary, Glasgow, who submitted sketch plans and advised as to the setting out of the hospital and its laboratories, under the direction of Mr J.S.Cleland, Secretary for Public Works. At a special meeting of the Board, held on 13 October 1920, the sketch plans were presented by Colonel Mackintosh and adopted by the Board as the general outline in respect of the provisions of the hospital. The building was estimated to provide for 870 beds at a cost of approximately £1,742,500.00

Figure 5: Minature model of hospital

The most urgent requirement was thought to be the Maternity Wing and the University placed £20 000 at the board's disposal for this purpose. The plans included a 26-bed maternity section costing £35 000. In addition to the funding shortfall, other problems with the water mains and a public driveway traversing the site resulted in the project being shelved. This was later overcome by the Secretary and Treasurer of the Board, who was asked to visit Pretoria whilst on leave in Johannesburg. He returned with a proposal presented to the Board on 24 October 1923, in which the plans were rearranged and estimates were revised. The Board then decided to invite tenders for the building of the Maternity Block.

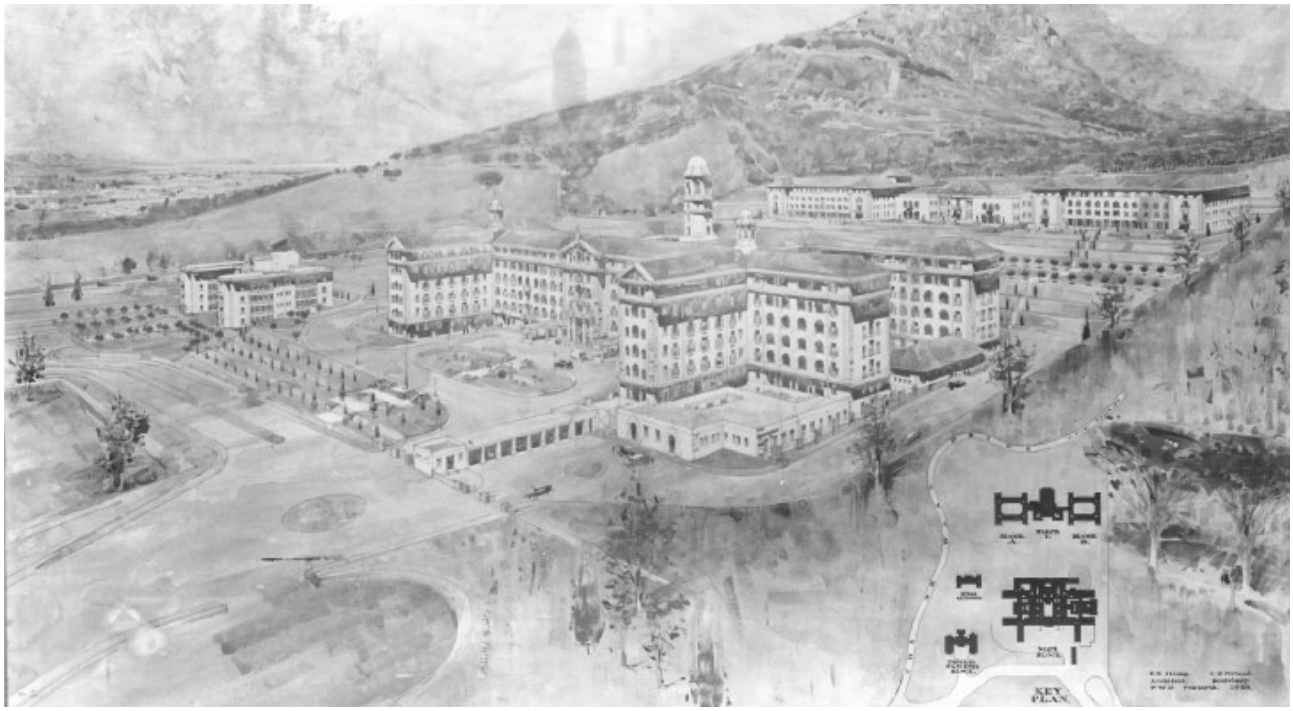
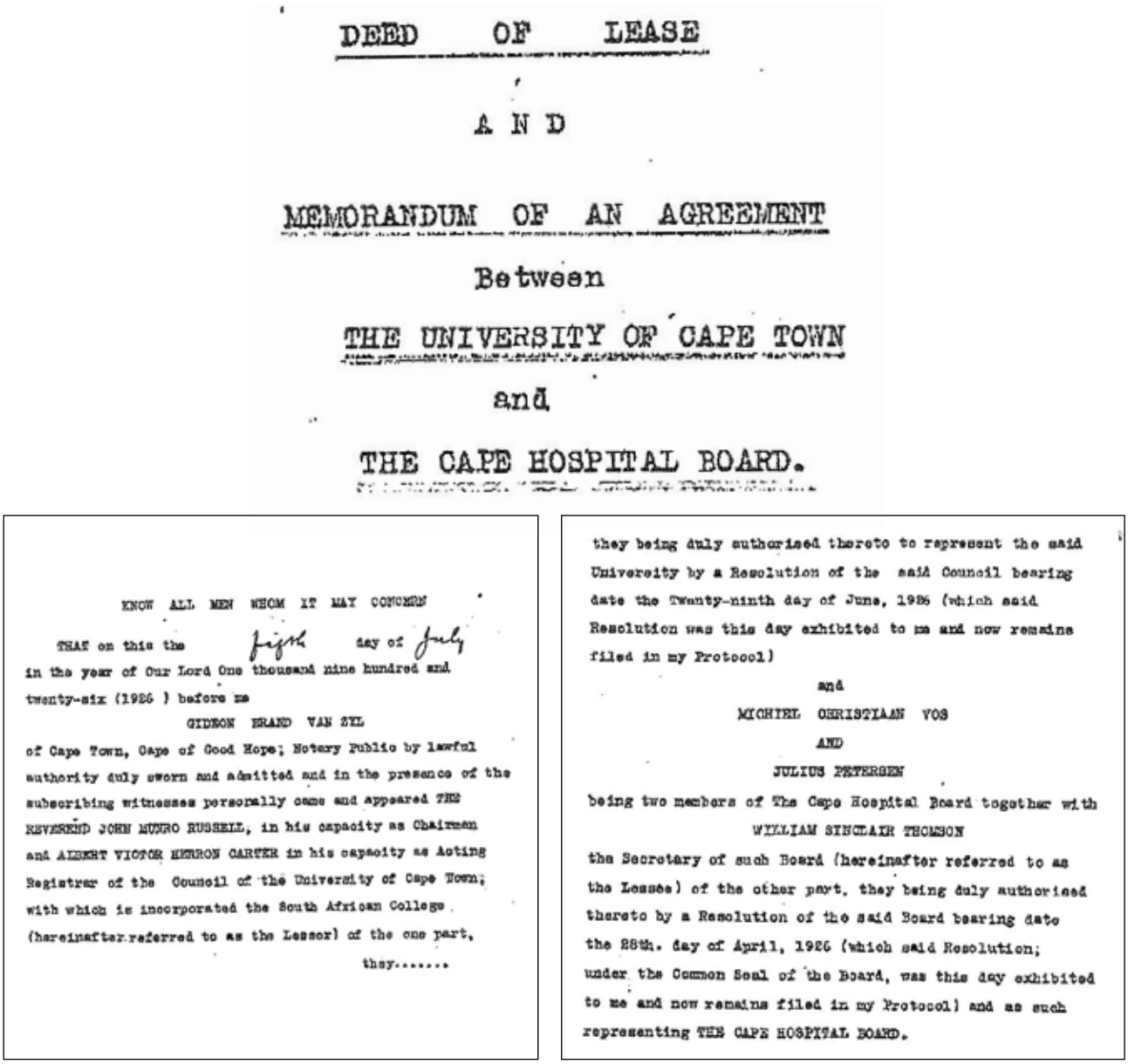


Figure 6: Sketch of the proposed plans

The legal battles came to a conclusion in 1926, when a 99-year lease of the site, approximately 11 hectares, was signed between the University of Cape Town and the Board at a peppercorn rent of £1 sterling per annum. Some of the conditions of the lease included that the new hospital for the sick was to be built within five years and that professors and students of the Medical School should have access to the hospital for teaching and training and that the University wanted representation on the Board. This decision was passed by the Board on 27 October 1920.

The Board continued to raise funds for the building of the hospital. The first donation was received and recorded at the Board meeting of 23 March 1922 from the estate of the late F.J.Pearce, who gave £100 and from the Women's Hospital Board of Aid, a sum of £500 was earmarked for the furnishing of one maternity ward at the hospital. It was only at the Board meeting of the 25 June 1924, that a principle was adopted to set up a permanent Association to raise funds for building and endowing the new hospital.

The first signs that the hospital was being erected was in April 1927, when the ground was levelled. Progress was slow and it was only two years later in 1929 that the earth works and stone pitching was completed, with building to have commenced at the end of March 1929, but the Administrator had not signed approval for the scheme by that stage. Bed pressures were noted again and again with services for the sick and the poor being wholly inadequate. During 1928, an inspection of institutions managed by the Board was carried out by Dr A.J. van der



DEED OF LEASE

A N D

MEMORANDUM OF AN AGREEMENT

Between

THE UNIVERSITY OF CAPE TOWN

and

THE CAPE HOSPITAL BOARD.

KNOW ALL MEN WHOM IT MAY CONCERN

THAT on this the fifth day of July in the year of Our Lord One thousand nine hundred and twenty-six (1926) before me

GIDEON BRAND VAN ZYL

of Cape Town, Cape of Good Hope; Notary Public by lawful authority duly sworn and admitted and in the presence of the subscribing witnesses personally came and appeared THE REVEREND JOHN MUNRO RUSSELL, in his capacity as Chairman and ALBERT VICTOR HERRON CARTER in his capacity as Acting Registrar of the Council of the University of Cape Town; with which is incorporated the South African College (hereinafter referred to as the Lessor) of the one part,

they.....

they being duly authorised thereto to represent the said University by a Resolution of the said Council bearing date the Twenty-ninth day of June, 1926 (which said Resolution was this day exhibited to me and now remains filed in my Protocol)

and

MICHIEL CHRISTIAAN VOS

AND

JULIUS PETERSEN

being two members of The Cape Hospital Board together with

WILLIAM SINCLAIR THOMSON

the Secretary of such Board (hereinafter referred to as the Lessee) of the other part, they being duly authorised thereto by a Resolution of the said Board bearing date the 28th. day of April, 1926 (which said Resolution; under the Common Seal of the Board, was this day exhibited to me and now remains filed in my Protocol) and as such representing THE CAPE HOSPITAL BOARD.

Figure 7: Cover and Page 1 of original lease agreement

Spuy, the Assistant Health Officer in the Department of Public Health. His report re-iterated the acute shortage of beds, with a chronic condition of overcrowding at all Peninsula Hospitals. The scheme was finally approved on 22 April 1929 and immediately upon its receipt, the Public Works Department was requested to proceed as rapidly as possible with the working drawings. At that stage, it was hoped that building would commence by the end of 1930 and would take 3 years for completion. The planning phase, having come at the end of a series of previous schemes, allowed for many lessons that were learnt to be implemented. There was a departure from the lay-out being a pavilion type of hospital construction and radical alterations were made to the plans after Mr J.S.Cleland, the chief Government architect, had visited Europe. The actual design was done by Mr F.D. Strong, an architect in the Department of Public Works, who worked under the Secretary for Public Works, Mr T.S. Cleland.

Negotiations continued between the Board and the Provincial Administration for funding to build the 850 bed hospital at a cost of £735 200. This provided for a six storey main block including an outpatient department. At this stage, it was also proclaimed to name the hospital "Groote Schuur Hospital". With the war having passed some years before, the name "Peace Memorial" was no longer appropriate and then the name "Somerset Hospital" appeared to have been lost in the mounds of paperwork over the seventeen years since the initial stages in 1921. The name Groote Schuur Hospital thereafter remained and has appeared in all subsequent Provincial Ordinances and Acts of Parliament.

The site was handed over to the contractors on 20 January 1931, for the laying of the foundation of the main building at a cost of £49 846. Mr M.C. Vos, the vice chairman of the Board, because of his expert knowledge on the topic, planted all the trees and shrubs at the site of the new hospital. It was meant to be a two-staged project with separate contracts for the foundation and superstructure. The two foundation stones were laid, one by the Governor General of the Union of South Africa, the Earl of Clarendon, and the other by the Administrator of the Cape of Good Hope, Mr J.H Conradie. Under each stone was buried a casket containing the Programme of the ceremony, a brief account, on parchment, of the events leading up to the realization of the project and a few Union of South Africa coins.

Figure 8: The Governor General, the Earl of Clarendon laying one of the foundation stones on 12 April 1932

Figure 9: Mr F.B. Morris and Mr J.H. Conradie inserting coins into the foundation

The foundation was completed in the early part of 1932, but there were ongoing delays in proceeding with the next stage of building the superstructure of the main block. For this phase, the lowest tender was accepted to be that of Messrs Douglas and Munroe, Ltd., at a cost of £362 700. The building commenced on 3 May 1933 and because of the steep slope, three terraces had to be constructed and for reasons of economy, the Board decided to employ convict labourers. A fresh bout of protests against this, resulted in further delays and the Board resorted to unemployment relief through the Department of Labour.

Figure 10: Stinkwood mallet and Trowel used during the foundation laying ceremony in 1932

Figure 11: Two foundation stones

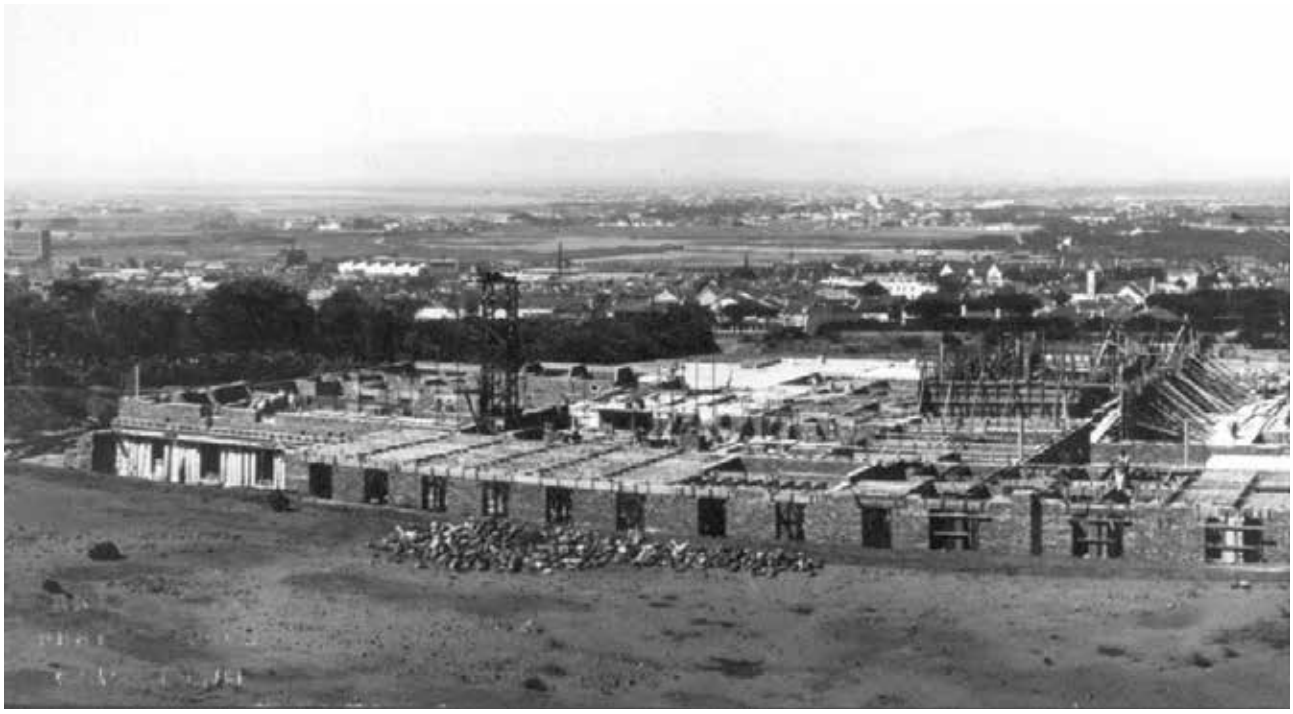
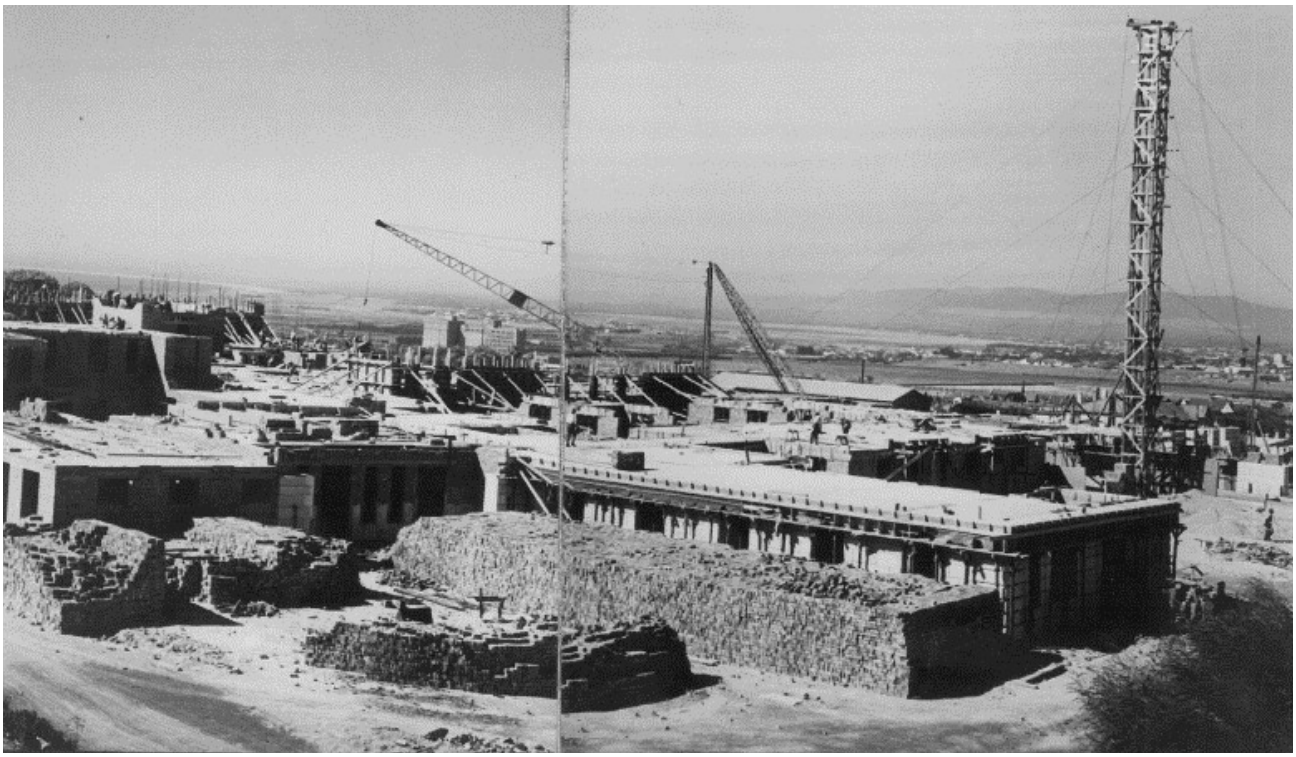


Figure 12: Construction commenced on 3 May 1933



GROOTE SCHUUR HOSPITAL

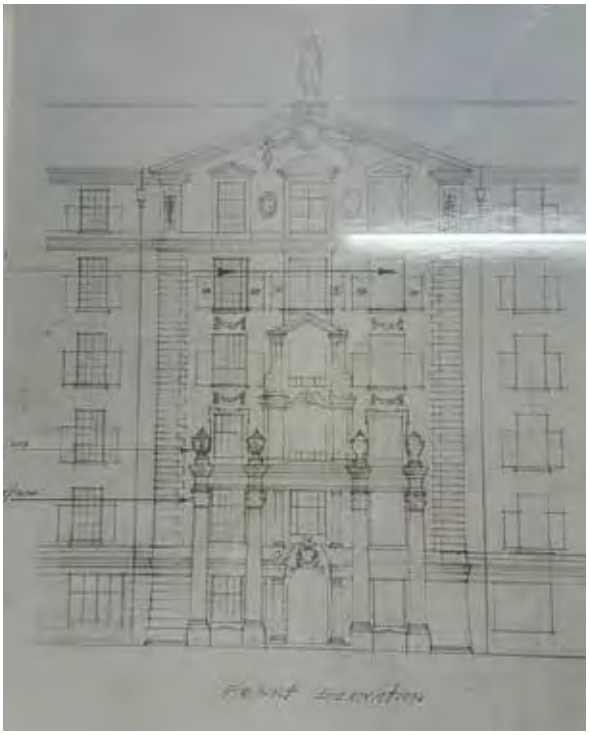


Figure 13: Architect's impression of Front Elevation

Figure 14: Completed Front Elevation

Figure 15: Completed building in 1938

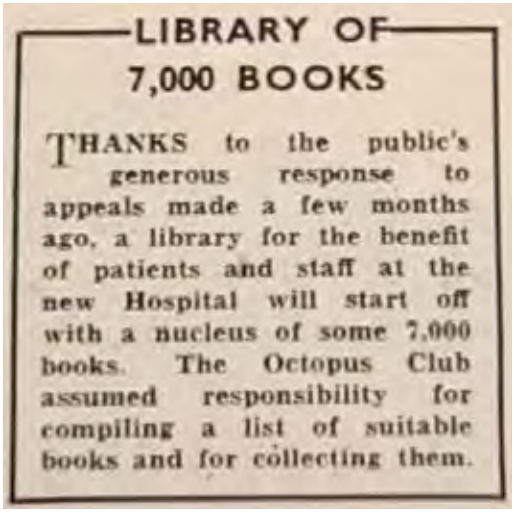
Figure 16: Side view of building

Figure 17: View from the back of the building showing the Chapel

By 1935, the Board started discussions around purchasing equipment for the hospital, and soon realised that this was not going to be possible without outside help. A committee was established under the chairmanship of Mayor J.D. Louw with Mr A.N. Foot as Vice Chair and Mr E.R. Syfret as Honorary Treasurer. A large group of volunteers was enrolled and they launched a public appeal for contributions towards the cost of equipping the hospital estimated to be around £150 000.

Figure 18: Appeal for equipment donations poster

Over the following years, the country was in the middle of the great depression and the Board faced many financial crises related to the building, while trying to maintain the upkeep of all the other facilities and from time to time, alterations and additions were made to the plans, resulting in certain of the projects, such as the central laundry and the staff accommodation, having to be abandoned. By 1934, the cost had exceeded the original estimate by £135 000. The number of beds was revised, resulting in the total capital cost being £801 000. The Board then appealed to the public for funding the equipment and other needs, to which there was a magnificent response. Every individual was asked to donate one day's pay to the hospital. This fundraising drive was initiated on 17 January 1936 and by the end of the month, more than £10 000 had been received, with the figure doubling in the next month. By March of 1937, the target of £75 000 was exceeded by £6 000. All sectors of the community participated in the form of donations, balls, concerts, bazaars, etc. At the end of the war, there was a balance of £560 in the troops' refreshment fund and this was also donated towards equipping Groote Schuur Hospital. These funds were specifically earmarked for the children's ward. Mr Ahmed Ismael from the Indian Congress donated a large sum of money as did members of the Jewish community. Donors could name a bed for £50. Schools in the Peninsula participated in competitions to raise funds. Realizing that they too would use the services, the Council of Namaqualand also donated a small amount to the fund. This response clearly showed that Groote Schuur Hospital was and still is indeed the people's hospital.



LIBRARY OF 7,000 BOOKS

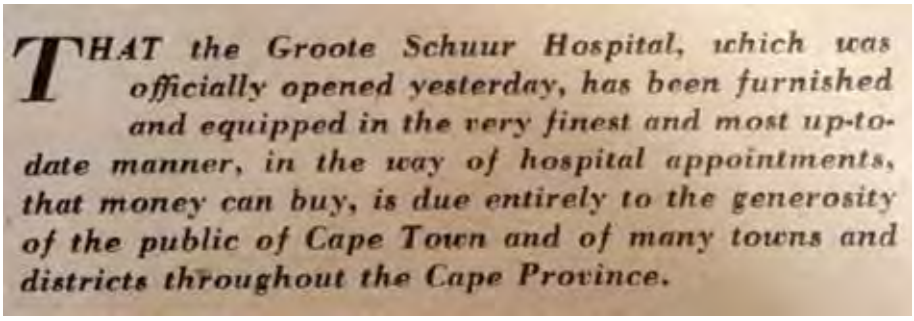
THANKS to the public's generous response to appeals made a few months ago, a library for the benefit of patients and staff at the new Hospital will start off with a nucleus of some 7,000 books. The Octopus Club assumed responsibility for compiling a list of suitable books and for collecting them.

Public Raised £81,000 for

IN January, 1936, the Cape Hospital Board, after negotiations with the Provincial authorities, made a direct and personal appeal to the public for £75,000 towards the cost of equipping the new hospital, the buildings for which were then rapidly taking shape.

The cost of the buildings themselves, which eventually worked out in figures totalling roughly £830,000, was found by the Government. Under the laws of the Cape Province, however, the matter of who shall provide funds for the purchase of hospital equipment is not specifically laid down by law.

The Ordinance of 1933 permits the Hospital Board to raise loans for this purpose subject to conditions laid down by the Administrator.



THAT the Groote Schuur Hospital, which was officially opened yesterday, has been furnished and equipped in the very finest and most up-to-date manner, in the way of hospital appointments, that money can buy, is due entirely to the generosity of the public of Cape Town and of many towns and districts throughout the Cape Province.

Groote Schuur Hospital: 1938 to 1948

The building was completed and officially opened on 31 January 1938, by the Governor General of the Union of South Africa, Sir Patrick Duncan.

At the opening, attended by numerous dignitaries, he remarked that "…. we have here accommodation for 859 beds which will have to be increased before long to 1400". The main hospital consisted of the main six storey block, a single storey wing for outpatients, a three storey block for private patients and the resident doctors' quarters on the main terrace and the second terrace above it being the Nurses' Home, named Clarendon House in honour of the Earl and Countess of Clarendon. Lady Clarendon showed a keen interest in Nursing and social welfare matters.

The hospital boasted a magnificent structure of superb craftsmanship with a wealth of intricate decorative detail, built of solid stone and overlooking most of the Cape Peninsula. According to Mr Cleland, the secretary for Public Works, who was in charge of the design of the hospital, the building takes the form of a double cross, similar to the game noughts and crosses, with large wings extending at right angles in order to ensure maximum light and ventilation. Everything was designed to promote recovery. Windows were positioned to ensure plenty of sunshine and light in every section, cool breezes in hot weather and ample ventilation, without the risk of draughts, in bad weather. Balconies and verandas and the use of all flat roof surfaces, made it possible to move patients out into the fresh air and sunshine whenever circumstances allowed it. The hospital was composed of two almost identical parts, with an imaginary dividing line extending from the ground floor to the top storey delineating the possibility of dividing the hospital for `Europeans' and `non-Europeans'.

The base is of granite faced pre-cast stone blocks in the plinth with marble based artificial stone, above which, the walls have been built of approximately 10 000 000 well-burned wire cut clay bricks. In addition, the building used 700 tons of steel, 9 500 cubic feet of concrete, 82 000 square feet of roof tiling and 61 000 square feet of glass creating a length of frontage at 536 feet. As symbols of healing, there were many decorative features added. Hygeia, the goddess of health, welcome the sick and suffering with her ever-flaming torch, above

the central gable, mistaken by many as Florence Nightingale. According to Greek Mythology, Hygeia is the daughter of Asclepius, the god of health and healing often depicted with a wand in the coils of a snake or with a scroll, symbolising knowledge. The statue Hygeia was the work of Ernest Quilter.

The central portal is flanked by Corinthian columns with unusual indigenous flora. Other embellishments include Grecian urns, swags, wreaths, and cherubs. Two Zimbabwean birds, replicas of those found at the Zimbabwe ruins, gaze down from the top of the original water towers.

The three towers of the building likewise carry symbolic features. There are eagles on the turrets on the side of the hospital, to signify the soul. The angels with spread wing, the work of Ethel Wynne-Quail, are on the northern and southern gables as well as the fasces, which incidentally were also used by Julius Caesar and Mussolini, as an emblem of authority. Beautifully crafted teak doors give the entrances a warm finish. Vladimir Meyerowitz's magnificently carved fanlights arch over the five solid teak entrance doors, embellished with brass escutcheon plates depicting Mercury's caduceus (mistaken for Asclepius' staff).

In front of the old hospital, known as Palm Court, twin lily ponds were constructed, with a pathway between them, and two lions' heads, the work of South African sculptor, Mitford-Barberton, spewing water into the ponds.

Wards were styled to accommodate the Florence Nightingale philosophy of care and to honour this, a brick from Florence Nightingale's home is encased in glass in the Chapel.

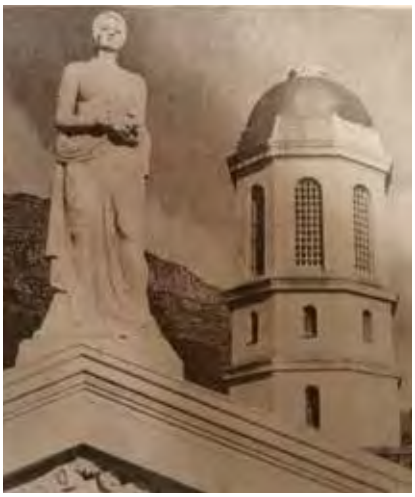
CAPE TIMES GROOTE SCHUUR HOSPITAL SUPPLEMENT, FEBRUARY 1, 1938.

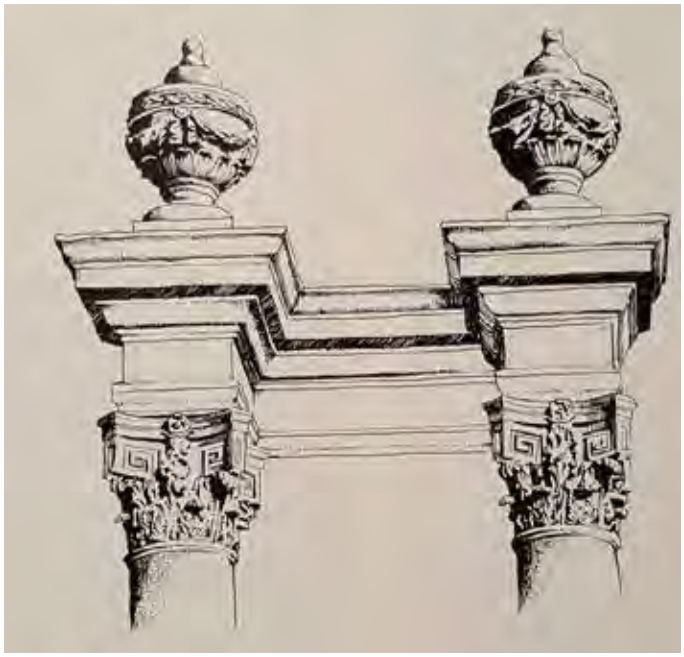
New Hospital Opens Its Doors This Week

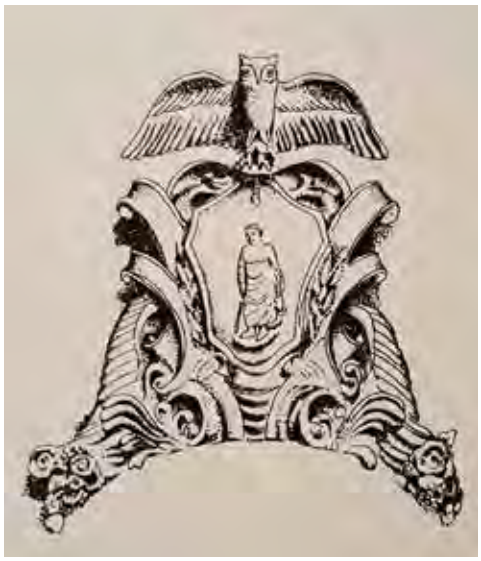
BUILDING in which CAPE TOWN can Take PRIDE

THIS is indeed a memorable week for the sick and suffering of the Cape and for those doctors and nurses immediately responsible for their treatment and care.

Mr. J. S. Cleland, Secretary for Public Works, who designed the Groote Schuur Hospital.








12½ TONS OF STAINLESS STEEL
HOT FOOD CONVEYORS,
KITCHEN EQUIPMENT,
HANDRAILS, SINKS & TABLES
made for Groote Schuur Hospital
BY
MEWA MANUFACTURING CO.
FABRICATION SPECIALISTS IN STAINLESS STEEL
HERBERT SQUARE, CAPE TOWN


THE LARGEST ELECTRICAL MANUFACTURING ORGANISATION
IN
THE BRITISH EMPIRE
G.E.C.
EQUIPMENT INSTALLED IN GROOTE SCHUUR HOSPITAL
INCLUDES
THE BRITISH GENERAL ELECTRIC CO., LTD.
HERBERT STREET — CAPE TOWN


10,000,000
BELLVILLE
BRICKS
were used in the construction of this Hospital
IF THESE BRICKS WERE PLACED
END TO END
they would extend all the way from
CAPE TOWN
to
JOHANNESBURG
and then on to
DURBAN
AND, IN ADDITION
several hundred thousand
HUME
FACING BRICKS
were supplied for the fine exposed brickwork of the cladding, etc.
BUILD FOR POSTERITY AT NO GREATER COST
WITH HUME PRODUCTS
THE HUME PIPE CO. (S.A.) LTD.
NEW ZEALAND HOUSE, BURG STREET, CAPE TOWN
Makers of Facing Bricks and Roofing Tiles of every shade and pattern
IF IT CAN BE MADE IN BRICK, WE CAN MAKE IT!


1,299 EPEDA MATTRESSES
supplied to the New Hospital
NOTE:
Epeda
MATTRESSES


HOSPITAL EQUIPMENT
supplied by
J. NESBIT-EVANS & CO.
GUARANTEED FOR 20 YEARS
H. J. STEPHENSON & Co.
P.O. BOX 2490
CAPE TOWN
P.O. BOX 5574
JOHANNESBURG


NEW GROOTE SCHUUR HOSPITAL, CAPE TOWN
"UNITY" ELECTRIC PANEL HEATERS
EASTIAN & ALLEN AUTOMATIC ELECTRIC BOILERS
OPERATING THEATRES
AIR-CONDITIONED
A. E. BARKER


TERRAZZO
WALL LININGS,
LANDINGS,
STAIRS,
RISERS,
ETC
8,500 Super Feet
Supplied and
laid by
UNION CEMENT WORKS


LAUNDRY
EQUIPMENT
GROOTE SCHUUR HOSPITAL
SUPPLIED BY
THOMAS BRADFORD & CO.
Laundry Engineers
MANCHESTER • LONDON • LIVERPOOL
D. DRURY & CO. (1930) Pty. Ltd.
W. D. HEARN & CO.


The entire
Ground Floor
of the magnificent
GROOTE SCHUUR
HOSPITAL
has been painted with
DULUX
The World's Wonder Paint
DULUX
BARRY COLNE & CO., LTD.

GROOTE SCHUUR HOSPITAL 1938 to 1948

Furnishing every aspect of the hospital was no easy task. The kitchen needed to provide 900 meals per day for which they used 80 pounds of meat daily. They had to provide the kitchen with 1000 egg cups, 2000 plates, 100 large dishes, 72 gravy boats, 72 sauce boats, 1000 tumblers, 500 table forks, 500 dessert forks, 500 large knives and 500 small knives, among others. For other needs, they ordered 128 000 yards of butter muslin cloth at a cost of two and one sixth pence per yard, 2500 yards of linen for sterile towels, 2500 yards of calico for triangular and roller bandages, 1200 yards of calico for theatre table covers, 4200 yards of flannelette for bandages and 260 yards of green casement cloth for abdominal covers used in theatre.


900 i
An electric vegetable slicer and juice extractor.


The Corridors of Hope


An electric potato peeler.

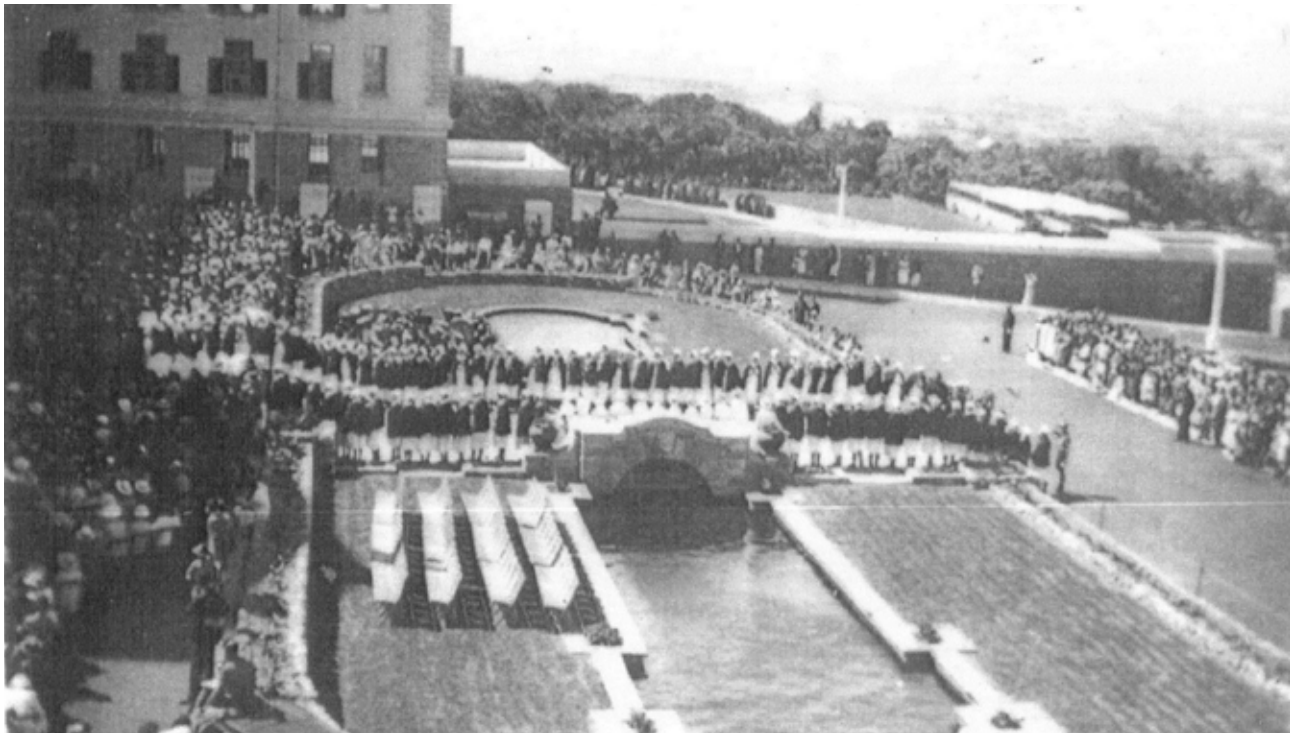


Figure 19: Nurses 'guard of honour' across the lily pond at the opening ceremony

Figure 20: Numerous guests at the opening ceremony

Figure 21: Guests in Palm Court

Figure 22: The lily and fish pond

Figure 23: The silver key to the hospital was made in Johannesburg and presented to the Governor General at the opening ceremony.

At the time, the staffing consisted of Dr de Wet, the only Medical Superintendent, two senior housemen and 19 interns. The clinical professors were honorary members of the hospital staff and headed their respective departments.

HONORARY MEDICAL STAFF OF THE GROOTE SCHUUR HOSPITAL AT THE TIME OF OPENING, 1938

Front Row: Prof. B. J. Ryrie, Drs. A. Gordon-Forbes, J. S. du Toit, Prof. C. F. M. Saint, Dr. J. Luckhoff, Miss Pike (*Matron*), Dr. B. de Wet (*Superintendent*), Dr. A. W. Sichel, Dr. D. P. Marais, Prof. Campbell, Drs. J. L. Sandes, W. Lennox-Gordo

Second Row: Drs. E. van Hoogstraaten, A. Goldberg, te Water Naude, R. L. Impey, F. Forman, A. Chapman (*Secretary*) W. P. Holder (*Asst. Secretary*), Prof. J. F. Brock, Drs. Moorees Bosman D. Dowie-Dunn, V. Brink, P. Roux.

Third Row: Drs. R. L. Forsyth, G. Sacks, A. Marais-Moll, R. Wolff, M. Cole-Rous, R. L. Townsend, W. Rabkin, L. Tomoroy, H. Wolff (*Dental Surgeon*), W. Rosenblatt (*Dental Surgeon*).

Fourth Row: Drs. J. A. S. Marr, Z. Cohen, P. Massey; J. Smith H. Berelowitz, F. N. Krone, R. Lang, B. Knoblauch, Prof. G. C. Linde

Back Row: Drs. H. Bell, J. Wicht, G. A. Elliot, N. Peterson.

Figure 24: Medical staff in 1938

The very first patient admitted on 31 January 1938 was 13-year-old William Keene. He had a fractured leg and an injured hand after his bicycle was hit by a motor car. This was the beginning of excellence in patient care for Groote Schuur Hospital.

Figure 25: Nursing Management in 1938
E. van Breda, M.Maidwell, F.Herholdt, P Gregg, J Evans, P. Elington, O Norton,
Sister Drysdale (Asst Matron), Miss Pike (Matron), Sister Loopluy (Sister Tutor), J.Monntik
Insert: Miss Knowlton (Asst Matron)

Figure 26: Dr Abelson - The first doctor to anaesthetise a patient at Groote Schuur.

Further strain on both the services and the finances was felt with the Second World War (1939 to 1945), and the hospital was unable to consider completing the building projects while at the same time feeling the acute stress of a shortage of skilled nurses. Even though the hospital was built for 870 beds, these could not be used to their full capacity because part of the hospital was used to accommodate nurses and cleaning staff. Thus, only 797 beds were available. Equipment was only provided for 628 beds of which only 428 were available for immediate use. On Thursday, 3 February 1938, a decision was taken to close the New Somerset Hospital temporarily and move all its patients and staff across to Groote Schuur Hospital. Thanks to the hard work of the first Medical Superintendent, Dr J.M.B. de Wet and the first Matron, Miss Evelyn M. Pike, the move happened smoothly.

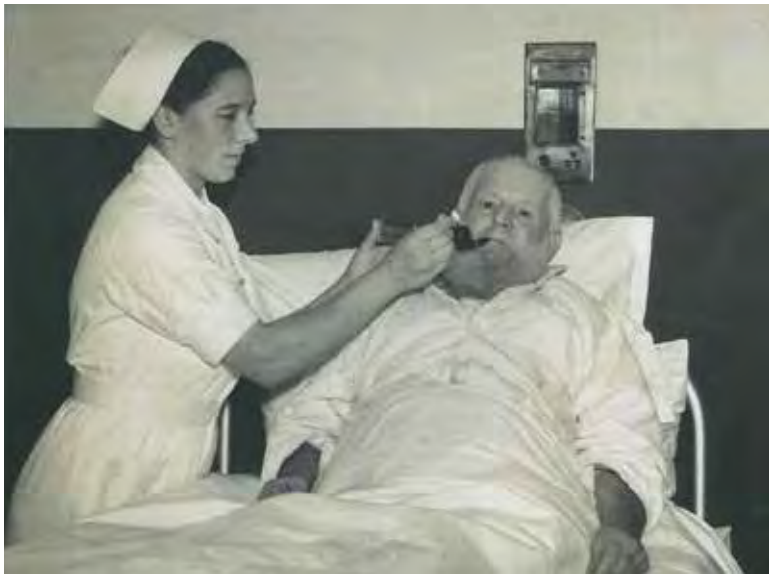


Figure 27: Mr William Lynch, the first patient to be admitted to Groote Schuur Hospital from Somerset Hospital on 3 February 1938, has his pipe lit by Sister Helene de Waal. (Courtesy of Mrs H. Vorster)

While this provided temporary relief to the shortage of beds, it was short-lived. During the Second World War military patients had to be accommodated and at the same time, there was a significant increase in the number of civilian patients attending outpatients. In 1942, the Nurses occupying some of the hospital beds, were moved to the private patients' block and the domestic staff, moved to other quarters. While this meant that there were no longer facilities for private patients, the space made available resulted in more patient being accommodated. These service pressures were reported throughout the 1940's and remained a matter of grave concern to the Board.

By 1944, the Cape Hospital Board established a special Hospital Planning Committee to review the need for additional space. In particular, the need for an Out Patient department was proposed due to the existing accommodation being inadequate. 1944 also saw the inauguration of a Plastic Surgery Unit. A large number of cases received treatment, including skin grafting for burns, treatment of disfigurement due to burns, repairs of malignant growths on the face, treatment of lupus, cleft lip, etc. The block system of training nurses yielded satisfactory examination results and it was shown that Groote Schuur Hospital was training more nurses in proportion to the number of beds than any other hospital in the Union. The first male nurse to be trained at Groote Schuur Hospital, commenced on 1 January 1947 and was subsequently appointed to the establishment on 1 October 1949. In 1950, he was promoted to Charge Male Nurse.

Since the hospital's inception, it is noted that due to the patient load, the clinical records departments had been cramped in their area of work. Shortages of staff were reported in Nursing, Physiotherapy, Radiography and other departments, mainly due to their workload and poor salary scales. Challenges remained constant with the filling of vacant posts.

Matron Pike, who had introduced this nurse training and who had occupied the post of Matron since 1936, retired in December 1945. Her position was taken over by Miss S.M. Marwick, the Matron of Port Elizabeth Hospital. In the same year, the Red Cross Society funded and paid for the services of an Occupational Therapist and the beginning of an Occupational Therapy Department. The services were soon taken up and before long, the need for larger accommodation became imminent.

Due to the high demand for water supply, the Board decided that instead of only relying on the Municipal connection, it would construct a 100 000-gallon reservoir at an estimated cost of £2000. This was erected in 1946 and cost £3500.

Figure 28: Swimming baths and hockey field

To improve the number of nurses, the Nursing College was established and the block training method developed at Groote Schuur Hospital would be used for all trainees. In 1947, the Board raised the problem of the discrepancies between the salaries of `European' and `non-European' nurses, and urged the Provincial Administration to at least consider that `non-European' nurses earn 80% of the salary paid to European nurses. Groote Schuur Hopsital at the time did not have `non-European' nurses.

At Groote Schuur Hospital, two new tennis courts, a hockey field and a swimming bath was proposed to be constructed at a cost of £2000 for use by the `European' staff only.

The Provincial Administration in 1948, then also appointed a Commission of Enquiry to investigate the staffing and reorganization of Groote Schuur Hospital. The findings of the Commission noted: "… almost from its inception, Groote Schuur Hospital was called upon to deal with more patients than the number for which it had been designed." The hospital also decided to appoint Dr H. de Villiers Hamman as the first Neurosurgeon, thereby saving the hospital from the humiliation and inconvenience of sending all the Neurosurgical cases to Johannesburg.

Figure 29:
Matron Loopuyt leading graduating nurses in taking the Nightingale oath, 1947

In 1949, the Cape Hospital Board was terminated and according to the Cape Provincial Ordinance No.18 of 1946, the Provincial Administration would take over from the Hospital Board the direct administration of all hospitals as from 01 January 1950. In the last Board minutes of 1949, it was noted that the "pressures on beds was unabated and congestion in the outpatients' department continued to be a matter of grave concern."

The Cape Hospital Board should be acknowledged for the outstanding work it had done to make health care in the Cape Province a reality. Together with the public, they consistently worked to raise funds to build more hospitals in order to serve the health needs of the communities. Since its inception in 1913, it had seen two world wars, the Great Depression and faced many challenges. It had many chairmen under whose guidance the Board maintained its direction and steadfastly served the hospital staff and its patients.

Groote Schuur Hospital: 1950 to 1960

The Provincial Administration took over the control of hospitals in 1950 and the first meeting of the Groote Schuur Advisory Committee to the Medical Superintendent, Dr J.M.B de Wet, took place on the 30th July 1951. Others in attendance included Professors J.F.Brock and F.Forman, joint Heads of the Division of Medicine; Professor J.F.P.Erasmus, Head of the Division of Surgery; Professor E. Crichton, Head of the Division of Obstetrics and Gynaecology; Professor M.vd Ende, Head of the Division of Pathology; Doctors A.M.Moll, S.Berman and A.I.Goldberg as Medical Committee representatives and Dr N.H.G. Cloete, the Assistant Medical Superintendent who was appointed to the committee as the Secretary. This was a new epoch in the history of Groote Schuur Hospital and it was emphasized that a close liaison between the administration and the clinical divisions would facilitate a smooth and efficient management structure. All the clinical heads gave their commitment to this. Later that year, on 19 December 1951, an agreement was signed between the Provincial Administration and the University of Cape Town, relating to the organization of teaching hospitals. The terms of the agreement stated that the University would be responsible for teaching and research and the Provincial Administration for patient care. This agreement was the start of a relationship that built the sustainability of the hospital. Medical staff gave up their honorary posts to take up salaried posts, financed by the Provincial Government, but having a dual responsibility to both the University for teaching and the hospital for the provision of healthcare.

The Provincial Administration continued to support Groote Schuur by providing intricate and expensive equipment required to provide highly specialised services in every branch of Medicine and Surgery. It also made considerable extensions and alterations to the building structure, including the purchasing of the private properties occupying the land between the hospital and the main road.

Throughout the 1950's, the services were under significant pressure, with the hospital doing three times more that it could accommodate. Nurses were pressured to do more and due to the shortage of staff, had wanted to close wards, which the chairman viewed with grave concern. It was thus indicated that the administration re-introduce the Block system for Nurse training. This allowed for sufficient staff to be present without compromising their training. Additionally, it was agreed that minor procedures be done in a separate ward, thereby relieving some pressure on the ward staff.

A hospital school was established in April 1950 and on 26 May 1952, it was decided that the executive committee find ways to establish a laboratory within GSH.

The following years note that the hospital was struggling to create a structure of posts to meet the service needs. Most of these years involved the creation of additional posts as motivations were received. However, funding constraints remained a barrier. The interest in specialization gained momentum and many of the medical students chose to become specialists. An increase in subspecialties was also noted during this time, making the hospital a place where expertise became the norm. However, it started to replace the reason why the hospital was built in the first place, to provide generalist care to the population.

At the start of 1953, it was noted that the Medical Superintendent of the hospital carried responsibility at the teaching hospital commensurate to the specialist level posts. This post was therefore upgraded to reflect this. Other services such as microfilming were introduced in order to address the burden on folder management. The Pathology Laboratory opened at Groote Schuur in 1953. As problems arose, policies and procedures were developed to deal with them, for example, in April of 1953, a labour process was outlined to include, 1). Warning, 2). Reprimand and 3). Disciplinary action. Processes were also recorded in writing on how to deal with joint staff if they failed to adhere to their duties in the agreed manner. In the latter part of 1953, a letter was sent to the Provincial Administration regarding the untenable position of the Out Patients Department, where it was felt that they were not doing justice to patient care because of the patient load and made a suggestion that it should only be for cases that needed specialist opinion. A committee was established to review this

over the next three months, after which they presented their findings and recommendations. One of these recommendations was that as a teaching hospital, there should not be unrestricted patient attendance, but that casualty and dispensary patients (i.e. not referred by a General Practitioner) should be separated into a Groote Schuur Casualty Department.

Staff were also becoming accustomed to the intention of the joint agreement and certain amendments were made by unanimous agreement, such as the proposed modifications to Clause 8(4) on page 15 of the joint agreement which stipulated that grades A and B staff who were paid 95% by the Provincial Administration and reporting to the Medical Superintendent, be afforded the same opportunities as those in grades B and C, who were paid 50% by the Provincial Administration and 50% by the University, to also perform teaching and research.

1954 saw certain blood investigations such as Grouping and Cross-matching being taken over by the hospital lab and due to the advanced equipment being purchased, an equipment committee was established. Advances in technology were seen to enhance patient care and many of the clinicians started promoting research in this field, albeit slowly, since the Heads of the various departments placed a stronger emphasis on clinical practice.

On 8 December 1955, an operation was successfully performed at Groote Schuur Hospital as the first one in Africa, to remove a tumour from the adrenal gland on a patient for a condition called Primary Aldosteronism. Professor James Louw from the Department of Obstetrics and Gynaecology was responsible for introducing the 'Pap Smear' to South Africa in 1955.

Figure 30: A Radiographer positions a patient for an X-ray while her colleagues position the X-ray machine and X-ray plate in 1958.

Funding constraints also limited the proliferation of research activities during this time. Of significance is that Allan Cormack, who worked as a Groote Schuur Hospital physicist during the 1950's, had become interested in the mathematical problem of creating a correct radiographic cross-section in a biological system during his time at Groote Schuur. His work was used by a British computer specialist to develop the world's first Computer Scanning machine. The 1979 Nobel Prize was jointly shared by the two gentlemen.

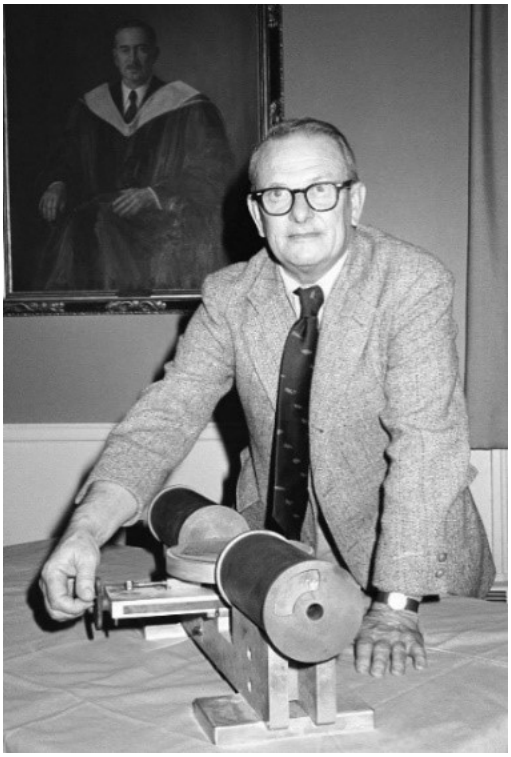


Figure 31: July 01 1957 - September 1957
Prototype of first CAT scanner. Allan Cormack developed a prototype of the world's first computer-assisted tomographic (CAT) scanner.

Figure 32: December 10, 1979
Allan Cormack and Godfrey Hounsfield shared the Nobel prize in Medicine for the development of the CAT scanner.

Africa's first successful open heart surgery was performed by Dr Chris Barnard in 1958 after his return from Minnesota, USA with a heart-lung machine, donated by the US government. 3 previous unsuccessful cardiac operations were attempted by Walter Phillips, in charge of thoracic surgery at GSH, in the year or so before Barnard's return using a more primitive machine and lacking the expertise Barnard had gained in Minnesota.

Figure 33: Nurses put on a Christmas show with Dr Visser - 1955

Groote Schuur Hospital: 1960 to 1970

This was the decade of miracles and many firsts for Groote Schuur Hospital. At the start of 1960, the hospital had a total of 882 beds and 1900+ staff. The departments, both specialist and sub-specialist were well established and provided a significant inpatient and outpatient service. This was the first year that the first annual report was published at Groote Schuur Hospital. As in the previous decade, services continued to be divided into `White' and `Non-White' sections, with greater pressures being experienced on the `non-White' side. The Langa riots and the Ndabeni train accident, both in 1960, reflected the level of care being offered to patients. No patient received alive at the hospital died in the Casualty department. However, the two incidences resulted in a reorganization of the area, with the creation of resuscitation bays as well as the fast-tracking of patients with more serious injuries into ward beds, particularly in the Surgical Department. It is particularly interesting to note the amount of work done by the small number of staff. For example, in the Department of Anaesthetics, with 10 full time staff, 6 registrars and 11 sessional staff, they managed to administer anaesthesia for a total of 16 422 operations during the 12 months of 1960. A year later, the service had increased by 1 050 operations more than the previous year.

As the services became more established, the support services staffs' work became onerous and this resulted in specific areas being allocated for the different functions, for example, the establishment of a stationery store due to the many forms and stationery items used, and separate accommodation for stores, among others.

On 01 March, 1960, the Carinus College of Nursing closed and Groote Schuur Hospital took over the training of nurses at the hospital together with all the administrative functions attached to these students. New regulations were enacted on 8 July 1960, committing the training of nurses to a continuous three-year period together with practical training in the different wards and departments covering all clinical areas. This allowed for nurses to receive a much more balanced nurse training under the 'Block-Collegiate-System'with a steady number being trained annually.

In 1961, the Maternity Block accommodating 108 patients, the C-floor theatres and the squash courts were completed. In addition, the Administrative building, now known as Health Park, and the Cafeteria Blocks were handed over for use. The Maternity building included special features of storks on the sides of the balconies.

Figure 34: Health Park admin building and squash courts on the right

Figure 35; Mr P.J.Loubscher unveiling the plaque at the Groote Schuur Maternity Centre

Figure 36: Groote Schuur Maternity wing

Figure 37: Stork features on the Maternity Building

The Groote Schuur Teaching Hospitals' Board funded the development of a temporary building adjacent to the existing outpatients for the Out Patients' dispensary, thereby creating more space for the overcrowded department.

With the additional Cafeteria blocks, the Catering department was now responsible for the main Kitchen, Nurses' Home Kitchen, Doctors' Residence Kitchen, Moslem Kitchen, Kosher Kitchen, 'White' cafeteria and 'non-White' Cafeteria, in total producing almost 3500 meals per day.

Clinically, the Cardiothoracic team performed a complete correction of a transposition of the great vessels. This operation was the fifth successful one of this nature done in the world, and in order to perform it, a new technique was developed in the research laboratory. Another technique of total cardiopulmonary bypass with profound hypothermia was also developed in the laboratory at Groote Schuur.

During 1961, the Groote Schuur Hospital Benevolent Association was formed by previous members of the Hospital Board with Mr Alfred Friedlander as Chairman and Mr Henry Clarke as Secretary and Treasurer. The Association raised funds to provide tea and biscuits to patients waiting outside Out Patients and to provide financial assistance to very needy patients.

A new three-floor parking garage for 200 vehicles and two new wards for `non-White' patients (Neurology, Neurosurgery and Medical) were completed in 1962.

Figure 38: Parking garages added to the hospital structure

Excavations for the new Out Patients block were also commenced with a target to completion of three years at a cost of R1,107,777. Due to the increased number of patients, the Department of Medicine developed an Out Patient booking system, leading to considerable improvements in the size of the clinic.

The beginning of 1962 saw the Departments of Neurology and Psychiatry become independent departments, having previously been combined. Each started with their own heads of department, senior consultant staff, registrars, housemen, nursing and other staff. The hospital had to be reorganised in terms of allocating beds, clinics and other services to the separate departments. Cardiothoracic surgeries performed had increased the reputation of the department and many patients from all over South Africa and the neighbouring countries were being referred to the unit. The success of the surgeries cannot only be attributed to the surgeons, but also to the "backroom boys", the highly specialised technicians who managed the important machinery during the cardiopulmonary bypass surgeries. The unit had performed 98 surgeries in 1962, between Groote Schuur Hospital and Red Cross Hospital, and boasted an under 12% mortality rate. A prosthetic heart valve, the Lenticular Prosthesis was developed in the Surgical Research Laboratory and used on 7 patients as valve replacements.

The number of patients versus services continually widened between the facilities provided for `Whites' compared to those for `non-Whites'. Almost all departments mention this to be a problem in terms of providing an adequate service and an increasing waiting list for major procedures, particularly for the `non-White' patients.

A decision was taken by the Administration that `coloured' nurses could train at Groote Schuur Hospital to service the `non-White' patients so that they could treat patients of their own race and that this would provide more opportunities for employment to this sector.

The idea of functioning as a health system was embodied by the Obstetric Department when in 1963, they formed the Peninsula Maternity Services, which incorporated the Peninsula Maternity Hospital, the Mowbray Maternity Hospital and Groote Schuur Hospital functioning under one teaching facility. The services however, were still somewhat divided with the `non-White' patients attending the Peninsula Maternity unit.

The Groote Schuur Maternity building opened two additional wards for `non-White' patients, staffed by `non-White' nurses, and noted that many of the deliveries from this group were complicated cases with a higher mortality rate. Births from these complicated pregnancies highlighted the need for a Paediatric service within the building.

The Park Road Hospital for alcoholism changed its name to `William Slater' Hospital in honour of the retired Provincial secretary. This hospital together with the Day Hospital services (functioning in two houses near Groote Schuur Hospital converted for this purpose) were incorporated into the expanding Groote Schuur Psychiatry department. With all the additional beds incorporated into the hospital, the total number of beds was increased to 1500 and all the ancillary and support departments were required to support these additional facilities.

Additional structures were created with the opening of five additional wards in the `Tens' block, a new building for the radiotherapy department to be planned next to the `J' block, planning towards a recreational hall for the staff and the commencement of the building of the Out Patients Block in December 1962. The kitchens were to be refurbished and an additional reservoir was to be built for the hospital's water supply.

On all accounts, the hospital was growing steadily and was repeatedly commended for the excellent services rendered. Staff at the hospital were committed to clinical services, always putting the patient first, while at the same time also concentrating on advancing their knowledge through research. The teaching of students and registrars received great benefit due to this as it added to the intellectual stimulus of the students.

Stimulating and informative discussions became a highlight of the multidisciplinary team meetings, for example, between Pathologists and Physicians; Surgeons and Physicians; Radiologists and various departments, and this also provided a huge benefit to the post-graduate students.

The Cardiothoracic Department in particular gained increasing prestige during these years due to the scope of surgical corrective techniques they had developed and provided, with a very low mortality rate. The waiting list for some non-urgent cases was as long as three years.

May 1963 also saw the first `non-White' labourers' department being inaugurated. This included Cleaners, Ward and Theatre Orderlies, Waiters and Cooks.

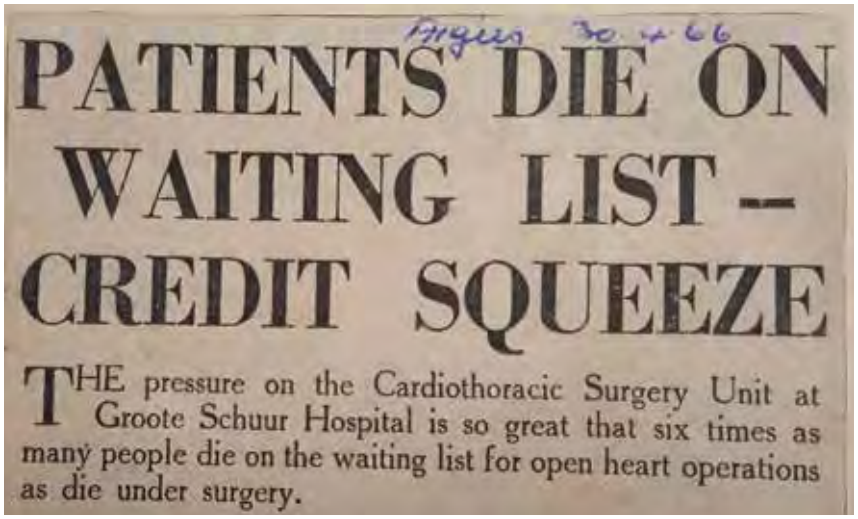
1964 was an iconic year, specifically the thirteenth of January. It was the first year that about 30 `Coloured' nurses were employed to work in the `non-White' wards at Groote Schuur Hospital from October 1964. While they were allowed to work at the hospital, their accommodation remained a problem, and plans were being developed to build a college and residence for `coloured' nurses in the Athlone area. These nurses were only allocated to the `non-White' beds and the workload was significantly above that in the other wards, with a bed occupancy above 100%. There was however recognition of this by the management and the need for a remedy to be found to relieve this enormous pressure.

Figure 39: a 'non-White' Surgical Ward

Hospital's bed scarcity for non-Whites

Cape Times 29.4.66

UNLESS a remedy is found for the scarcity of beds for non-Whites at Groote Schuur Hospital a major breakdown can be expected. This warning is given by Dr. J. G. Burger, Medical Superintendent, in the Groote Schuur Hospital group's annual report.



Argus 30.4.66

PATIENTS DIE ON WAITING LIST — CREDIT SQUEEZE

THE pressure on the Cardiothoracic Surgery Unit at Groote Schuur Hospital is so great that six times as many people die on the waiting list for open heart operations as die under surgery.

In 1965, three standing committees were established – The Infection Committee, the Equipment Committee and the Pharmaceutical Committee. It was also the year of another innovation on 3 March 1965, with the first pre-birth blood transfusion for a baby at 32 weeks of gestation by members of the Obstetrics and Gynaecology Department under X-ray guidance.

As with the previous years, the Cardiothoracic Surgery Department remained at the top of their game having performed many surgeries, but kept their mortality at a low 3.7%. Other departments were also very active in research with an amount of 170 papers being published and this number grew annually. The Department of Psychiatry completed an intensive study on alcoholism in the communities and there were many others.

As stated in the Secretary's report: "Like everything else, these improvements revolve around the patient, but one improvement which affects the patient more profoundly than most other administrative activities is the speeding up of the patient through the non-medical formalities." This related to a new system of housing and accessing medical records, where the search required the scantiest amount of patient information. Coupled with this, was the introduction of a secretarial service for the wards, and the creation of 21 posts of Women Clerks, increasing the number of administrative staff from 157 in 1964 to 207 in 1965.

On 11 August 1966, the new Out Patients Building was finally opened. It was in planning for nine years, took two and a half years to build and provided the hospital with much needed space to accommodate the many patients.

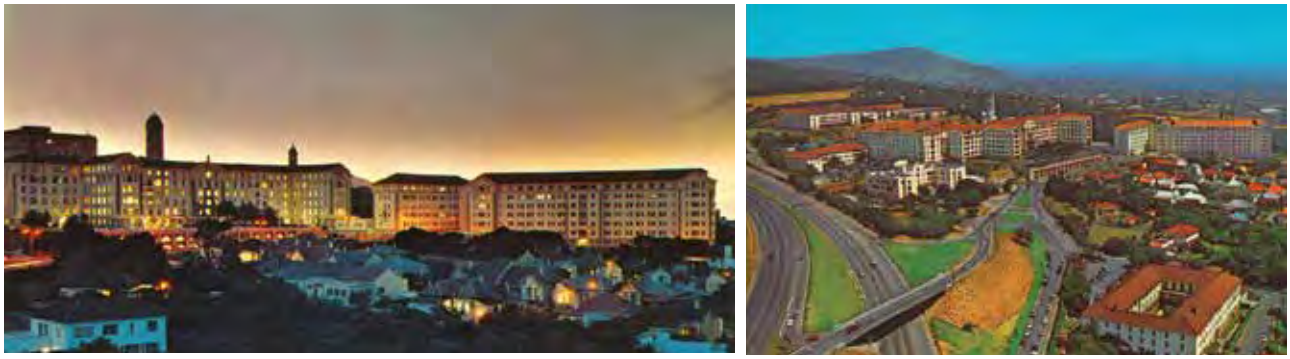


Figure 40: Groote Schuur Hospital with the Outpatient section at the north end.

Figure 41:
The State President, Mr. C. R. Swart, at the opening of the R1,300 000 Outpatients Building

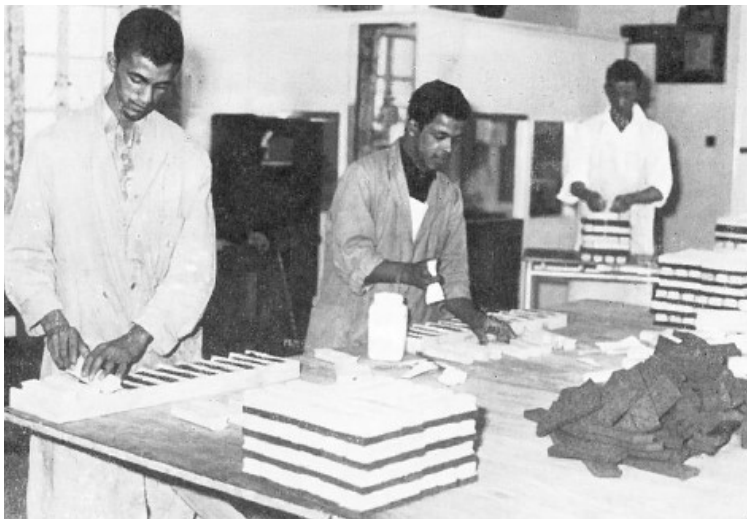


Figure 42: Work Assessment Unit

The Psychiatry services were attending to about 10 000 patients between the different facilities as out patients. Special facilities were provided for Geriatric patients, adolescent patients, a `non-White' alcoholic treatment group and Electro-convulsive therapy.


Prof. A. Bull (above) and Dr. L. Besseling, who with Mr. I. Mason, of the University of Cape Town, developed the bloodwarmer. Report below.

UCT blood-warmer may sell abroad

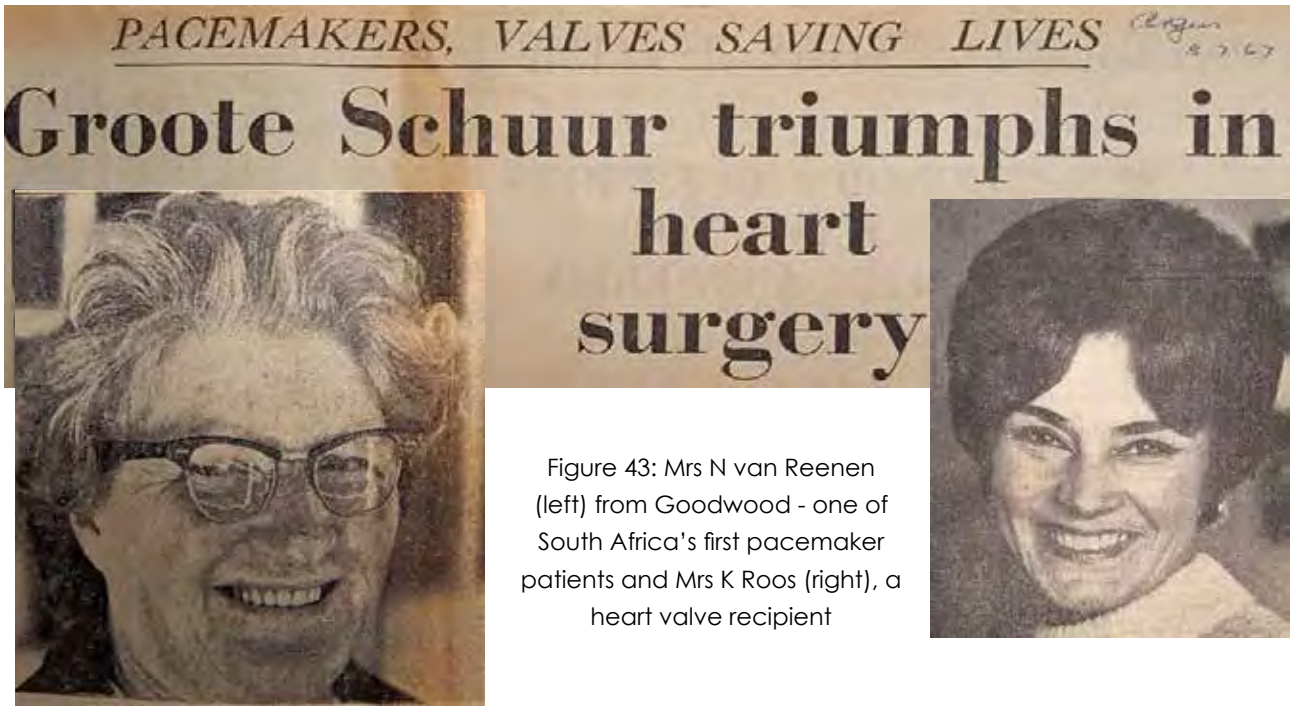
1966 was also the year when the hospital performed the first triple heart valve operation successfully. In addition, the new X-ray therapy treatment floor was completed and occupied, with two Cobalt units, four Orthovoltage X-ray machines, a skin therapy unit and a Hyperbaric Oxygen cylinder for Radiation therapy.

In Occupational Therapy, the Work Assessment Unit was commenced, resulting in many severely handicapped patients being allowed to return to work in the open labour market.

After seventeen years of service, the Principal Matron in Nursing, Miss E.J.Fouche, retired. Many sad farewell events were scheduled for her. Towards the end of 1966, a decision was taken to build a recreation hall for the staff on the estate. Despite the overcrowding, long waiting times and other problems, the hospital was still praised for the services rendered.

1967, was the year of innovation. In May, members of the University and Hospital developed the world's first blood warming machine. Dr J. L.N. Besseling from the Department of Engineering and Dr A.B.Bull from the Department of Anaesthesia proudly assisted the clinicians with blood transfusions and in the operating theatre. The machine was considered to be an accomplishment on both the medical and technical aspects of patient care.

1967 was also the year when the first kidney transplant was performed in the Cape as well as the first valve and pacemaker insertion.


PACEMAKERS, VALVES SAVING LIVES

Groote Schuur triumphs in heart surgery

Figure 43: Mrs N van Reenen (left) from Goodwood - one of South Africa's first pacemaker patients and Mrs K Roos (right), a heart valve recipient


First city kidney transplant soon

VROU KRY 'N NIER IN EERSTE KAAPSE OPERASIE

Skenker Is Oorlede

Figure 44: First Kidney transplant recipient in the Cape

GROOTE SCHUUR HOSPITAL 1960 to 1970

However, the year 1967 is bound to remain at the top of the list in the annals of the history of Groote Schuur Hospital, as the year of the first human to human heart transplant operation in the world performed by Dr Christiaan Barnard on 3 December 1967. On 14 December, the University of Cape Town conferred an Honorary D.Sc. on Professor Barnard and at the same time it was announced that the Freedom of the City of Cape Town would be granted to him.

Words of praise and congratulations came from all over the world, including the pride felt by fellow South Africans. Deservedly, the scientific community was in awe of this achievement and invitations quickly poured in for Professor Barnard to address various forums. This event proved the need for co-operation between many different departments and that doctors cannot perform their highly specialised skills without the assistance of nurses, technicians, paramedical personnel, maintenance staff, administrative staff and others. These joint efforts should be complimented and continued in the spirit of maintaining excellence in healthcare, since it also provides a platform for many interesting debates on moral, ethical, scientific and religious viewpoints, all of which need to be respected and weighed up against possible benefits. This event certainly placed Groote Schuur Hospital in the spotlight and remains the one achievement for which the hospital is still famous.

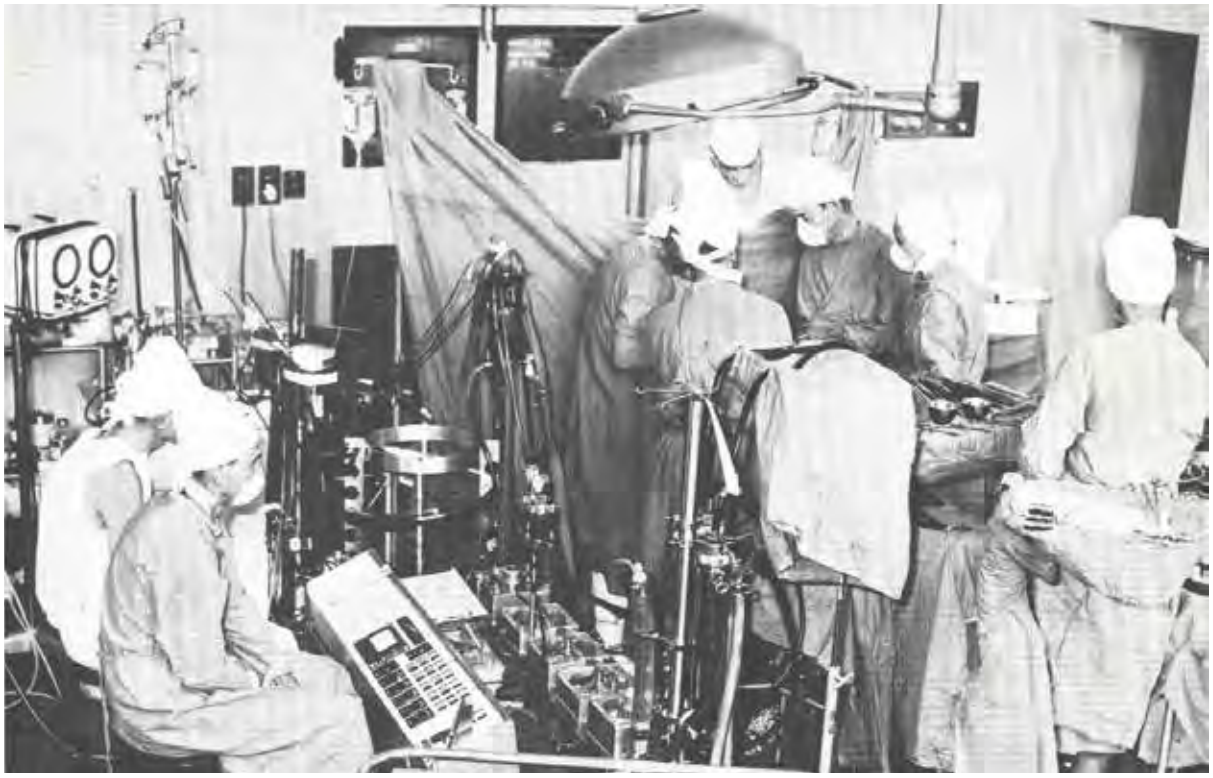


Figure 45: World's first heart transplant

Heart Transplant Team December 1967

Front row, sitting (from the left): Miss J. Pritchard, technician; Miss A. Lambrechts, theatre sister; Miss S. M. Roussow, theatre sister; Miss P. Jordaan, theatre sister; Miss A. Friedman, technician and Miss E. van den Berg, technician (in white coat).
Second row (from the left): Miss F. North, technician; Dr. J. Orinsky, anaesthetist; Dr. T. O'Donovan, surgeon; Prof. C. Barnard, Prof. V. Schrire, Dr. R. Hewitson.
Back row (from the left): Dr. M. C. Botha, Dr. S. C. Bosman, Dr. J. T. Hitchcock, Mr. J. van Heerden, technician; Mr. N. Vermaak, technician.

Figure 46: Transplant team - 1967

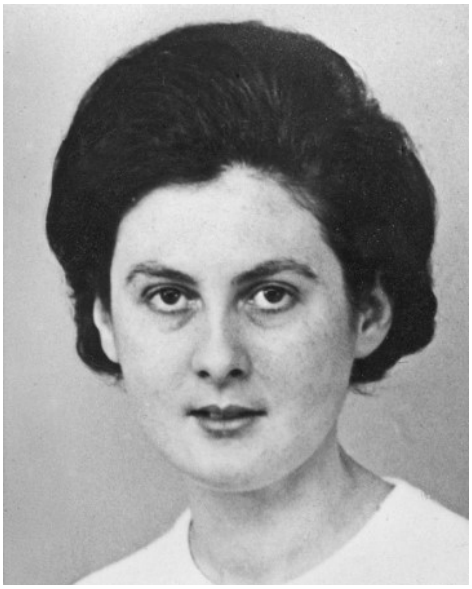


Figure 47: Denise Darvall

This world-wide accomplishment owes an acknowledgement to Denise Darvall, the 25-year-old who symbolically represents every donor that has come after her. What started out as a family outing and a stop at a bakery in Main Road, ended in the loss of life of both Denise and her mother. They were knocked down by a speeding vehicle while crossing the road. Her life was the price paid for Professor Barnard and Groote Schuur's success in performing the world's first heart transplant. We thank the Darvall family for this.

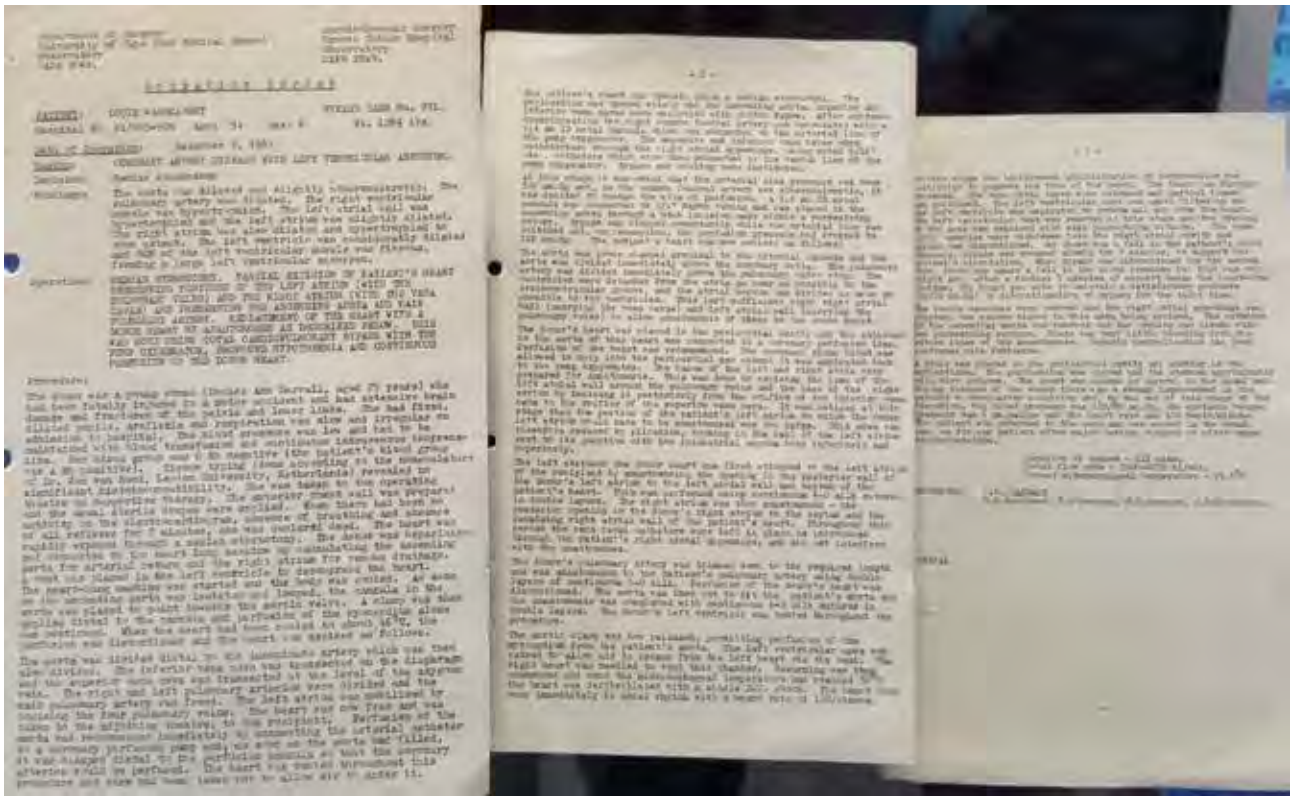


Figure 48: The operating notes

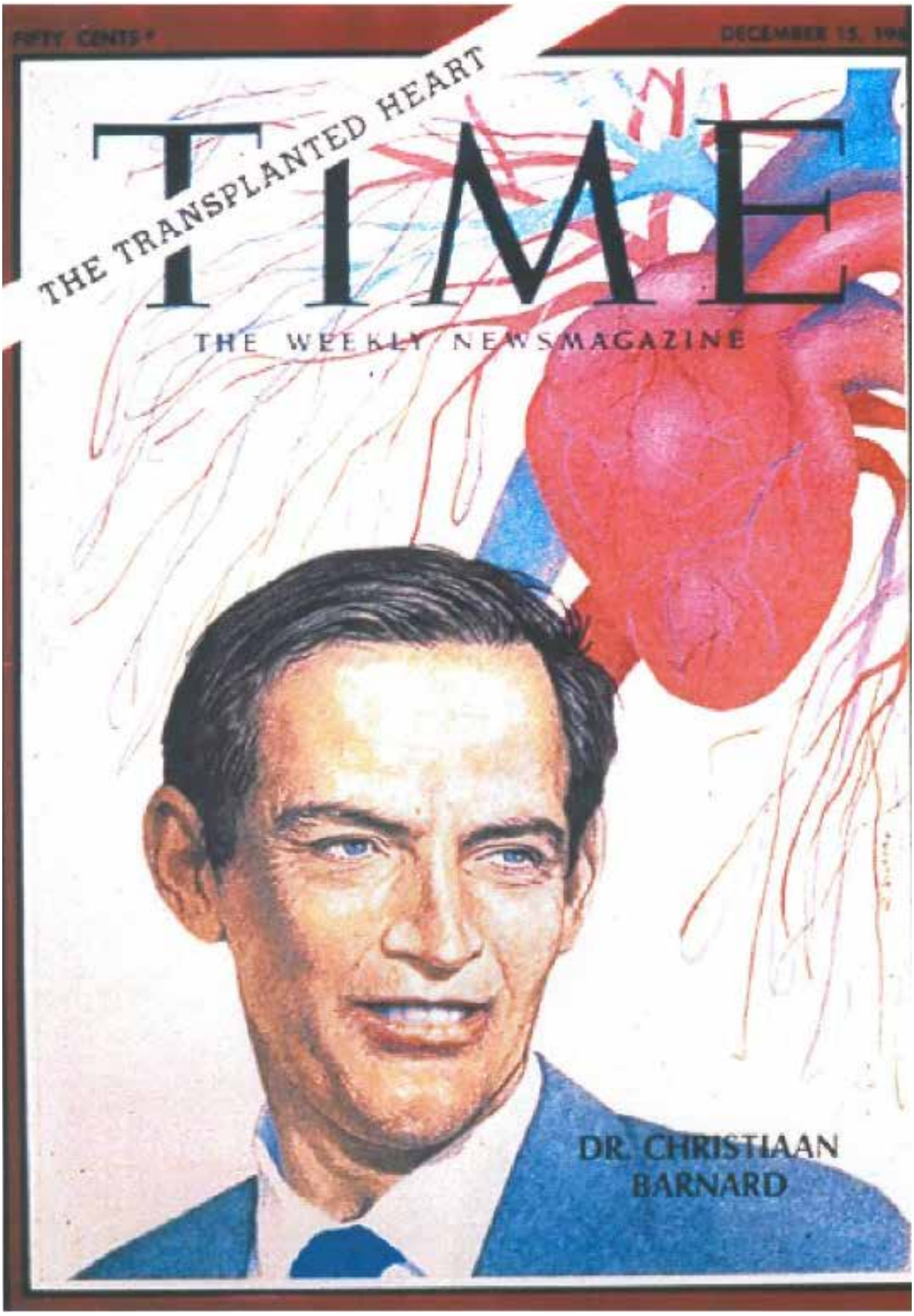


Figure 49: Professor Chris Barnard on the cover of Time magazine 15 December 1967

THE CAPE TIMES

LATE FINAL

MONDAY DECEMBER 4, 1967

WORLD'S FIRST HEART TRANSPLANT

Groote Schuur doctors make history

LIFE BEATS ANEW FOR CITY MAN

A TEAM of University of Cape Town surgeons made medical history early yesterday morning by successfully transplanting a human heart at Groote Schuur Hospital — the first time this has been achieved.

HEART DONOR HAD STOPPED TO SHOP

Donor Ann Darvall, 25-year-old accounting-machine operator at a Cape Town bank, whose heart was used in the operation.

His will to live inspired doctors, says wife

'Phone the Cape Times

41-0661

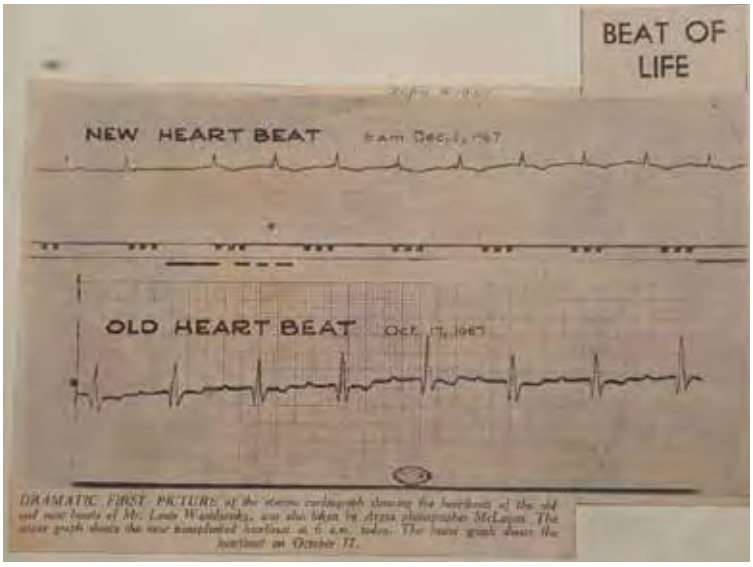
INSIDE

Dick Stent on Davis Cup chances

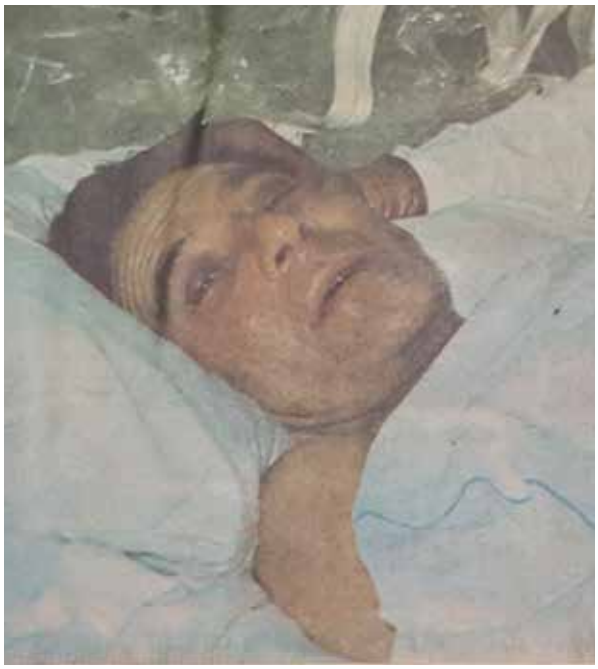
—PAGE 15

HEART OP. NEWS

WORLD'S FIRST
HEART
TRANSPLANT
Groote Schuur
doctors
make history



DRAMATIC FIRST PICTURE of the electro cardiograph showing the heartbeats of the old and new hearts of Mr. Louis Washkansky, was also taken by Argus photographer McLaren. The upper graph shows the new transplanted heartbeat at 6 a.m. today. The lower graph shows the heartbeat on October 17.



ROUND - THE - CLOCK WATCH is being kept on Mr. Louis Washkansky in his Groote Schuur Hospital room, where a trained surgeon and a trained nurse are on duty all the time. On duty today were Dr. T. F. Hitchcock (right) and Sister G. G. Hall.

DR. I. OZINSKY, a member of the team of doctors and nurses which assisted with the heart-transplantation operation.

NURSES AND A DOCTOR who assisted with the historic heart-transplantation operation at Groote Schuur Hospital on Saturday night are (from left) Sister J. Fox-Smith, Miss P. Hatchford, a theatre matron, Sister S. M. Rossouw, Dr. T. O'Donovan, Mrs. E. Kingsley, senior theatre matron, and Sister A. Lambrechts.

THE TEAM WHICH DID IT

Times 30/12/67

THE full heart transplant team which took part in the Washkansky case at Groote Schuur Hospital earlier this month is published to-day in the special edition of the *SA Medical Journal*:

They are:

Department of Surgery, Medical School

Prof. C. N. Barnard, Associate Professor, Head of Cardiothoracic Unit.
Mr. R. P. Hewitson, Part-time Senior Surgeon.
Mr. T. G. O'Donovan, Senior Surgeon.
Dr. M. S. Barnard, Surgeon.
Dr. S. C. W. Bosman, Registrar.
Dr. J. F. Hitchcock, Registrar.
Dr. C. Venter, Registrar.

Department of Anaesthetics, Groote Schuur Hospital

Dr. J. Ozinsky, Senior Anaesthetist.
Dr. C. Moss, Anaesthetist.
Miss F. North, Technician.

Blood Grouping Laboratory, Medical School

Dr. M. C. Botha, Pathologist.
Miss J. Pritchard, Principal Medical Technologist (Blood Transfusion Technology).
Miss D. van den Berg, Learner Medical Technologist.
Miss M. Vooys, Medical Technologist (Clinical Pathology).

B 2 Theatre, Groote Schuur Hospital

Sister J. Fox-Smith, Senior Sister.
Sister P. Jordaan, Senior Sister.
Sister A. Rautenbach, Sister.
Sister S. Rossouw, Sister.
Sister A. Lambrechts, Sister.

Ward C 2/4, Groote Schuur Hospital

Sister G. Hall, Sister.
Sister S. Newey, Acting Sister.
Sister I. Papendieck, Sister.

Cardiothoracic Surgery, Medical School

Mr. J. van Heerden, Senior Technician.
Mr. A. Hope, Principal Technician.
Mr. N. Vermaak, Technician.
Miss G. Friedmann, Learner Technician.
Miss Ann Levett, Secretary.

Department of Pathology, Medical School

Prof. J. G. Thompson, Head of Department.
Dr. G. Selzer, Senior Pathologist.

Department of Chemical Pathology, Medical School

Prof. J. E. Kench, Head of Department.
Dr. G. M. Potgieter, Senior Pathologist.
Dr. M. C. Berman, Senior Pathologist.
Dr. K. Arntsen, Pathologist.
Dr. E. Simson, Pathologist.
Mr. A. Wheatley, Medical Biochemist.
Dr. B. P. Mather, Registrar.
And all Medical Laboratory Technologists.

Haematology Laboratory, E Floor, Groote Schuur Hospital

Dr. R. S. Mibashan, Senior Physician.
Mr. M. S. Conradie, Senior Technician.
Mrs. E. Pereira, Senior Technician.
Miss B. G. Marshall, Learner Technician.
Miss A. Castley, Learner Technician.

Department of Bacteriology, Groote Schuur Hospital

Dr. A. A. Forder, Senior Bacteriologist.

Cardiac Clinic, Groote Schuur Hospital

Prof. V. Schrire, Associate Professor and Head of CSIR Cardiovascular Pulmonary Research Unit.
Dr. W. Beck, Senior Cardiologist.

Dr. M. C. Botha

Prof. Velva Schrire

Radiotherapy Department, Groote Schuur Hospital

Dr. M. B. Bennett, Senior Radiologist.
Dr. P. L. M. le Roux, Senior Physicist.
Mr. L. F. Rapley, Physicist.
Dr. E. E. D. Mills, Registrar.
Miss J. M. Runnals, Principal Radiographer.
Miss B. H. Bishop, Radiographer Gr. II.
Mr. E. F. Rhategan, Technician.
Mr. A. G. Medcalf, Senior Technician.

Department of Medicine

Prof. L. Eales, Professor of Clinical Medicine.
Prof. W. P. U. Jackson, Senior Physician.
The Staff of the Diabetic Clinic
Dr. S. Bank, Assistant Physician.
Dr. G. N. Thatcher, Assistant Physician.

Department of Diagnostic Radiology

Dr. L. Werbeloff, Senior Radiologist.

wedding parties...
Stuttafords
The Cape Argus
CITY LATE
WONDOSOL
Patient's condition 'first class', Groote Schuur doctors say
CRISIS AFTER 7 DAYS
MAN WITH A NEW HEART
Three years' work on 'op'
Louw tells of key factor in heart transplant
Thirty-two hours after his historic heart transplant at Groote Schuur Hospital, Mr. Louis Washkansky is maintaining his satisfactory condition, Dr. L. C. Berger, Medical Superintendent of the hospital, said this afternoon that the 55-year-old patient's condition was unchanged since this morning.
THE critical part in the heart transplantation would be in about a week's time, Prof. J. H. Louw, head of the Department of Surgery at the University of Cape Town Medical School, said today.
Crucial time
Round the clock
They will miss Denise...
DENISE ANN DARVALL, 23-year-old lodge
Fund for Darvalls! Page 2.
More pictures, Page 3.
Chances of survival, Page 4.
The Argus medical correspondent, Page 6.
Leading article, Page 16.
Medical world thrilled, Page 17.
Woman had no chance of survival
By a Staff Reporter
MR. LOUIS WASHKANSKY, whose life expectancy was not longer than a few weeks because of a seriously diseased heart, is treated in a special ward at the hospital and under round-the-clock observation of his doctors.
Partly cloudy
This month 5 people have died on W.P. roads
This day last month: 3
This day last year: 6
Her kidney helps a boy (10)
DAVIS CUP: SPAIN WINS. REPORT Page 2
Other pages
LOOK MA! NO PINS...
Snap Nappy
HEAD OF TEAM
And a surgeon took the pictures, too!
CHURCHMEN APPROVE

ARGUS HEADLINES OF THE WEEK highlight the dramatic sequences in the story of the Groote Schuur Hospital heart-transplant operation.

Province paid for transplant

THE cost of the heart transplant operation on Mr. Louis Washkansky, and on all other open heart patients in the province for that matter, was borne by the Provincial Administration, Dr. J. A. Hendrikse (Director of Hospital Services) said today.

During 1967, there was also a revision to the agreement between the University of Cape Town and the Cape Provincial Administration, with the creation of a new body, the Teaching Hospitals' Central Advisory Committee, to replace the old advisory committee and many other committees.

In the first half of the year, two patients with chronic renal failure underwent twice-weekly peritoneal dialysis using the R.S.P. Kolff twin coil artificial kidney, obtained on loan to the hospital. Both these patients subsequently underwent bilateral nephrectomies and successful renal transplantation.

The Department of Anaesthesia together with the Gynaecology Department instituted the first pre-admission clinic at Groote Schuur, the results of which were promising enough for a publication. Another achievement was the move of the Radiology Department to the Out Patient Building, with fourteen new X-ray rooms, each equipped with high speed automatic processes, such as the Skull unit, bucky tables with moving tops and fine grids, ceiling suspended X-ray tubes, miniature and high KV chest X-rays and multi-directional tomography, permitting short exposure times and an improved picture quality. The department at Groote Schuur became the only hospital in the country to produce fully processed films in 90 seconds.

The hospital school established in 1950, was expanded to two schools to accommodate the `White' children under the Cape School Board and one for `non-White' children, under the Department of `Coloured' Affairs.

The hospital was growing in structure, services, staffing and publications. By the end of 1967, staffing had increased to more than 5000 and the staff published about 211 papers in reputable journals.

Once again, the unsatisfactory conditions of overcrowding in the `non-White' wards was raised in 1968 with a bed occupancy of 111%, but still no plans were being made to remedy this.

Organ transplantation made considerable progress, with two more patients receiving cardiac transplants, Dr P. Blaiberg and Mr P. Smith.

Second transplant patient doing better than first

By JOHN SCOTT,
Cape Times Medical Correspondent

SLIGHT electrocardiographic changes, which in Mr. Louis Washkansky were interpreted as evidence of rejection, have appeared in Dr. Philip Blaiberg, the second heart-transplant patient.

Figure 50: Dr Blaiberg and Professor Barnard do the unthinkable. They are examining Blaiberg's heart after he received the heart of 24 year old Clive Haupt in the second transplant operation at Groote Schuur

Dr Bob Frater who started cardiac surgery at GSH together with Dr Chris Barnard before he became head of Cardiac Surgery at Albert Einstein's in New York related a personal story of his experience with Professor Barnard.

I am wondering if I should be saying anything about Chris. I met him first in 1950 when he gave part of our class at UCT a session on TB when we were rotating through" Infectious Disease". He was a medical registrar at the time.

He made no attempt to give us a methodical lecture but instead described his current research. TB spinal meningitis was a common disease and not yet treatable with antibiotics. The pathology was a fibrinous inflammation which caused spinal nerve paralyses. He was treating it with intra-spinal injections of fibrinolytic enzymes. He gave up quite soon after the lecture. But he made a tremendous impression on us.

Cardiology in Cape Town was superb. There was Goetz (student inventor of the best plethysmograph in the world) the Director of Surgical Research; The full time chief of Cardiology was Velva Schrire, ex-serviceman, totally absorbed with a desire to learn everything about the heart. There were also Louis Vogelpoel and Maurice Nellen, two private physicians on the voluntary staff of GSH, as passionate about the heart as Velva and spending hours every day with unpaid efforts to learn all they could about the heart. I was as fascinated as they were

about the heart. When I got to Mayo as a Fellow, I knew more cardiology than all the Mayo physicians except for Burchell, the Chief of Cardiology.

I graduated, interned, did research on a CSIR scholarship and left for the 'wanderjare' that any ambitious young South African was bound to do in those days. The first year was in England: Basic Science course at the Royal College of Surgeons in London (superb), followed by a Casualty job that was obligatory before taking the Final a few years later. Then across the Atlantic by sea and a train from Windsor to Rochester, Minnesota together now with our 2 month old infant. Mayo made the Surgical Fellows do three quarters of Medicine before doing Surgical rotations. Mayo said we needed to learn Medicine before we practised surgery. We saw it as gross exploitation.

In my third week on Saturday 15 of October 1955 I was on duty for the weekend on a Mayo service at Rochester Methodist Hospital called Medical Urology. I worked up, I think, 6 patients for prostatectomies on Monday. My wife and 2-month old infant were at home in our apartment. It would be Monday midday before I would see them again. We had come 9000 miles by sea and train to learn surgery at Mayo. I just had to see some surgery. I looked at the schedule for Saturday afternoon and saw Cardiac Surgery. Cardiology had been my favourite subject at Medical School but those were the glory days of general surgery. General surgeons did everything: they drained abdominal abscesses, opened skulls to drain subdural hematomas, amputated limbs, relieved intestinal obstruction. There were a few closed heart operations but not nearly enough to keep a surgeon occupied. I had already accepted that I would be training in general surgery. Very intrigued, I went to the operating room, put on gown cap and mask and entered the gallery that all Mayo operating rooms had in those days. The galleries were semi-circular and steep. The operating tables were placed parallel to and a yard away from the front wall of the gallery. The surgeon was on the far side of the patient facing the gallery so that he could talk to the visiting surgeons. Behind him was a big stainless steel machine connected to the patient by two transparent plastic tubes. One carried blue blood which was directed to the top of a vertical screen mesh down which it trickled becoming red by the time it reached the bottom and was then pumped back to the patient. I recognised instantly what I was seeing. In 1949, in our Physiology Class, we had a lecture from a visiting Dutch professor on a machine that could perform the function of the heart. His name was Jongbloed which translates to Youngblood in English. John Kirklin was the surgeon. Three standing men were running the machine. One was an Irish Cardiologist named Jeremy Swan, who later became known as the inventor of the Swan-Ganz catheter. One was David Donald, a Scottish veterinarian who had done much of the experimental laboratory work during the development of the heart-lung machine and the third was Earl Wood a research physiologist at Mayo who, during the war, had worked with a human centrifuge and invented the pressure suits that stopped the allied pilots from fainting when they came out of a dive.

That evening I called my wife from the hospital and told her we would be staying longer than we planned and on Monday I went to the Mayo Foundation Office and added Thoracic Surgery to my Fellowship Plan. During the next 6 years I worked with Clagett, Ellis, and Kirklin, spent 9 months altogether in the Research Lab working on a mitral valve prosthesis and the use of autogenous pericardium to repair mitral valves and completing training as a General and Thoracic Surgeon. 90 miles to the North Walt Lillehei had a flourishing programme in Cardiac Surgery. I made it my business to get to know him and stayed in contact for the rest of his life. The University trainees did not operate on Saturdays and would come down to Rochester, 90 miles to the South to watch us operate. and ask us questions.

In Cape Town, Schrire wanted to get cardiac surgery going as soon as possible and it was arranged for Chris to join the Lillehei programme which was part of Owen Wangensteen's Department of Surgery at the University of Minnesota. Wangensteen was the most remarkable Chief of an academic surgical training programme in the USA at the mid-century. In two years Chris, not yet a trained general surgeon, completed a PhD in Surgery, was given a substantial sum of money by Wangensteen to equip an open heart unit in Cape Town. He visited me in Rochester and asked me to join him in Cape Town as soon as I had finished at Mayo. I had thought of going

for a PhD but Mayo, sticking to the rules, required an extra two years and a second language. I presume Chris' second language was Afrikaans, I joined Chris at Groote Schuur and Red Cross in January 1962. I did not realise it at the time but I was displacing Rodney Hewitson , a very good Thoracic surgeon and a thoroughly decent man as first assistant. I had come with the promise of doing one case a week as soon as I had settled down. Things went well. There was no other place in the world with a unit staffed by two trainees one from Lillehei and one from Kirklin. But after 3 months I had yet to do a case. I asked Chris when I was going to start doing my own cases He told me not to worry, it would happen.

One risk that patients receiving transfusions and surgeons pricking their fingers in the 60's was hepatitis. And this is what happened to Chris. He developed severe hepatitis. He announced that all surgery would be cancelled until he was better. Schrire refused to accept this. He went to Chris in his hospital bed and told him that surgery would continue. "We brought Frater back from training in America so as not to be dependent on one surgeon and surgery will continue. And you are too sick to argue with me". I heard this news and was obviously delighted. On the ward was a patient with a syphilitic ascending aortic aneurysm which had eroded through the sternum and presented as a 4-inch pulsating hemisphere. Soon after that I met Dr Schrire and said "Thank you for what you did. I have put a case on for tomorrow. "I know", he said, "and I have cancelled it". "But he's going to die if we don't fix it" I replied. "Yes and it will be tomorrow, if you operate. I have put an ASD on the schedule. Send her back to me with her ASD nicely closed and we will all be happy". He saved my career.

I had a couple of months to operate as the senior surgeon.

During that time, I did a series of repairs of rheumatic mitral insufficiency using autogenous pericardum. I had done a successful animal study before I left Mayo. In the short term they did very well. While Chris was still in hospital there was an article in Die Burger about the Department achieving a revolutionary advance. When I asked him Chris said he knew nothing about it. (I could always tell when Chris was lying)

20+ years later Chris and I were invited to the same Cardiac Surgery Conclave in Northern France. We were chatting and I said "Chris, do you remember when you got hepatitis and had to stop operating for a while?" Chris replied " Yes, and you started doing mitral valve repairs using pericardium and I was sooo jealous."

There are hundreds of other stories and anecdotes, e.g. things he used to say when he was upset. We were operating on a well-known cricketer's mitral valve. It was a difficult case. Chris: "Call Professor Schrire immediately!" Schrire comes into the Theatre and puts his nose over the anaesthetic screen. Barnard: "Val, I just wanted you to see what shit you give me to operate on". Schrire: "You can do it, Chris " and walks out.

I ended up liking Chris. He was flawed. He came from a poor Afrikaner family which worked at the sendingskerk - that coloured parshioners attended. As I suspect you know he was not racially biased. He was not at all sophisticated. He was deeply devoted to his patients.

One last story that I witnessed. When he had completely given up surgery and had started a health clinic in Cos, he was visiting America and was interviewed by a reporter.: "Dr Barnard, you were a famous cardiac surgeon but I understand you sell cosmetics these days". Barnard: "Yes I do" and leaning forward and peering closely at the reporter's face "And, as a matter of fact, you look as though your face could benefit from my ointment. Why don't you buy yourself a tube and use it on yourself?"

Many American cardiac surgeons were very biased towards him. He was thought to have "stolen" their ideas. In the UCT animal lab, the technique for transplanting hearts (two dogs each with a beating transplanted heart as the end of the experiment) had been done before I got back.

I also knew Hamilton Naki. He was a very nice man. He was my assistant in an experiment developing a monoleaflet valved pericardial patch for Tetralogy cases.

Hamilton Naki (26 June 1926 - 29 May 2005)

The Hamilton Naki story

The story of the world's first human-to-human heart transplant cannot be told without mentioning Mr Hamilton Naki, who was a laboratory assistant to Professor Christiaan Barnard and was recognised for his self-taught skills in organ transplantation on animals in the laboratory setting.

Hamilton Naki was born in Ngcingane, in the Transkei region of the Eastern Cape. He was schooled up to the age of 14, after which he moved to Cape Town and started working as a gardener at the University of Cape Town. In 1954, Robert Goets, from the Department of Surgery, asked Naki to assist him in the laboratory with the animals. He started out by cleaning the cages and then progressed to helping with the actual operative procedures, mostly on dogs. Several years after Dr Goetz left, Naki started assisting Professor Barnard as a laboratory assistant. His surgical skills were immediately recognised by Barnard, who then asked him to assist with the surgeries on these animals. In later years, Barnard was quoted as saying "If Hamilton had had the opportunity to study, he would probably have become a brilliant surgeon". These skills were also used for research on other organ related transplants, such as liver transplantation. He continued to do this work until his retirement in 1991, when he received a gardener's pension of R760 per month as per his job title and not as a laboratory assistant.

Naki worked at the University during the heyday of the apartheid years. He would not have been allowed to enter a theatre, touch a `White' patient or even interact with one during this time, because he was a `black' man. It has repeatedly been said and printed in the media that Naki had participated in the operation on 3 December 1967. However, having spoken personally to those who were part of the team at the time, it was noted that the accident took place in the evening on that Saturday night and by the time the decision was taken to do the transplant, many staff members, including Naki, wound not have been present at the hospital. Given that the methods of communication did not exist at that time; it would not have been possible to call Naki to theatre at 11pm. In addition, it has been said, that with so many other staff members who were part of the team, there would not have been any way that Professor Barnard could have included him inside the theatre, since he was a `black' man and the patient was a `White' man. Despite this, with medical history being made, it would have been unethical to allow an unqualified person to even assist. The Chief Medical Superintendent at the time also denied having been asked by Prof Barnard for such permission. It can therefore be confirmed, without any doubt, that Mr Hamilton Naki was not present at the time that the heart transplant took place.

Despite everything, the work that he performed in the laboratory contributed to the knowledge and skill that Prof Christiaan Barnard and his brother Professor Marius Barnard, developed in being able to perform the procedure as a world first. Naki should have been

acknowledged for his background work at that time, but it was only after his retirement and post 1994, that he received public recognition of this work, including:

- Metropolitan Eastern Cape Award, 2002.
- The Bronze Order of Mapungubwe, 2002 - One of the highest South African civil honours presented to him by President Thabo Mbeki.
- Black South African Heroes Award, 2003.
- An honorary Master's Degree from the University of Cape Town in 2003, presented by Chancellor Graça Machel.
- He was part of the "senior civil guard of honour"at the 2004 opening of the Parliament of South Africa.
- The name of the Salazar Plain in Cape Town was renamed the Hamilton Naki Square, 2017.
- A block of flats in Langa has been named after him.

The Nico Malan Recreation Hall.

In addition, more corneal grafts were being done at Groote Schuur than anywhere else in the country. Several kidney transplants had also taken place with equal success. These procedures highlighted the need for a dedicated intensive care unit for transplant patients, which was established in the administrative section of the main building. Ward B1 was also changed into a post-operative intensive care unit, thereby reducing the burden on the wards. A special cardiac unit was established in ward A10, by shifting Gynaecology patients to one floor of the Maternity Building. The area had been used by Gynaecology since 1938 and 30 years later, needed to make way for the Cardiac Block to be used by Dr Barnard. The Obstetric Department was one of the first in the world to introduce diagnostic ultrasound into routine obstetric practice and the Diasonograph, bought in 1968 was the 12th machine ever made. The Mature Women's Clinic, which was established in 1968 was one of the first such clinics to be established in the world and pioneered hormone replacement therapy in South Africa.

The Nico Malan Hall was officially opened on 2 October 1968. The Teaching Hospitals' Board had made a financial contribution towards the building of the facility. The board also investigated the need for a crèche for the convenience of married women, and started planning towards this. Other building projects included planning towards a medical casualty and an accident unit due to the high demand for this service.

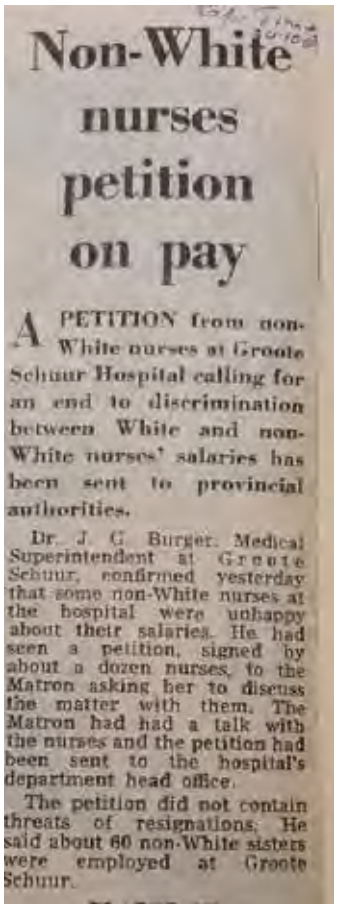
These demands were presenting themselves faster than it was possible to provide them. However, it is noted that the ingenuity of the architects and engineers was paramount in keeping pace with these changes and appreciation was extended to the Provincial Administration and the Teaching Hospitals' Board who provided most of the funding for the work.

GROOTE SCHUUR HOSPITAL 1960 to 1970

The year 1969 was like any other. Further advances were made and research was ongoing. It seems that the clinicians were becoming more daring, conducting experiments on baboons, making artificial hearts, etc. Dr Marius Barnard had also started on a new Lung Transplant project. The hospital seemed to be at a peak with innovations in the different departments. In March 1969, a successful corneal auto-transplant was performed, restoring the sight of a 48 year old man who had resigned himself to blindness.

MAN'S SIGHT RESTORED BY TRANSPLANT

A SUCCESSFUL corneal auto-transplant—a comparatively rare operation—carried out by the Ophthalmology Department at Groote Schuur Hospital, has restored the sight of a 48-year-old Coloured man who was almost helpless through blindness for years.



Non-White nurses petition on pay

A PETITION from non-White nurses at Groote Schuur Hospital calling for an end to discrimination between White and non-White nurses' salaries has been sent to provincial authorities.

Dr. J. G. Burger, Medical Superintendent at Groote Schuur, confirmed yesterday that some non-White nurses at the hospital were unhappy about their salaries. He had seen a petition, signed by about a dozen nurses, to the Matron asking her to discuss the matter with them. The Matron had had a talk with the nurses and the petition had been sent to the hospital's department head office.

The petition did not contain threats of resignations. He said about 60 non-White sisters were employed at Groote Schuur.

In May 1969, the fifth heart transplant was done, this time on the first `Coloured' female, Mrs Dorothy Fischer. It was also the first heart-swop operation performed in South Africa on a `non-White' female. She lived with her new heart for 12.5 years.

Miss P.H. Brassell was appointed as the Chief Matron of the hospital following the resignation of Mrs L. Murray. At this stage, the nursing establishment had grown to 1540 posts, and the profession was offering many post-graduate courses for specialization. On 25 July 1969, the Administrator of the Cape, Dr Nico Malan, opened the "Nico Malan College of Nursing" for `coloured' nurses, where they then received their theoretical training and which was also used for their accommodation. As with all `non-White' staff, there was a huge pay discrepancy between what they earned compared to their `White' colleagues. For example, a `White' nursing sister would earn R2040 per year, while a `non-White' sister earned R960 per year, increasing to a maximum notch of R1500. This discrepancy was the same for doctors, cleaners, porters and all other `non-White' staff at the time. They were also required to work only in the `non-White' wards, which were much busier that the `White' wards.

Groote Schuur Hospital: 1970 to 1980

The services were more settled and efforts were concentrated on providing more holistic care to the patients, by improving the relationship between staff. This yielded considerable success as evidenced by the numerous compliments received from patient letters. However, the strain on `non-White' patient beds continued, while the bed occupancy on the `White' side was low. This was seen in the Neonatal unit, which had become a dedicated unit only for the referral of babies with congenital disease, while on the `non-White' side, with the unit overflowing, Dr A.F Malan and a registrar were responsible for all the babies. Dr Malan was also tasked to look after the Neonates at the Peninsula Maternity Hospital. While these dedicated staff provided the best care that they could, there were obvious discrepancies in the facilities and equipment available in these two sections.

Progress on interdisciplinary care continued with more divisions and departments working together to provide more holistic care. Standards of care were set and maintained.

In the early part of 1971, Day Hospitals in the communities were established and as they became fully operational, the number of patients attending Groote Schuur decreased. In the Casualty unit, there were 5 444 fewer patients seen in 1971 compared to the previous year. The Day Hospitals were also taking over more of the return visits for dressings, etc. A decision was then taken to divide the Casualty Department into a Trauma Unit and a non-Trauma section. The different sections were then allocated to the Department of Surgery and Medicine respectively and staffed by these departments.

One of the world's first heart-lung transplants was done by Professor Chris Barnard at GSH in 1971. The patient only lived 18 days.

Of note, was the appointment of Dr Brian Kies, as the first `non-White' registrar at UCT/GSH in Neurology, who worked under trying circumstances, such as not being able to use the sleeping quarters when on call, and only being allowed to work in the `non-White' wards.

The year 1972, saw the Cardiothoracic team continue to innovate with the introduction of a new technique for the surgical treatment of infants with congenital heart disease. The process of Surface Cooling with limited cardio-pulmonary bypass, deep hypothermia and circulatory arrest allowed for much greater success with this type of corrective surgery. It was also decided that Cardiac Surgery and Thoracic Surgery would be two separate departments.

With the bed pressures being considered as unacceptable, numerous motivating reports were written to the Provincial Administration and it was in April 1972, that they commissioned an independent architectural and consulting engineering firm to carry out the professional services required to consider the redevelopment of Groote Schuur.

1973 was considered to be the Year of the Midwife Obstetric Units (MOU's), the first of which was established at the Lotus River Day Hospital. Dr J. Smith and Dr F. van der Merwe should be acknowledged for the advance in obstetric care. The unit would be managed by Midwives, with the support form Groote Schuur Hospital as well as a direct line of access for complicated deliveries via the Flying Squad. This brought about significant improvements in Obstetric care with little expenditure or increase in personnel. Another advance in history was the appointment of the first `non-White' Clinical Matron at Groote Schuur Hospital, Mrs D.E. Lewis.

The heterotopic or commonly known in lay terms as the "piggy-back" heart transplant was developed in the UCT animal laboratory and the clinical cases were a world-wide first in 1974.

GROOTE SCHUUR HOSPITAL 1970 to 1980

The message from the Principal Medical Superintendent, Dr J.G. Burger, in every annual report noted the tremendous and praiseworthy efforts of all the staff to make this hospital the world-renowned teaching and clinical unit it had become. There were years when the financial situation allowed for quick progress and there were other years when the effects of the strain demanded much effort to keep the hospital functioning. 1975 was one such year when many changes had to be made. By November of that year, the Stage C report depicting a sketch design with 1820 beds was put forward for the new hospital. While this planning was ongoing, promises of funding for projects were not forthcoming and while some building continued, they could not be furnished and used until the financial situation had improved. The building of the Radiotherapy unit had to be stopped. Some promises were kept and it was the first year that medical staff, including registrars were to receive a generous non-pensionable allowance for overtime. By the end of 1975, computerised electrocardiogram machines were installed to be made functional by 1976.

Despite the dire financial circumstances, 1975 was a year of another 'first' for Groote Schuur Hospital due to the outstanding event of the world's first vascularized Human Fallopian Tube Transplant performed by Dr Brian Cohen and his team. It was also the year that Professor Gaisford Harrison of the Department of Anaesthesia discovered that Malignant Hypertension could be treated using Dantrolene. Harrison experimentally induced malignant hyperthermia with halothane anesthesia in genetically susceptible pigs, and obtained an 87.5% survival rate, where seven of his eight experiments survived after intravenous administration of dantrolene. The efficacy of dantrolene in humans was later confirmed in a large, multicentre study published in 1982, and confirmed epidemiologically in 1993


Nog 'n eerste vir Groote Schuur

Deur JACC VIVIERS


Fallopian tube transplanted

By BOB MOLLOY
Cape Times
Science Reporter

The hospital continued to grow in size, services and staff numbers. Building projects in 1976 included a new Chemical Pathology and Bacteriology Laboratories in the extended Out-Patient Department with the Gastrointestinal service and the Gastrointestinal motility clinic housed in the same building.

An EMI scanner was installed in the Neuro- Radiology department for non-invasive Neurological investigations and the Linear Accelerator Building was almost completed.

This head scanner was first manufactured in 1973 and Groote Schuur received one in 1976.


Figure 51: EMI Head Scanner in the X-ray department

It is repeatedly noted that accommodation and crèche facilities for `non-White' nurses were inadequate. Given all the space constraints, it was hoped that the new year in 1977 would be the start of the first phase of the Groote

Schuur Redevelopment Plan, at a cost of R6 million. However, the plans needed to be redone because of the central government Department of Health restrictions on bed numbers and the Treasury norms relative to areas and costs.

The role of the new Principal Medical Superintendent of the hospital was only for eight months due to his untimely death as a result of illness. The post was then taken up by the first woman Principal Medical Superintendent, Dr Hannah Reeve Sanders.

1976 is well known in the South African history as the year when there were many student riots and protests against unequal education. Despite this history, the hospital reports indicate a minimal impact on patient numbers. It is assumed that many of the patients were possibly treated at Somerset Hospital.

The first Advanced Midwifery Course in South Africa for Midwifery sisters was held at Mowbray Maternity Hospital with all participants achieving a pass and one candidate obtaining honours. Another achievement for the hospital was the cabinet approval for a 200MeV open Sector Cyclotron for Radiotherapy and the production of isotopes in the Western Cape as a National facility. Financial constraints continued in 1977 and a Cost Control Board was established to effect cost-savings for the hospital. At the same time, funds were allocated to a computerised patient registration and folder control system. A huge fire at the hospital workshop severely hampered maintenance work. Building works continued on the Linear Accelerator and with the Observatory Boy's High School site being handed over by the Provincial Administration to the Hospital Department, a new crèche was envisaged for the staff of Groote Schuur Hospital.

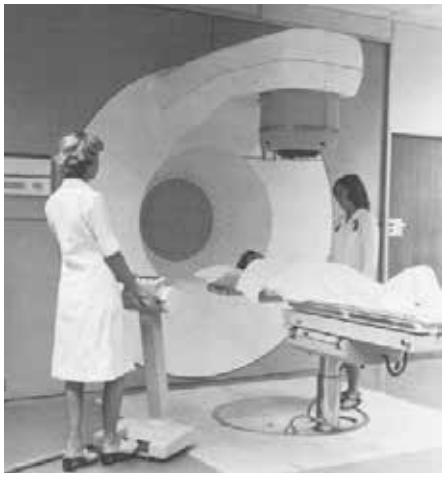


Figure 52: Linear Accelerator in use at Groote Schuur Hospital

By 1979, the long-awaited Linear Accelerator building was completed with the hope that many more patients could now be treated.

After many years of motivation by the Consortium, established in 1973, it was finally agreed in principle around November 1979, that the planning of building a new Groote Schuur Hospital Building could proceed with 1722 beds and a gross area of just under 170 000m2. This brought new hope to the ever-increasing problem of a shortage of beds and other accommodation.

The financial situation remained a cause for concern at the start of the new decade, with the hospital facing not only a shortage of applicants for nursing, radiographic and other posts, but also the draining away of many staff to the private sector, where salaries were more attractive than those offered in the public service. The severe nursing shortage meant a reduction or curtailment of some essential services and a deterioration of the quality of care offered. This also led to an increase in the waiting lists for certain procedures and the mortality in some departments such as Neonatal services.

Figure 53: The Pharmaceutical Manufacturing Department in 1980.From left to right are: Messes Samuel (Surname unknown), Fred Berham (Pharmacist), Theo Mtombeni, Joshua Mbula and Alfred Ngqukuvana (Technical Assistant)

Groote Schuur Hospital: 1980 to 1990

At the same time, the number of patients steadily increased, with referrals from other Provinces and areas outside of the country. The need for strengthening the Primary Health Services in the community remained urgent, while the hospital struggled to maintain the standard of care for patients, teaching and research. Specialised procedures were also in demand, such as bronchoscopy and endoscopy numbers that had doubled from the previous year. New ways of managing Diabetic patients, such as the appointment of a Diabetic Nurse Educator, increasing home-monitoring, etc, were put forward with collaboration between departments like Obstetrics and Medicine. Another innovative initiative was the appointment of a renal transplant and dialysis coordinator in January 1980, the first such appointment in South Africa. This allowed for more transplant patients to benefit from the life-saving surgery. Trauma cases increased by 5.3%, severely impacting on the Orthopaedic services.

Figure 54: West wing extension to the Maternity building (1980).

The Maternal and Neonatal services were reorganised into the Peninsula Maternity and Neonatal Service, responsible for all maternal and neonatal care in the Cape Peninsula outside of private services. The Peninsula Maternal and Neonatal Service (PMNS) was established in the early 1980's as a result of the efforts and vision of Professor Dennis Davey and Professor Atties Malan. This service was developed in an attempt to improve maternal and neonatal care in the Cape Town Metropole by offering a structured service delivery model for Obstetrics and Neonatology. Patients were triaged to the appropriate levels of care, shared protocols were developed and central to this was a transport system which ensured that patients could move easily from one level of care to the other. The PMNS was regarded internationally as a model of innovative safe maternal and neonatal care, particularly but not exclusively, applicable in a developing country.

Another major event in 1980 was the building of the west wing extension to the Maternity Building, to accommodate the Neonatal service, a large staff tea room and the move of the Andrology service from Medical School.

The most notable event was a welcome relief that the Central Government had allocated a substantial amount of funds for the redevelopment and enlargement of Groote Schuur Hospital, with work to commence in 1981. The property to the east of the hospital, about 7.5 hectares, was consolidated for the new structure with a final bed number at 1437 beds.

During the design stages, several factors such as the topography, site size limitations and the preferred orientation for the major facades relative to the old building had to be considered. The following principles, among others, led to the application of a disciplined, rationalized and integrated approach to the architectural, structural, mechanical and engineering design of the new building:

- Flexibility in planning to accommodate variations in requirements and future upgrades
- The ability to accept change without major disruptions
- The location of major circulation and engineering services cores to provide an effective pattern for person traffic, goods flow and engineering services.
- The installation and maintenance of engineering services without major disruptions.

R200-m facelift for Groote Schuur

Argus late final 10.1.80

Property Editor

TREASURY approval for about R200-million is now awaited for a major redevelopment scheme for Groote Schuur Hospital, says the director of works of the Cape Provincial Administration, Mr R A Cunninghame.

These criteria resulted in a design that included so-called multifunctional zones and the horizontal service distribution space as interfloors.

1981 started out with many disruptions due to the building activity, with the demolitions in Clee and Mostert roads affecting access to the hospital for vehicles.

Services continued to expand and function under significant stress. The increasing number of renal transplants resulted in the facilities for haemodialysis being stretched. It was therefore decided to open a new unit for peritoneal dialysis, thereby strengthening this programmeme. Paediatrics and Child Health were given divisional status and separated from the Department of Medicine.

Another world first for Groote Schuur Hospital came when a method for storing and preserving donor hearts by hypothermic perfusion was developed by Mr W.N. Wicomb and his colleagues. This method was used on four transplants performed at Groote Schuur Hospital, with the donor heart being stored for 7-17 hours.

Figure 55: Mr Winston Wicomb with his invention

The completion of the crèche in the Main Road meant that children initially housed in the Mostert and Clee Road houses, could be moved into the new building.

The history of the crèche was obtained by Mrs Gemel in consultation with one of the first employees at the facility, retired Nurse MacZantse, who explained that the crèche opened on 1 March 1977 in Clee Road, Observatory. This crèche operated in a house with about 20 children who were supervised by two nurses, and catered for all children of registered nurses aged between 6 months to 6 years at a fee of R4.99 per child. The Clee Road facility existed for 4 years before moving to the Observatory Boys School Building in Main Road, Observatory. The building was divided into sections - one for the 'White' children named the Groote Schuur Pre-primary and the

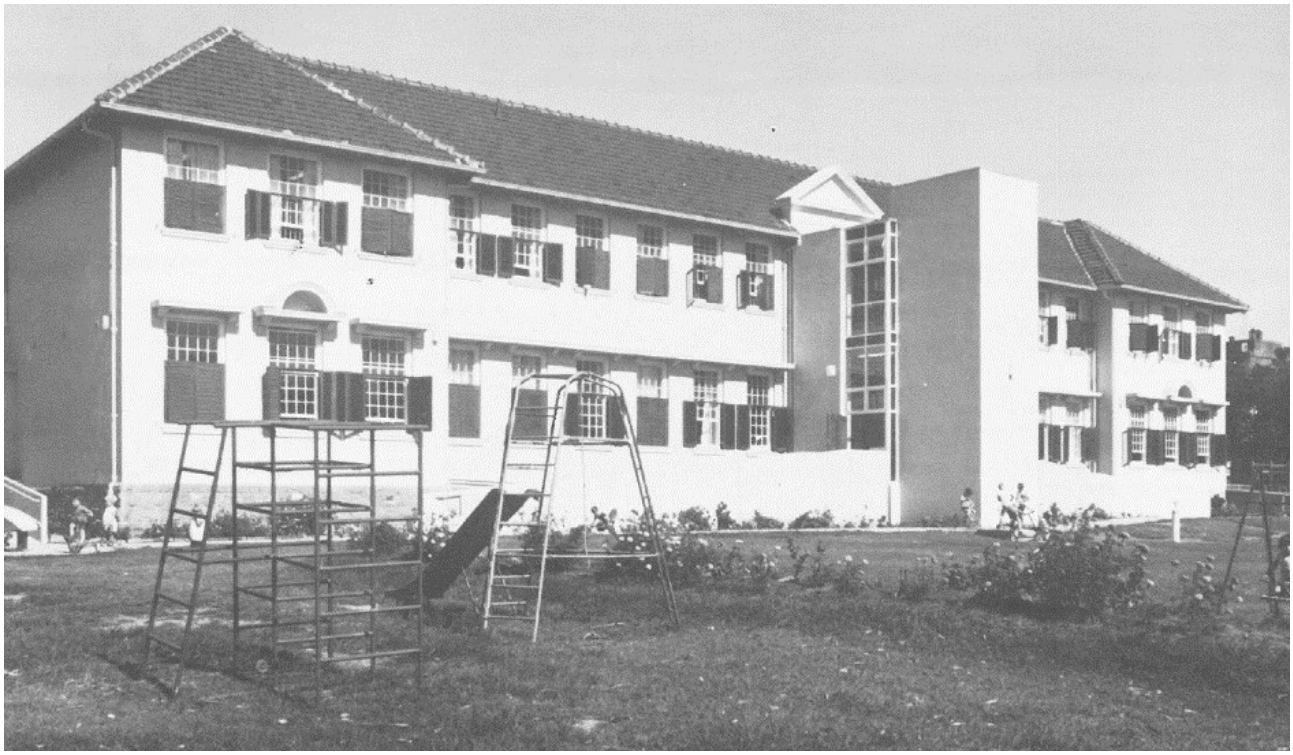


Figure 56: The completed crèche

other side, for the 'non-White' children, named Oaktree Preschool. The Groote Schuur Pre-primary enjoyed lessons from qualified staff from the Cape Provincial Department of Education, while the Oaktree children were taught by nurses, from 1982 until 1989, when the Department of Coloured Affairs Education Department stepped in to upgrade the pre-school and provided a grant-in-aid subsidy for the appointment of a Principal. Post-1994, the crèche became one and was opened to all children of all Groote Schuur staff, with the 3 months to 2.5 years in the section that was the Groote Schuur crèche and the children aged 3 to Grade R, in the Oaktree School area. Eventually, the Grant-in-aid was withdrawn and in 2012, the Oaktree Pre-primary applied for and was awarded a subsidy for a Grade R class teacher. To date, the Grade R class benefits from this subsidy and continues to function.

After ten years of planning, the New Main Building of Groote Schuur Hospital finally commenced in 1982 with the acceptance of the LTA/Comiat joint venture to tender for the work to be done.

Building would start in 1983 and take six years to complete, with an envisaged building that could accommodate 1400 beds, 128 intensive care units, 24 operating theatres, 5 wings, seven floors and a maximum length of 250m linked by primary circulation cores and corridors. The building included a 5 floor parking garage for 1100 cars, landscaped into the sloping structure.

About 1200 people were to be involved in the building phase of the new hospital and the final figures were that the hospital building would comprise 125 000m2 of functional area space spread over seven user floors, with a maximum length of 250 m2. In addition, there would be 75 000 m2 of interfloor construction forming the horizontal service distribution space. The entrance to the Emergency Department interfaced with the fourth level of the parking decks, and included a large covered area for ambulances.

The building was to be constructed of in-situ and pre-cast elements, the latter totalling 20 000 in number. 110 000m^3 of concrete and 14 000 tonnes of steel reinforcing and mesh would be used.

The repetitive nature of the structure allowed for the use of industrialised methods of construction, with the main elevator and service shafts to be cast in-situ from user floor to user floor. Then, the erection of precast floor troughs at each level would take place. The precast main beam soffits would be placed into position by crane and propped at the ends and third points with temporary staging. The floor troughs would then be placed into position resting on the precast main beam soffits. The infill concrete would be used and once cured, the temporary staging removed. In this way, floor by floor would be constructed and because of the slope of the site, building had to be done from a west to east direction. All the precast concrete was to be manufactured on site.

Acknowledgements must be extended to the architects, the civil, structural, electrical and mechanical engineers, the quantity surveyors and the contractor appointed to do the work, LTA Comiat Joint Venture. The large structure would indeed be a marvel of its time with modern features that remain relevant to this day. The structure blended into the hospital against the backdrop of Devil's Peak and represents what we know as Groote Schuur Hospital.

Figure 57: Model of the new building

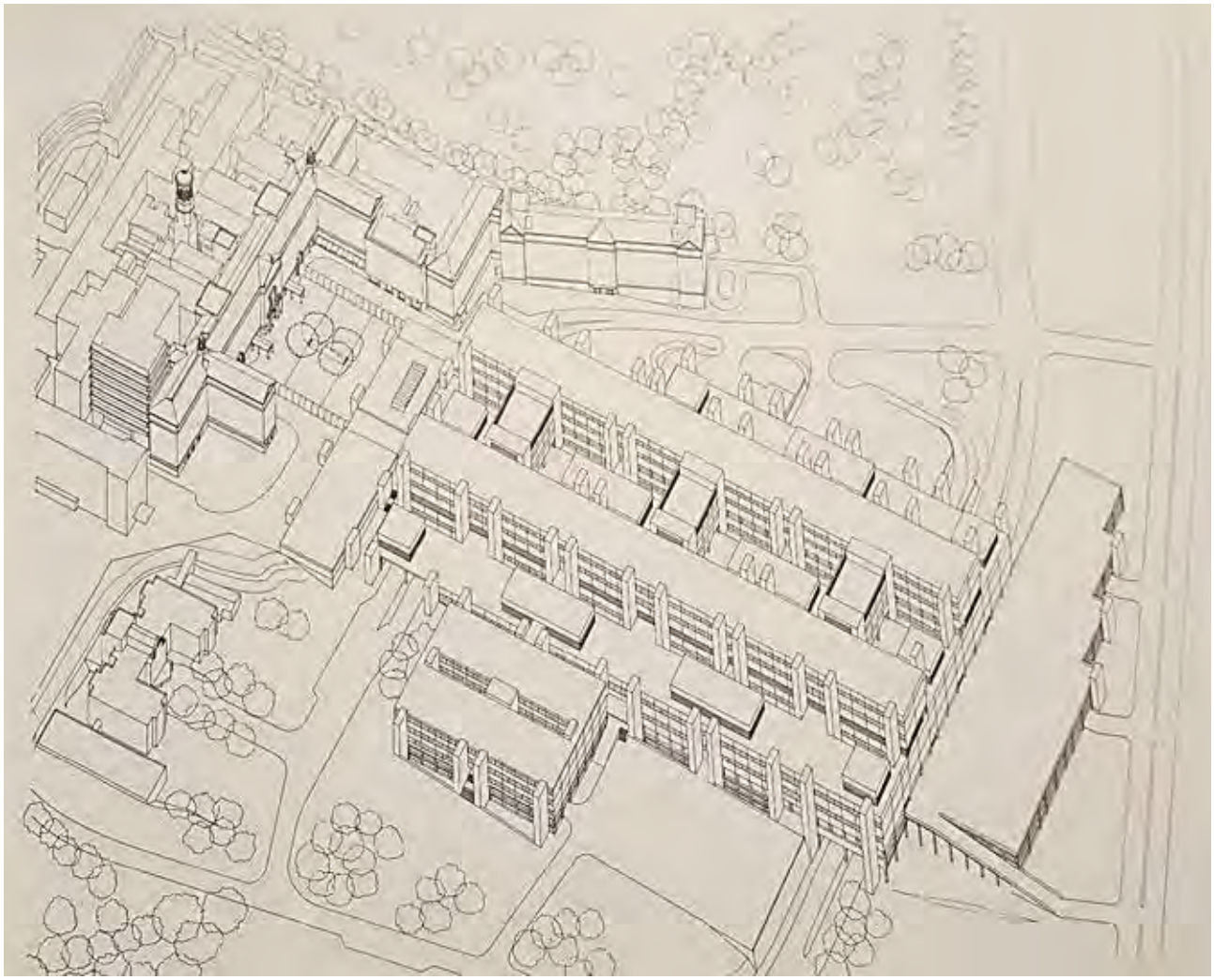
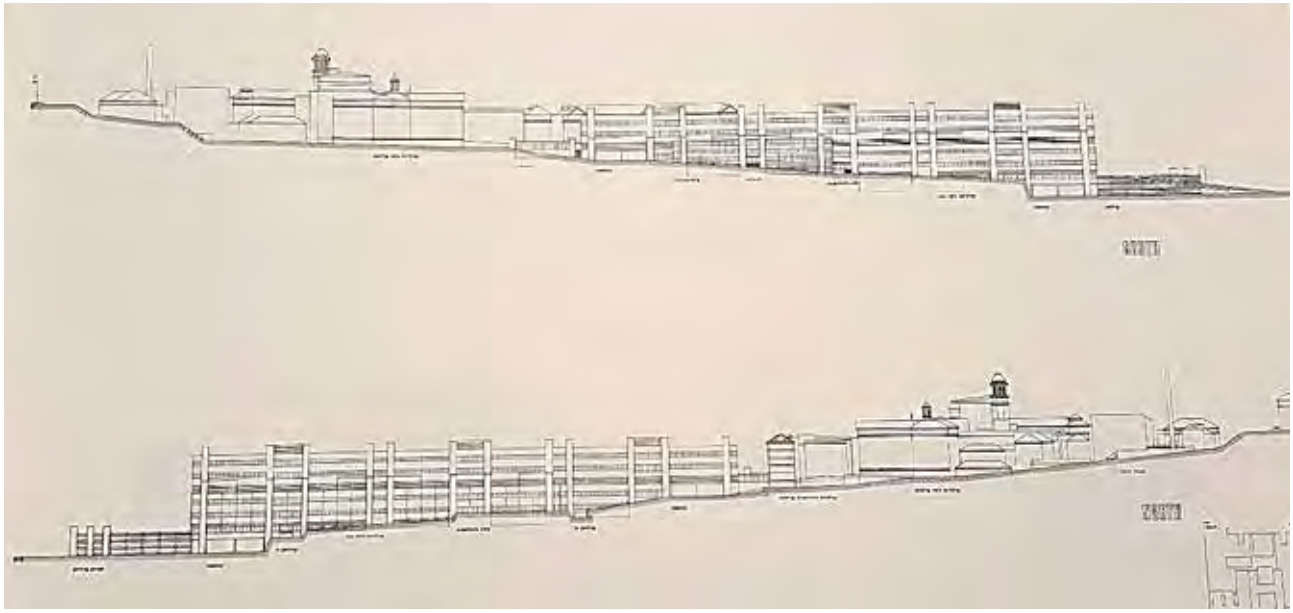


Figure 58: Architechts impression of the building



The excavation work commenced in 1982 and on the 10th of January 1983, the hospital held a `Turning of the Sod' ceremony, attended by staff from the Hospital, the University, Public Works and the construction company it was only on 5 September 1983, that the foundation stone of the new hospital was laid by the State President, Mr Marius Viljoen.

Figure 59: Turning of the Sod ceremony

It was only on 5 September 1983 that the foundation stone for the new hospital was laid by the State President, Mr Maruis Viljoen.

Figure 60: Laying the Foundation stone for the New Main Building on 5 September 1983.

Dr H-R Sanders, Chief Medical Superintendent; Mr E. Louw, Administrator of the Cape Province; Mr P.J. Loubser, MEC Hospital Services; Mr M. Viljoen, State President and Prof J.H. Louw, Chairman of the Teaching Hospitals' Board.

Figure 61: New Main Building under construction

GROOTE SCHUUR HOSPITAL 1980 to 1990

With the building project underway, service innovations such as the first human liver transplant in the Cape took place at Groote Schuur using a new heterotropic liver transplant technique by placing a piggy-back liver in the patient's abdomen. While this was the first liver transplant for the Cape, the use of this technique was a first in the world. It was also the year when the Breast Clinic was started by Professor Dave Dent and sadly for Groote

Schuur Hospital, Professor Chris Barnard retired from clinical service. His retirement left a void in the department and he was honoured through several farewell events as well as the creation of a Christiaan Barnard Chair in Cardiothoracic Surgery.

At the start of 1984, the redevelopment was in full force and progressing swiftly ahead of schedule. The new crèche was occupied and the Maternity block wing was fully commissioned. On the financial front, there was a need for continuous rationalization in the face of escalating demand and rising costs, requiring the Teaching Hospitals' Board to embark on a massive fund-raising drive.

Interesting developments during the year were the introduction of the top-up cart system for medication and supplies. A Nursing development unit developed programmemes for nurses which included standardised clinical activities, team building, leadership, group interaction, communication and conflict resolution. The programmemes were open to all nursing personnel, ward staff and porters. Among the Medical Superintendents, Dr G.A. Lawrence was the first `non-White' medical manager appointed in March 1984.

Tumultuous times presented themselves in 1985, with a very tense political climate, impacting on the staff, who continued to offer egalitarian treatment to all the patients. The country was struggling with a high inflation rate and staff salaries were not increased. As a result, many staff members were emigrating abroad or leaving to work in the private sector. Patient activities saw an increase in all spheres and the hospital management faced the challenges of rising costs and the need to maintain services while implementing Phase 1 of the new building. The L-block was completed at a cost of R3.1 million and fully commissioned ahead of schedule in December 1985. The building would house all the equipment, including the cobalt machine required to treat cancer patients.

Figure 62: L Block construction completed in 1985.

As is usual at Groote Schuur Hospital, the year was not without its special achievements, with the first Laser Surgery to remove a growth in the trachea. The first successful series of heart-lung transplants in SA and amongst the first series in the world were performed by Bruno Reichart at GSH starting in 1985 up to the end of 1989.

Laser surgery is SA first for Groote Schuur

Heart-lung patient

Mrs Lorraine Greenwood (right), the latest heart-lung transplant recipient, with her mother, Mrs Rachel Roman (middle), and sister Mary-Anne.

GROOTE SCHUUR HOSPITAL 1980 to 1990

'Non-White' nursing students were progressing well at the Nico Malan College and were proving to be an asset to the hospital.

Holding the proof of their hard work during the past year are six of the award-winners of Cape Town's Nico Malan Nursing College. From the left they are Ms Wilma Februarie, Ms Sarie Jonkers, Ms Denise Lopser, Ms Jean Fredericks (tutor), Ms Joan Petersen and Ms Jennifer Jones. 29-6-85

By mid-1986, there was a change of guard with Dr Hannah-Reeve Sanders, after serving Groote Schuur Hospital for ten years, being appointed as Senior Deputy Director: Department of Health Services. This was the first time that a woman had been appointed to such a high position. She also received the "Cape Woman of Achievement award". Her leadership and management skills had carried the hospital through many trying times. Her post was filled by Dr Joce Kane-Berman.

Sanders appointed to top hospital post

Provincial Reporter

THE CHIEF medical superintendent of Groote Schuur Hospital, Dr Hannah-Reeve Sanders, has been appointed senior deputy director of hospital services — the highest position held by a woman in the Cape provincial administration.

Announcing Dr Sanders's appointment to the vacant post, the Administrator, Mr Gene Louw, said yesterday that she was "eminently suitable" for the job and would take over on July 1.

LONDON

Dr Sanders

While there was always a system of payment for hospital patients, 1 April 1986 saw the end of free hospitalization in the Cape Province and the introduction of a hospital fee structure based on the principle that all patients should make some contribution towards their health care costs. The amount was calculated based on a sliding scale depending on the income or tax paid by the family unit.

On the clinical front, the Cape's first test tube twins, Michael Jamian and Marvin Donnay Arnolds were born on 18 August 1986, by Caesarian section at Groote Schuur Hospital to Mrs Ella Arnolds of Mitchell's Plain. While a first for the Cape, they were the fourth in South Africa.

South Africa's first and the world's second test tube quadruplets were born at Mowbray Maternity Hospital in May 1986.

Within Groote Schuur Hospital, Professor Bruno Reichart performed the 100th heart transplant and the transplant team also successfully completed the 600th kidney transplant.

The Department of Haematology used for the first time in South Africa, a new technique to overcome the graft versus host disease in bone marrow transplants.

The move into the new hospital proceeded steadily requiring the acquisition of new equipment to facilitate the exchange cart system, the new sterilising system, the pneumatic tube system, a central vacuum cleaning system and the Cook-Chill system, which was pioneered at Groote Schuur Hospital. In addition, a totally new computer network system had to be installed, to incorporate the new fees system; the in-house designed equipment acquisitioning system (PEACH – Planning, Equipment acquisitioning and Commissioning of Hospitals); a new computerized inventory system (PEAR – Planned equipment asset register); an input-output system (GRAPES – Goods Received and Payments Effected system) and then a separate system (QUINCE – Quasi Non-Consumable Equipment) to control non-inventory items, for example, crockery, cutlery, brushware, linen, etc. This fruit salad appeared to be the most efficient of hospital systems, even compared to the standards being applied today.

The first department to move into the new building was Medical Records in December 1986. The first patients to move over were from Radiotherapy, who moved to wards F7 and F8 on 21 June 1987 and the others followed.

A surgical team reattached a severed hand of a 28-year-old patient during an 11 hour surgery and the hospital had its first set of test tube triplets.

There was a change in the name of the Head of Nursing to Deputy Director: Nursing, with Miss June du Preez promoted into the post. 1986/87 was the most notable year in the history of Groote Schuur Hospital as well as South Africa, when the services moved into the new building. In light of the political and economic developments as well as government policies on segregation at the time; the grossly overburdened services in the `non-White' wards; the divided training of students and the severe staff shortages, the hospital management and staff made a conscious decision to re-organise the staffing and structure towards consolidated wards in the New Main Building. There was support from the Faculty of Medicine as well as the National Medical and Dental Association of South Africa (NMDA). With this backing, the hospital decided to fully integrate services at the hospital, which resulted in:

1. Streamlining of the functioning of the clinical services;
2. Facilitation of student teaching;
3. Closer collaboration between medical and nursing staff and
4. Functioning more optimally and efficiently.

UCT medical faculty to fight hospital apartheid

Staff Reporter 15-4-87

THE medical faculty of the University of Cape Town will continue to fight for medical care free from discrimination, a faculty spokesman said today.

He was responding to a report in The Argus yesterday that the new Groote Schuur Hospital, which opens in 1989, will have racially segregated facilities in accordance with Government policy.

"The faculty has consistently opposed apartheid in all aspects of medical care," he said.

"It has progressively eliminated discrimination at student, staff and patient level.

"The faculty does not intend retrogressive moves and will continue to do all in its power to provide medical care free from all discrimination for all its patients."

The new Groote Schuur will be segregated

Staff Reporters 14-4-87

THE new R200-million Groote Schuur Hospital which opens in 1989 will be racially segregated "in accordance with Government policy"

Figure 63: Panoramic view of completed New Main Building

The Emergency units and Outpatient facilities were also fully integrated.

GROOTE SCHUUR HOSPITAL 1980 to 1990

On 31 January 1988, the hospital celebrated its 50th anniversary. The jubilee celebrations were marked by commemorating the many individuals who had contributed to making this hospital great.

Figure 64: Chapel windows

The Teaching Hospitals' Board donated a stained glass window to the hospital chapel in honour of the birthday. The birthday year was also marked by the surgical team, led by Professor Terblanche successfully transplanting a liver into a 48-year-old woman in October 1988. This was the first operation of its kind in South Africa and was made possible after the return of Professor Delawir Kahn who spent two years at the University of Pittsburgh studying the liver transplant programmeme. In July of the same year, the 100th Live Related Donor kidney transplant took place, with two brothers from Mauritius coming down to Cape Town for the operation. Since its inception to the end of March 1989, the hospital had performed 160 heart, 800 kidney and 3 liver transplants.

Another South African first for the department of Pharmacology, was the development of a "South African Medicines Formulary" in conjunction with the Medical Association of South Africa as a comprehensive medicine prescribing guide.

Finances remained challenging and a Cost Awareness Committee was established to replace the previously created Cost Control Committee. The budget was monitored more stringently on a monthly basis with set targets and indicator measures. Despite this, the hospital budget was overspent by R30 million.

April 1988 also saw a memorable event for the history books, with the disparities between salaries of the different racial groups being abolished. This beneficially improved morale of the staff even though there was a `stilstand' imposed on the filling of posts at the time.

The last changes to the new building were being implemented with wonderful new equipment having been acquired. The Records Room for example, was housed on two floors with folders and X-rays kept on the A level, while microfilms were kept in a specially designed dust free room on the B floor. The Central Distribution Unit had designed a unique system of transporting goods to the wards at scheduled times via 12 dedicated lifts manned by lift attendants. These included exchange carts, patient meals, case carts, refuse, linen, mail, speciality carts, etc. A daily average of 55 exchange and 35 Pharmaceutical carts were transported on a 24-hour basis.

The fully computerized pneumatic tube system became operational in March 1988. It had 13 separate zones and could transport goods at speeds of 5m per second over distances of approximately 1000 metres. The endpoint was to have 90 stations supported by 9000 metres of 150mm internal tubing, with each station having a micro-processor communicating with the zone processor which is controlled by the main controls.

In order to improve the cafeteria facilities in the New Building, the Teaching Hospitals' Board committed R70 000 towards creating a better environment. Through various fund-raising events, the board also raised R55 000.

The new building would increase much needed parking facilities from 1308 to 2359 spaces. The building was indeed the most modern structure of the times, with up to date internal features, making it a huge pleasure for the dedicated staff to continue their work. The patient areas boasted adequate facilities for patient care, space for families to interact with their loved ones and with the staff and space for the teaching of students.

The saddest part of 1988 was the dismissal of the Chief Medical Superintendent, Dr Joce Kane-Berman because of some brave comments made related to the future of an undivided South Africa and in particular that she

would like to see Nelson Mandela in cabinet. She was transferred to Western Cape region, but was later reinstated into her position at Groote Schuur Hospital following labour action. The event came at a most inopportune time when the hospital was moving buildings and staff needed a sense of security. Her position was temporarily and very ably filled by Dr Gilbert Lawrence.

The architects impression of the proposed link-bridge between Groote Schuur Hospital and UCT Medical School

In 1989, through donations received from the D G Murray Trust, Old Mutual and the De Beer's Chairman's Fund, the University started planning the link bridge between the Hospital and the Medical School Library across Anzio Road.

Figure 65: Professor Laurie Adams with `Tom'

A world first was the discovery of a technique to locate brain tumours without invasive surgery, with the use of a plastic head dubbed `Tom'. With CT scanners, they were able to pinpoint the exact location of the tumour and thereby facilitate an accurate placement of the proton beam for treatment, without needing to constantly shift the patient.

While all departments were slowly settling into the New Main Building, the years 1989 to 1990 were momentous years in the history of the political transformation of South Africa. Many protests disrupted service delivery due to the unavailability of staff, but overall, it was a positive change towards a new future for South Africa, leaving many uncertainties of some of the comforts left behind and the many certainties of a future with equality for all. The ideological paradigm, the economic climate, the population growth, all impacted on the future of the health services. Additionally, the expansion of private health care and the fragmented service delivery model in place at the time, undoubtedly hampered the provision of healthcare to those most in need in the communities. All of these impacts left many uncertainties in the minds of the people delivering healthcare in South Africa coupled with the uncertainties in academic medicine.

Groote Schuur Hospital: 1990 to 2000

A significant development in 1991 was the appointment of the Academic Health Complex Board, in order to achieve autonomy of the academic hospitals. From the start, Groote Schuur Hospital managed not only the activities of its hospital, but also that of Red Cross War Memorial Children's Hospital, Valkenberg Hospital, the Avalon Treatment Centre, William Slater, Mowbray Maternity, Peninsula Maternity and all the Midwife Obstetric Units.

On 26 September 1991, a Dedication ceremony was held to dedicate the new hospital building and all its staff "to the service of humanity, to alleviate suffering, to promote health and to respect the dignity and privacy of those whom we serve." At this ceremony, the State President, F.W.de Klerk unveiled a commemorative plaque. As in previous years, funding constraints hampered progress and nursing shortages impacted on service delivery. A joint agreement was signed with the Peninsula Technicon for the training of radiographers. It was a sad year for the Maternal services with the closure of the Peninsula Maternity Hospital after 70 years of service and its amalgamation into the Mowbray Maternity Hospital.

nr. Havilon Maloy

Nuwe hartoperasies om hartklop-defek te herstel

Deurbraak vir SA met hartoperasie

Mediese Verslaggewer

'n HARTOPERASIE om 'n seldsame elektriese fout, wat 'n hart lewensgevaarlik vinnig laat klop het, te herstel, is onlangs vir die eerste keer in Suid-Afrika in die Groote Schuur-Hospitaal gedoen.

Die pasiënt, mnr. Havilon Maloy van Belhar, voer nou 'n normale lewe nadat sy hart voor die operasie teen 'n dolle 260 slae per minuut geklop het. Dit is drie keer te vinnig en lewensgevaarlik omdat die hart nie kans kry om die bloed deur die liggaam te pomp nie.

Die pasiënt se hart klop nou normaal ritmies omdat die foutiewe geleiding deurgesny is en die elektriese impulse normaalweg in die hartweefsel gelei word.

Dit was, sover bekend, slegs die derde keer ter wêreld dat 'n nuwe veilige operasie uitgevoer is om 'n fout in die elektriese geleidingsweefsel in die hart te herstel. Die operasie is volgens dokters van die Groote Schuur-Hospitaal seldsaam omdat die toestand seldsaam is en dokters voorheen nie gedink het dié defek kan chirurgies reggestel word nie.

In 'n operasie op 16 Januarie vanjaar het 'n span hartchirurge en hartspesialiste saamgewerk om 'n "elektriese kaart" van die hart saam te stel om die presiese posisie te bepaal van waar die foutiewe elektriese impulse "soos 'n masjiengeweer afgevuur word sodat die hart verskriklik vinnig klop". Deur 'n dun draadjie deur 'n aar tot in die pasiënt se hart te stoot, kon hartspesialiste die "elektriese kaart" saamstel.

Die fout was in die regter-pompkamer. Chirurge kon toe op die presiese plek 'n flappie in die hart sny om die foutiewe elektriese verbindings met 'n vriestafie by minus 90 grade Celsius deur te sny sonder om die normale geleidingsweefsel te beskadig. Die flappie word dan weer in sy oorspronklike posisie gebeg, maar die foutiewe elektriese verbindings kan nie weer geheg word nie.

Vóór die nuwe tegnieke en kennis aan dokters kon toon presies waar die elektriese fout in die hart en die normale geleidingsweefsel is, was daar 'n veel groter kans vir beskadiging van die normale geleidingsweefsel.

Dr. Ulrich von Oppell, wat pas van Amerika teruggekeer het waar hy nuwe tegnieke bestudeer het om hartklop-defekte veilig te herstel, het gesê vinnige hartklop word meestal goed met middels beheer. In 'n klein persentasie van gevalle klop die hart egter só vinnig dat 'n operasie nodig is – soos in die geval van dié pasiënt.

Clinically, the Cardiac Team claimed another first for South Africa, when Professor Scott Miller and Dr Ulrich van Oppel performed an Arrythmia operation at Groote Schuur saving the life of Mr Havillon Maloy.

Limited private practice for full-time medical staff was approved in principle by cabinet in December 1991 and a policy document was only issued by the National Department of Health in August 1992. Following this, it was agreed that the staff of Groote Schuur and Red Cross Hospitals could have group private practices.

1992 was also filled with strike activities which required sensitive handling by the management team.

The heart team suffered a huge blow when they were forced to perform a heart transplant operation at the City Park private hospital, since they were barred by striking staff. However, in the same year, the team celebrated the 25th anniversary of the first transplant and of the 80 survivors at the time, 57 attended the tea to commemorate the event. Among them, Mr Dirk van Zyl, the longest surviving patient, 21 years after his transplant.

Figure 66:
Prof Barnard with Mr van Zyl

Figure 67: Some of the 100 recipients of heart transplants

Work on the buildings continued in stages during 1993 as the New Main Building was occupied, the Old Main Building was refurbished, Outpatient sections had to be re-organised and Psychiatry occupied the J block. Labour unrest and financial constraints remained the order of the day, with the hospital still over-budget by R34 million.

Another Hand Replant operation was performed by Dr Martin Singer on Mr Makwenka Ntlomelwana from Khayelitsha, whose hand was chopped off by a robber, making the hand unit one of the best in the country.

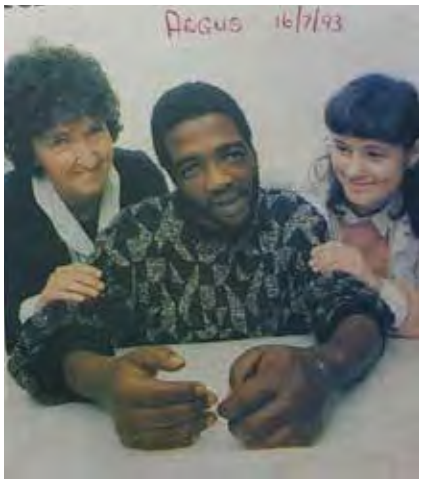


Figure 68: Mr Ntlomelwana with Groote Schuur Physiotherapists in recovery after the hand transplant

Figure 69: Prof's Del Kahn and Johan Brink - Transplant surgeons

However, financial constraints impacted heavily on the future of transplant surgery due to the lack of staff and the need to save funds. A call was made to raise funds for these procedures.

1994 heralded the birth of a new democracy in our country and was seen by many as a time of challenge and opportunity. However, the new government brought with it a change in the Health Services though the National Health Plan, which was also developed into a Provincial Health Plan. This plan proposed changes to the structure

of the Academic Region, dismantling what had existed and centralising the control of the Academic Hospitals at Head Office, under a Chief Director: Supraregional Services. The year continued through financial strain and an overspend of almost R100 million was projected. Drastic cuts were inevitable as the country attempted to redistribute the healthcare resources to previously underfunded provinces. The Western Cape was spending R1.99 billion annually, but was only funded at R1.66 billion. Posts remained unfilled due to the moratorium, but the work had to continue. Ernst and Young developed and implemented a Management Accounting Process (MAP) as a financial and costing system that reflected various expenditure items at the lowest cost centre level. Monthly information was timeously provided in a user-friendly format, facilitating better control of the buying and spending patterns. For Human Resource Management, the Persal system was implemented in April 1994.

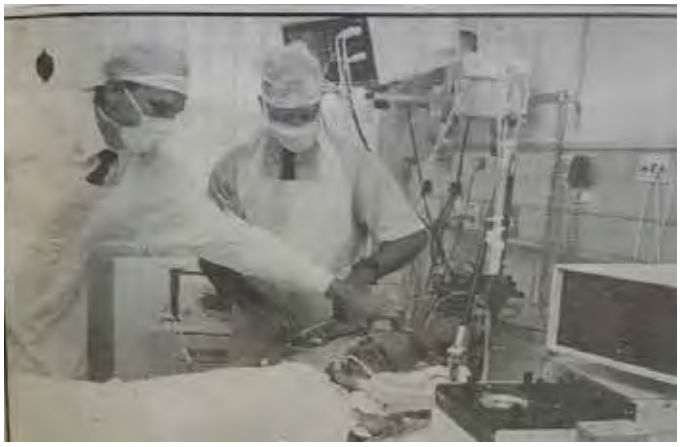


Figure 70: Surgeons Mike Worthington and Johan Brink with Mr Crooks

On the clinical side, the hospital performed its first multi-organ transplant, of a heart and kidney in February 1994 on Mr Michael Crooks, a 44-year-old Vereeniging journalist. This was the first multi-organ transplant in Africa.

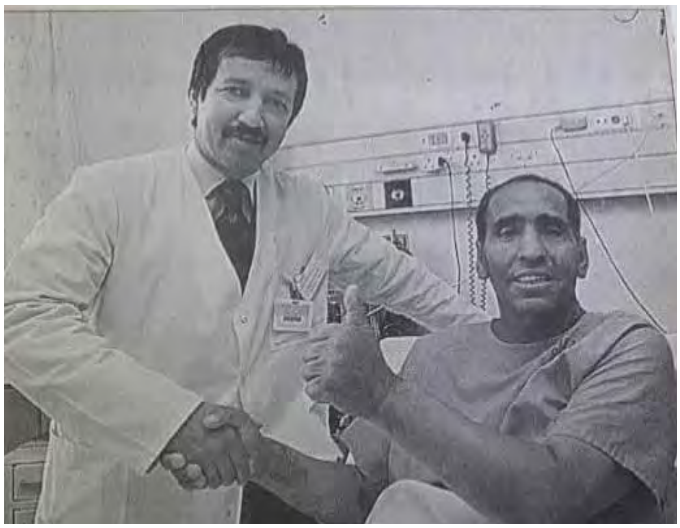
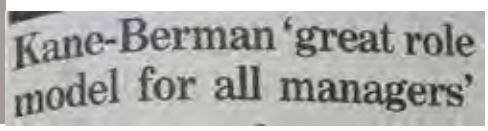


Figure 71: Prof Del Kahn with Mr D'Ambrosio, the 50th recipient of a liver transplant.

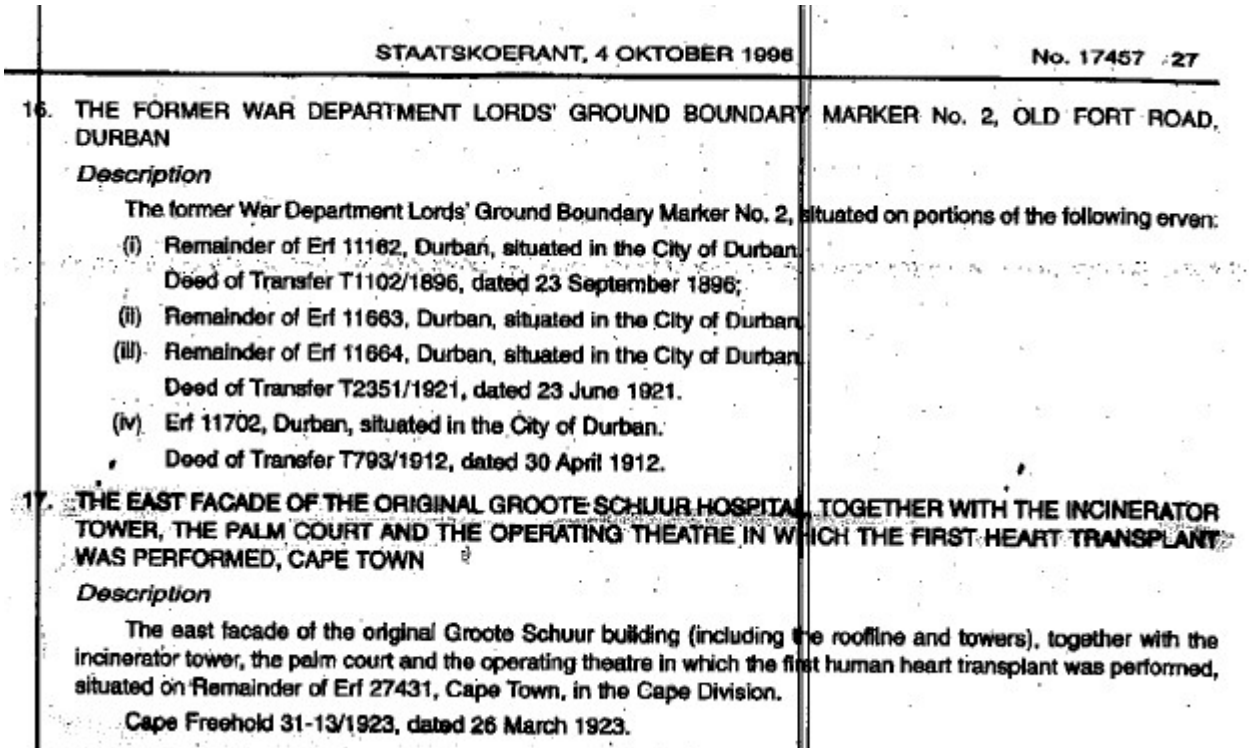
A major change in 1995, was the move of Dr Kane-Berman to the Department of Health Provincial Administration as the Chief Director Finances and Administration. Dr Peter J. Mitchell then took over as Chief Medical Superintendent from January 1996. These were changing times and rationalization and restructuring were terms prominently used. Finances were redirected to other Provinces and the strengthening of Primary Health Care was the priority of Government. A huge question mark hung over the future of tertiary and quaternary services. The Gauteng Province placed a ban on all transplants, which meant that the Western Cape, mainly Groote Schuur, was serving the entire country for this service. A milestone achievement in July 1995 was that the hospital performed the 50th liver transplant.


Kane-Berman 'great role model for all managers'

The Western Cape Provincial Health Plan was finally signed and implemented in 1996. The academic hospitals were placed under a Chief Director: Supraregional hospitals and there were four new geographic regions, each under new headship. The Groote Schuur Hospital Region included Groote Schuur Hospital, Mowbray Maternity Hospital, the Midwife Obstetric Units, Valkenberg Hospital, the Carinus Nursing College, Avalon Treatment Centre, William Slater Hospital and Princess Alice Orthopaedic Hospital.

Budgets remained constrained and there was still a limitation on the filling of posts. In addition, the Voluntary Severance Package (VSP) was introduced and had a significant impact on quality and experienced staff who left because of the VSP. As part of the rationalization process, the Joint Implementation and Monitoring System was introduced early in 1996, requiring many links to be established to integrate the services. G.F. Jooste was opened in September 1996 and required much support in the form of staff, equipment and posts. This service hugely reduced some of the burden on the trauma and casualty units at Groote Schuur Hospital. The rationalization initiative also meant that a total of 60 medical and 12 radiotherapy beds had to be closed due to financial and staffing problems.

Of historical interest is that the Groote Schuur Hospital Old Main Building facade, the incinerator, Palm Court and the Charles Saint Theatre were declared National Monuments.



STAATSKOERANT, 4 OKTOBER 1996 No. 17457 27

16. THE FORMER WAR DEPARTMENT LORDS' GROUND BOUNDARY MARKER No. 2, OLD FORT ROAD, DURBAN

Description

The former War Department Lords' Ground Boundary Marker No. 2, situated on portions of the following erven:

(i) Remainder of Erf 11162, Durban, situated in the City of Durban;
Deed of Transfer T1102/1896, dated 23 September 1896;

(ii) Remainder of Erf 11663, Durban, situated in the City of Durban;

(iii) Remainder of Erf 11664, Durban, situated in the City of Durban;
Deed of Transfer T2351/1921, dated 23 June 1921.

(iv) Erf 11702, Durban, situated in the City of Durban.
Deed of Transfer T793/1912, dated 30 April 1912.

17. THE EAST FACADE OF THE ORIGINAL GROOTE SCHUUR HOSPITAL, TOGETHER WITH THE INCINERATOR TOWER, THE PALM COURT AND THE OPERATING THEATRE IN WHICH THE FIRST HEART TRANSPLANT WAS PERFORMED, CAPE TOWN

Description

The east facade of the original Groote Schuur building (including the roofline and towers), together with the incinerator tower, the palm court and the operating theatre in which the first human heart transplant was performed, situated on Remainder of Erf 27431, Cape Town, in the Cape Division.

Cape Freehold 31-13/1923, dated 26 March 1923.

By 1997, the impact of the budget reduction, the drain of skilled nurses due to the VSP and the closure of beds was being noticed in the services. The year's budget was again significantly reduced and despite the losses in staff numbers, on 13 June 1997, all vacant posts were abolished in an attempt to remain within budget. In total this was a 12% reduction in the number of posts at Groote Schuur. Beds were reduced further to 1163, which was 260 less than the 1423 used during 1995. The reduced funding necessitated more rationalising to the extent that services and clinics had to be consolidated, for example, the Medical and Surgical Gastroenterology units functioned as one clinic.

The Groote Schuur Hospital Teaching Hospital Board responded to these budget cuts in an open letter to the Western Cape public. See next page.

Success stories: Debra Viret, seated, and Nopasika Matshaya are strong and healthy aft having liver transplants. With them is Delawir Khan, head of Groote Schuur's transplant u and Wendy Spearman, director of the liver transplant unit.

A decision regarding the management of the teaching hospitals was the formation of a committee called the "Associated Academic Hospitals (AAH)", made up of representative from Groote Schuur Hospital, Tygerberg Hospital, Red Cross Children's Hospital and the two Oral Health Centres, under the leadership of Dr A. McMahon.

On 3 December 1997, the Groote Schuur Transplant Museum was officially opened. Other organ transplants, such as liver and kidney, were being done in far greater numbers, benefitting many more patients and constantly advancing and improving the programmeme, since the procedures were often quite complex, requiring the efforts of multidisciplinary teams to work together successfully.

GROOTE SCHUUR HOSPITAL

Argus 5/12/97

OPEN LETTER TO THE PEOPLE OF THE WESTERN CAPE

Dear Friends,

Today, 30 years ago, the world's first human heart transplant was performed at Groote Schuur Hospital. The hospital looks back with pride at this historic milestone, which earned the hospital and South Africa's health services international recognition. The heart transplantation service is, however, only one of many highly specialised services which have been provided over many decades, to our patients in the Western Cape and beyond.

On this occasion, we wish to rededicate ourselves to the service of you, the people. We are deeply committed to continuing our tradition of the highest possible quality of patient care, research and the teaching of health care workers.

BUT:

We regard it as our duty to inform you of our grave concern over the current and future threats to the Western Cape health services in general, and to Groote Schuur Hospital in particular. Drastic health budget restrictions have already been imposed over the last years. Even greater budget cuts are being proposed for 1998.

For Groote Schuur Hospital this could mean:

- severe curtailment or even closure of many highly specialised services
- marked delays in, or non-availability of, operative procedures or outpatient appointments
- collapse of services for the management of cancer patients
- lack of emergency care for patients with heart attacks, motor vehicle accident injuries, gunshot wounds or other serious conditions
- inability to provide specialised care to pregnant mothers and newborn babies.

The inevitable result will be a further significant deterioration in the quality of clinical care due to shortages of staff, equipment, drugs and other resources. As Groote Schuur functions as a tertiary referral centre both locally and nationally, the implications for referring hospitals and their patients are equally serious.

We call upon you, as the community we serve, to join us in voicing our deep concern over, and registering protest against, the proposed health budget cuts in the Western Cape.

- Support the hospital
- Contact your MP
- Inform others of the health service crisis
- ACT NOW!

Dr AW Barday
Chairperson, Teaching Hospital Board

Dr PJ Mitchell
Chief Medical Superintendent

Groote Schuur Hospital Region.

This notice paid for independently by the Groote Schuur Teaching Hospital Board.

1997 was hugely unfortunate for the hospital with the first baby being lost from the Maternity Unit. Baby Zephany Nurse was not found until 17 years later. While the hospital felt responsible for the loss of the baby, lessons learnt resulted in more stringent measures being implemented to protect the little newborns.

The following year was much the same except for the implementation of two policies, including the supernumerary policy and the introduction of an Organizational Rights agreement, which was signed between the Unions, the Staff associations and the Provincial Government of the Western Cape in June 1998.

The National Department of Health identified the need for the decentralization of hospital management and secured funding from the European Union to assist with this. Initiatives included the appointment of technical consultants and the twinning of the hospital with a similar facility in the United Kingdom. Exploratory discussions were held and some staff visited the Birmingham Hospital as part of the twinning proposal.

In line with the Provincial Health Plan, Groote Schuur Hospital was asked to transfer Mowbray Maternity Hospital and all the MOU's to the Metropolitan Region. The Avalon Treatment Centre was transferred to function under the Department of Psychiatry at Groote Schuur and the Princess Alice Orthopaedic Hospital was relocated to the New Main Building at Groote Schuur Hospital. In addition, The Carinus College of Nursing would merge with other Nursing colleges to form the Western Cape College of Nursing.

From 1994, the optimism of a promised future became more and more bleak with every passing year. 1999 was no different and the budget constraints meant a further closure of 200 beds. Following discussions of the impact this would have on the services, it was agreed that 60 beds could be reopened. As part of the rationalization process, a facility for Day Surgery was planned for an area within the Emergency Unit. The area adjacent to the Trauma and Emergency Units was handed over to contractors in September 1999 for the building of a helistop, which was completed and officially opened in December 1999. This was a vital achievement, especially for the Trauma Unit to receive more urgent patients timeously to save their lives

In addition, the Trauma Unit also received a donation from the De Beers Foundation of a Lodox full body X-ray machine. This acquisition of such a machine greatly benefitted the management of trauma patients, and more especially multi-trauma cases. The biggest concern at the time was that the change of the millennium would cause a collapse of the computerised systems and the hospital placed much effort and planning into ensuring that the information management systems and medical equipment were Y2K compliant.


Y2K: race is on for hospitals

A doomsday was predicted with the hospital on the alert for mass casualties, planning for water and electricity cuts, etc. but with all the staff and managers on site, the night of 31 December 1999 was uneventful and the hospital welcomed the new millennium on 1 January 2000 without any problems.

Groote Schuur Hospital: 2000 to 2010

As the new year gained momentum, July 2000 saw the Western Cape Department of Health implement the objectives of "Transformation 2000" and by December 2000, the high level posts approved by cabinet had been filled. For Groote Schuur Hospital and Red Cross Children's Hospital, Dr Norman Maharaj was appointed as the Chief Executive Officer. This was the first black person to head the hospital. The other post that was approved was that of a Finance Director for the same hospitals, to which Mr T.S. Salie was appointed. Prior to this, all non-clinical activities were managed by the Hospital Administrator. The year also noted new regulations that had to be implemented, such as the Public Service Act Regulations, a new Provincial Administration of the Western Cape Disciplinary process, the Employment Equity Act, the Skills Development Act and the Basic Conditions of Employment Act. Other changes included a new leave dispensation and a new Senior Management Salary Package. While the senior posts were filled, other posts were still meant to abide by the moratorium and further losses were seen due to staff accepting the Voluntary Severance Package. Linked to these changes, the hospital was also part of various discussions related to the implementation of a new Hospital Information System as well as a new Integrated Business Information System. The Clinicom and Billing modules were introduced in December 2001.

The Day Surgery Unit was initiated but due to staff shortages, could only function with one Gynaecology slate per week. Plans were being drafted for an upgrade to the Outpatients and Maternity Buildings as well as the formation of a multidisciplinary Intensive Care Unit. A 6-bedded Stroke Unit was opened in the Neurology ward and work was commenced on the upgrading of the Maternity Building, the Outpatient reception, Pharmacy and ENT areas as well as the façade of the Old Main Building. Discussions were initiated to consolidate the ICU's in order to improve efficiencies.

Figure 72: Stroke Unit with 6 beds, each monitored by an overhead camera.

A proposal submitted by the University of Cape Town to establish a private hospital on the Groote Schuur premises was realised when the Provincial Administration of the Western Cape signed an agreement with them on 11 January 2001. The space identified was part of the D floor of the New Main Building. At the same time, planning was underway at Groote Schuur to establish a private ward in G4 in order to increase revenue to the hospital.

Planning and rationalizing were words that remained at the forefront of all discussions, and efforts were made to use the European Union funding, for visits to the twinning hospital in the United Kingdom to learn about improving the services. These visits continued into the year 2000 on a monthly rotational basis. During 2000, the National Department of Health was very active in setting up the National Health Laboratory Services, which was enacted in January 2001. The Mental Healthcare Act was also legislated in 2000.

The Hospital Board remained active in collecting funds for the hospital and in April 2000, joined forces with the Argus and Pick 'n Pay to launch an appeal to raise R2 million for a spiral CT scanner to be used in the Trauma Unit.

The appeal was concluded at R1.7M and the new Siemens scanner was installed in the Trauma Unit in January 2001.

A new Linear Accelerator was also placed in the Radiation Oncology Department.

As part of 'Transformation 2000', many senior posts were established and filled at the Provincial Department of Health, including the appointment of Professor Craig Household as the Superintendent General for Health. The Provincial Government also initiated the redrafting of the Joint Agreement between the Province and the Higher Education Institutions.

With the many legislative and policy changes, meetings were required to plan, implement and iron out logistics. The proclamation for the implementation of the National Health

Figure 73: Spiral CT scanner in the Trauma unit

Figure 74: From left - Prof Andy Nicol, Head of the Trauma Unit at Groote Schuur; Chris Whitfield, Saturday Argus Editor; Jonathan Ackerman from Pick 'n Pay and Neil Lipsitz from Siemens

Figure 75: Patient being treated onin the new Linac machine

Laboratory Services (NHLS) was signed by the President in September 2001. Staff working in the laboratories received letters indicating that they would be transferred from the Provincial Government posts into the NHLS structure.

Patient services were pressured in the Trauma Unit, Theatre, ICU, Neonatology and many other areas. Nursing shortages constantly threatened the curtailment of activities, resulting in waiting lists becoming increasingly longer and this in turn manifested in increased complaints from patients and their families. In an effort to address some of the bed shortages, the Bioethics Unit together with the Neurosurgery Department developed a Head Injury Policy, outlining under which clinical conditions, care would be initiated and committed to. This policy would then assist staff in the Trauma Unit who constantly had to deal with the need for ventilator spaces and critical care services. Of note, is that the lack of services for adolescent patients with suicidal tendencies was acknowledged.

Major equipment challenges came to the fore during 2001 and an equipment summit was held to develop a 5-year equipment acquisition plan based on specific priority areas. Additionally, in November 2001, discussions commenced to establish a Quality Assurance Unit, reporting to the Chief Executive Officer.

Groote Schuur was saddened by the news of Professor Chris Barnard's death on 2 September 2001 and in a written tribute to him, Professor Commerford remembered how the achievements of those years instilled a huge sense of pride and excitement amongst the junior staff, who were all motivated to try and emulate them. He recollected how Professor Barnard was meticulous about his operating notes, how he would demand very high standards of punctuality, record-keeping, the availability of notes and laboratory results as well as an adherence to a strict dress code. He also noted that Groote Schuur Hospital owed him a debt of gratitude for the service he established and the standards that he set at the hospital.

The year 2002 commenced with the opening of the UCT Medical Centre. With the private hospital based within the hospital premises, regular meetings were held between the managers of the two hospitals in order to maintain a good working relationship. Medical staff were asked to primarily do their approved Remunerative work outside of the Public Services (RWOPS) at this hospital and this was monitored by the RWOPS committee.

April 2002 saw the implementation of the new National Tertiary Services Grant, which would be linked to the Provincial Government through a Service Level Agreement. This grant would primarily fund a proportion of the needs of the Tertiary Hospitals. Other funding sources were from the Health Professions' Training and Development Grant and the Provincial Equitable Share.

The National Treasury made available funds to improve financial management at public hospitals. This was known as the 4x4 Health Financial Management and Pilot Hospitals' Plan. Groote Schuur and Red Cross Children's Hospitals were allocated an amount of R7.5M and Dr Maharaj then arranged for an urgent work-study investigation to determine the number and level of posts to be created in terms of the new structure. For Groote Schuur, this included two Director level posts, one each for Clinical services and Finances and a number of Deputy Director posts. The hospital management team was growing, with the addition of a Deputy Director for Human Resources post. Mr Errol Brierley took up this position. One of the Medical Superintendents was asked to manage some of the support services, until a Deputy Director for Support Services could be appointed.

Major challenges were being experienced with equipment and the hospital, together with the Hospital Board and dedicated Provincial funding managed to secure a new MRI machine, a Cardiac Catheterization Unit, Renal Dialysis machines, Anaesthetic machines, Bronchoscopes, ICU and other Radiological equipment. Financial challenges continued to cripple the services, with a need to close a further 100 beds and 4 theatre rooms, despite the many service demands. This placed severe strain on the hospital and its staff.

Finances remained a sore point and focus of significant concern. Measures were implemented to control costs, including a Cost Centre Accounting System, increasing revenue, blocking the filling of posts through an

approval process from the Establishment Control Committee, reducing the number of sessional hours by 60%, various non-personnel savings such as blood, lab and radiological usage monitoring, vetting of stores purchases and restrictions on high cost consumables, which by inference meant restrictions on the number of patients that could have procedures that used these consumables.

By April 2002, all the laboratory staff had been transferred to the National Health Laboratory Services.

Refurbishments commenced in the previous year were concluded and the new OPD reception, Maternity building and in June 2002, the private ward was opened in ward G4. In addition, the MRI unit and a dedicated Rape crisis centre in the Emergency unit were officially opened by the Minister.

Figure 76: HBA minibus

The Hospital Benevolent Association purchased a minibus vehicle to transport patients from the Main Road to the entrance of the hospital at Palm Court and then back down again, once they were ready.

This service proved very popular with the patientsService related achievements included a donation of R750 000 from the One to One Foundation in the United Kingdom, for the use of Antiretroviral medication in children.

Dr Paul Roux, a Paediatric specialist with a special interest in Infectious Diseases, particularly HIV, led this programmeme and successfully started the treatment on young children in an effort to offer them an improved quality of life growing up. The Western Cape and Groote Schuur Hospital were among the first in the country to initiate this treatment, despite a firm governmental policy on the use of Antiretrovirals. Dr Roux's dedication in this field has grown a cohort of healthy young adults living full lives today. Below is a brief history written by Dr Paul Roux.

Figure77: Dr Paul Roux with one of his little patients

Paediatric HIV/AIDS care at Groote Schuur Hospital

During 1998, with more than 50% of inpatient beds in the Paediatric ward at Groote Schuur Hospital occupied by sick and dying children with HIV/AIDS, a group of clinicians agreed to found an NGO so as to address - as Medical Anthropologist Ms. Lorraine Vivian put it – 'the impossible burden of the mother of an HIV-infected infant'.

A steering committee was assembled and an NGO was registered as a Section 21 Company in August 2001 and was able to begin, as stated in the NGO's Constitution, to 'raise support for the daily needs of children and families affected by HIV and AIDS'.

Meanwhile, clinicians set up the G26 Paediatric HIV/AIDS Service at Groote Schuur, and began delivering what care they could to a growing cohort of HIV-infected children.

In December 2001, one of the steering committee members, Ms. Sonja Giese, attended a children's conference in London, UK, and met Mr David Altschuler, Chair of the One to One Children's Fund. Mr. Altschuler visited Groote Schuur Hospital in February 2002, and offered financial support for an HIV/AIDS-related project in Cape Town. Three projects were presented for possible funding:

1. *Extension of a step-down ward at the Sarah Fox Children's Convalescent Hospital in Athlone;*
2. *Establishment of a community-based HIV/AIDS service for children; and*
3. *Access to Anti-retroviral therapy (ART).*

One to One chose option 3, but there was a problem, because access to ART for patients with HIV/AIDS was against what was then South African government policy and could therefore not be offered in a public institution such as Groote Schuur Hospital.

On the advice of Dr Glenda Gray (now heading the South African Medical Research Council) clinicians then designed an operational research project, and submitted a research proposal designed to answer whether 'mothers of children with HIV/AIDS, attending a South African hospital in the public sector were able to adhere to an anti-retroviral therapy regimen'. The Human Research Ethics Committee of the School of Health Sciences at the University of Cape Town then approved this proposal. Hospital administrators at Groote Schuur were therefore able to give permission for 'the One to One ART Project' to commence.

(In 2008, a paper was published, reporting on adherence in the G26 HIV/AIDS Service: Muller AD, Bode S, Myer L, Roux P, von Steinbuchel N. Electronic Measurement of Adherence to Pediatric Antiretroviral Therapy in South Africa. Pediatr Infect Dis J. 2008 Mar;27(3):257-62).

The first children began to receive ART in May 2002. Physical results were almost immediately evident and a paper delivered at a local conference eighteen months later could demonstrate an eighty percent reduction in hospitalization needs in the first 100 children receiving ART in the year following initiation of treatment, compared with their needs the year before.

Volunteer care-givers at Nazareth House, a local orphanage, reported that children who had previously always come last during sports events were now placing, and even winning. One little girl, who subsequently went on to meet the then British prime minister Gordon Brown, and has now been adopted into a British family, was proud to report that she had won her race at the 'Inter-Catholic' sports day.

The G26 Paediatric HIV/AIDS Service was able to extend treatment to children living in other orphanages (Beautiful Gate, Baphumelela, Home from Home) as well as to children from Victoria and Somerset Hospitals.

Six months after the roll-out of the One to One ART project, insights gained from a visit to the project by Mr Terry Waite prompted One to One to extend access to ART to include mothers of children on treatment, so as to reduce the risk of orphanhood in the treatment cohort.

By the time the South African government released state-funded anti-retrovirals to the G26 HIV/AIDS Service (in November 2004), 250 children and 100 mothers were on treatment at the Groote Schuur Hospital clinic.

The One to One ART project also provided numerous junior doctors at Groote Schuur with experience in the use of anti-retroviral drugs and also created a training opportunity for pharmacists at the hospital.

Clinicians were able to develop an operational plan to optimize the clinic experience of patients and parents and evolved the concept of an ART 'treatment team' consisting of nurse, pharmacist, counsellor and clinician.

Between June 2004 and August 2005, thanks to funding from Rotary International, 10 treatment teams – each with nurse, counsellor, pharmacist and clinician - from clinics across the sub-Saharan region visited Cape Town and attended a week of ART – related training. These ten teams included teams from Rwanda, Zimbabwe, Zambia, Lesotho, Ethiopia and Kenya, who were identified for us by Dr Chewe Luo, then a member of the Kidzpositive Board. The first Treatment Team conference, funded by One to One was held in December 2005 - and led to the establishment of Paediatric Anti-Retroviral Treatment for Africa (PATA). This new organization has gone on to mobilize and strengthen a network of frontline healthcare providers to improve paediatric and adolescent HIV prevention, treatment, care and support in sub-Saharan Africa.

In addition to support for the Groote Schuur Hospital Paediatric HIV/AIDS Service, Kidzpositive was also able to extend support for similar services at Victoria and Somerset hospitals as well as at community clinics in the Crossroads Community Health Clinic and Mitchell's Plain Day Hospital, in the form of adolescent psycho-social support, an early childhood development project and advanced health iteracy and psycho-social training for lay counsellors.

According to the Provincial Western Cape Health Facilities Board Act No 7 of 2001, the Teaching Hospitals' Board would be replaced by the Groote Schuur Facilities Board. This changeover took place in July 2002. In accordance with the Act, adverts were placed in the newspapers, nominations accepted and the new Board was appointed by the Provincial Health Minister to commence their first meeting in April 2003.

On 29 October 2002, Minister Piet Meyer and Professor Craig Household launched the "2010 Vision Conceptual Framework". This vision outlined a bed, staffing and service plan for the Western Cape to meet the needs of the population by strengthening Primary Health Care as a priority. Unfortunately for Groote Schuur, the plan did not allow for any further expansion and the bed numbers were divided into tertiary and secondary level beds. This was done on the basis that 90% of healthcare contacts happen at the primary level, 7% at the secondary level and only 3% at the tertiary level. Another principle that was used included the decreasing funding envelope year on year from the National Tertiary Services and Health Professions Training and Development Grants.

The healthcare framework assumed hospitalization in defined levels of care, with Groote Schuur Hospital providing level 2,3 and 4, and bed numbers, budgets and staffing were allocated accordingly.

Definitions of levels of care:

Level 1	Care delivered by general practitioners, medical officers or primary health care nurses in the absence of any specialist other than a family medicine specialist. • Primary health care clinics, community health centres and district hospitals operate at this level.
Level 2	Level 2 care is care that requires the expertise of general specialist led teams. This includes: • General Surgery; • Paediatrics; • Emergency Medicine; • Orthopaedics; • Obstetrics and Gynaecology; • Radiology; and • General Medicine; • Psychiatry; • Anaesthetics.
Level 3	Level 3 care is care that requires the expertise of a specialist working in a registered subspeciality.
Level 4	Level 4 care is provided by sub-specialties and includes services which are: • Very new; • Require scarce expertise; • Require highly expensive technology; and • As a result are found only in one or two centres in the country.

There were significant changes in 2003, with the restructured management arrangement and Dr Maharaj became the Chief Executive for Groote Schuur Hospital alone. Dr Dennis Adams became the Chief Executive at Red Cross Children's Hospital.

With the closure of Conradie Hospital, the acute care services were shifted to Groote Schuur and required some planning to accommodate the 2 ICU, 4 high care and 12 ward beds together with a small rehabilitation unit for this service, which was opened on 1 April 2003.

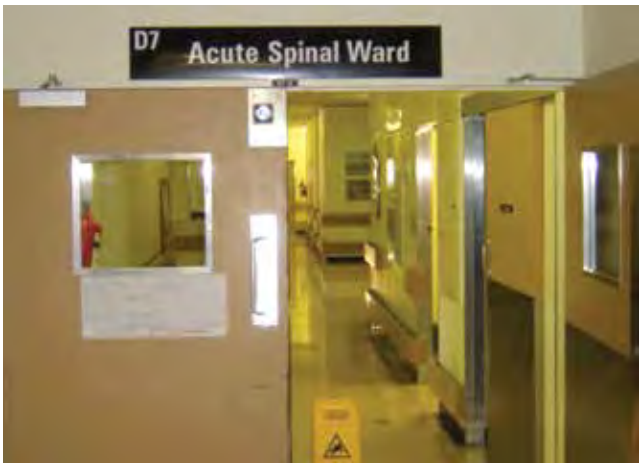


Figure 78: Acute Spinal Care services

In May 2003, Groote Schuur delivered a 'miracle' baby that had grown attached to the mother's liver rather than the uterus. This became a medical highlight in South Africa and Internationally and our doctors and nurses were once again praised for their dedication and team efforts to ensure a healthy, live delivery of this baby. It was the first time in the world that the baby had survived and since then there have been 21 described liver pregnancies, with only 2 live births.

In the same year, GSH received the award for being the first public tertiary health facility in South Africa to receive Baby Friendly Hospital Status from Unicef.

Top notch: Bets Steyn, assistant director of nursing, and tiny Tiron Windvogel, two months, celebrate Groote Schuur becoming the first tertiary hospital in the world to get Unicef approval with 'Baby Friendly Hospital Initiative' status. This accreditation is part of a global strategy aimed at decreasing infant death and disease rates.

Another South African first was the implantation of a titanium bone into the arm of a 19 year old man, giving him a chance to do things he otherwise would not have been able to. With the prosthesis locally produced, it cost R40 000 compared to the R250 000 if it had been bought from the United Kingdom.

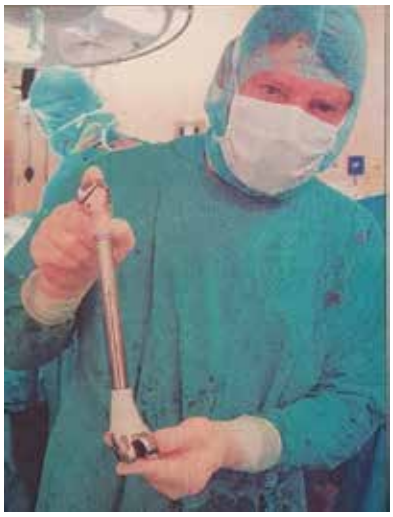


Figure 79: Dr Keith Hosking with the titanium implant

The Provincial Health Department formalised many reporting structures and specifically, the finances for Groote Schuur Hospital were grouped together with Tygerberg and Red Cross Hospitals as part of a Programmeme 5 report.

Services were ongoing during 2004, with the opening of the joint Haematology high care unit in F4, where 6 beds were for public patients and 6 for private patients linked to UCTPAH. The billing processes were done by UCTPAH and then claimed back by GSH. The consolidation of the ICU's as multidisciplinary facilities took place in November 2004 and was considered to be a better way of managing this scarce resource, where life and death decisions of who gains access to these beds had to be made on a daily basis. However, the impact of nursing shortages, especially in Theatre, ICU and Maternity was being felt by the services. All elective surgeries had to be consolidated into the 4 week days, with Friday being an option for the G4 private slate, if staff were available. Shortages were also noted amongst the Radiographers, with an implication for after hours cover, especially in the Trauma and Emergency Units.

Professor Martin Singer, a dedicated hand surgeon who started the Hand unit at Groote Schuur Hospital in 1966, was the first South African and African to be awarded the 'Pioneer of Hand Surgery' award from the International Federation of Societies for Surgery of the Hand. This was not only a personal achievement, but also an acknowledgement for the Hospital, which had provided Hand Surgery services to many patients, and one of a few such services in the country.


Professor Martin Singer

Cost-savings were still high on the priority list with posts being frozen and a new Staff Performance Management System was implemented.

There was another change in guard with Dr Maharaj leaving Groote Schuur and Dr Japie du Toit being appointed as the Acting Chief Executive Officer. Dr Peter Mitchell also retired in this year and was replaced by Dr Saadiq Kariem as the Chief Operational Officer.

Patient service demands appeared to be more difficult to manage, given the reduced budget, staff and multitude of regulations that would require infrastructure and additional staff in order to ensure compliance. To alleviate the bed pressures, a Transit Lounge was opened on 26 September 2005 in the Emergency Unit area. The idea was to free up beds in the wards for

acute patients by transferring the discharged patients to the Transit Lounge to await their medication and/or transport home. There were also some discussions with Booth Memorial to establish a step-down facility in one of the medical wards at Groote Schuur, but this did not materialise. The hospital seemed to be shifting from being a frontline leader to merely managing to get by day after day. Transplants in particular had been reduced considerably, due to the limited medication budget, donor availability and the lack of a national coordinating body governing transplantation where there could be a single waiting list as well as standard criteria for both public and private patients. More and more transplants were being done in the private sector than in public hospitals. Despite that, in 2005, Groote Schuur performed its 500th transplant, but the numbers since 1967 had reduced dramatically.

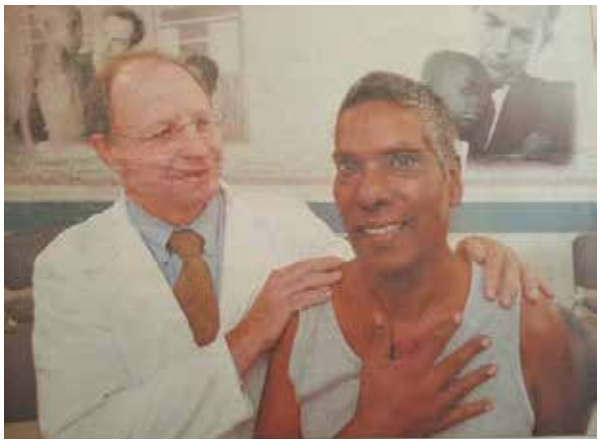


Figure 80: Professor Brink with the 500th transplant recipient, Mr Jhamunpursad

Figure 81: Two patients who celebrated being the longest kidney transplant recipients. Mr Hankey is 34 years and Mrs Naidoo 50 years post-transplant

From 1967 up to 2005, 505 transplants were performed on 471 patients; 17 heart-lung transplants were done one 15 patients; 2 Xenogenic transplants in 2 patients; a lung transplant in 1 patient; 73 Heterotropic transplants in 68 patients and 412 Orthotopic transplants. Funding was however diverted to more challenging conditions and to address the long waiting lists for e.g. Cataract Surgeries and Arthroplasty Surgery, both impacting on the patients' quality of life.

Over the five years since the change of the millennium, GSH experienced a real time reduction in its budget, while expenditure was increasing due to rising medical inflation and costs. This resulted in the curtailment of many services during those years. Bed numbers were reduced by another 100 beds. This resulted in the total number of beds equating to 906; Operating lists were cut; Patient transport was stopped; Sessional posts were reduced by 60% and the appointment of new staff was limited to only critical posts being advertised and filled. These measures were implemented at the same time that the provincial population was growing at a rate significantly higher than the rest of the country; there was an increase in the number of ageing patients with chronic conditions such as hypertension and diabetes; an increased demand for the treatment of cancers and organ transplants; an increasing trauma epidemic in the Western Cape and the rising TB and HIV prevalence – all of which were reflected in the Burden of Disease reports from the Medical Research Council and Statistics South Africa population figures.

Added to these pressures were human resource shortages throughout the entire health care system. However, specialized services were more vulnerable to the skill gaps because the delivery of specialized services rested in the hands of such a small number of highly skilled professionals. Nursing personnel had the highest attrition rate from public sector services, due to attractive offers from private healthcare and health facilities abroad. Up to 15% of staff required had to be accommodated from agencies on a monthly basis. Many of the full-time staff worked additional overtime in certain specialties, because agencies could not supply enough nurses to cover the specific needs. As a result, staff were overworked, stressed and reached burnout more quickly, resulting in an increase in the number of nurses being treated for these conditions. Up to 20 nursing staff were on long-

term sick leave every month, most of whom were being treated for anxiety, stress, substance abuse and other psychiatric related disorders. A staff satisfaction questionnaire administered at the time showed that 11% of the staff rated satisfaction / morale as poor or very poor, while only 35% were satisfied. Most highlighted low salaries as the most important reason for their dissatisfaction. The introduction of a scarce skills allowance for certain categories of nursing staff had divided this profession even more, with many trained personnel not receiving the appropriate remuneration due to non-certification. In healthcare, experience should not be traded for any number of qualifications and many staff members, who had worked for 30-40 years, who offered dedication and loyalty to the profession, the institution and the service, were not being recognized or rewarded for their efforts.

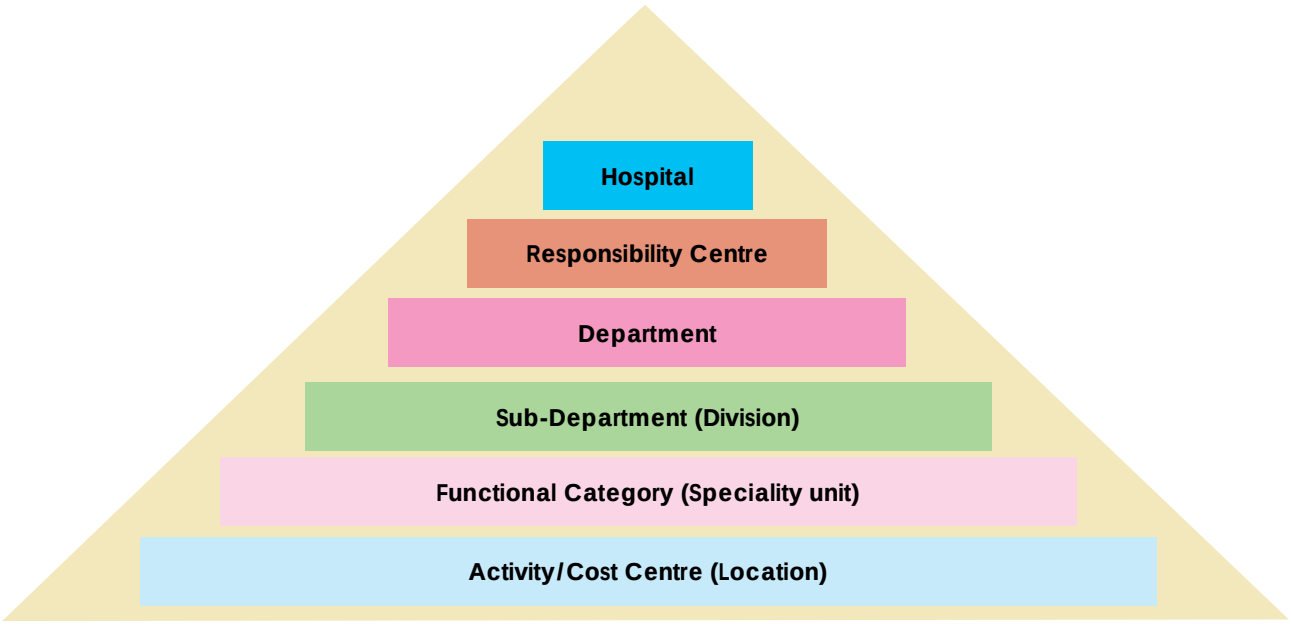
With budgetary cuts, many non-clinical services also suffered due to non-replacement of staff and decreased funding. The building infrastructure, equipment, cleaning services, etc. were severely neglected, resulting in the hospital having to replace and repair many items which were needed for patient care. Maintenance of basic infrastructure that supply e.g. electricity and water were in need of urgent attention. The air-conditioning system and other piping in the hospital had become corroded due to non-maintenance and needed to be replaced. Quality patient care depended upon these basic non-clinical services being provided and adequately maintained.

In order to ensure that patients were being treated at the appropriate levels of care, GSH had to reduce certain patient activities, which were to be provided at primary and secondary levels. This approach was in keeping with the Healthcare 2010 plan.

By 2005, additional funding was being received for the treatment of HIV/Aids, comprising of three sub-budgets for an anti-retroviral clinic service, funding for a research project in Psychiatry and funding for a programmeme for the prevention of mother to child infection. These had to be separately monitored and reported on, since the funding was from a separate National Conditional Grant. Groote Schuur Hospital, having started the ARV programmeme prior to this, had already recorded 2139 adult and 2210 paediatric ARV patients. In addition, 167 mothers were also being treated at the paediatric clinic. The dedicated HIV/AIDS fund paid for staff, certain laboratory tests and antiretroviral medication; all other needs were funded from the hospital budget. The psychiatry budget was used to fund a Senior Specialist in Psychiatry to conduct research reviewing the neuro-psychiatric presentation and management of HIV/AIDS.

The Provincial government also allocated additional funding for specific projects, called 'Policy Option' funding to address the dire needs and service pressures in Obstetrics and Neonatology, ICU / Theatre bottlenecks/ to modernise theatre management and to address waiting time and access. Business Plans detailing each of these areas were developed and approved prior to implementation, which provided a much needed relief to the financial situation at the hospital.

Controlling the finances was prioritised by the Department of Health, with the implementation of various new information systems, including the Business Accounting System to monitor payments made. The implementation of these systems posed many teething problems initially. The finances themselves were allocated to specific Functional Business Units, and then again sub-allocations were made to the activity centre or cost centre. This system allowed for improved monitoring of expenditure at the lowest level. The cost centre structure is outlined below:



At the start of 2006, the Community Service programmeme for nurses was commenced and Medical internship was extended to two years. These requirements had to additionally be accommodated at the hospital.

During 2006, planning was underway for the implementation of the Healthcare 2010 plan (HC 2010), which proposed the provision of health care in the Western Cape Province taking into account population growth and dynamics as well as the funding envelope for health services. Subsequent to the approval by Cabinet in March 2003 of the HC 2010 plan, a Tertiary Services Mapping task team was established which considered the interdependencies of services across the tertiary platform and made recommendations for the actual number of tertiary beds that would ideally be needed for tertiary care in the Province. This plan was then further refined by the Provincial Administration of the Western Cape Restructuring Task Team which had also considered the secondary level facilities and needs, taking into account the present infra-structural limitations of hospitals across the Province. The task team then released the Integrated Service Plan of the Health Department which allocated 1036 beds (public and private) to GSH. These were divided into 686 tertiary beds and 350 secondary beds, an increase of 120 beds from the 916 present at the time. Apart from the bed allocations, wards, staff and all costings had to be restructured in order to support this division, which proved to be quite challenging. The hospital had also to ensure that only appropriate patients were seen in the outpatient services. This required the identification and shifting of patients to other levels of care, where the current staffing and structures did not necessarily support the need. It was on this basis that the Medical Outpatient clinics for General Medicine were closed. The restructuring also allowed for some innovative thinking in the Neonatal Unit, where through re-organising the space better, the service was able to accommodate 20 Kangaroo Mother Care Beds.

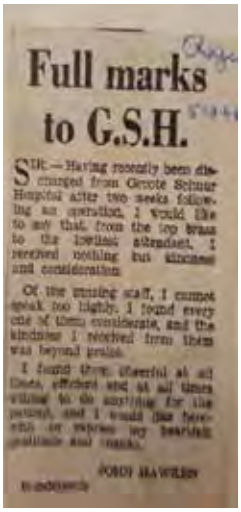
However, financial constraints remained the challenging priority and by December of the same year, the situation had worsened to the extent that bed closures were being considered, the special hip and knee project that had been initiated between GSH and UCTPAH had to be stopped and various cost cutting measures were implemented. Among these, there was a reduction in the time spent by newly appointed nurses on the induction programmeme from 1-3 months to 1-2 weeks.

The Western Cape Department of Health continued with plans towards implementing the Healthcare 2010 plan which was converted into a more detailed document named the Comprehensive Service Plan. With the envisaged strengthening of the Primary and Secondary care services as well as the coordination of these between the levels of care, some specialist services were allocated a Lead Clinician or a Co-ordination Clinician,

whose role was to plan across levels. These clinicians were selected from within the existing staffing structures and they were then allocated additional duties. Another key appointment at the hospital was that of the Quality Assurance Manager on 3 July 2006.

Clinical activities remained pressured during 2006, with the beds having being closed and nursing shortages resulting in a greater usage of Agency staff. These staff were often not initiated to work in our hospital, resulting in a standard of care that became difficult to control in the face of meeting the critical norm in order to ensure that there were sufficient numbers of staff to look after the patients. The full-time staff and more senior staff worked more overtime in order to keep some consistency, but this situation did affect the level of care offered. In addition, the new Staff Performance Management System that was implemented meant that only a few staff members received a bonus for exceptional work performed and while many staff felt that they were extending themselves above and beyond their required duties, they were not being recognised for this, thereby demoralising the staff more.

Despite all these changes, the general public impression remained positive.

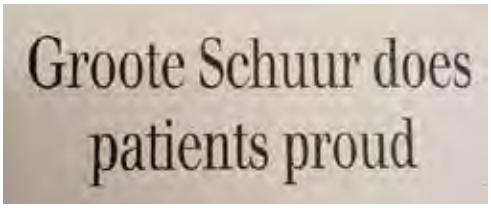


Full marks to G.S.H.

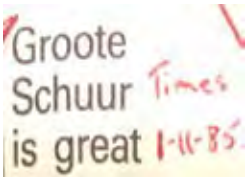
SIR,—Having recently been discharged from Groote Schuur Hospital after two weeks following an operation, I would like to say that, from the top brass to the lowliest attendant, I received nothing but kindness and consideration.

Of the nursing staff, I cannot speak too highly. I found every one of them considerate, and the kindness I received from them was beyond praise.

I found them, generally at all times, efficient and at all times willing to do anything for the patient, and I would like herewith to express my heartfelt gratitude and thanks.



Groote Schuur does patients proud



Groote Schuur Times is great 1-11-85

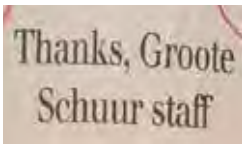
Hospital gets a '5-star' rating

Times 11.11.66

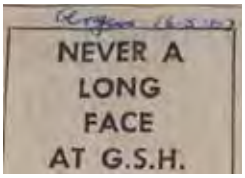
BEING a bed patient at Groote Schuur Hospital was like living in a five-star hotel, according to Cape Town city councillor Mrs. Lucy Hall.

Mrs. Hall, who had spent a short time there, told the Cape Teaching Hospitals Board meeting that she could now speak from "inside knowledge".

"And I rate it as a five-star hotel."



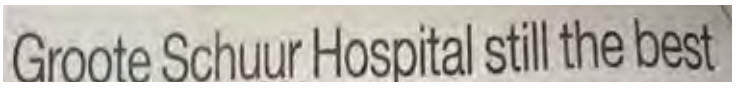
Thanks, Groote Schuur staff



NEVER A LONG FACE AT G.S.H.

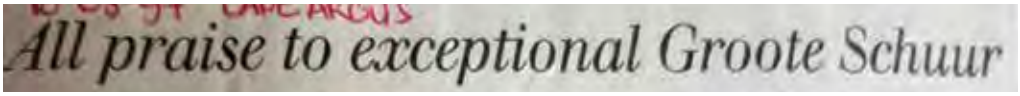
Groote Schuur still excels

But resources are being steadily eroded



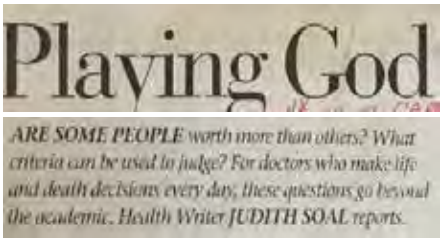
Groote Schuur Hospital still the best

Groote Schuur Hospital really has a heart



All praise to exceptional Groote Schuur

The highlight of the year was the installation and commissioning of the new Varian Linear Accelerator, which was a state of the art machine with a 120 multi-leaf collimator for beam-shaping. Together with the machine, an ARIA Oncology Management System was also installed as a software package that linked the new Linac, the Simulator and the Planning Computer, thus integrating the activities. Another achievement was the opening of the R12 million Cath Laboratory, funded through the DG Murray Trust.


Playing God

ARE SOME PEOPLE worth more than others? What criteria can be used to judge? For doctors who make life and death decisions every day, these questions go beyond the academic. Health Writer JUDITH SOAL reports.

The issue of making life and death decisions on patients is part and parcel of medical care, but came to the fore as a result of these decisions having to be made in light of the resource constraints. Rationing care is difficult for any person, but more so, for someone who took an oath never to do harm and to try their utmost to save the life of their patient. It was said at the time, and is no different today, that the doctors were required to 'play god', often feeling compromised in terms of their moral and ethical beliefs. This was the case with patients who needed renal dialysis. Many deserving patients were being sent home to die because of a lack of resources to attend to them all. The selection process involved the use of specific criteria, but this was still very limiting and many patients were turned away. This unfortunate reality became an ethical dilemma of access to care in a resource-constrained environment and the ability of the system to still meet the growing health needs of the population.

During 2006, a total of 121 patients were assessed for the long term dialysis and to be placed on the transplant programmeme. However, the hospital could only offer dialysis spaces to 40 of these (33%), 12 (9.9%) were placed on a waiting list pending space being available when needed, 3 patients were transferred to other facilities and the remaining 66 patients (55%) were offered conservative therapy only. These figures represented approximately 60 patients per million population assessed and 20 patients per million population accepted. When compared with "best practice", the service rendered illustrated the inadequacy of our provision of renal services. The number of transplants remained inadequate due to a shortage of donors. The average monthly number of patients receiving acute haemodialysis continued to rise: 105 in 1998, 229 in 2005/6 and 250 in 2006/7. The available equipment was being utilised to the full. During the year, the unit started using "Slow low efficiency dialysis" (SLED) as a continuous mode of dialysis. This modality uses standard dialysis equipment and provides effective continuous dialytic therapy at a substantial financial saving.

Constraints were felt in other departments as well. In Ophthalmology, comparisons were constantly made to previous years when there were fewer restrictions, for example, in 1987 there were 43 747 outpatients seen, in this period there were only 39 211 outpatients seen. Similarly, whereas in 1987 there were 18 elective lists each week and 2 167 surgeries were done, in this period there were only 8 elective lists each week and only 1 120 surgeries were done. In this period, with this shrinking service delivery, the population of the Metropole quadrupled from 0.75 million to 3 million, but the surgical output halved. There was not a corresponding expansion of eye care services at the primary and secondary level, resulting in the consequence is that patients with cataract, glaucoma, and diabetic retinopathy were left untreated, with growing waiting lists and individual cases progressing until it was too late for them to receive treatment. Some initiatives were pursued through other sources of funding such as the Christoffel Blindenmission, which assisted with funding for five additional cataract surgery lists with 1020 additional patients receiving care.

There were rising tensions and frustrations from all quarters and relationships became strained with confrontational meetings between the medical staff and the senior management of the Province and between the staff and the hospital management, resulting in these tensions playing themselves out in the media. The lack of adequate funding was the source of this tension, but there was also a lack of understanding that services at the community level needed to be strengthened and that this could only happen through redistribution. The anger levelled at the management at times seemed misdirected.

Hospital funds cuts 'disastrous'

cash before care'

Groote Schuur needs drastic solution as health costs rise

Staff shortages 'a threat to health'

Budget cuts for state hospitals would undermine a tradition of excellence

Top docs blow whistle on massive hospital cuts

Groote Schuur budget 'to be slashed by R19m, Tygerberg by R11m'

Further bed and budget cuts loom for hospitals

261 hospital beds in 1982 – only 60 today

In response to this, the Physiotherapy department started a programmeme to get staff to be healthier through campaigning a stairs week (using the stairs rather than the lift) and a back week emphasising that prevention is better than cure. Staff were encouraged to become more active. Yoga and aerobics classes were commenced and massagathons were hosted during the year.

in September 2006, the Department of Home Affairs allocated a clerk to the Hospital to deal with the registration of births in the Maternity Unit, thus negating the need for parents of newborns to spend hours in queues at Home Affairs Departments around the country.

Other services remained sole providers for the country, such as the Pharmacology Drug Assay Laboratory, which was the only unit accredited to perform the tests in the country. The Pharmacology Analytical Laboratory serviced Groote Schuur and about 20 other institutions in the Western Cape, and provided assays for about forty different drugs. It is the only Pharmacology Laboratory in the country which is fully accredited with the South African National Accreditation System (SANAS) and the only public sector laboratory offering assays for antiretrovirals, antitubercular drugs and the immunosuppressive drug sirolimus.

Similarly, the Dermatology Phototherapy Unit was the only training and referral centre of its kind in South Africa drawing patients from all over Southern Africa for management of difficult skin conditions. The patient load was at 400 to 500 patient visits per month.

The eventful year did not end there. Staff members engaged in a strike for better salaries, again impacting on service delivery and creating an environment of tension at the hospital, with some staff fearing for their safety during these times of unrest.

The year ended on a worse note with another 60 beds being closed, among them the private ward (G4) beds, since it was thought to be unethical to keep these beds open while significant pressures were being experienced on the use of beds for indigent patients. Following this announcement, a group of concerned staff formed the Groote Schuur Crisies Committee. The media carried this news both from the perspective of the patient as well as in an adverse way of the decision negatively impacting on patient care. Organisations such as the Treatment Action Campaign (TAC) also protested peacefully outside Groote Schuur Hospital.

With the Quality Assurance department functional, the Infection Prevention and Control nurses were shifted under that banner as well, from Feb 2007. On 22 August 2007, an interdenominational Chapel was opened on the E floor of the New Main Building. The best news came in October 2007, when the Neonatal Unit at Groote Schuur was awarded R1.5M from the Fuchs Foundation as start-up funds to establish the Newborns Trust, which would become a sustainable source of additional funding for neonatal care. The year was abuzz with shifting wards and patients in line with the level 3 and level 2 split in line with the Comprehensive Service Plan. At the same time, bed closures were planned and the cost-saving measures remained in place. The Oasis group donated a laser machine to Dermatology, which was placed in C9. In an effort to monitor the laboratory tests usage, a laboratory controller was appointed to act as a gatekeeper. The Occupational Specific Dispensation was being introduced for Nursing and discussions around the interpretation of certain categories was ongoing.

Once again, there was a change in guard, with the hospital bidding farewell on 31 October 2007, to the Chief Executive Officer, Dr Japie du Toit, who had only held the position for 3 years. He was replaced by the appointment of Dr Saadiq Kariem.

The hospital proudly celebrated the 40th anniversary of the world's first heart transplant in December 2007, starting with the Morning Live television show broadcasting from the hospital. Staff and visitors were greeted with heart-shaped chocolates and there was an exhibition, the "Journey of the Heart" sponsored by Teruma, which captivated all those who took the time out to see it. Recognising the important role played by our current transplant team, all staff involved in transplantation were invited to a tea and given a commemorative gift.

This was followed by an Academic Highlight with a number of prominent speakers. A select group of guests were then invited to the official opening of the Heart of Cape Town Museum after a major refurbishment, by Mr Hennie Joubert at a cost of R4 million, and the day ended with a gala dinner in commemoration of the first human heart transplant.

The Heart of Cape Town Museum is a celebration of the life of Professor Christiaan Barnard and contains various artefacts. Letters, photographs as well as life-size wax models of the theatre, the patient, his office, among other things. The museum is indeed an asset to the hospital.

Figure 82: Model of Professor Barnard in his office

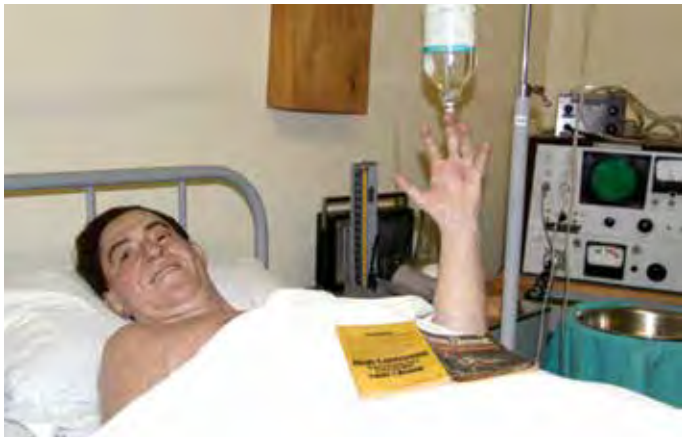


Figure 83: Model of heart recipient patient, Mr Washkanski

Figure 84: Model of the operating team

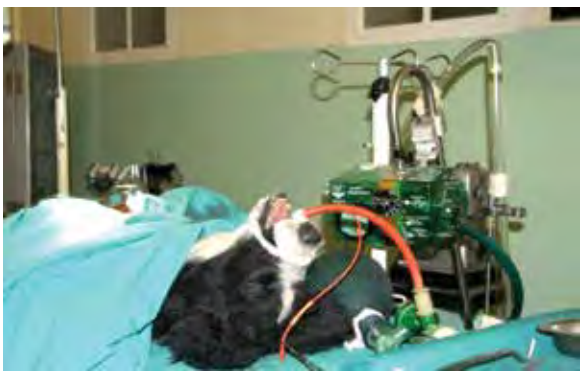


Figure 85: Model of the animal lab where many experiments took place

Guests of honour at the 40th anniversary were members of the original operating team, together with the National Minister of Health, the Premier, The Mayor of the City of Cape Town and the Provincial Minister of Health. To mark the occasion, a scholarship in the name of Hamilton Naki, a member of the Research Team working in the animal laboratory, was sponsored by Netcare and announced at the function.

Following the 40th celebrations, the hospital kicked off the new year celebrating 70 years of caring, with a concert in Palm Court for the staff who were treated to a musical celebration. Three identical concerts (morning, afternoon and evening) were held, giving all staff the opportunity to attend. In order to illustrate the positive response to the celebration, the following quote by a General Assistant who visited the Public Relations office needs to be shared "Before the concert there was a dark cloud hanging over the hospital. Nobody smiled and greeted, but after the event it was like God opened the skies and shone the sun into Groote Schuur Hospital. Everyone is smiling and happy."

In March 2008, the hospital proudly boasted the acquisition of a state-of-the-art neuronavigation system to be used by Otolaryngology (ENT) and Neurosurgery for advanced skull base, brain and sinus surgery. The Western Cape Department of Health acquired the R1.5 million BrainLAB neuronavigation system as a private/public venture with BrainLAB. March 2008, was also a month of some relief and good news, when an announcement was made to increase the budget for Health and Education.


Huge cash boost for health and education

Another world first was the transplantation of kidneys from HIV-positive donors to HIV-positive patients. Three such operations were done between September and November 2008. The hospital later allowed for these to continue as part of a research project, understanding the risks and time frame to note whether or not this would benefit the patients in the long term.

Other activities for 2008 included the hospital hosting 30 student volunteers on Youth Day, 16 June, to perform various tasks and assist in Medical Records, Admin Registry, Rochester House, the Welcome Desk and Catering.

On 22 June 2008, a new Linac machine was commissioned.

During 2009, various waiting time initiatives were introduced to alleviate the pressures, but these were not sustained. The Pharmacy in Outpatients, for example, reduced their waiting time from four hours to one hour using Lean methodology, but the capacity of the staff to maintain the one hour was not transferred during the project. The appointed gate-keeper for laboratory tests was actively blocking some investigations according to specified criteria in order to make some savings. Surgeries had to be cancelled due to shortages of staff or the reduction in operating slates. In addition, new policies on starting times, cancellation rate, the WHO checklist, and monitoring the number of operations had to be introduced.

Activities at the hospital remained strained during 2009, where, despite the small funding boost, services were struggling to keep pace with the demands. This was clearly seen in terms of the number of complaints received from patients and the perceived deterioration in the quality of care offered. There was further conflict when the hospitals were asked to amalgamate the Trauma and Emergency units and plans had to be developed to effect this, but they were never realised, despite ministerial intervention. It was felt that for such specialised care, the units had to be separated to achieve greater effectiveness.

Groote Schuur Hospital 2010 to 2017

At the start of this decade, the hospital staff were feeling demoralised. There were many expectations on the services with no relief in sight. The implementation of bed and staff numbers according to the 2010 plan had limited movement between the different areas, since some wards were allocated only for level 2 and others for level 3 patients. In a large hospital, where there is such a rapid turnover of patients who flow from one area to another, these divisions posed restrictions that became difficult to manage. Additionally, the implementation of the Occupational Specific Dispensation for Nursing, where specialization in a specific field was required to work in certain departments, resulted in a further limitation to be able to move staff around and together with the level 2 and 3 split, imposed some rigidity to the system. Not only were beds and staff realigned, but all the support functions, including the finances, also needed to be separated and reported upon between level 2 and level 3. The frustrations amongst staff and the health system as a whole were noted and a revision of the implementation of Healthcare 2010 became imminent.

However, there was huge excitement at the hospital with South Africa successfully hosting the 2010 FIFA World Cup Soccer Tournament. The hospital was not immune to planning around this event for matches played in Cape Town and the Emergency and Trauma units were prepared for both individual and mass casualties if the need arose. Staff had to be reminded of the implementation of the Disaster Plan and various desk top exercises were facilitated by the Emergency Medical Services.

Building Works and projects continued with the relocation of the Engineering Department workshop to the Healthpark building. The Hospital Facilities Board, as always, assisted staff and patient initiatives to improve the facilities and patient care. The Oncology Areas were revamped and the Wembley Group, through Mr Gangraker, donated two golf carts to transport patients and visitors up and down the long corridors of the hospital.

The Physiotherapy Department started a new service on Vestibular Rehabilitation, which was the only clinic of its kind in the public sector. The Post-operative high care capacity was increased and additional theatre slates allowed the hospital to address the long surgical waiting listsOf note, was the installation and complete digitization of the Radiological service through the introduction of the Picture Archiving and Communication System (PACS).

In order to be more patient-centred, the hospital entered into an agreement with a private provider for Radiotherapy services to patient in the Eden district. This would allow for patients to remain close to home with their families during the treatment and would reduce the cost and risks associated with their travelling to Cape Town. Figure 88: The introduction of the Antibiotic Stewardship Programmeme resulted in the hospital saving R3M over a 3-4 year period.

Figure 86: Golf carts donated by Mr Gangraker

Figure 87: Picture Archiving Computer System

For the implementation of the Comprehensive Service Plan, which absorbed much of the time in the previous decade, 2010 was the line in the sand and the Department of Health initiated a new service horizon plan for 2020, with a focus on patient-centred care, increasing health outcomes and having a value-based service organization. At the same time, there was a reflection on the implementation and success of the 2010 plan and it was recognised that the rigid division between level 2 and level 3 services within one hospital was difficult to sustain, especially given the service demands. Within Groote Schuur Hospital, departments started to re-organise the way that their wards functioned – for example, the Department of Medicine re-introduced a firm system for the intake of patients; the Department of Surgery re-organised their wards, so that all acute care General Surgery would be housed in one area and similarly, other departments integrated their services for greater efficiency.

The first Bone Anchored Hearing Aid (BAHA) was implanted at Groote Schuur in February 2011 by Dr Estie Meyer, an ENT Surgeon at Groote Schuur Hospital. This was a first in a public sector hospital in the Western Cape. The BAHA system consists of a small titanium implant that is placed in the bone behind the ear where it grows together with the living bone. The BAHA system is normally indicated for patients who were born without ear canals or have middle-ear problems and cannot wear conventional hearing aids. A new BAHA team was then established consisting of Dr Estie Meyer (Otologist) and audiologists Sharon Pithey, Megan Ferguson and Shanaaz Marlie. The team was clinically supported by Southern ENT, the South African distributor of the European imported BAHA system.

There was a realignment of the management structure of the hospitals with both Dr Kariem (CEO) and Dr Linda (COO) being shifted to the General Specialist and Emergency Services as Chief Director and to Red Cross War Memorial Children's Hospital as the CEO respectively. Dr Carter was laterally transferred from Tygerberg Hospital to become the CEO of Groote Schuur. Dr Bhavna Patel was then appointed as the COO.

By the start of 2011, all the previously cut theatre slates were reinstated and additional slates for Orthopaedics and General Surgery were commissioned. The hospital was involved in a pilot to introduce Operating Theatre Practitioners (OTP's), which proved to be a very useful way to bolster the availability of scrub staff. However, difficulties were experienced in appointing these staff since they did not belong to any registered body and it was unclear to whom they would be accountable and what their scope of work would be. The opening of the post-anaesthetic high care beds in the B-suite of theatre reduced the burden on ICU to accommodate post-operative patients.

Concern was growing about the high resistance rate to last-line antibiotics at the hospital and Professor Marc Mendelson initiated an Antibiotic Stewardship programmeme by setting up an Antibiotic Stewardship team ward round to monitor the prescribing of these agents. Various policies and protocols were developed as a result of the initial findings and the programmeme became hugely successful.

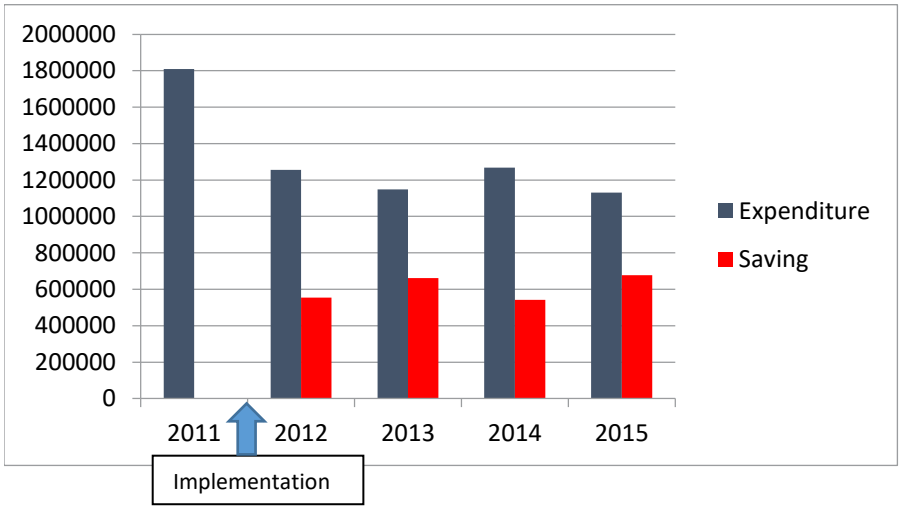


Figure 88: The introduction of the Antibiotic Stewardship Programmeme resulted in the hospital saving R3M over a 3-4 year period.

The Quality Assurance Department was also involved in developing an Adverse Incident Monitoring Tool and the Intensive Care Wards implemented the Best Care Always programmeme to monitor specific adverse events.

Pressure on the beds in the Emergency Unit and the inadequate facilities to house patients who are close to the end of life, resulted in the creation of a 4-bedded cubicle in ward G16, where patients could die with dignity with their families at the bedside. The unit within the ward was furnished with additional soft touches to create a calmer environment.

At the beginning of 2012, the Khayelitsha District Hospital was commissioned and funds (R29M) were diverted from Groote Schuur Hospital at the expense of the closure of 24 beds at GSH. A survey done later in the same year reflected that very few patients from Groote Schuur had actually shifted to Khayelitsha during this process. At the same time, the building of the new Mitchell's Plain Hospital was nearing completion and further budget shifts were anticipated.

The Faculty of Health Sciences marked their centenary celebrations (1912 to 2012) and the Department of Medicine used this opportunity to honour 39 of its own staff who had published a paper that had been cited at least 100 times. Professor Bongani Mayosi was also awarded the National Science and Technology Forum

(NSTF)-BHP Billiton Award for his outstanding contribution to Science, Engineering, Technology and Innovation (SETI) through management and related activities over the previous five to ten year period.

In the Department of Surgery, a memorandum of understanding was concluded with a non-governmental organization, Pink Drive, for the delivery of mammography services to identified patients attending the Breast Clinic at GSH. This assisted in decreasing the waiting time for mammography and significantly improved the services for Breast Cancer patients. The waiting time from making the diagnosis to the surgical treatment of the cancer was reduced from eight weeks to two weeks because of this additional resource. Infrastructure improvements were happening slowly, with the ablution facilities refurbishment continuing. The Maternity Building waiting area and three patient lounges were refurbished through a generous donation from the Foschini group and Clicks.

Figure 89: Opening of the renovated patient waiting areas in the Maternity Building

In Pharmacy, the A12 Pharmacy store was upgraded in order to ensure compliance with the Pharmacy regulations.

During 2012, some achievements included the installation of a new Lodox machine, used in the Trauma Unit to take full body X-rays of patients presenting with multi-trauma. Financial audits occurred annually and to enable the department to minimize audit findings, a Devolved Internal Control Unit (DICU) was established. The staff were provided from Head Office, and their sole purpose was to constantly check on compliance-related issues. A Management Control Instrument was introduced to assist management in determining the rate of compliance with various regulations, instructions and policies. This system proved its usefulness to the Department of Health in the Western Cape with it never having achieved a qualified audit.

The Engineering Department continued to render a service that focused on prompt, correct and effective maintenance to the hospital, staff and indirectly to the patient. The ethos of the department was changing from "What can the Hospital do for Me" to an Ethos driven by a dedicated commitment and a saying, "We shall provide a comfortable, safe stay to the patient through good maintenance, courtesy and dedication". As a department they restored the hot water system to the OPD Building as an in-house activity, saving the Department of Health about R300 000 and this new energy amongst the Groote Schuur staff was being used to generate ideas on water, coal and electricity savings as 'green' initiatives.

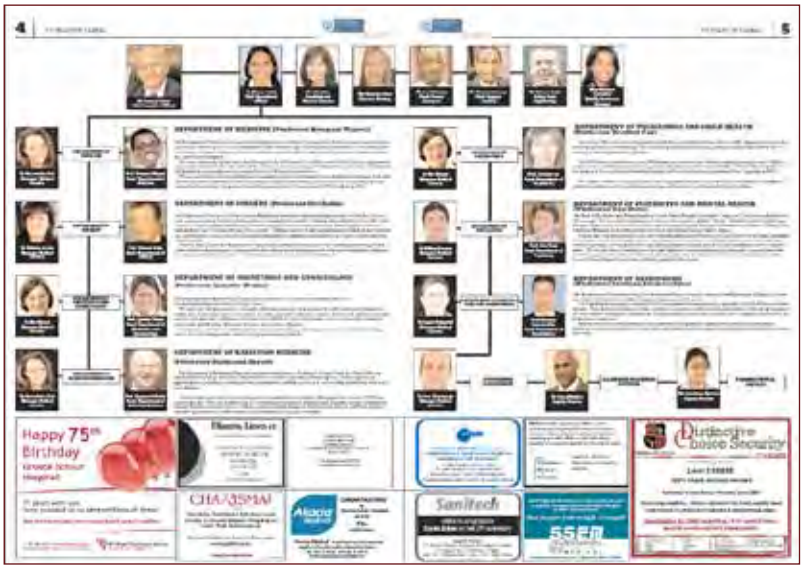
The Multilateral agreement between the Provincial Department of Health and the four Higher Educational Institutions was concluded and signed during 2012, with a target of the following year being set aside to draft and sign the Bilateral Agreements.

Figure 90: Professor Craig Household signing the agreement with the Vice Chancellors of the University of Cape Town, University of Stellenbosch, University of the Western Cape and the Cape Peninsula University of Technology.

By 2013, the hospital celebrated its 75th birthday with a concert for the staff and the Argus added a Supplement to their newspaper on the day. During the year, there was also a Masterchef competition, won by the Physiotherapists.

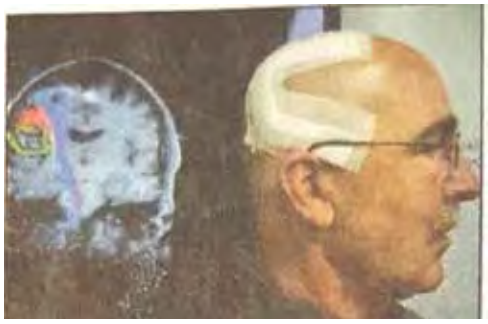
The two newly built district hospitals (Mitchell's Plain and Khayelitsha) were fully functional and some of the Groote Schuur Hospital staff opted to transfer to these hospitals for personal reasons, such as proximity to home, reduced travel costs, etc. Despite having an open advert to fill nursing posts, attracting specialized nurses was problematic and the reliance on agency staff increased further. With the opening of the Mitchell's Plain District Hospital, the GF Jooste Hospital was decommissioned from 1 October 2013, with a promise of re-building the hospital over the following 5 years. Due to this closure and the fact that Mitchells Plain was a district hospital, some of the services had to shift to Groote Schuur Hospital. An estimate of patient numbers showed that 90 additional beds were required, but only 30 were authorised to be opened, including 22 medical and surgical beds and 8 high care beds to cover both Emergency and Trauma units.

New services were commissioned to improve patient care, such as the Pain Control Clinic, Intestinal Failure Unit, the additional colonoscopy service, appointment of a Palliative Care nurse for the newly commissioned Palliative Care Service and the appointment of a Breast Health Co-ordinator. In June 2013, an Endobronchial Ultrasound Bronchoscopy (EBUS) slate was started in ward E16. Groote Schuur is only one of two hospitals in the country using this technology. The other is Nkosi Albert Luthuli Hospital in Kwazulu Natal. This technology allowed biopsies of glands related to Tuberculosis, Lung Cancer and Lymphoma, without the need to cut the skin of the patient. Essentially Endobronchial Ultrasound Bronchoscopy is a brand new technique which targets patients with severe unstable asthma. EBUS is a camera tube that goes into the lung and under ultrasound guidance the lymph glands in the chest can be biopsied. It's an out-patient procedure and the main advantage is that it saves an operation. The equipment cost is approximately R2 million.



Supplement to the Argus in 2013.

A first Haploid mother to child transmission was done in E5 Haematology. A new Linac machine was opened in Radiation Oncology, with the first patient being seen in February. At the same time, plans were being drafted for the building of an additional bunker for another Linac machine, because the older machines were now becoming obsolete and the newer machines allowed for more patients to be treated during the same amount of time. The Cardiothoracic Department inserted six Trans catheter aortic valve replacements (TAVI's). This was another first in the South African public sector for Groote Schuur.



A patient at Groote Schuur Hospital became the first in a South African public hospital to undergo surgery for a brain tumour using intra-operative fluorescence, a new technique that lights up the affected area of the brain using a chemical that is ingested before the surgery. Pioneering neurosurgeon Dr Sally Röthemeyer of the Division of Neurosurgery conducted the six-hour operation on a 52-year old patient who was later discharged.

The hospital was becoming an attraction to foreign students, especially those wanting to gain more experience in Trauma. It is interesting to note that the Danish government also wanted to sign an agreement with Groote Schuur Hospital to send their military personnel to learn more from us, since their country was `not at war' and their staff were not trained to manage trauma.

Figure 91: Trauma students with the GSH Trauma specialist, Professor Navsaria (far left)

With the PACS fully implemented, the staff were being trained on how to use the RIS part of the system. UCTPAH provided an additional mammography service to the patients with breast cancer, further reducing the waiting time for this procedure. In addition, the Radiology Department received a new CT scanner worth R 7 million, the first 160 slicer on the African continent. The main advantage was the faster acquisition of the image at a lower radiation dose to the patient.

To assist patients to find their way around and to speak to them about waiting times, queue marshals were introduced in the Central OPD and the Pharmacy waiting area. Another initiative to reduce waiting times was the commencement of a special 'Lean Management' project with the assistance of an external consultant.

Improving quality was a strategic priority and the efforts linked to this bore fruit when the National Department of Health conducted the National Core Standards audit and Groote Schuur Hospital scored 82%.

As part of promoting Wellness amongst the staff, health days were planned, Back Week, Stairs Week, an annual fun run, yoga, swimming and belly dancing among other activities were ongoing and proved popular with the staff.

The Provincial Department, in an effort to contribute towards youth development and employment, introduced an EPWP programmeme and Groote Schuur Hospital was asked to take about 15 young people for a twelve-month internship. The skills acquired could then be used to apply for jobs as they became available.

More and more departments were making enquiries about making the hospital more electronic friendly so that patient information could be available at the staff's fingertips, so that research could happen at the bedside and as a way of integrating all the different systems in place at the hospital to be able to manage the patient more holistically and reduce the duplication of tests and investigations. However, since these systems were all provincially based and any new system required vendor approval, etc., – the realization of such an integrated patient information system was not realised.

Many of the departments wrote their own software and started to use them in the wards. Others, like the Trauma Unit piloted an electronic trauma health record, which yielded very positive results and was used to motivate to the Province to start engaging along these lines. The software used in the Trauma Unit allowed for reports to be generated that, for example, indicated the numbers and mechanisms of injuries seen at the hospital and where the patients originate from, thereby identifying the hotspots for trauma in the Cape Peninsula. This information in turn could be used for upstream prevention measures to be put in place.

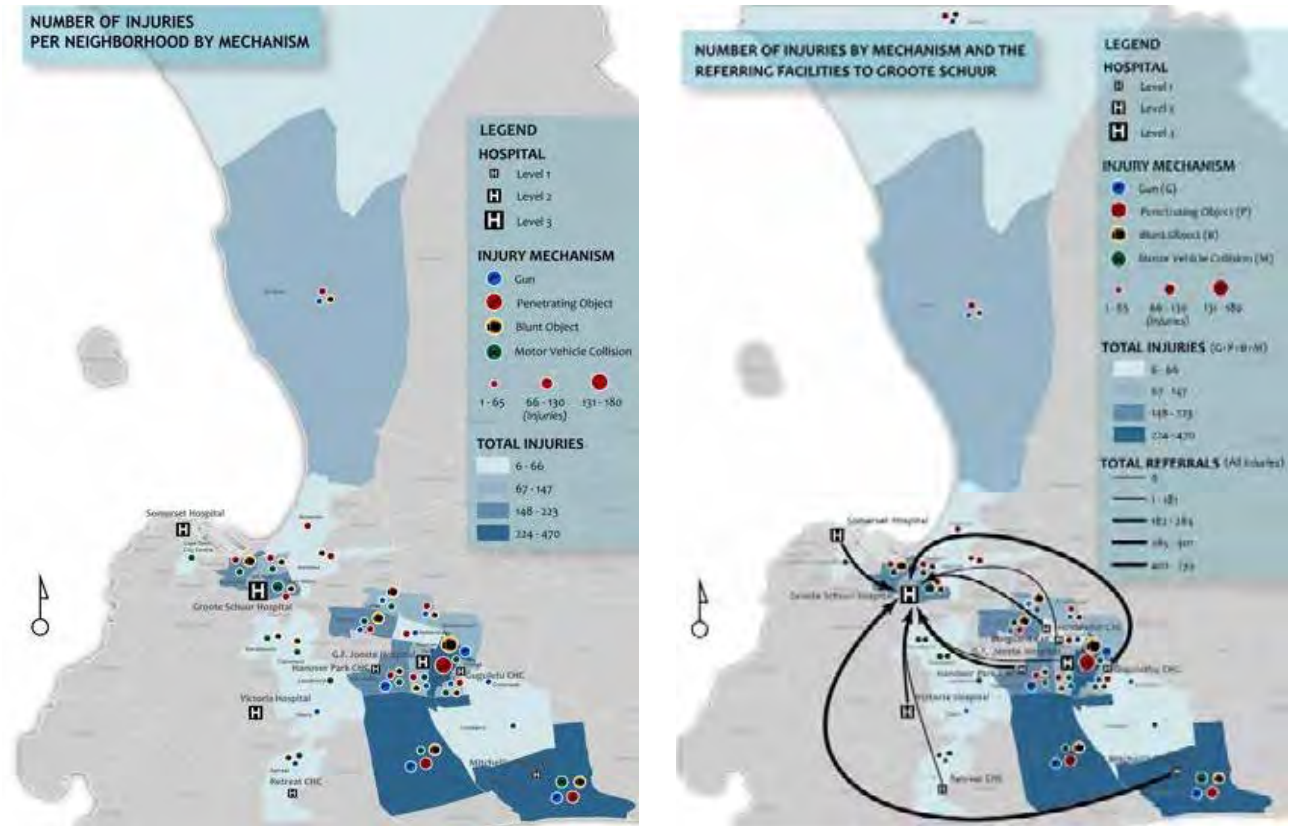


Figure 92: Trauma unit reports on injuries in the Cape Peninsula

The year saw at least a start to the installation of Wifi in the hospital, with the G and F floors of the New Main Building being completed.

Facilities Management embarked on a project to upgrade the ablution areas, since many patient complaints relating to this had been received. Other infrastructure projects included the building of a Hybrid theatre to function across multidisciplinary departments.

GROOTE SCHUUR HOSPITAL 2010 to 2017

Engineering activities included the replacement of all the hospital's water reticulation piping, since they were made of asbestos and besides being a health hazard, had become brittle. The Boiler House functioned more efficiently following the refurbishment and emissions were decreased to almost zero. Through the steam reticulation system, the coal used as a fuel then generated steam, which was then used to sterilize, cook and produce hot water for both space heating as well as hot water for patient care use. This novel innovation not only reduced electricity consumption, but also water usage. However, the City of Cape Town and Eskom, the electricity suppliers, had increased the tariffs to such an extent that the reduced use of energy did not translate into reduced costs to the hospital.

Before	After	
		Soot separator
		Re-lagging of steam pipes
		Re-lagging of steam flue
		Boiler house

Before **After**

Boiler house elcetrical

Boiler house emissions

Linked to transplants, the Strangeboat Foundation requested a stone from Groote Schuur to symbolically represent the stone from Africa towards a commemorative garden, the Circle of Life, being built in Salthill, Galway, Ireland to recognise all the donors of organs for transplant surgeries. One stone from each continent was to be placed in this garden.

Figure 93: Dr Bhavna Patel and Dr Dion O' Cuinneagain at the presentation ceremony

Figure 94: Sculpted candle to be placed in Palm Court

In return, the Foundation sculpted a candle, that was then returned to Groote Schuur to be placed in the palm court garden.

With the appointment of Professor Swanevelder as Head of Anaesthetics, many new initiatives were introduced, such as, workshops on trans-oesophageal echocardiography, and these were offered to both public and private sector doctors. In addition, the Groote Schuur theatres broadcast a live workshop while operating on a Urology-Gynaecology patient.

Figure 95: GSH lit in purple for World Prematurity Day

On November 17, the Newborns Trust celebrated World Prematurity Day and a purple light was shone on the hospital.

What seemed to be a 3-year cycle of CEO turnover was once again being felt, with Dr Terence Carter taking up a position at the National Department of Health on 1 June 2013. Dr Bhavna Patel was appointed as CEO in the same year.

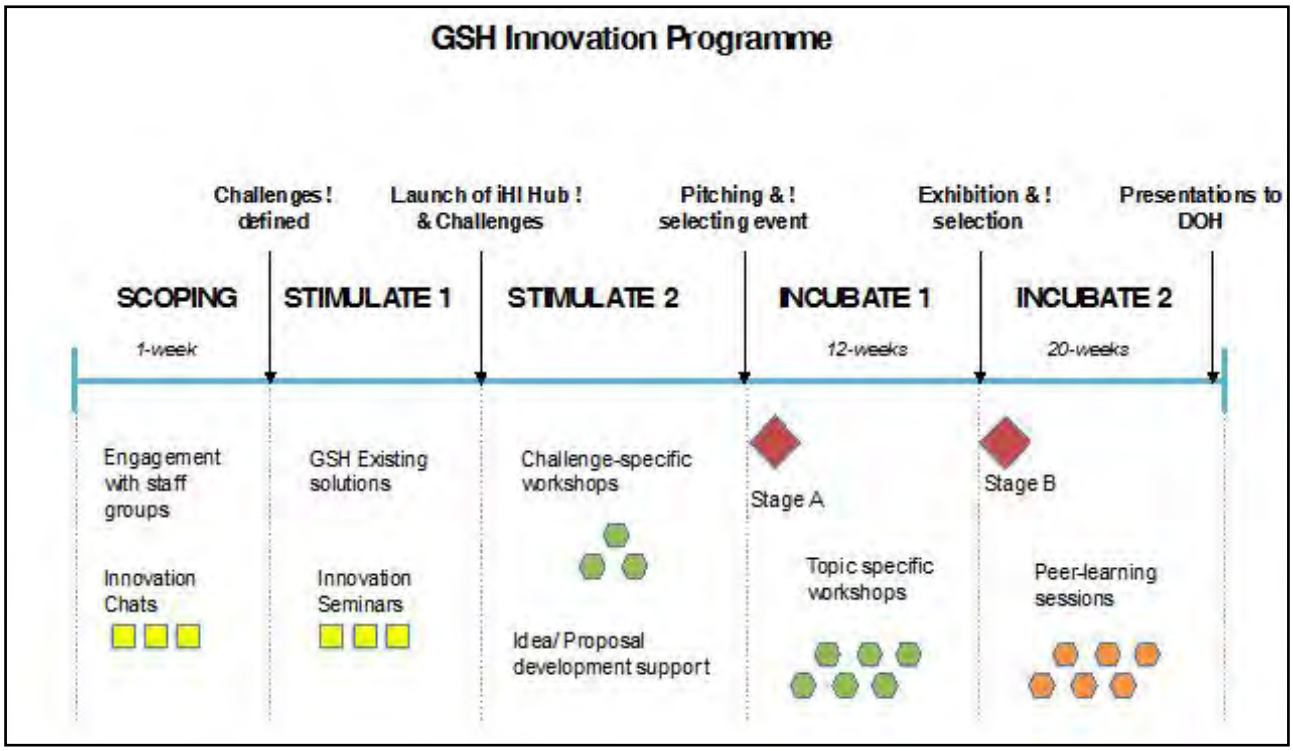
At the start of 2014, the Lean Management project was taking shape in Outpatients. The project specifically looked at the journey of a patient from the entrance, through Administration to get the folder, thus also involving Records management, then to the Eye Clinic and any investigations if required and lastly to Pharmacy before exiting the building. All the role-players were involved along the patient journey in an effort to reduce the time the patient spent in Outpatients for the visit. The programmeme included the training of the managers of these areas and the development and monitoring of standard work practices to assist in monitoring the progress of the project. The project yielded positive results with the reduction in total waiting time from 8 hours to 4.5 hours.

Through the generosity of an anonymous donor, the hospital was able to run additional theatre slates on a rotational basis. While the funds, theatre and surgeons were available, the constraint came from the availability of specialised nurses. However, many additional patients received their surgeries.

Due to a National problem with electricity, there were rolling blackouts and the old generators at the hospital, while functional, could not be exposed to lengthy periods of activity. These needed to be monitored and replaced. Luckily, due to the hospital receiving its power from two substations, an agreement was reached with the City of Cape Town not to shut down both stations at the same time, thereby protecting the hospital from the power cuts. However, there remained the concern of a total power outage and contingency plans had to be developed to address this.

At the Annual Operational Planning meeting, Dr Patel introduced a vision and a new challenge to the management and staff of the hospital, encouraging them to develop Innovation, Leadership and Change. A Leadership Development Programmeme was also started with the Executive Management team and various workshops were held. Dr Patel, together with the Executive team, engaged both external and internal parties to assist with this programmeme and made it applicable, relevant and practical for the managers with each receiving tools at the end of each session in order to assist them to use the lessons learnt in their environment. The Systems Thinking Workshop was one of the first sessions to be held and senior clinicians also participated, resulting in a few recommendations that helped shape the way forward and identified the pressure areas requiring added effort. Furthermore, the GSH Facilities Board were excited at the changes being made and committed R2M towards driving innovation at the hospital. After much consideration, it was agreed that this could not be done internally and assistance was sought from the Bertha Centre for Social Innovation and Entrepreneurship, based at the University of Cape Town Graduate School of Business. The consultants assisted the hospital management to drive a call for innovative ideas that could be implemented in one of 8 categories, which were identified during

a one week scoping exercise. A process of evaluations followed and additional expertise was commissioned by the Bertha Centre to coach the various innovation project owners. The project was hugely successful, ending with about 15 innovation projects. The word 'Innovation' was described as something different for Groote Schuur that could improve the patient experience and not necessarily something 'new'.



Eight Grand Innovation challenges		
	1. Using waiting time more effectively The Time Machine	2. Sustaining a culture of care and dignity Dare to Care
3. Tracking and communicating eBoard	4. Patient records and notes ICU 24hr patient flow chart	5. More efficient entry and exit Streamlining referrals LEAP Motion Controller
6. Improving care for specific patient groups Adolescen pill box	7. Working better with community service Informed consent – Organ donation	8. Boosting volunteer resources Resource Hub


INCLUSIVE HEALTHCARE INNOVATION
New Possibilities
Bold Solutions
Better Patient Care
INNOVATION CHATS @ GROOTE SCHUUR HOSPITAL
SPEAKER PROFILES


HOW CAN YOU RE-IMAGINE HEALTHCARE?


INNOVATION HUB

Figure 96: Patient Ester Arthur with Professor Karen Sliwa-Hähnle

On the clinical side, the Radiotherapy Department used a newly implemented rapid arc technology, improving the time taken for radiation treatment. Antibiotic stewardship activities were taken to the next level with the initiation of an Antimicrobial Stewardship committee. The main objectives of this Committee were to roll-out the Antibiotic Stewardship in a sustainable manner, train more staff and monitor and act/advise on trends in this regard, eventually also extending to hospitals outside of Groote Schuur. A wonderful achievement was that one of the heart transplant patients was the first to carry a healthy pregnancy to term and delivered a bouncy baby girl (figure 96).

Since the early 90's, when Dr Paul Roux had initiated antiretroviral therapy at the hospital to children who were HIV-positive, there had been a growing cohort of children who had reached the adolescent years. The services for adolescents were inadequate and there was a poor transition from Paediatrics into adult care, with patients often being compromised. With this in mind, a combined adolescent and adult clinic was established for HIV patients, housed in the same area. A Rapid Assessment Clinic was also introduced in the space. This was becoming a new way of functioning as multidisciplinary teams and was most certainly feeding into the vision of Leadership, Innovation and Change.

The new Linac Bunker building project progressed very slowly and seemed riddled with problems and delays, increasing fears that they would not meet the target date for the installation of the machine, which had already arrived at the hospital.

The focus on quality remained a priority and the rewards were seen in letters of compliments received from patient:

"Please ensure this compliment reaches the staff and hospital managers.
I visited Groote Schuur Hospital last night, to visit a client. I was pleasantly surprised at the look and feel at the hospital. One easily has certain reservations when it comes to a state hospital, but besides it being old, the hospital was very clean. Wherever I moved, most of the staff were friendly and helpful, and there was order in all the wards I moved through. I was especially impressed in Ward F5, where we were. It was during the night shift on Thursday, 24 April 2014.
Thank you and keep up the good work!"

The positive experiences were also being noticed by some donors and on the 18th of July a media event was held at GSH covering the story of individual patients who were positively affected by the donation of 10 orthopaedic implants and the collaboration with Unipalm, with other donors also coming forward.

Figure 97: Dr Joey Moodley and Mr Ragi Moonsamy donated the implants

Other quality initiatives included a project led by the CEO on improving hand hygiene. The results were very encouraging and resulted in a paper being published in the South African Medical Journal as well as a presentation being made to the International Hospitals' Federation conference in Chicago in the following year.

Information technology was advancing faster than it was possible to keep up with and change. The Department of Medicine trialled and implemented the Electronic Continuous Care Record (ECCR), which was then expanded to include the Surgical wards. In the Paediatric Ward the use of technology resulted in an improvement in the management of diabetic patients. Computer software was installed to assist with glucose profiling using self-testing. Patients tested levels at home and the device stored these values. When they came for their follow-up the data was downloaded and trends could be determined. Using graphic presentation patients were then educated on how to improve their glucose control.

To promote some Christmas cheer, the Facilities Board decided to offer all patients at the hospital a food parcel. Various donations from companies contributed towards a large bag filled with goodies and the Board decided to make this an annual event.

Significant progress was made in 2015, with a framework for the vision of the hospital being identified as 'Leading Innovative Healthcare'. The framework outlined each aspect of the vision statement and together with the innovation projects and all the improvement projects, was called the Groote Schuur Performance System, or GPS, which outlined the roadmap towards achieving the vision or true north. Learnings from Dr John Toussaint and other similar interventions contributed to the GPS being built on using Lean Leadership principles.

In line with the GPS, a space was refurbished with the support of the Bertha Centre and the University of Cape Town Faculty of Health Sciences, as the Innovation Hub. The intention with the use of the space was to create an environment where staff could think outside of the box and away from their normal work environment without the usual distractions. The Innovation Hub was opened on 17 March 2015.

Figure 98: New mammography machine

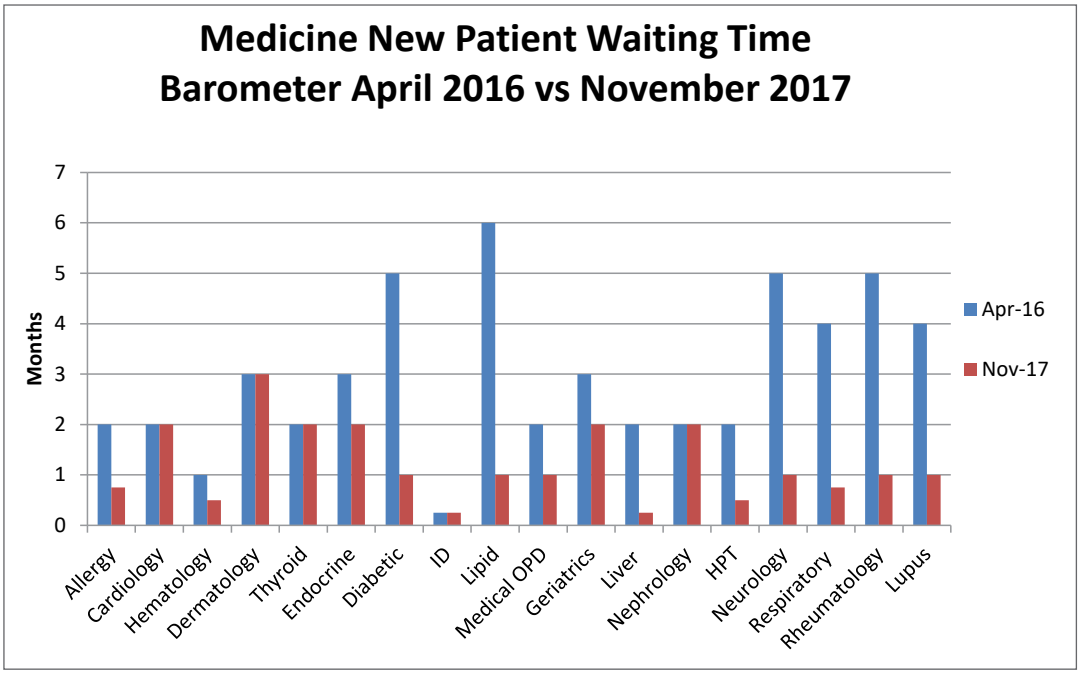
With innovation being the buzz word, Dr Kit Vaughn, CEO of Cape Ray, a company he formed after leaving the University of Cape Town Biomedical Engineering Department, developed a machine that combined the ultrasound and mammogram procedures into one machine. The device was being tested at Groote Schuur Hospital and was proven safe after being used on more than 50 patients. This was another world first

Clinically, another innovation came from Dr A. Chin of the Department of Cardiology, who implanted the world's smallest heart pace-maker into a patient. Groote Schuur became the first hospital in the Middle East, Africa, Central Asia and Turkey to implant this Medtronic Micra Transcatheter Pacing System (TPS). The pacemaker, a miniature device, does not require the use of wires, known as "leads," to connect to the heart. It is attached to the heart via small tines and delivers electrical impulses that pace the heart through an electrode. Dr Chin noted in an interview:

Figure 99: World's smallest pacemaker

"We are proud that Groote Schuur Hospital was selected among an elite group of institutions to take part in this global clinical trial. If positive, the results of the trial could potentially benefit the more than one million people globally who receive pacemakers".

Outpatient waiting times were reducing consistently due to active interventions to only allow the referral of patients who need to be seen at a tertiary level. The graph below shows the change in the different departments within Medicine.



During the month of August Mr Smith, Head of Engineering, presented a paper at the Bi-annual Conference of the South African Federation of Hospital Engineering. This paper was written to highlight how GSH had managed to save on utilities over the four years from 2010-2015 by implementing various initiatives, and was met with rave reviews. Electricity usage remained stable, but municipal tariffs increased year on year; Coal consumption decreased by 42% and water consumption by 51%

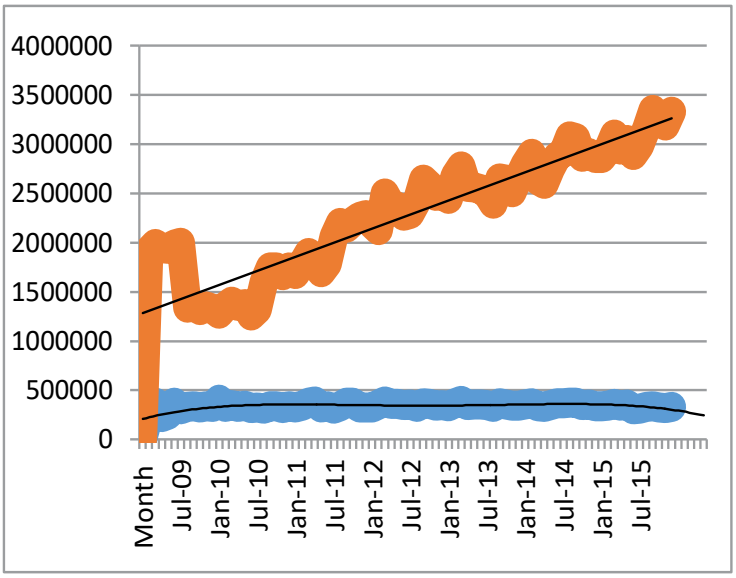


Figure 100: Electricity cost (orange) versus consumption (blue)

In the latter part of the year, the hospital hosted a cook-off competition, where the proceeds of the event would be donated to a worthy cause. The event brought together many staff members and some healthy competition in making the best food, judged by an independent panel of celebrities, among them, Mr Pieter de Villiers (ex Springbok coach).

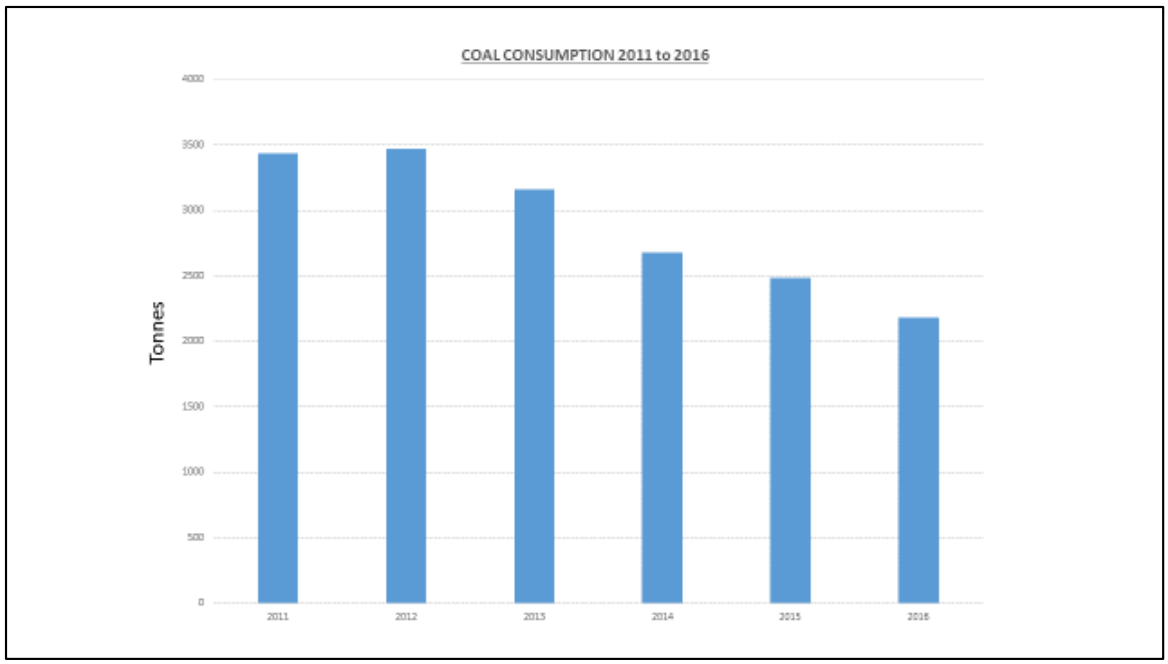


Figure 101: Coal consumption – down by 42%

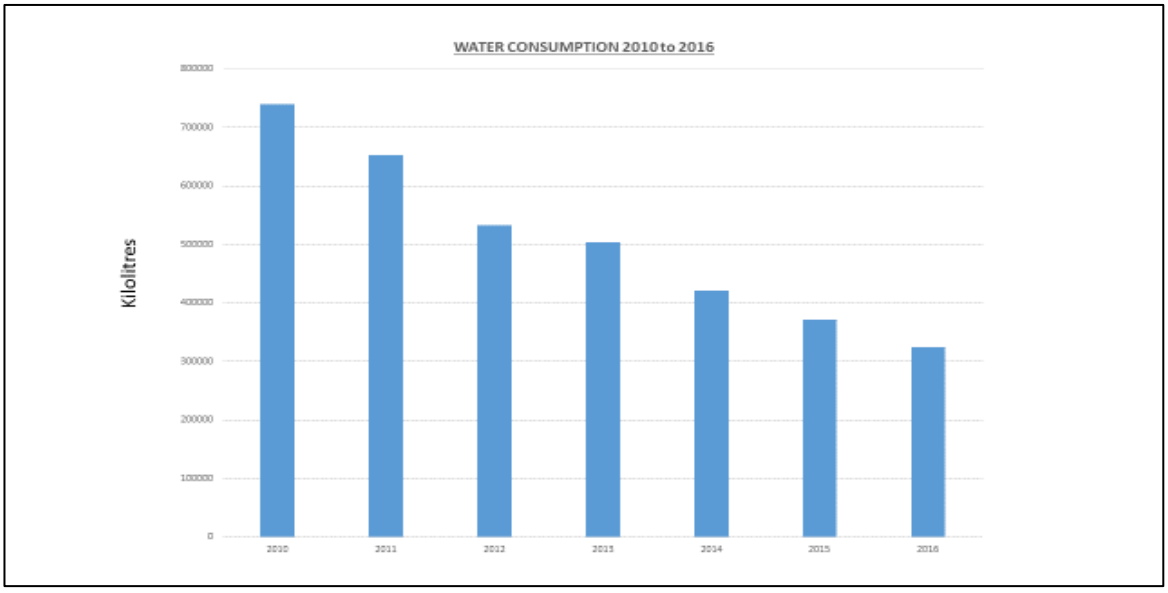


Figure 102: Water consumption – 51% saving






The first half of this decade was indeed building up excitement amongst both the management and the clinicians. Generally, a positive vibe was present around the hospital, despite the ongoing bed and financial pressures. Services were particularly stretched in Emergency Unit, Trauma Unit, Psychiatry, Intensive Care and the Acute Spinal Cord Injury Unit. The patient load was being experienced not only as an increase in numbers, but also in patient acuity. On top of that, many of the more experienced nurses were either retiring or resigning following a rumour about the actions of government related to the state pension funding, indirectly impacting on the services. However, doom and gloom did not prevail and staff pulled together to find different ways of working so that the patients could receive better care. This philosophy seemed to be the consistent thread.

The innovations drive had sparked new thinking on all fronts and the pneumatic tube system, which had stopped working over the years was resurrected and recommissioned to assist Pharmacy to receive their scripts earlier and not depend on a messenger to fetch them from the wards.

The antibiotic stewardship programmeme was working well and a total of R1.6M was saved through appropriate antibiotic prescribing. An Orthopaedics sports clinic was trialled in outpatients as a means to use the resources differently.

Figure 103: Dr Scherman with his patient

Another clinical innovation for the Cardiothoracic Department was when Groote Schuur Hospital became the first hospital in South Africa to perform an open heart aortic valve replacement through a keyhole incision. The operation was performed on a young patient on 29 March 2016, under the leadership of Dr Jacques Scherman. In an article for the newspapers, he noted that *"The laparoscopic route procedure results in less surgical trauma which leads to faster recovery times and eventually cost-savings for the hospital"*. A further article from the News 24 internet site quotes that the Western Cape Health MEC Nomafrench Mbombo, said she was excited by the hospital's latest achievement. The MEC indicated that *"The tradition of innovation continued by healthcare workers at Groote Schuur Hospital exemplifies what we mean by providing quality healthcare to the people of the Western Cape".*

The Division of Cardiology was the first to perform a leadless pacemaker implantation on the African continent. In the month of October, they implanted two leadless pacemakers for clinical indications in patients with difficult vascular access, thus expanding the ability to provide life-saving treatments to patients with cardiac conduction defects.

A multidisciplinary group led by Critical Care developed a training course on Extracorporeal Membrane Oxygenation (ECMO) treatment, which is a technique of providing both cardiac and respiratory support to persons whose heart and/or lungs are unable to provide an adequate amount of gas exchange to sustain life. This was also in line with the hospital's intention to re-start the heart-lung transplant programmeme in 2017. The division of Dermatology established a new Multidisciplinary Drug Allergy Clinic with input from Allergology, Clinical Pharmacology and Infectious Diseases to assist in sorting out complex issues of causality association and future management for patients with suspected drug allergies.

A new interventional bronchoscopy service, headed by Prof Dheda, was initially piloted and was fully established at the E16 Respiratory Clinic. Services include the performance of ultrasound-guided biopsy of mediastinal lymph nodes and lesions. This substantially cut down the mediastinoscopy rate thus saving valuable resources,

and also providing a same-day discharge patient service. Also offered was a flexible medical thoracoscopy with potential same-day discharge, and bronchial thermoplasty; a novel application of heat therapy to the airways. A new Sleep Disorder Clinic was established in E16, co-led by Dr Greg Symons and Dr Ricky Raine.

Figure 104: Prof Dheda

Other collaborative work between the Departments of Surgery and Aneasthetics on the early recovery after surgery programmeme (ERAS) continued to collect data. Allied Health staff (Physiotherapy and Dietetics) were also part of the team.

Through a donor project, 10 additional arthroplasty operations were performed at Groote Schuur. This assisted in reducing the waiting time for these procedures.

On the 19th of May, Wayde van Niekerk handed over a Cheque of R 500 000 to the Newborns Trust, which would be used towards the much needed upgrade of the Newborn Unit at GSH. Planning for the upgrade had been ongoing for seven years and this was realised when a donor offered the full amount required for the refurbishment. Work was to commence in January 2017. Wayde van Niekerk's association with the Newborns Trust as the official ambassador reached new heights when he won the Olympic gold medal for winning and breaking the world record for the 400m sprint. He has since won and broken many more world records and improved his personal best as well. Being a premature baby himself, he certainly inspired the staff and parents to maintain hope of a bright future for the little ones that are cared for in the unit.

Figure 105: Three of the patients who received new joint implants

On 7 September 2016, the hospital hosted the opening of the Christiaan Barnard Hybrid Theatre Suite by Mr Barnard junior, Prof Zilla and Dr Patel (from left to right) and on 16 August Minister Nomafrench Mbombo opened Linac 5 (here seen with Ms Burger and Prof Parkes (left to right).

Groote Schuur Hospital had entered 5 projects into the Public Service Innovation Project competition, of which 3 were shortlisted as finalists for the 2016 Public Sector Innovation Awards Ceremony and all received awards.

1. Hospital Waste Management – Won 2nd runner up in the Innovative Enhancements of Internal Systems of Government category
2. Energy saving won 3rd runner up in the category of Innovative Solutions reducing the Cost of Delivery Services,
3. Flow Management won 3rd runner up in the category of Innovative Service Delivery Institutions

The hospital was immensely proud of these achievements. With a focussed stimulus on leadership, the hospital was involved in organising a Provincial conference on Leadership, which was attended by about 250 delegates and set the foundation for future shared learnings on Leadership.

Following a year full of innovation, 2017 started out with Prof Lubbe, Prof Semple and Dr Mustak performing ground-breaking surgery by using the eye socket as an entry point for endoscopic minimally invasive surgery. To our knowledge, such an operation had never been performed in the world. Using the new contralateral technique has many advantages to patients like no evidence of any surgical intervention post-operatively, no swelling, no sutures, no ICU stay and shortened hospital stay. Eye and brain lesions previously deemed inoperable because of the risk of complications can now often be addressed with safety.

Figure 106: Professor Lubbe (left) with Dr Hamzah Mustak (far right)

Figure 107: Tyler Baker with his mom Dedre Doolabh

A first for Groote Schuur was the insertion of ear lobes on a young 15-year-old boy who was born without an ear canal and ear lobes. The Department of Technology at the University of the Free State constructed the ears and a surgeon from Gauteng came to assist Dr Estie Meyer to perform the operation. The operation was funded by the Fuchs Foundation. His expression of gratitude was an inspiration to all the staff involved in the procedure.

In March 2017, The Groote Schuur Hospital Catheter Lab and its team of staff members had the honour of hosting all six live cases for the 'AfricaPCR'. The meeting co-directed by Prof. Mpiko Ntsekhe is an Interventional Cardiology Collaboration between the South African Society of Cardiovascular Interventionalists, the Pan African Society of Cardiology and the European Association of Percutaneous Interventionalists. The 6 live cases which were beamed from the hospital over the 2.5 days, were the congress highlight and the lab and its staff received universal commendation.

Cardiology is also the only provider of an Electrophysiology(EP) service in the public sector and they therefore embarked on the training of a Fellow in electrophysiology with the aim of expanding EP access and service provision to patients across the Province.

Dr Greg Calligaro returned from Sydney after completing his training to restart the lung transplant programmeme at Groote Schuur Hospital, hopefully later in the year. Other doctors have also been trained abroad.

The article by Dr Patel and Prof Weimann on green leadership at GSH to combat Climate Change was published in the South African Medical Journal in January 2017.

The GPS was progressing well with the scaling of the Leadership development programme to the General Management level. Various improvement projects are progressing well and it is hoped that this will create a culture of continuous improvement with the ultimate aim of changing the organizational culture of Groote Schuur Hospital towards one where there is a constant energy to improve and problems are jointly solved through a process that seeks to first identify the cause and then find solutions, using a multi-disciplinary team approach. Below are some of the improvement projects and their achievements.

GPS PROJECTS

The Emergency unit decreased waiting time for patients from more than 25 minutes to under 15 minutes in the ante room and triage areas.

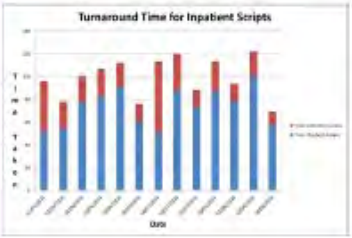
The team is led by Sr McKay.

Eye and Gynae OPD clinics reduced patient throughput time from an average of 6-8 hours to 3-4 hours.

The team is led by Sr Steenkamp.

Facilities Management staff reduced waiting time for GSH ID cards from 20 days to one day. The team is led by Mr Petersen.

Medical Records delivery from the time of request reduced from 72 minutes to 48 minutes. The team is led by Mr Weeder.

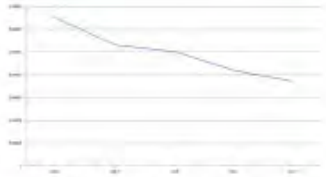


Turnaround time for inpatient scripts improved from more than 2 hours to less than 60 mins. Team led by Mrs Naicker.

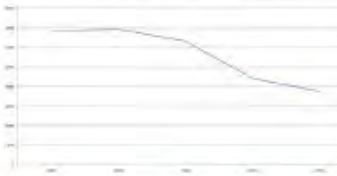
GSH GOES GREEN

As part of our green initiatives, we have reduced coal, water and electricity usage as well as improved waste management. GSH won 3 prizes for this at the CPSI awards ceremony.

Water consumption



Coal consumption



Starting time in theatre at 08h00 improved from less than 30% up to 60%. This is a massive 50% improvement and has increased further to 80% at present.

Dr Agata Krajewski won first prize for this presentation at the Anaesthetics conference in Arizona, USA.

LET US ALL COMMIT TO BEING PROUDLY GSH

A wellness area was opened on the E floor for staff to relax in a calm environment away from their pressured work place. This area is the first of other similar spaces to be provided in the hospital for the staff.

Figure 108: "The Grotto" - a staff relaxation area

The hospital was buzzing with planning efforts towards celebrating the 50th anniversary of the world's first human to human heart transplant at Groote Schuur Hospital on 3 December 1967 as well as the 80th anniversary of the hospital on 31 January 2018. The Groote Schuur Hospital Facilities Board appointed Professor Marion Jacobs as the official fundraiser to use these milestone events as an opportunity to increase the revenue to the hospital to fund much needed items of equipment and projects to improve patient care. Additionally, a marketing company was contracted to assist in providing support to increase the profile of the hospital by developing a marketing and fundraising strategy. The Cardiothoracic Department planned an academic symposium with a host of renowned international speakers to commemorate the event; the hospital staff involvement was linked to an event to celebrate donors and recipients of all organ transplants as well as having a television and radio broadcast streaming live from the hospital; an interactive exhibit area and an air force display.

There is indeed so much more that we can do and much to look forward to in order to continue to make Groote Schuur Hospital an outstanding beacon of ongoing excellence in clinical service, teaching, training and research for the next 80 years and beyond.

Celebrating the 50th anniversary of the world's first human to human heart transplant.

Unveiling of the re-gift of a candle sculpture from the Strangeboat Foundation

Plaque noting the symbolism of the sculpture as representing a light for the humanity of all donors and the medical and nursing staff involved in transplant work

An air display forming a heart to commemorate the event

Heart shaped cake for the event

A 3-d model of a heart on display

Transplant recipients and donors attending the event

Exhibition on the life and work of Professor Chris Barnard

1. Department of Medicine (Professor Ntobeko Ntusi)

The Department of Medicine is the largest Department at Groote Schuur Hospital (GSH) and in the Faculty of Health Sciences at UCT, and has consistently been a leading Department of Medicine on the continent for the past century. It consists of 19 clinical divisions and 12 research units. Academic staff members include 30 Professors/Associate Professors; 52 Lecturers/Senior Lecturers; and 61 Specialists/Sub-Specialists. The Department provides all levels of medical education including undergraduate training in medicine and allied health sciences, registrar and senior registrar training, biomedical graduate education, and continuing medical education. The Department's strategy for growth in research has been premised on encouraging staff members to apply for research grants and for rating by the National Research Foundation; the development of a clinical research training programmeme; and the establishment of a clinical research support unit. These concerted efforts have been matched by a rising performance in research outputs, from about 100 publications per year in 2005 to over 500 in 2016. Each month, over 38,000 outpatients are seen in the Department. Consultation and inpatient services are provided in Allergology, Cardiology, Clinical Haematology, Clinical Immunology, Dermatology, Endocrinology, Gastroenterology, General Internal Medicine, Geriatric Medicine, Hepatology, Human Genetics, Nephrology, Neurology, Occupational Health, Respiratory Medicine, and Rheumatology. The Department has strong links with a number of secondary hospitals (George, New Somerset, Mitchells Plain, Victoria, and 2 Military).

The first Professor of Medicine and Head, Prof. A.W. 'Oubaas' Falconer, arrived from Aberdeen, Scotland, in February 1920 to establish what was then known as the Division of Medicine at the new University of Cape Town Medical School, based at Somerset Hospital. In 1938, GSH opened, at which time Falconer retired and was succeeded by Profs Jack Brock and Frank Forman who were the joint heads of the Department from 1938 to 1954. As student numbers increased, the emphasis of the Department was on clinical teaching. The legendary combination of Brock and Forman served the Department well: while Forman was inspiring generations of medical students in the finest traditions of clinical medicine, Brock began to lay strong foundations for medical research. In 1954, Professor Brock assumed the sole Headship of the Department, and during his term, from 1954 to 1970, the Department expanded through the establishment of specialist Divisions and clinics and the escalation of the research effort. This period of expansion arguably represents the golden era of the Department. The establishment of specialist clinics, like the Cardiac Clinic in 1951, made it possible for great achievements such as the first human heart transplant to occur. Brock was succeeded by Prof. Stuart Saunders in 1971 as the fourth Head of the Department. Saunders steered the Department successfully through a period of changing fortunes and political unrest, which had a significant impact on the life and work of the Department, resulting in the first major exodus of highly qualified staff in 1977 and 1978, following the 1976 uprisings of school children against Bantu education. The chronic problem of healthcare budget cuts and the flight of staff into the private sector and overseas continued in the era of Prof. Solomon Benatar, from 1981 to 1999. Professor Benatar stabilised the Department in the midst of an increasingly hostile environment, and handed over to Prof. Ralph Kirsch in 1999 a Department that was sound. Prof. Bongani Mayosi was appointed Head in 2006, a role he played with distinction until 2016. During his tenure, the Department's scholarly outputs grew exponentially and the reputation of the Department as a center of clinical, educational and academic excellence was well established. The Department I inherited in 2016 is in a great state of health, brimming with talent, enthusiasm and diversity. The Department is undoubtedly the finest Department of Medicine in Africa, a tribute to the vision of my predecessors.

The Department has provided many firsts in the public sector in South Africa and the continent.

The Division of Neurology

When GSH opened in 1938, the care of patients with neurological and psychiatric disorders was in a combined Department of Psychological Medicine, headed by Dr F. Kooy, the first trained neuro-psychiatrist in Cape Town, who had trained in Holland and had been appointed to this post in 1925 at Somerset Hospital. With the move to GSH, the department was soon renamed the Neurology and Psychiatry Department, and acquired its first beds in a dedicated ward. Dr Kooy worked hard to establish the department, and in 1949 opened the first EEG laboratory in the country. In 1951, the leadership passed to Dr Sam Berman, who, with his colleagues, continued to expand the two disciplines, culminating in 1962 with the Department being split into independent departments of Neurology and Psychiatry, with Berman as the first head of the Department of Neurology. His untimely death in 1963, was followed by Dr Jim MacGregor succeeding him for 15 years as the part-time acting head. Prof. Francis Ames succeeded to the headship in 1976. The clinical service and patient numbers continued to grow, but fortunately an increase in staff was able to absorb this, and still start a number of special clinics in addition to the existing general outpatients. Special clinics for epilepsy, multiple sclerosis, chronic intractable pain (together with the Anaesthetics Department) and Huntington's Chorea were started, and the clinical neurophysiology service was expanded to include electromyography and nerve conduction studies. Outreach visits began, both to the Eastern Cape and local hospitals, to see patients and teach. The clinical psychology service expanded to include hospital-wide referrals and student teaching. Prof. Ames showed her moral leadership when, with others, she successfully confronted the SA Medical and Dental Council over their handling of the doctors' role in the death of Steve Biko in 1977 while in police custody. In the interests of rationalisation, after 34 years of independence, Neurology was incorporated into the Department of Medicine in 1986. Dr D. Philcox became head in 1986, and continued to expand the services while consolidating the previous activities. Further special clinics were established: sleep disorders (1987) and intractable epilepsy (1986). Dr Philcox started the Divisional interest in myasthenia gravis. An epilepsy surgery programmeme was started, with long-term video-EEG monitoring of patients with intractable epilepsy to identify surgical candidates. The first temporal lobectomy for epilepsy in the country was done in 1988, with a successful outcome. In conjunction with neuro-surgery, a clinic to assess children with spasticity from cerebral palsy was started, and this led to the first selective dorsal rhizotomy in the country in 1989, with gratifying results in restoring the ability to walk. The introduction of botulinum toxin treatment enabled the starting in 1992 of a focal dystonia clinic to treat these disorders. In 1992, headship passed to Prof. Roland Eastman. Despite post reductions and financial constraints, the departmental services continued due to exceptional effort by all the staff. A neurogenetics clinic was started in 1992 in conjunction with Genetics, unique among public hospitals, seeing a wide range of conditions, and providing an expert predictive testing and counseling service. The large number of new patient referrals was successfully dealt with by starting, in 1998, a fast-track service to see patients triaged to this stream. In 2001, an acute stroke unit was opened, the first in the country, offering a new approach to stroke with rapid assessment, thrombolysis therapy, early active rehabilitation and a true multi-disciplinary approach. The management protocols were soon in demand in the private sector and other public hospitals, and stroke care courses for staff from other centres were initiated. The first dedicated myasthenia clinic on the continent was started in 1996 and is now a national referral centre for the disorder, and has a strong research component both nationally and internationally, which has greatly improved the outcomes of this disorder. In 2010, Prof. Alan Bryer assumed the headship, which continues to date. The stroke unit has acted as a model for the accreditation of stroke units elsewhere in the country, and remains unique in a public hospital. Similarly, the neuro-genetics and myasthenia clinics continue to offer a unique service in the country.

The Division of Geriatrics

The Division of Geriatric Medicine at Groote Schuur Hospital is one of only a handful of academic geriatric medicine units in South Africa and is the oldest. It was started in 1981 and was headed originally by Prof. P. De V Meiring, the first William Slater Chair of Geriatric Medicine at the UCT. Subsequent Heads of the Division have included Prof. Steve Louw, Prof. Adrian Wilson and Prof. Sebastiana Kalula. Professor Marc Combrinck is the current Chair. Geriatric Medicine operates a new patient geriatric medicine clinic, a follow-up clinic, as well as a Memory Clinic service, each on one day of the week. The Memory Clinic is run jointly with the Department of Psychiatry (Division of Old Age/Neuro-psychiatry) and the Neuropsychology Unit of the Department of Psychology. The Division of Geriatric Medicine also contributes to the running of the Stroke Unit of GSH with the Division of Neurology. The Division of Geriatric Medicine is closely allied to the University of Cape Town's Albertina and Walter Sisulu Institute of Ageing in Africa (IAA).

The Division of Clinical Pharmacology

Clinical Pharmacology services at GSH were established in 1976 with the opening of therapeutic drug monitoring laboratory, which offers a battery of drug assays, complemented by specialist drug and toxicology assays, for individualised patient care. Prof. Peter Folb was the first Head of Department before Pharmacology was incorporated into the Department of Medicine. He was succeeded by Prof. Gary Maartens, who is the current Head. The Division provides a clinical consulting service on all aspects of therapeutics to the GSH drainage region and has spearheaded the recognition of Clinical Pharmacology as a specialty: until 2014 we were the only centre in South Africa training Clinical Pharmacology registrars. The Division plays a major role in hospital, provincial, and national drug policy. Our Medicines Information Centre, established in 1980, offers telephonic advice to healthcare workers, houses the national TB/HIV hotline, and is a WHO collaborating centre. The Division is committed to rational, cost effective drug use in our practice and teaching and has produced the South African Medicines Formulary, now in its 12th edition, since 1988. Finally, our research has made important contributions to national and international guidelines on the treatment of the three major infectious diseases in Africa: malaria, tuberculosis, and HIV.

The Division of Cardiology

Founded in 1951 by Prof. Velva Schrire and Dr Maurice Nellen, the Cardiac Clinic was the first subspecialty clinic in the Department of Medicine and first dedicated Division of Cardiology in the country. The first two decades under Schrire were characterised by the establishment of the Cardiac Clinic as a leading pioneering unit comparable to the best in the world. A lot of important "firsts" in the country were achieved over that time. Cardiac catheterisation was first performed at GSH in 1953 while the first dedicated modern catheterisation lab in South Africa was established here in 1957. 5 years later (1962) the first permanent pacemaker in an adult was inserted followed 6 years later (1968) by the first pacemaker in a child (an 11-month-old baby with congenital complete heart block.) The recipient of the first heart transplant, Louis Washkansky, had his cardiac diagnosis and suitability for transplant confirmed in the clinic prior to being referred to Prof. Christiaan Barnard in Dec 1967. Following his premature death in 1972, Prof. Schrire was replaced by Prof. Walter Beck, who was appointed Head until 1986. These years saw the consolidation of the gains that were made under Schrire and witnessed the training of a large cohort of cardiologists who have gone on to become key opinion leaders in the field both locally and globally. The country's first percutaneous angioplasty, and the first radiofrequency ablations were all performed during this time ushering a new era of interventional and electrophysiological therapy in the country. Prof. Patrick Commerford took over as Head in 1987 until he retired in 2012. Despite the political instability of his this era, the introduction of widespread austerity measures, and a significant flight of skills and staff, the clinic was able to continue to live up to its status as a premier cardiac unit. Amongst its many important achievements was its major contributions to a number of "breakthrough" trials which led to significant advances in the management of patients with heart failure and acute coronary syndromes. In 2013, Prof. Mpiko Ntsekhe

led the Division, ushering in the expansion of the clinical training platform to allow greater throughput of high quality trainees; an increase in patient access to tertiary and quaternary therapy; and a realignment of the research focus to include more interdisciplinary local investigator initiated and investigator led studies while continuing participation in large international studies. The Cardiac Clinic has taken special pride in having led the way within the Department as a model of being able to achieve racial and gender transformation while improving and increasing the quality of clinical training, service and research outputs. Allied to the Division is the Hatter Institute for Cardiovascular Research in Africa.

The Division of Nephrology and Hypertension

The Hypertension Clinic was founded by Dr Maurice Nellen, one of the original members of the Cardiac Clinic, in 1960. In 1968 Prof. Willem Lubbe together with Prof. Coenie Marais, father of Prof David Marais, further developed the clinic. However, in 1978 Prof. Lubbe left for New Zealand. Prof. Lionel Opie ran the clinic until 1998 when Prof. Brian Rayner took over the reins. Prof. Lennox Eales stimulated initial interest in renal medicine at Groote Schuur Hospital. Owing to his interest in porphyria, the renal/porphyria laboratory was a prominent feature and supported the clinical service as well as much of the early research. Dr Geoff Thatcher (1972-1976) carried this work forward, and stimulus for the early development of the Groote Schuur Renal Unit was provided by an active transplant and dialysis service. His successors were Dr Martin Gregory (1977-1979), Prof. Roal van Zyl Smit (1979-1998), Dr Michael Pascoe (1999-2008), and Prof Brian Rayner (2008-present). Prof Rayner combined the Renal and Hypertension Clinics under one Division of Nephrology and Hypertension. Since the small beginnings in the J block of GSH there has been a major growth in patient services. Currently there are over 150 patients receiving regular chronic dialysis, nearly 500 patients with functioning kidney transplants, an extremely busy acute dialysis and general nephrology services, and a tertiary level hypertension clinic. In recent times a HIV and adolescent clinic have been established. The Division has seen massive changes in clinical service due to the consequences of the HIV epidemic resulting in an increased burden of both acute and chronic clinical services. As a result of the expansion in services the Renal Unit will undergo a major refurbishment to accommodate increases in staff and services. It is important to note that initially the general surgical service performed renal transplants, and this included a single kidney transplant carried out by Prof. Christiaan Barnard. Dr Jacobson ran the transplant unit until the early 1990s when Prof. Del Kahn returned from the USA after completing his training as a transplant surgeon, and started a liver transplant programmeme in addition to kidneys. Prof. Elmi Muller in 2016 took over the running of this unit, and is doing pioneering work in HIV positive-to-positive kidney transplantation.

The Division of Haematology

Haematology at UCT and GSH has had a complex orgaisational structure. Established in 1972, and initially led by Prof. Peter Jacobs, the Department of Haematology consisted of a clinical programmeme and a diagnostic section. Prof. Jacobs was succeeded by Prof. Nicolas Novitzky and the clinical services of the Division were organised under the umbrella of the Department of Medicine, while the laboratory diagnostic sections were under the broader organisation of the Department of Pathology and National Health Laboratory Service (NHLS). The Clinical Haematology Division consists of a busy outpatient clinic located in E5 and patients are treated in specialized focused clinics. These clinics include the Groote Schuur Comprehensive Haemophilia, Lymphoma, Multiple Myeloma, Myeloproliferative and Genetic Anaemia dedicated clinics. The clinical programme includes the only publicly funded hematopoietic stem cell transplantation programme in the country and patients are referred from all corners of South Africa for this modality. Although autologous and allogeneic stem cell transplants were performed since the late 1980s as experimental programmes, we have seen the transformation of what was a relatively low volume research tool for selected individuals into a routine therapeutic procedure. A dedicated unit with isolation facilities and intensive care equipment in F4 has allowed the expansion of this programme at GSH, another first in South Africa. T-cell depletion of the host or of the graft are effective strategies in preventing this immunological phenomenon. Our outcomes in patients undergoing allogeneic stem cell

transplantation and those with Aplastic Anaemia have compared favourably to those published in international literature. More recently a haploidentical (mismatched) transplant has also been developed which is particularly relevant for countries where matched unrelated donors are not available.

The Division of Hepatology

The Liver Unit at GSH, which was started by Prof. Stuart Saunders in the 1960s has grown enormously and now comprises the Liver, Porphyria and Liver Transplant clinics as well as having dedicated Liver inpatient beds. The subsequent Heads of the Division included Prof. Ralph Kirsch and Prof. Wendy Spearman, the current Head. The Division provides a full-time telephonic consulting service on the management of acute and chronic liver disease and a weekly clinico-pathological review of liver biopsies from the state and private sector from all provinces. Presently, we follow-up 3000 liver patients, 100 Porphyria patients and 250 liver transplant patients and see over 350 new patients annually. The Liver Unit provides a unique service in the Western Cape, as it is a dedicated liver service for the assessment and clinical management of patients with acute and chronic liver disease and the need for liver transplantation. We also run the only active Porphyria service on the African continent with combined diagnostic, therapeutic and research components. Prof. Pete Meissner and his team together with colleagues from the USA and Wales were responsible for discovering the R59W gene defect responsible for variegate porphyria in South Africa.

Division of Lipidology

The Lipid clinic at GSH was first started in the late 1950s due to some members of the Cardiac Clinic, especially Prof. Brock, having an interest in nutrition and medicine. In the late 1960s the clinic involved Dr S Truswell, while in the 1970s it was Prof. George Watermeyer who provided the clinical lead. Both Dr Truswell and Prof Watermeyer were members of the Department of Medicine at GSH. The Provincial Administration of the Western Cape provided funding for a lipid laboratory to be started. In the 1980s Prof. Mike Berger from the Department of Chemical Pathology developed an interest in Lipidology. He established a laboratory within Chemical Pathology at Red Cross Hospital and took up leadership of the clinic. In the early years of the clinic, all patients were seen at Red Cross Hospital, even if they were adults. Prof. Mike Berger took up a position in Durban 1990 and Prof. David Marias took over the running of the clinic and laboratory. Support for the laboratory from the Provincial Administration was minimal after 1990 and the laboratory was mainly developed and run on proceeds raised from clinical drug trials. Under the leadership of Prof. David Marais, the laboratory was initially located in the Old Main Building of GSH and subsequently moved to the Chris Barnard Building in 1997. Prof. Marais took over the running of the Division of Chemical Pathology in 2011 and the laboratory moved to the sixth floor of the Falmouth building, where it is currently still located. Following Prof Marais's move to Chemical Pathology, Prof. Dirk Blom became head of the Lipid Clinic. Currently the Division of Lipidology provides clinical services mainly on an outpatient basis but does also offer a consultation service for inpatients with severe disorders of lipoprotein metabolism. Additionally, the Division of Lipidology is engaged in clinical research including research on novel lipid-lowering and anti-atherosclerotic agents. The division also provides an ultrasonographic service for the determination of carotid intima media thickness. The Division is actively involved in developing local guidelines and policies. The Lipid Laboratory provides specialised investigations for dyslipidaemia that are generally not available elsewhere in the country. Routine investigations include determination of lipoprotein particle size by non-denaturing gradient gel electrophoresis, ultracentrifugation and analysis of VLDL composition for the diagnosis of dysbetalipoproteinaemia and genotyping to detect mutations in the LDL-receptor, apolipoproteinE and lipoprotein lipase. More specialised investigations such as measurement of 7-dehydrocholesterol for the diagnosis of Smith-Lemli-Opitz syndrome, measurement of plant sterols for the diagnosis of sitosterolaemia, cell culture and analysis of other genes are performed as required. The laboratory has recently acquired novel equipment (HPLC with time of flight mass spectroscopy and Direct Analysis in Real Time) that will expand its diagnostic capabilities considerably.

The Division of Infectious Diseases and HIV Medicine

Was founded on 17th April 2007, headed by Prof. Marc Mendelson, who is still the current head. It started life as a single consultant-led service with a single senior registrar. Today, the Division has 3 full time Infectious Diseases specialists, a variable number of sub-specialist trainees and rotating medical registrars. In the past 10 years, the Division has trained 11 Infectious Diseases sub-specialists, ten of whom are in South Africa's public health service. The Division provides a clinical infectious diseases service to GSH, and performs weekly outreach and support rounds to New Somerset, Victoria, Mitchells Plain, Brooklyn Chest, DP Marais, Mowbray Maternity, and False Bay hospitals. We run an integrated infection service with NHLS Microbiology and Virology laboratories. The Division is a national training centre for Antibiotic Stewardship and the first African site in the GeoSentinel Travel Surveillance Network, playing an important role in sentinel surveillance of travellers and migrant populations. Allied to the Division are the independent research units of the Desmond Tutu HIV Centre, and the Centre for Infectious Diseases Research Initiative.

Other Divisions within the Department of Medicine include Allergology and Immunology, Dermatology, Endocrinology, Gastroenterology, General Medicine, Human Genetics, Occupational Health, Respiratory Medicine, and Rheumatology.

2. Department of Surgery (Professor Graham Fieggan)

The early practice of surgery in the Cape is described in detail by Professor Jannie Louw in his epic In the Shadow of Table Mountain, with the arrival of the remarkable Professor Charles Saint on 01 March 1920 marking the birth of surgery as an academic discipline. Considered one of the finest ever graduates of his medical school, his mentor Professor Rutherford Morrison described him as "one of the most, if not the most, distinguished student that has ever been in Newcastle." His emphasis at this nascent medical school was on teaching, with generations of early students benefitting from the "Saint method" which was based on the inculcation of principles, many of which were captured in his book An Introduction to Surgery (still in circulation when I was a clinical student in the 1980s!

Naturally the early years of surgery were spent at Somerset Hospital, and Professor Saint led the establishment of the new department at Groote Schuur Hospital in 1938 where he established a busy service with considerable input from part-time members of staff from private practice - a tradition which has remained a feature of surgery at GSH.

The war years presented a particular staffing challenging with many surgeons enlisting but the service continued and Professor Saint retired in 1946 after 27 years of service which unquestionably set the department on the road to greatness.

The early "Division of Surgery" encompassed General Surgery and a number of nascent specialties, including Ophthalmology (with the first recognized specialist in the country, DJ Wood), Otolaryngology, Orthopaedic Surgery and Urology, with Neurosurgery, Plastic Surgery, Thoracic Surgery and later Cardiac Surgery emerging in the postwar years. No mention of this era is complete without the name of Tinus de Jong, a struggling artist newly arrived from Amsterdam who was paid 200 pounds to produce clinical paintings for teaching ENT and Ophthalmology- many of which are still in existence. Given his skill, and well-founded fame as an artist, this was a very good investment!

Saint was followed as Professor of Surgery and senior surgeon by Marcus Cole Rous who had the misfortune of promptly suffering a myocardial infarct but remained in the position for 2 years before resigning. Francie van Zijl was a temporary replacement- he was to go on to become the first Head of Department at the newly

established Stellenbosch University Medical School, and the University Council decided to alter the terms of the appointment of the Head of Surgery to a full-time post, the first of many Joint Appointments to be made with the Province. This close relationship between the University and the Provincial Department of Health has perhaps been the greatest strength of the academic health system.

JFP Erasmus was recruited from Johannesburg- a general surgeon with a special interest in Neurosurgery, he was hailed as a leading "physiologist-surgeon" of his era and today would be considered a surgeon-scientist of great distinction. He remained in the position until 1955 when he left to take up the headship of Neurosurgery at the University of Pretoria.

Erasmus was followed by Jannie Louw who is without doubt one of the great names in the history of South African medicine. Louw ran the Division until 1980, an era that saw tremendous growth in scientific surgery thanks to the JS Marais Surgical Research Laboratory, which enabled world-leading research in transplantation, as well as the emergence of a full range of surgical specialties. Apart from his own work in establishing Paediatric surgery, chairs were endowed in specialties such as Neurosurgery, Ophthalmology, Orthopaedics and Otolaryngology, all of which became independent departments within the broader Division of Surgery. Two epochal events of Louw's tenure were the opening of Red Cross War Memorial Children's Hospital 1956 and the crowning achievement of the first human heart transplant performed at Groote Schuur Hospital by Christiaan Barnard in 1967. The galaxy of outstanding surgeons from this era deserves a volume in its own right- there are simply too many to mention without doing someone the disservice of omission.

Louw was succeeded in 1981 by his protégé Professor John Terblanche, a hepto-biliary surgeon whose collaboration with Stuart Saunders in building the MRC Liver Research Unit enhanced the medical school's international reputation. Following Terblanche's retirement, Professor Delawir Kahn, a renowned transplant surgeon, was appointed to the Chair of General Surgery with the headship shared for the first 5 years, with David Dent taking over as Head of the broader Division of Surgery. Dent, who had made numerous contributions across the breadth of surgery and was an inspirational teacher, was faced with implementing the re-organization of the faculty, which entailed creating one Department of Surgery from many previously independent Departments, most of which by now had their own Chairs and well-established traditions.

Del Kahn succeeded Dent as Head of the newly reorganized Department in 2005 and the ensuing decade saw further strengthening of surgery, despite a period of major financial challenges and potentially divisive policies such as separating tertiary services from Level 2 services. An inspirational teacher, Kahn was a worthy recipient of UCT's Distinguished Teacher Award and nurtured the creation of the UCT Student Surgical Society, which continues to go from strength to strength and will doubtless produce the next generation of leaders of surgery at GSH.

2017 saw the installation of the first woman as Head of a Division when fellow transplant surgeon Elmi Muller succeeded Kahn in the Chair of General Surgery. Once again the headship was shared, with neurosurgeon Graham Fieggen appointed as the overall Head of the Department of Surgery. Given the tremendous strength of the department with world-class leadership in ever specialty, we look to build a modern progressive surgical enterprise, building on our rich traditions of clinical teaching, research and innovation. Key aspirations in the years ahead are to foster diversity through an active approach to transformation and establish our place in the global surgery arena.

Heads of Divisions

Chris Barnard Chair of Cardiothoracic Surgery - Peter Zilla

Professor and Head of Emergency Medicine - Lee Wallis

Professor and Head of General Surgery - Elmi Muller

Helen and Morris Mauerberger Chair of Neurosurgery - Graham Fieggen

Morris Mauerberger Chair of Ophthalmology - Colin Cook

Pieter Moll and Nuffield Chair of Orthopaedic Surgery - Robert Dunn

Leon Goldman Chair of Otolaryngology - Johan Fagan

Charles F.M. Saint Chair of Paediatric Surgery - Alp Numanoglu

Head, Division of Plastic and Reconstructive Surgery - Don Hudson

Head, Division of Urology - John Lazarus

Heads of the Department of Surgery

Charles F.M. Saint 1920-1946

Marcus Cole Rous 1947-1948

JFP Erasmus 1950-1955

Jan H Louw 1955-1980

John Terblanche 1981-1999

David Dent 2000-2004

Del Kahn 2005-2016

Graham Fieggen 2017-present

3. Division of Neurosurgery (Thembani Hina and Graham Fieggen)

Professor JC "Kay" De Villiers has written extensively about the origins of neurosurgery in Southern Africa, suggesting that this may have been the earliest form of surgery practised here, based on Drennan's anthropological description of skulls that had undergone procedures of some sort. During the colonial period, trephining was performed for head trauma by a number of local practitioners and during the Anglo-Boer War missile wounds were treated with quite sophisticated surgery. Remarkably, cerebral surgery was performed by a few courageous general surgeons who depended on clinical localisation to determine where to open the skull, with the first successful case being removal of a left frontal meningioma by Dr CC Elliott in 1906.

Neurosurgery emerged as a discipline thanks to the pioneering efforts of Macewen and Horsley in 19th century Britain and developed as a modern specialty under the leadership of Cushing and Dandy in the USA early in the 20th century. The next generation of leaders incuded Norman Dott in Edinburgh who played an important role in the genesis of neurosurgery in South Africa. The first neurosurgical unit in the country was established in Johannesburg by Rowland Krynauw who had studied in Edinburgh and Oxford and returned to South Africa in 1940. He is best known for pioneering the use of hemispherectomy for treating intractable epilepsy in children with infant hemiplegia, truly a groundbreaking innovation.

The first neurosurgeon in the Cape was Herman Lochner de Villiers Hammann, son of Johan Hamman, an ENT surgeon and the honorary German consul to the Cape. de Villiers Hammann matriculated from the Wynberg Boy's High School in 1929, obtained a BA degree from UCT and then proceeded to Munich, where he obtained his MD and proceeded to train in neurosurgery, returning in 1946 after spending time with Dott in Edinburgh. He commenced private practice in Cape Town and offered part-time services to GSH but met with resistance

from some who believed the surgical facilities were insufficient for this new specialty- perhaps exacerbated by his wartime German training. He was eventually appointed to the staff, first as a registrar in March 1948 then as honorary neurosurgeon in 1949.

View of the J block from the New Main Building

Frustrated by the unsatisfactory theatres he had to contend with, Hamman discovered an unused theatre in the GSH Nursing Home (the Private Block- now known as J Block). This was made available as a neurosurgical theatre on 15 August 1948 and was shared by neurosurgery and cardiac surgery until 1960, and neurosurgery continued to thrive in J Block until the opening of the New Main Building in 1988. It is indeed an exciting development that all the neuro disciplines will return to J Block to join Neurology, Psychiatry and Psychology, following the completion of the GSH Clinical Neurosciences Centre in 2019.

Hamman took on his first trainee in JP van Niekerk, who became the first graduate in neurosurgery at UCT when he obtained a ChM in 1956. JFP Erasmus, a trainee of Krynauw's, was appointed to the Chair of Surgery at GSH in 1950 and continued to do one neurosurgical operating session per week. 1952 saw the return of Alec Gonski, another South African pioneer trained by Dott, who was appointed as the first full-time neurosurgeon at GSH. He continued to serve as a part-time member of staff after starting private practice a year later, and played a major role in the development of neurosurgery at GSH. Following the Sharpeville massacre, Gonski left for Sydney, Australia where he developed an outstanding neurosurgical department.

Another significant milestone was the return in 1966 of UCT graduate Kay de Villiers from training with Wyllie McKissock at Atkinson Morley Hospital in London. Appointed as a full-time consultant, he succeeded Hamman as Head of Department in 1970 and became the first incumbent of the newly established Helen and Morris Mauerberger Chair of Neurosurgery in 1976. De Villiers made an enormous contribution to neurosurgery both here and abroad and is particularly remembered for popularising the trans-sphenoidal approach to pituitary tumours, and together with Daan De Klerk introduced microneurosurgery following training with Yasargil in Zurich.

No history of this period would be complete without mention of Peter Keet who commenced training as a registrar in 1952 and remained on staff until his untimely death in 1988. Other notable trainees of this era were Peter Rose-Innes (who became HoD at Tygerberg Hospital), Peter Le Roux, Paul Cluver, Freddie Kieck (who pioneered cerebrovascular surgery after a stint in Boston), Roger Melvill (who continues to make significant contributions to functional neurosurgery), Warwick Peacock and Jonathan Peter.

In 1980, following a year as a fellow in pediatric neurosurgery in Toronto, Peacock took up a consultant post at Red Cross War Memorial Children's Hospital where he established a world-class service. Best known for pioneering the use of selective dorsal rhizotomy for spasticity, he was succeded in 1985 by his close friend and former classmate Jonathan Peter, who followed Kay de Villiers as Chair of Neurosurgery in 1995.

Much-loved and universally admired, Jonathan Peter appreciated the importance of developing sub-specialty expertise which stimulated a remarkable period of growth. Notable achievements along the way were the development of the Cape Town Stereotactic Pointer by Graham Fieggen and Allan Taylor, in collaboration with Laurie Adams in Biomedical Engineering, the establishment of a world-class neurointervention unit by Taylor in 2003 and the emergence of an innovative skull base service in collaboration with ENT and Ophthalmology.

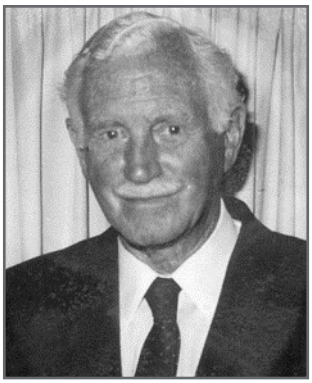
Current staffing includes Patrick Semple (pituitary and neurocritical care), Allan Taylor and David Le Feuvre (vascular and skull base), Sally Rothemeyer (oncology and functional), Crispin Thompson (spine) and a world-class paediatric neurosurgery service provided at RCWMCH by Tony Figaji, Llewellyn Padayachy, Nico Enslin and Ncedile Mankahla. Under the leadership of Graham Fieggen who followed Jonathan Peter as Chair in 2008, the Division has continued to embrace the challenges and opportunities of South Africa, with a commitment to transformation and strengthening neurosurgery in Africa, with trainees from Uganda, Zambia, Kenya, Libya and Nigeria.

4. Department of Orthopaedics (Professor Rob Dunn)

When GSH originally opened in the late 1930's, no provision was made for Orthopaedic surgery due to the dominance of General Surgery. Despite this, Orthopaedic surgeons Hamilton Bell and Pieter Roux established a fracture clinic in a converted kitchen in the basement and performed the surgery in casualty.

Once the Pieter Moll and Nuffield Chair of Orthopaedic surgery was established, Prof Lewer-Allan was the first incumbent in 1955. He had an interest in prosthetics, developing the Prosthetic limb, and wrote on modern strategies in scoliosis surgery. He ran the department for 21 years during a time that GSH provided a general Orthopaedic service consisting mostly of trauma, whilst the elective surgery took place at Princess Alice Orthopaedic Hospital in Retreat.

Drs JG du Toit, AD Keen and AB de V Minnaar were the first three Orthopaedic Registrars to train at GSH. Dr Keen obtained his ChM in 1944 and continued to work at GSH until he left to farm in the 1950's before moving to Windhoek to practise Orthopaedic Surgery.



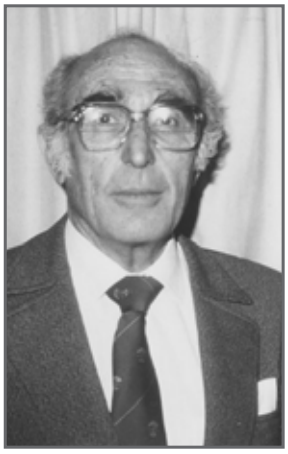
In 1974 he was asked to return to GSH to resuscitate the ailing Orthopaedic Department which he did with his work ethic, efficiency, and organisational skills. Ward rounds started at 06:45 where he saw every inpatient daily expecting the same from his junior staff. He revitalised theatres with patients asleep and ready for surgery by 08h00 – a pioneer of the current 8am start time initiative! His theatre lists ran between 14 and 18 cases a day with a massively positive impact on the huge orthopaedic surgical backlog. Dr Keen insisted that every outpatient be seen on the day that they arrived - clinics often ran until after 6 PM. He reorganised post- and undergraduate teaching. He was instrumental in persuading Professor George Dall to take the Chair of Orthopaedic surgery, not wanting it due to his aversion to administrative work.

Professor Lewer-Allan was succeeded by Prof Des Dall, Brookes Heywood, Sakkie Learmonth and Johan Walters. Their focus remained largely on Princess Alice Orthopaedic Hospital where rapid surgical developments were taking place in the realms of joint replacement and spinal surgery.

During this period GSH was largely trauma orientated with consultants sharing roles both in the Orthopaedic and Trauma Units. With all this trauma, a need for a dedicated Hand unit was identified. This was initially conceived by Orthopaedic Surgeons Dr's Kling, Jaffe, Heywood and Plastic Surgeon Engelbrecht in a document dated

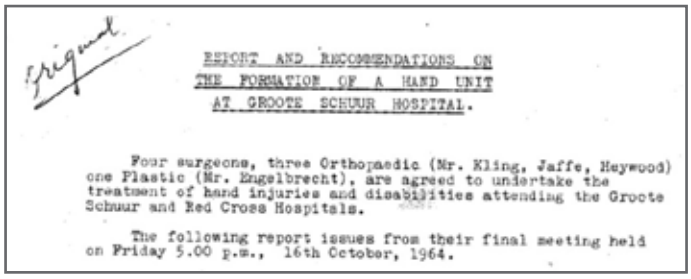
1964. It took the vision and drive of Martin Singer to realise this goal. After obtaining his MBChB at UCT in 1944, Dr Singer completed his orthopaedic training at the Royal National Orthopaedic Hospital in London. He returned to Cape Town in 1956 commencing private practice with public sessional involvement at the local hospitals – Princess Alice, Maitland Cottage and GSH. He was responsible for starting the Hand Unit in 1966, building this over the years into the multi-disciplinary practice with Plastic Surgery as it is today.

The GSH Hand Unit was the first in the country and today still bears his name. He worked in it from 1966 to 1998 with passion and referred to it as his "love affair with hands". This initiative was again difficult, starting behind a screen in the old trauma unit without even rudimentary equipment. He later invited plastic surgeons to be part of the team to realise his inherent visionary approach as a multidisciplinary speciality. Singer made it mandatory for all hand registrars to train in microvascular techniques in the small animal lab, operating on rats.



Under Singer's guidance, the hand clinic introduced a number of firsts: the first hand replants in South Africa and the first Brachial Plexus injury clinic.

Singer also had an influence on the management of lower limb trauma, introducing a cast bracing technique at GSH in 1981 to shorten hospital stay after femoral and tibial plateau fractures; a "hot box" therapy to manage hand patients in an atmosphere of dry heat to prevent spasms; and stockinette sleeve dressings enabling patients to move their hands straight after surgery.



Original

REPORT AND RECOMMENDATIONS ON
THE FORMATION OF A HAND UNIT
AT GROOTE SCHUUR HOSPITAL.

Four surgeons, three Orthopaedic (Mr. Kling, Jaffe, Heywood) one Plastic (Mr. Engelbrecht), are agreed to undertake the treatment of hand injuries and disabilities attending the Groote Schuur and Red Cross Hospitals.

The following report issues from their final meeting held on Friday 5.00 p.m., 16th October, 1964.

His vision of a dedicated internationally recognised high volume Hand Unit has been realised under the current leadership of A/Prof Michael Solomons, consulting 18881 outpatients and performing 1,710 surgeries per annum.

With the late 70's planning of the New Groote Schuur Hospital there was the usual bartering for beds against the powerful General Surgical Department under Prof Jannie Louw. Des Dall motivated for a minimum of 140 Orthopaedic GSH beds based on the rapidly increasing service demand. Despite initial agreement by Prof Louw to accommodate us, this did not come to pass and we were allocated 128 beds.

In the 90's Orthopaedics led the way in Surgery in terms of transformation with the two full time GSH consultants being Chris Maraspini and Gordon Siboto. Dr Maraspini was the first female Orthopaedic Surgeon to qualify at UCT and Dr Siboto the first black Orthopaedic consultant. They ran the GSH trauma service at a very difficult time of continuous cost cuts despite increasing workload. Dr Maraspini ensured every trainee obtained a complete trauma education. Dr Siboto developed the service at GF Jooste and subsequently Mitchell's Plain Hospital despite obstruction from the administrators. He developed the pelvic and acetabular reconstruction service for which GSH is locally and internationally recognised. This has been taken over by his mentee, A/Prof Sithombo Maqungo following Gordon's premature death.

In the 1990's there was increasing pressure by the province to rationalise services with the closure of Princess Alice Orthopaedic Hospital. Despite protestation by the Orthopaedic department, the result was inevitable with less and less support for our elective service. In 1998 PAOH closed and the service relocated to GSH with no additional beds – the service had to be absorbed by GSH with a few sessional staff and additional lists.

This was a tragedy for Orthopaedic Surgery and our patients due to the severe contraction of the service. Our 197 PAOH beds had been lost. Our 128 GSH beds were re-organised into 32 adult elective, 21 Paediatric and the rest in two trauma wards. The only way to protect the elective service and training was for trainees to operate on trauma at night – all night. Today "after midnight" remains the Orthopaedic registrar's preserve when the other disciplines tire and we gain access to theatre. Within a few years the paediatric ward was closed leaving 2 adolescent beds of the 21.

One of the strengths of the Orthopaedic Department has been the involvement of many highly skilled private practitioners participating as sessional staff despite poor remuneration. This has allowed our patients access to the best treatment and the trainees exposure to the highest level of skill training. With PAOH closing much of this was lost, but fortunately there was a loyal contingent that kept things going initially and then rebuilt.

Despite the massive reduction in beds, orthopaedics had dramatically changed, with more aggressive surgical intervention and post-operative mobilisation allowing shorter admissions. Lack of funding hampered growth however into the mid 2000's.

This lack of funding resources forced the closure of the Spinal Unit at Conradie Hospital in 2003, but provided an opportunity. Robert Dunn, the resident GSH spine surgeon at the time, realised that if well managed, this would bring additional resource to GSH. Despite some local resistance, a proposal was put together which the province had no choice but to accept, as there was no alternative offered. A 6 bedded High Care unit with 3 ventilated beds plus a 15 bedded acute care ward was established with 3 additional lists for spinal cord injured patients. With this came a principal specialist and MO post. This was the start of the rebuild at GSH. The province needed the management of acute spine injury patients to work well after the closure of the world-renowned Conradie Unit. So it did. The unit has gone from strength to strength with 180 admissions per annum and remains a regional asset. A second MO post was added. With Robert Dunn taking on the Head of department / Chair in 2012, the ASCI unit is now run by Nick Kruger.

The value of Orthopaedic Surgery has increasingly been realised by management, with an understanding that the care of the musculoskeletal patient is much more than merely fixing fractures. The GSH-based Princess Alice Adult Reconstructive Unit, as it is now known, is flourishing once again. The province now better understands the burden of disease and participates actively with additional arthroplasty lists. Local government has invested, together with the private sector, in arthroplasty waiting list reduction initiatives.

GSH is currently well recognised for its spine, upper limb, hip and knee arthroplasty and musculoskeletal oncology units, which attract patients from all over. This recognition is manifested by an increasing number of national and international visitors as well as supernumerary trainees. The private sector currently funds 5 full-time fellowship posts where junior consultants receive sub-speciality training, to their own benefit and that of our patients.

Under current leadership, the department has taken a much more local evidence based approach – asking hard questions on resource allocation for maximal benefit via appropriate audits and research. To this end the iQual initiative runs with projects by trainees assessing quality of care, management of waste, water, theatre time – all in an effort to stretch what we have further. Research has been consolidated under the Orthopaedic Research Unit, accredited by UCT and slowly drawing funding. Multiple locally appropriate themes such as Gunshot trauma, infection, HIV, osteoporosis,

are the envy of other units country-wide. A recent addition of MSc in Global surgery is attracting foreign students to come and research uniquely SA problems for SA solutions.

Currently the GSH Department of Orthopaedic Surgery is annually servicing 32 532 outpatients and performing 7428 surgeries. This represents a 20% p.a. increase over the last 5 years.

Despite this massive clinical load, our research output remains high and we have maintained a 100% pass rate amongst our candidates in the specialist exam for the last 10 years. For this, we thank our hard-working, committed staff and the support of the current hospital management.

5. Department of Obstetrics and Gynaecology (Professor Lynnette Denny)

The Faculty of Medicine of the University of Cape Town was initiated in 1912. It was the first Medical Faculty in South Africa and grew out of the expanding tertiary component of the South African College, which started as a high school, mainly for boys, in 1820. The discovery of gold and diamonds in the 1880s precipitated a need for mining skills and thus departments of geology and mineralogy were established. Along with these, science laboratories were built and Faculties of Medicine, Education and Engineering were established in the early 1900s.

Initially medical training was only in the basic sciences and students had to complete their clinical component overseas. In 1920 the first clinical professors were appointed, making it the first fully fledged Faculty of Medicine in sub-Saharan Africa. The first three clinical professors at UCT were Professor AW Falconer in Medicine, Professor CFM Saint in Surgery and Professor Eric Cuthbert Crichton in Obstetrics and Gynaecology. They had all trained in the United Kingdom.

Professor Crichton began campaigning early for better care of his patients and wrote to the Faculty Board soon after assuming the Headship of the Department, complaining of the inadequate accommodation for maternity patients of the poorer classes. Of the 23 beds at the Peninsula Maternity Hospital (PMH), only half were under his care. He asked for temporary accommodation for 20 patients in the grounds of the PMH at an estimated cost of £1 200.This set the tone for Crichton's leadership of integrity and humanity. He constantly sought to improve the lot of his patients and his students and is remembered for his enthusiasm in imparting his wide knowledge of the subject and his sense of obligation to the education of his students. In the 31 years of Cuthbert Crichton's headship, a number of changes in the medical and political arena occurred which were to impact on the practice of Obstetrics and Gynaecology.

World War 2 saw restrictions in resources and equipment. The introduction of penicillin in the 1950s had important implications for the treatment of puerperal sepsis, which was responsible for a very high maternal mortality rate. At about the same time, the election of 1948 made apartheid official, though racial segregation had been the norm since colonial times. This policy of apartheid had implications both for patients and for medical students and staff.

Cuthbert Crichton retired in 1951 and was succeeded by James T. Louw. While Crichton was primarily a teacher of obstetrics and was most at home in the labour or antenatal ward, James Louw excelled in gynaecological surgery. The availability of sulphonamides and later penicillin altered the morbidity of surgical procedures.

With gynaecological surgery becoming a safer option, this allowed for more procedures to be done and for techniques to be developed, and James Louw excelled at this. James Louw is credited with introducing cervical cytology into Cape Town. He forged strong relationships with colleagues internationally. Through his great enthusiasm and energy James Louw built up and consolidated the department which Crichton had established. However, he was never able to see the fruits of his labour. In January 1964, at the age of 50, he suffered a sudden and unexpected myocardial infarction and passed away.

For a year the Department was run by Dr Pat Massey, who kept things going despite her busy private practice, until Professor Dennis A. Davey became Head of Department in 1965.

Where Cuthbert Crichton had developed the practice of rigorous clinical teaching and James Louw had brought his superb surgical skills to bear, Dennis Davey instituted a culture of academia in the Department. Dennis Davey had visited the Department as a registrar, working with James Louw for a few months and was, in fact, on holiday in South Africa when James Louw died. He had started his illustrious academic career by completing a Ph.D on hypertension in pregnancy prior to specializing in Obstetrics and Gynaecology. This was the start of a lifelong interest in pre-eclampsia which persists to this day. Dennis Davey made many contributions to the discipline, speaking regularly at local and international conferences, publishing numerous articles and contributing four chapters to Dewhurst's Textbook of Obstetrics and Gynaecology, one of the most popular textbooks of Obstetrics and Gynaecology. He was a great supporter of evidence-based medicine and indeed Obstetrics and Gynaecology took the lead in this regard with the establishment of the Oxford database, later to become the Cochrane database, which analysed research studies on the basis of their clinical method and the soundness of the evidence.

Dennis Davey also supported the concept of sub-specialisation and, in his tenure, subspecialist Gynaecological Oncology was established under the leadership of Basil Bloch; the beginnings of Reproductive Medicine came to light with a dedicated Gynaecological Endocrine Clinic and a Menopause Clinic, established by Dennis Davey and Wulf Utian. Maternal and Fetal Medicine also developed. In 1970 the first ultrasound machine was introduced into the Department. In 1990, the South African Society for Ultrasound in Obstetrics and Gynaecology was started by Associate Professor Edward Coetzee.

An important development at the time was the formation of the Peninsula Maternity and Neonatal Services (PMNS) which was a unique concept at the time. The service was instituted by Professor Davey and Professor Malan (neonatologist) to improve care of pregnant women and their babies in the Western Cape. The PMNS was a structured pyramidal system whereby low risk women were delivered at Midwife Obstetric Units (MOUs), secondary care was provided by Somerset and Peninsula Maternity Hospitals and tertiary care by Groote Schuur Hospital. Professor Herman de Groot was appointed Associate Professor and Head of Community Obstetrics. He is recognized nationally and internationally for his contributions to the development of this integrated service. An essential part of the service was rapid transport of patients to a different level of care if needed. A Flying Squad was used for this purpose. In the 1960s, this consisted of a Land Rover with a registrar, midwife and two pints of O negative blood but progressed over time to a well-equipped ambulance with resuscitation equipment. Professor Sue Fawcus (current head of Mowbray Maternity Hospital, Prof De Groot and Mr S Isaacs) published a 50 year audit of maternal mortality (MMR) in the PMNS from 1953 – 2002. Total number of deliveries increased from 7315 in 1953 to 27 575 in 2002. The maternal mortality ratio declined from 301 deaths/ 100 000 deliveries in 1953 to 31.2 in the triennium of 1987 – 1989. Comparing 1954 – 56 (MMR of 253.9) with the triennium of 1981 – 1983 (MMR 43.8) there was a marked decline in the MMR related to hypertension (80.4 – 11.3), haemorrhage (50.8 – 4.2) and cardiac disease (21.2 – 2.8). However from 1000 there have been increases in MMR largely due to the HIV epidemic. The sharp decline in the MMR from 1953 to 1983 shows that decline in MMR is possible and reasons for this include:

- The development of domiciliary midwifery, later to be replaced by the MOUs (Maternity Obstetric Units)

- The introduction of a 'flying squad', a dedicated ambulance for obstetric and neonatal emergencies, which particularly contributed to the decline in deaths from haemorrhage
- The improvement in critical care management of the hypertensive disorders of pregnancy

Another innovative development was the creation of an Obstetric ICU. This was prompted both by the lack of beds in the general ICUs and a desire to provide continuity of care and improved expertise in the management of critically ill Obstetric patients. In 1989 this unit was created and was run by Associate Professor John Anthony with input from anaesthetists, including Dr Peter Uys who was then the dedicated Obstetric anaesthetist. This unit provided critical care to the level of ventilation and also generated a significant amount of research in this regard. Professor Anthony had an interest in the haemodynamics of pre-eclampsia and developed expertise in invasive Swan-Ganz monitoring. Associate Professor Basil Bloch ran the Department for three years during Professor Davey's tenure. Professor Davey retired in 1991 and was succeeded by Professor Boet Dommisse who retired at the end of his 5 year contract.

In 1997, Professor Zephne van der Spuy was appointed Head of Department. She was the first woman to head a Department of Obstetrics and Gynaecology in South Africa. Zephne trained at Stellenbosch University and then specialized in Obstetrics and Gynaecology at the University of Cape Town, obtaining the medal for being the top candidate in this examination. After completing her MRCOG she spent six years in London at St Mary's and the Middlesex Hospitals doing her Ph.D in Reproductive Medicine.

Professor van der Spuy is a highly respected and dedicated teacher, spending many hours coaching registrars in examination technique. She won the Distinguished Teacher Award in 2010 where she is quoted as saying that " the best care of a patient comes through teaching, because as you teach you review and criticize, and so your treatment of the patient improves," She was responsible for appointing a dedicated educationalist to the Department, Professor Athol Kent.

Changes in the health policy designed to improve women's health included the Choice of Termination of Pregnancy Act in 1997, the Confidential Enquiry into Maternal Mortality and the availability of free health care for pregnant women and children under the age of 6 years. During this period the devastating impact of the HIV epidemic was felt throughout the country and in all disciplines, particularly obstetrics with transmission of the virus to babies. It was particularly difficult to care for patients with this disease at that time when it was not acknowledged by the government and as a public health disease and anti-retroviral medication was not made available. However, the country now supports a well-developed programmeme for the prevention of mother to child transmission of HIV and the treatment of HIV as well as comorbidities such as Tuberculosis.

Professor van der Spuy retired at the end of 2012 as Head of Department, having stepped down as HOD in 2010, when Professor Lynette Denny took over. Professor Denny was formally appointed to the post in 2013. Professor Denny brings to this position her high impact, nationally and internationally, as a clinician, researcher, teacher and leader. Her major interest is Gynaecology Oncology and she has been researching alternative methods to cytology for the prevention of cervical cancer for the past 20 years, working out of second hand shipping containers! Her Deputy is Professor Silke Dyer, who is also Reproductive Medicine Specialist with extensive collaborations in Africa, particularly in researching the impact of infertility on the lives of women in LMIC. Professor Susan Fawcus is an expert on safe obstetric practice and mortality and is head of Mowbray Hospital and Associate Professor John Anthony is head of the Maternity Centre at GSH and is an expert in critical care of mothers, in particularly hypertensive and cardiac disease. Dr Greg Petro is the head of OandG at New Somerset Hospital and level 2 OandG in Metro West. GSH, MMH and NSH function as one unit, with the different divisional heads. Gynaecology consists of three firms each with a subspeciality and a general component: Howard Firm (Gynaecology Oncology), Olarogun Firm (Reproductive Medicine) and the Jeffery Firm (Urogynaecology). Additionally the Department has a separate gynaecology emergency unit (C24) and runs a paediatric clinic at Red Cross Hospital – Dr Nomonde Mbatani) and specialized family planning clinics (Dr Malika Patel).

6. Department of Radiation Medicine (Professor Steve Benningfield)

Drafted by Professor Steve Beningfield- with major acknowledgements to Emeritus Professor Ronnie Kottler for kindly allowing use of his history compilation.

6.1 Radiology

Since Wilhelm Roentgen's historic discovery of X-rays in the German town of Wurzburg on the 8th of November 1895, and followed by the Curies' work on radioactivity, there has been continuous re-shaping of the emerging clinical services. Radiation Oncology is highly dependent on radiation to manage tumours. Diagnostic Radiology started using the penetrating properties of X-rays to identify pathology, and Nuclear Medicine made diagnoses by employing chemicals attached to isotopes and both have also evolved to offer therapy by image-guided procedures in Radiology and therapeutic isotopes in Nuclear Medicine. Medical Physics is the theoretical and clinical basis of all three specialties, so close collaboration is vital.

When Groote Schuur Hospital first opened its doors in 1938, both the Diagnostic and the Therapy X-ray Departments shared the same space on the "B-Floor" of the Old Main Building as recounted in Professor of Surgery Jannie Louw's fine book 'In the Shadow of Table Mountain', published in 1968. The Diagnostic Radiology section started with only four X-ray and fluoroscopy examination rooms, but further satellite facilities were soon provided in the orthopaedic, urology, cardiovascular and neurosurgical departments. After WW II, several ex-service doctors joined the department as radiology trainees under acting-head Dr Leslie Werbeloff, but had to complete their training and qualifications overseas. Once qualified, few radiologists remained on the staff for any length of time. By 1950, Radiology had two full-time and a few part-time sessional radiologists. Professor Jack Jacobson, a previous trainee, became the first Chair of Radiology from 1956 to 1958. In 1960, the hospital had a total of 11 X-ray rooms and two mobile X-ray machines.

When Radiotherapy moved to the J-block, space was available for modernisation. Professor Philip Palmer, an enthusiastic radiologist, dynamic administrator and a great planner had been appointed as Head of Diagnostic Radiology in 1964. He planned the future X-ray facilities, as well as the new Out-Patients, with much new X-ray equipment suited to the increased clinical demand. Included were a complex-motion tomography unit, an angiography unit with the cassette exchanger, an articulated arm U/S, a seminar room with X-ray film alternator and slide projectors and, in the J-block, a neuroangiography unit and an air encephalogram unit with a chair capable of 360 degrees of somersault rotation. Unfortunately, with many satellite units situated at great distance from the main department, efficient staffing and teaching resource-pooling was not possible.

Although Palmer, a graduate from England, was at GSH for only four years, he made such an impact that some of his methods still operate today, instilling a strong measure of decorum and pride in the department. He created a special film library, recruited radiologists, improved training and was also involved in the X-rays of the first heart transplant patient. He went on to the Chair of Radiology at University of California, Davis and received widespread international recognition and honours, remaining very active until his death in 2012.

In 1967 Prof Bryan Cremin, a keen organiser and academic, was recruited by Palmer to head paediatric radiology at Red Cross Children's Hospital. Cremin was then appointed Professor and Chairman of the overall department in 1973, but in 1980 returned to Red Cross. He produced over 200 papers and five textbooks, and was elected Emeritus Professor at UCT in 1995. He died in 2012 after a long illness.

In 1975 there were 18 specialists and 18 registrars, the latter rotating through the Red Cross Children's and Somerset Hospitals. A maximum was soon reached, and in the last 20 years there has been a reduction to the current tally of 8 specialists and 17 registrars. So rapid was the development of Radiology that by 1980 the

department was responsible for 45 X-ray rooms of various types and purposes, as well as 22 mobile machines stationed throughout the hospital!

Prof Ronnie Kottler returned from private practice to the Somerset Hospital in 1968 and, in 1973, moved to GSH concentrating mainly on gastro-intestinal radiology and mammography, becoming overall Head in 1981. By 1987 the New GSH building was completed and all the radiological facilities, except those in OPD and Maternity Blocks, were moved to a modern department. The planning team headed by the insightful Professor Kottler and senior radiographers spent many, many hours over several years carefully designing the 56 X-ray areas to conform to radiation protection regulations. After retirement in 1992, Prof Kottler was elected Emeritus Professor at UCT and an Honorary Consultant of GSH and continued to work and teach in mammography and gastrointestinal radiology, before retiring completely in 2013.

Professor Steve Beningfield joined GSH in 1983 and was appointed Head in 1993, with interests in interventive and abdominal radiology, and was involved in the digitisation of the Division. The senior staff members are the mainstay of the department, supervising and teaching radiology, training registrars, and conducting regular meetings with clinical firms.

Radiology derived great benefits from World War II technology, with the first real electronic magic arriving in 1960 as an 'image-intensifier', vastly enhancing visibility of X-ray procedures. There was no longer any need to work in a blacked-out room to adapt to the dark by wearing the infamous radiologists' red goggles for 20 minutes beforehand.

The transistor expanded into new imaging equipment such as ultrasound, based on the "ASDIC ping" for sonar detection of submarines and other underwater objects. Amazingly rapid progress soon followed, with Professor Dennis Davey and Dr Dick Kukard of the Obstetrics and Gynaecology Department acquiring the first unit in Cape Town in 1968. Sophisticated ultrasound machines have since revolutionised radiology, cardiology, vascular surgery and other medical sectors.

A most remarkable application of the computer to diagnostic radiology took place with the development of 'Computerised Axial Tomography' ("CAT scanning", or more simply, "CT"). In 1963 Dr Alan Cormack, a nuclear physicist from UCT, was assisting Prof JM Grieve's GSH Radiotherapy Department investigate the characteristics of a rotating source of rays being passed through an object. Cormack created a model and worked out a complex mathematical formula as an algorithm applicable to circular tomography. He published his work in a relatively obscure journal and left it at that. Prof Kottler recalls Prof Grieve, knowing Prof Kottler's own interest in simple tomography, explaining how they were trying to research the principles of circular tomography, moving in a circle around the patient. Some years later, with the use of Cormack's work, CT was commercially developed by Godfrey Hounsfield and the EMI record company. In 1979, Hounsfield and Cormack were jointly awarded the Nobel Prize for Medicine. Cormack's work has been well encapsulated in the book entitled "Imagining the Elephant" by Emeritus Professor Kit Vaughan, past Head of Biomedical Engineering at UCT.

The first EMI CT scanner at GSH was installed probably 50 meters from the site of this Cormack's first incredible insight. Although needing a waterbag around the head, and taking many minutes to construct 80-by-80 matrix images, it was nonetheless revolutionary. Prof Kottler remembers having had a brain-scan on this machine for his tinnitus; and recalls Dr's Mike Wright and Ben Mervis chuckling behind the control panel, taking bets on whether they would find cerebral atrophy!

The first 'whole body CT scanner' was purchased by the Volks Hospital in 1977, with Groote Schuur Hospital receiving theirs in 1981. The amount of trauma coming to GSH had increased dramatically, leading to a dedicated spiral CT scanner being placed in the restricted space of the Trauma Unit in 2001. This CT scanner was funded by an appeal strongly supported by Pick 'n Pay, The Argus and Siemens. Today, CT is regularly performed

in all radiology practices and on all body parts, and is one of the most effective investigations to visualise any organ in the body. At present, there are 6 CT scanners in Groote Schuur Hospital. Of these, three are in the Radiology Division and one each in Radiotherapy, Nuclear Medicine and the UCT Private Academic Hospital. A further CT is planned for the combined Trauma and Emergency Units.

Derek Stables (1968-1971) had a special interest in urological radiology and was the first at this hospital to perform 'Interventional Radiology', involving mainly the kidneys and ureters. Alan Goldin (1970-1978) further developed interventional arteriographic techniques in which, amongst others, he occluded blood-vessels with catheter-delivered cyanoacrylate glue ('superglue') to control haemorrhage. This was years ahead of its regular use. Goldin's interest was followed by Phil Harries-Jones (1981-1988). Toronto-trained in vascular radiology, he introduced additional angiographic interventional techniques such as angioplasties i.e. catheter balloon dilatation of arteries narrowed by arteriosclerosis, nowadays regularly used by radiologists, cardiologists and vascular surgeons.

A large space had been set aside in the new GSH radiology division for a Magnetic Resonance Imaging (MRI) scanner. MRI uses a magnetic field and radio waves instead of X-rays, and is especially useful in the examination of the brain, spine, joints and other organs. In 1985 the Medical Research Council [MRC] seized the opportunity and purchased an MRI unit after securing an arrangement with the Cape Provincial Administration to scan all their patients for a set price. By 1995, the MRI facility at the MRC was closed and patients were then referred to private practices at negotiated rates. However, despite the severe budget constraints, in 2001 both Groote Schuur and Tygerberg Hospitals were fortunately provided with their own top quality MRI scanners and currently own updated modern 1.5T Siemens units. UCT also has a 3T research MRI on the GSH premises.

From the mid-1990's, Magdel Shackleton, Steve Beningfield, Peter Bautz, Andrew Nicol, Sebastian van As, Egbert Hering, Gillan Bowie and others were involved with the originator, Herman Potgieter (de Beers), in the design and development of a new type of full-body digital radiography system known as "LODOX" (LOw DOse X-rays), based on an X-ray system for detecting smuggled diamonds.

The conversion of the hospital to the Picture Archival and Communication System (PACS) in 2010 introduced this amazing facility for eliminating X-ray films by having digital radiographs online and on multiple screens! A Radiology Information System (RIS) was also installed, replacing paper-based bookings with a digital equivalent. There are clearly severe challenges and threats for the present and future. In the last 20 years, all the medical schools and hospitals have suffered from financial and staff shortages, many posts having been 'frozen' and abolished.

It is extremely expensive to equip and maintain radiology divisions, with most imaging equipment becoming obsolete in less than 10 years. The art of balancing costly equipment and staffing remains the challenge. The Division has been able to maintain service thanks to very loyal and dedicated staff, registrars, radiographers, nursing staff, porters and support staff.

6.2 Nuclear Medicine

The GSH Nuclear Medicine Division was started by the late Professor Eugene Dowdle (Medicine), and then further developed by Dr Basil Shepstone (1970-1979), a very capable medical doctor and nuclear physicist who also trained and obtained his qualification in Radiology whilst head of his division. He later became a Professor of Radiology at Oxford University and Warden of Wolfsohn College. The headship of the Nuclear Medicine Division then passed on to Dr James Smith, then Dr Bruce Adams and in 1980, Dr Abe Fataar, who continued working even after retirement, with major contributions over many years from Prof Mike Mann. Dr Tessa Kotze is currently the Head of Division since 2005 with interests in thyroid imaging and treatment.

The use of radio-active isotopes in medicine was a further direct benefit of WW II technology. As in most hospitals, their use for diagnostic purposes falls under the Nuclear Medicine Division. A radioactive substance is injected into the patient and the scan obtained permits analysis of physiology and function of internal organs, as opposed to only demonstrating straightforward anatomy. There is close collaboration with the Radiology Division, as the syllabi overlap and the radiology registrars are exposed to work in that division.

The standard gamma cameras have been replaced by Single Photon Emission CT (SPECT machines), and in 2012, a SPECT-CT scanner arrived, allowing sophisticated nuclear imaging attached to an excellent CT scanner, extending the reach of Cormack's discovery.

6.3 Medical Physics

Medical Physics provides the pivotal theoretical and practical basis to the 3 clinical divisions, and is instrumental in ensuring Quality Assurance and compliance in environments of high risk procedures and equipment.

The energetic Prof David Shackleton was followed by his spirited partner, Prof Magdel Shackleton, as Head of Division; sadly, both passed away at early stages of their careers. Prof Egbert Hering brought his skills in refreshing the division, followed by Jan Hough for twoyears before we saw the leadership and administrative talents arriving with Hester Burger's appointment.

6.4 Radiography

The production of images, administering isotopes, delivering therapy and the actual day-to-day running is performed by a team of highly-skilled and well-motivated radiographers. Some have been on the staff for over 30 years. Miss Kate Brock stands out as a stalwart from 1949-1967. Betty Davis was in control from 1967-1985, followed by June Westgate, until her untimely death in 1991. Barbara van Vuuren took over from 1991 to 2000 and sadly died in 2017. Following her as Assistant Director, Gillan Bowie (1968-) was always the one to be called upon for a problem or a special technique and she became the first designated Clinical Tutor of Radiography in Southern Africa. The current assistant director in charge is Ms Nazlea Behardien-Peters who brings her good humour and sense to the fore. Ms Liz Greef was followed by Ms Lindsay Jaftha in Radiation Oncology, while Ms Gaseeda Boltman and Mr John Boniaszczuk have shared headship in Nuclear Medicine for many years. Every service is only sustained thanks to teams of very capable senior and chief radiographers.

For many years in Radiology, Sister Emma Clarke (1971-1992) provided the driving force behind the radiology nursing, followed by Sister Kader, Sister Dorothy Magwaxaza and Sister Penny Williams.

Berry Neumann (1981) will be vividly remember as the UCT senior secretary, who died in 2010. Ms Lee Koegelenberg now keeps Radiology running while Nadia Mitchell looks after the Department. Leonard Arendse was the messenger for the radiology division for over 20 years. He was preceded by "Howard" Arendse, a very well-known man who walks along the corridors, always singing at top of his voice – nice songs, good voice!

6.5 UCT Private Academic Hospital

When the new GSH opened, there were several wards on the upper floors which could not be used because of lack of resources. This favoured the establishment of the UCT Medical Centre (later rebranded as "UCT Private Academic Hospital"), initially through the impetus of Prof Ulrich van Oppell (Cardiothoracic Surgery) and a German healthcare company, Rhon-Klinikum. The hospital is now part-owned and run by Netcare and UCT. There are a large number of specialists, including radiologists, who participate in the various specialties. This 125-bed hospital with theatres and ICU is on the floor above Radiology in GSH, and includes a reasonably equipped radiology department which is now run along a limited private practice model. A state of the art catheterisation lab is shared mainly with neurosurgery, cardiology, surgery and radiology.

Notable achievements:

1. CT Nobel Prize Alan Cormack
2. Radiology of first heart transplant
3. Early use of cyanoacrylate for embolisation
4. LODOX (Low Dose X-rays) Mr Herman Potgieter from DEBEX, de Beers. First contact with Magdel Shackleton, prototypes developed with Trauma Unit at GSH
5. Drs AS Johnstone (Professor of Radiology at Leeds University)
6. Dr Sarel Oosthuizen (Professor of Radiology at Pretoria University President SA Medical and Dental Council)
7. Dr JB Muller (Professor of Radiology at Stellenbosch University).
8. Emeritus Prof JP van Niekerk Dean of the Medical School (1978-1998), editor SA Medical Journal, SA Medical Association, Health Professions Council of SA, politics of medical education
9. Associate Professors Lennie Handler, Hillel Goodman, Sally Candy, Tracy Kilborn

7. Department of Radiation Oncology and Medical Physics (Professor Jeanette Parkes)

(Liz Greef, Clare Stannard, Bridget Wyrley-Birch, Penny Engel-Hills, Hester Burger and Jeannette Parkes)
Heads of department:
Professor Muir Greave 1940-1964
Professor Rossall Seally 1964- 1986
Professor Dudley Werner 1987- 2004
Professor Raymond Abratt 2005-2014
Professor Jeannette Parkes 2015- present

Radiotherapy was first designated as an entity separate to radiology in 1950. At this stage, the department was allocated to the J-block. Cancer multi-disciplinary clinics were introduced as early as 1948, but the main multi-disciplinary teams were started in the 1960's. In addition, the 1960's brought the advent of cobalt machines and chemotherapy treatment as well as expansion of Oncology services satellite departments in Port Elizabeth and East London. The science of radiobiology was established at GSH during this period.

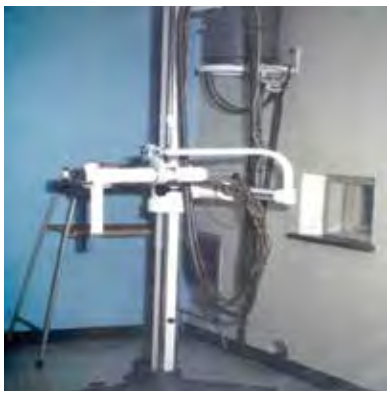


Figure: 100KvP used for skin work

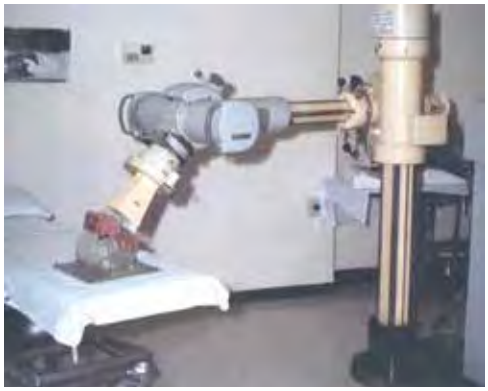


Figure: DXR 250 KvP in 1960's

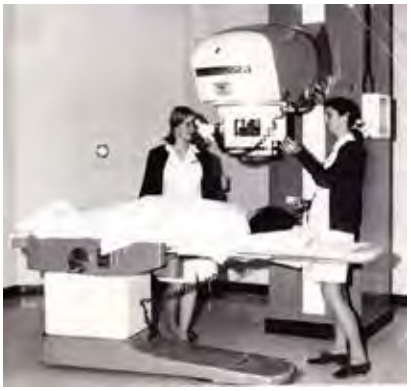


Figure: 1966 - New Cobalt-60 units

It was during this time, that the first heart transplant took place at GSH. From a radiation point of view, cobalt-based radiation therapy was used in an attempt to prevent rejection of the transplanted heart, and Mr Louis Washkansky was successfully transported in an oxygen tent and treated in the J-block. Treatment was done with a portable 1curie cobalt unit, specifically manufactured for this purpose by the Medical Physics and mouldroom staff.

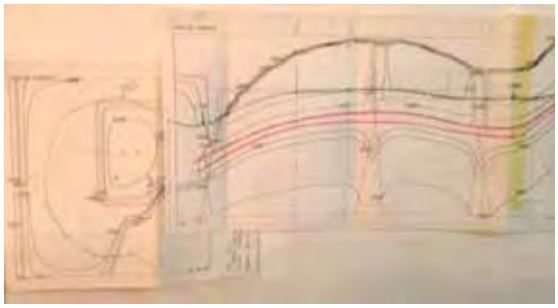
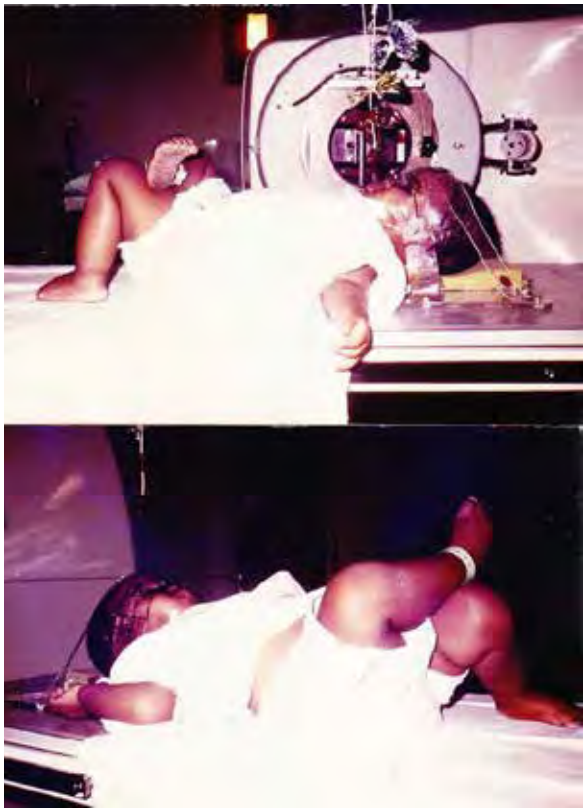
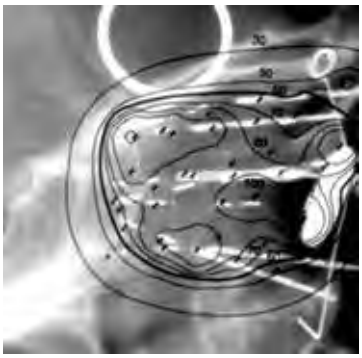


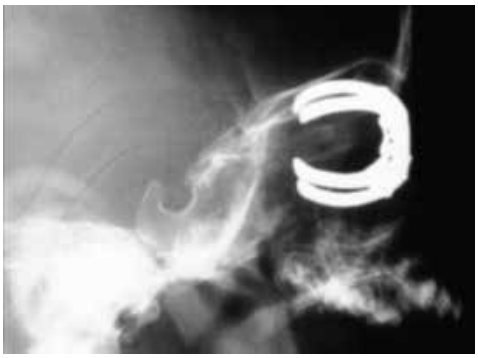
Figure: The TP-11 Planning System



Between the 1960's and 1977 all patient planning was done manually based on hand calculations. It was only in 1977 that first computer based treatment planning system was installed.

The 1970's saw the introduction of brachytherapy treatment to treat melanomas of the eye and retinoblastoma. This was a world first! Professor Sealy, followed by Professor Clare Stannard pioneered this work.





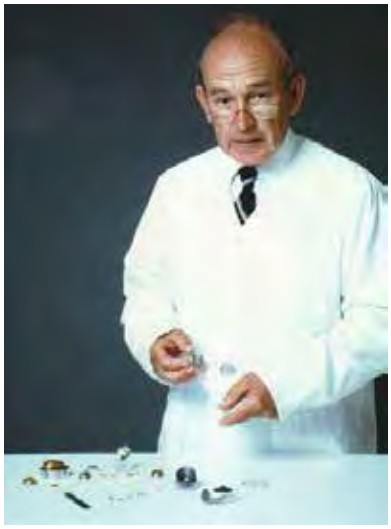


Figure: Professor Ross Sealy

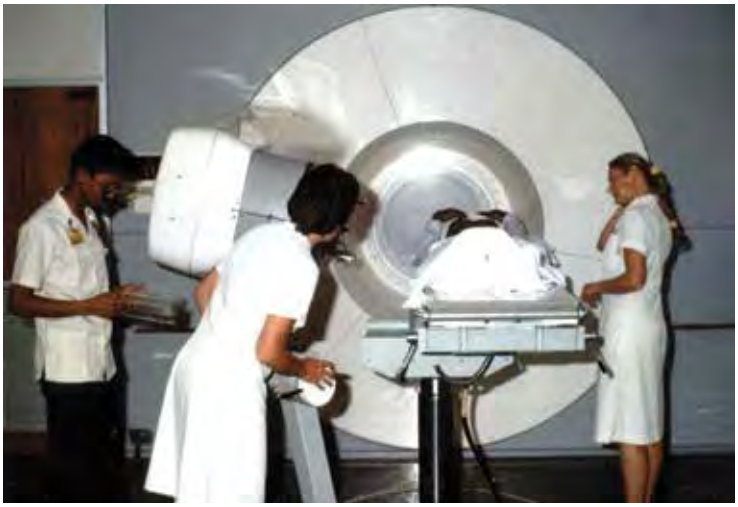
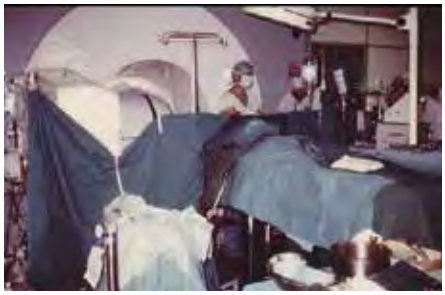


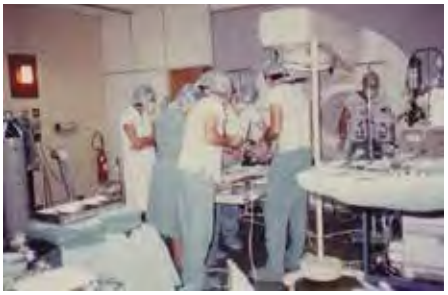
Figure: In 1979, the first Phillips SL75 Linear Accelerator (LINAC) was acquired at a cost of R455 000



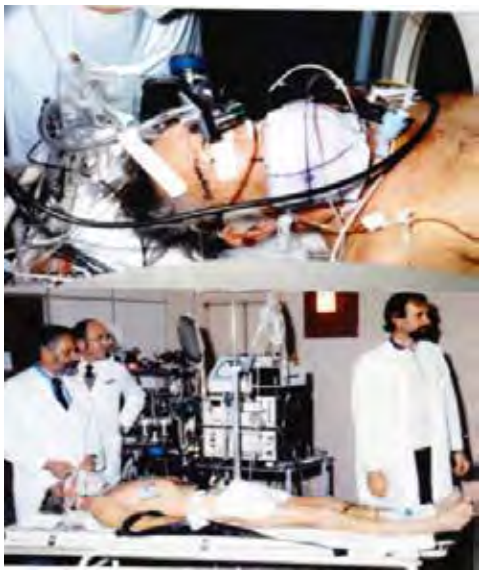
Then, with the expansion of the Oncology Unit, to include clinics, planning, a mouldroom and workshop, physics and a school of radiography, additional space was required. In 1986, the existing J-block was divided, and part of the building was expanded to what is now known as L-block.

During the 1980's radiotherapy was characterised by a period of clinical research with the use of deep hypothermia and hyperbaric treatment. This involved multiple departments including anaesthetics and cardiology and much anxiety!





The late 1980's and into the 1990's saw severe budget cuts at the large tertiary institutions, and at one stage an amalgamation between the Tygerberg Hospital and GSH Rad Onc departments was suggested. However, a petition launched in 1995, with over 11 000 signatures allowed the 2 existing academic departments to survive as individual entities. At this time, no funding was available for a simulator, and GSH saw tumour localisation through a customised image intensifier system, allowing visualisation of treatment fields.




It was during this period that the national Accelerator centre (NAC) was opened (now iThembaLABS). This centre opened under the department of Science and Technology and offered neutron and proton treatment to patients. The GSH staff were instrumental in both clinical work and research conducted there.

1 June 1995 Southern Suburbs Tatler

Groote Schuur Oncology department to move north?

CANCER patients who need radiation treatment may soon have to go to Tygerberg Hospital, unless serious notice is taken of a petition handed over to the local Minister of Health.

The Radiation Oncology Department at Groote Schuur Hospital has handed over a petition with 11 000 signatures to minister Ebrahim Rasool's office because of fears of rationalisation.

According to Liz Greeff, radiographer and driving force behind the campaign, the department was in danger of closing because of rationalisation at Tygerberg and Groote Schuur hospitals.

She said, however, that following investigations by doctors it was found that both departments would have to continue to operate in order to meet patient needs in the future.

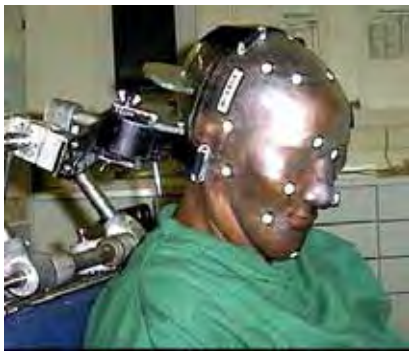
It was discovered that eight or nine treatment units were needed between the two hospitals. Each hospital currently had three.

"So in fact, we need to keep both departments and we actually need to expand in order to serve the public," said Ms Greeff.

"Three quarters of our patients do not have medical aid, so they have limited access to private treatment."

She said many patients came from the southern suburbs and Cape Flats and needed a hospital close to them.

"We have an internationally recognised department with plenty of expertise - our patients are the reason we're here."



In the late 1990's, under Professor Dudley Werner, a huge fund-raising appeal made the purchase of a new(refurbished) linear accelerator as well as a CT scanner, a brachytherapy afterloader and a planning system upgrade possible. Total public donations of nearly R9 million rand was added to the provincial budget of R3,7 million to allow major upgrades.

Right: The Table Mountain Lodge donated R8 000 to the oncology unit at Groote Schuur Hospital. The cheque was handed over at a dinner to mark the 50th anniversary of the formation of the lodge. Pictured here are (from left) the district grand master of the western division, Ray Carter, the master of the Table Mountain Lodge, Ed Chantler, and Professor Dudley Warner, the hospital's head of

Thanks for R3,5-m raised

Oncology staff express their gratitude

Sponsors honoured

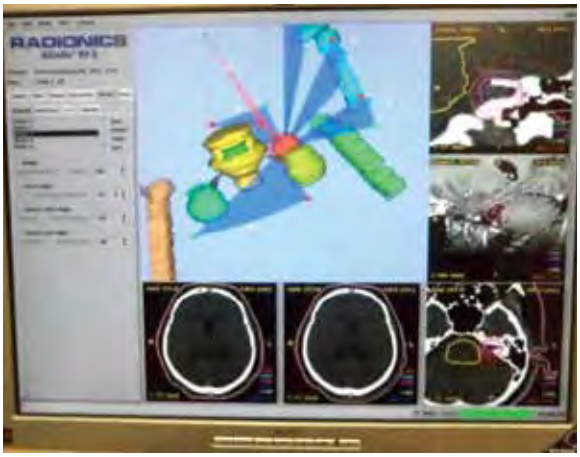
MANY SPONSORS FROM THE MOTHER CITY AND BEYOND, WHO WORKED TIRELESSLY TO MAKE THE CAPE ARGUS/GROOTE SCHUUR HOSPITAL CANCER APPEAL A SUCCESS, WERE ACKNOWLEDGED DURING A COCKTAIL FUNCTION HELD AT THE TEACHING HOSPITAL

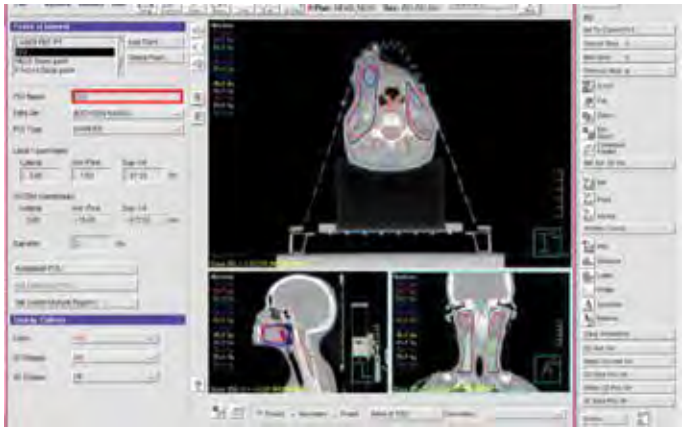
PROF DUDLEY WERNER, RADIOGRAPHER LIZ GREEFF AND TEACHING HOSPITALS BOARD CHAIRMAN ABDUL BARDAY

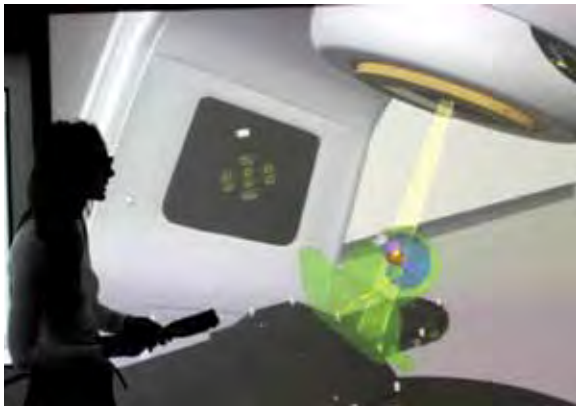
CAMPAIGN PATRON WENDY ACKERMAN, PRO PAT KOVARIK AND JOEY JAUCH OF THE TEACHING HOSPITALS BOARD

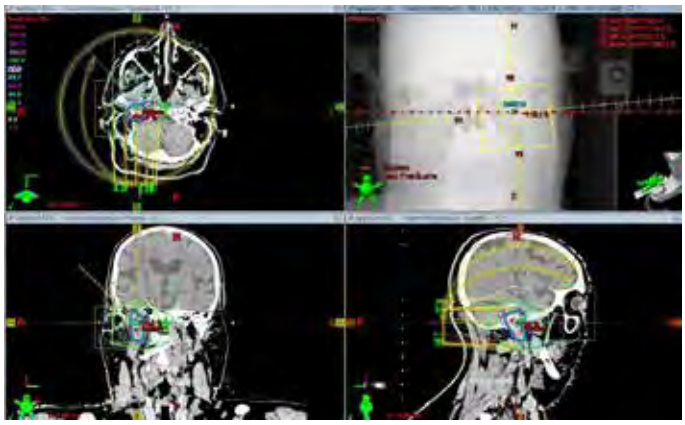
In 2003, a clinical audit done by the IAEA pronounced the GSH Oncology department as A1.

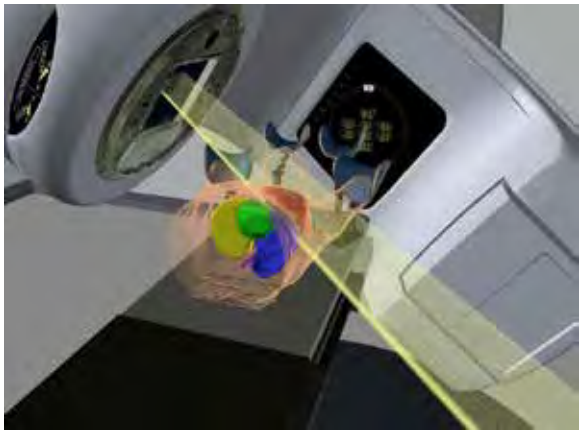
In 2005, Professor Raymond Abratt took over the helm. This time period heralded political change and a large investment in tertiary services. Digitalisation and integration of the entire Oncology platform was possible through massive capital and infrastructure development. Between 2007 and 2017, close to R100 million rand was made available by the national and provincial governments allowing the purchase of 3 additional linear accelerators, a new large bore CT scanner, and most critically, the ability to move from conventional 3-D conformal radiotherapy to embrace the most modern intensity modulated radiotherapy techniques. This allowed for patients to have more targeted treatments and experience fewer side effects. Funds were raised for a facility upgrade to improve the environment for all our cancer patients.







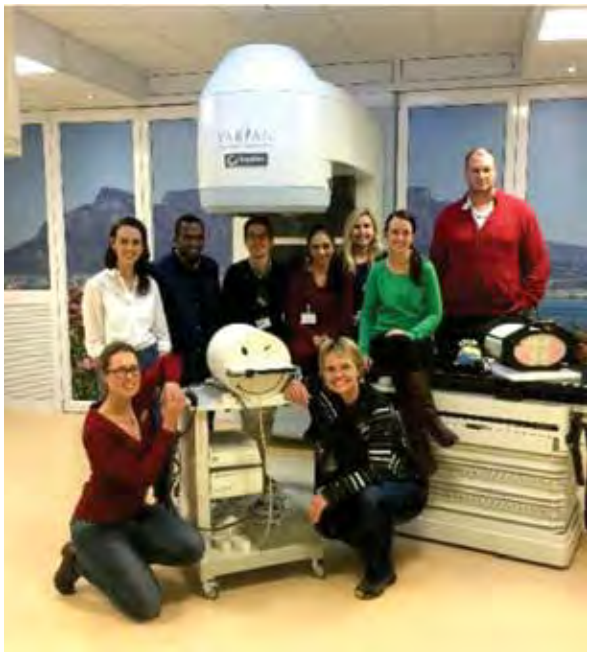




From 2010, the focus shifted to addressing long waiting lists of increasing numbers of patients, streamlining quality assurance programmes, introducing protocols, and updating curricula through the college of radiation oncology. In addition, the department entered into an agreement with a commercial company to provide radiotherapy training for teams from all over Africa. A computer planning laboratory linked to Switzerland, and a virtual linear accelerator(Vert) were part of the agreement; both a first in Africa.

In 2017, the department of Oncology at Groote Schuur Hospital has a permanent staff of 9 super-specialised consultants, with a registrar team of 8 local and 12 super-numerary registrars from other institutions in SA and beyond, 2 medical officers, 2 radiobiologists, a staff of 6 medical physicists, with an additional 9 medical physics support staff, 34 RTT's, 55 nurses, 3 social workers, 2 pharmacists, 2 research personnel, 19 clerks who work together in 24 multi-disciplinary teams with other departments, to supply radiotherapy, chemotherapy and general cancer support services to about 3000 new patients per year as well as to 36 000 follow up patients per year. We are able to offer image-guided radiosurgery and radiotherapy using the

most modern techniques, Paediatric radiotherapy, and brachytherapy. In addition, the department houses the largest teaching and training facility for radiotherapy in Sub-Saharan Africa and encourages multi-disciplinary research opportunities.



8. Department of Paediatrics and Neonatology (Professor Heather Zar)

Neonatology (Professor Michael Harrison)

The Groote Schuur Hospital Neonatal Unit in Cape Town.

Where we have come from and where we are going.

The neonatal unit in the Maternity Centre at Groote Schuur Hospital is one of two academic tertiary newborn care units in the Western Cape and it was the first tertiary hospital in South Africa to obtain "Baby Friendly" status from UNICEF and WHO.

Neonatal care at Groote Schuur Hospital has come a long way since the Maternity Block was opened in 1961. Initially, apart from a small bathroom-cum-nursery on each floor, no provision was made for ill newborn infants and sick infants had to be transferred to the children's ward at the main hospital.

In 1970 Prof. AF Malan was allocated to the full-time supervision of newborn infants in the Maternity Block. This led to the consolidation of the "bathrooms" and development of a high care area. Prof. H de V. Heese wrote a memorandum in 1973 pointing out the need for a modern neonatal intensive care unit to provide intensive care in a more appropriate setting for the increasing number of deliveries in the Cape Peninsula. Planning was begun in 1975 but the Current Neonatal Unit was only completed in 1982 as part of the Southern extension of the Maternity Block. Despite these difficult beginnings, Groote Schuur Hospital was among the first hospitals in the world to ventilate preterm infants. Neonatal nurse training initially kept pace with the demands of neonatal intensive care through a 6-month course begun by Miss Monk in 1975. Fortunately, some of those trained have stayed at Groote Schuur Hospital and form the backbone of the present service.

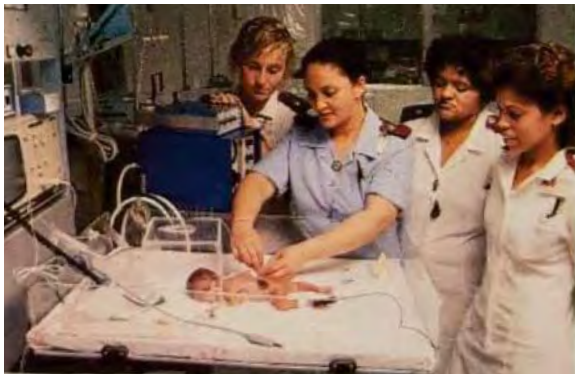
With the formation of the regionalized Peninsula Maternal and Neonatal Service in 1980, the Maternity Centre became the major referral hospital for obstetric and newborn patients requiring tertiary care. This trend has increased over the years placing more and more demands on staff and facilities, and in 1997, the area adjacent to the Neonatal Unit, initially used for growing infants, was converted into a Kangaroo Mother Care Ward in 1997. This has provided major relief on the demand for beds and nursing staff and has provided a teaching platform and example for the rest of the country.

The unit offers ventilatory support to many infants per year and is a specialist referral centre for infants who are known to have life-threatening abnormalities before they are born. Since the pioneering work on neonatal ventilation in the early 1960s by Profs Malan and Heese and later by Profs V C Harrison and M Klein, the unit has continued to actively contribute to neonatal medicine in South Africa.

Current research led by Profs M C Harrison and A R Horn, focuses on all modalities of preterm infant care and methods of induced hypothermia to protect the newborn brain.

In 2017, in conjunction with the Newborns Trust, a major refurbishment of the neonatal unit and fetal medicine unit has commenced. This has been made possible by major donations coupled with an increased footprint being allocated for the building works.

It is, above all, the dedicated staff that continue to provide the warmth and humane character that epitomises our unit.



Neonatal Medicine at Groote Schuur Hospital – Message from Professor Atties Malan

The specialized care of ill newborn infants developed worldwide in the late 1950's and early 1960's. The discipline became known as Neonatal Medicine. In 1963 Boet Heese, with the support of Prof Ford and Dr Burger, started a Neonatal Respiratory Unit in E1 (M) Children's Ward. He recruited Malan and Harrison as research fellows. The group published original data on ventilation, lung physiology, and clinical findings.

Groote Schuur Hospital had been built without Obstetric facilities. Maternity services were added in 1963 with the completion of the M Block. The only provision for babies were bathrooms-cum-nurseries. On their return from North America Malan and Harrison were appointed to care for newborn infants in the M Block and Mowbray Maternity Hospital respectively. This resulted in the rapid expansion and growth of Neonatal Medicine. Through exchange with the obstetricians a consolidated area on MC was designated as a high care neonatal facility. As the obstetric service grew, so increasing numbers of small and ill infants were treated in MC. Outborn admissions were also admitted.

From the beginning the crucial role of the nursing staff was recognized. With the support of Matron Monk, a 6 month training course for professional nurses was established. Many of these nurses remained on the MC staff for years. The teaching and training of medical staff has always been a major feature of the service. Consultants and senior registrars were encouraged to do clinical research.

Prof Heese, the HOD of Paediatrics, continued to provide invaluable guidance in the appointment of staff and planning new facilities. Credit must be given to Dr Reeve Sanders and subsequent medical managers, as well as other departments for their support. Neonatal Medicine has always functioned as an inclusive and harmonious family.

Significant developments were the description of an infant record, perinatal coding system, strict hand hygiene, breastfeeding, and maternal-infant and bonding. Pioneering achievements are the successful local Perinatal Education Programmeme, international scoring system and management for neonatal encephalopathy, and setting up a Kangaroo Mother Care ward on MC.

With the support of the Western Cape DOH, the Peninsula Maternal and Neonatal Service was commenced in 1980. This regional Service incorporated all the obstetric and neonatal services as an integrated whole. It was the envy of other health facilities.

The M Block was enlarged in 1982 to provide a theatre, modern neonatal ICU and HC areas, call rooms, offices and staff facilities. With the building of the new GSH, the closely associated departments of Obstetrics and Neonatal Medicine acquired offices and teaching rooms in the OMB. The bridge between the OMB and Maternity Centre continues to provide valuable direct access for the two departments.

Much has been achieved in the past 50 years. The outcome for ill infants has steadily improved, and very many junior doctors were trained in the care of newborn infants. Twelve doctoral degrees have been awarded, and some twenty international researchers and visitors were hosted. The DOH is thanked for their support of special leave for study and attendance at congresses.

The change in the tertiary / quaternary profile of Groote Schuur Hospital is placing more emphasis on "high tech" management of very immature infants. The standard of current treatment equals that of any international facility.

It has been a wonderful privilege to be part of the services provided by Groote Schuur Hospital.

9. Department of Psychiatry (Professor Dan Stein)

To understand fully the Dept of Psychiatry at Groote Schuur Hospital, it's useful to begin with some dates. Valkenberg Hospital is now more than 125 years old, Groote Schuur Hospital is 80 years old, and the Dept of Psychiatry is a little more than 50 years old. These dates emphasize that while mental disorders have long been recognized and treated, the initial approach was to treat those suffering from these conditions in psychiatric asylums, and a view of psychiatry as a key component of the rest of general hospital medicine is only a more recent one. We are fortunate that we now live in a time where psychiatry is increasingly accepted as an important branch of medicine (the one most concerned with the both the body and the brain-mind), and where it is acknowledged that all individuals have the right to treatment (including the most marginalised).

Our first Head of Psychiatry at Groote Schuur Hospital, Prof Lynn Gillis, fully understood the importance of psychiatry as a key medical discipline, and was able to appropriately grow the discipline at the hospital. He helped initiate

Profs Gillis, Nash, and Robertson.

a range of inpatient and outpatient services, relying heavily on nurse-led community-based interventions. He also initiated a registrar training programme, which has subsequently contributed dozens of psychiatrists to the Province and the country. Finally, Prof Gillis led a Medical Research Council Unit devoted to understanding the epidemiology of psychiatric disorders; so emphasizing the burden of disease due to mental disorders. He was ably assisted over the years by several pioneers of South African psychiatry, including Profs Eleanore Nash, Tuviah Zabow, Alan Flisher, Denise White, and Brian Robertson (who went on to become the second Head of Dept).

Over subsequent decades, the Dept of Psychiatry at Groote Schuur Hospital has continued to grow, to try and meet the substantial burden of disease due to mental disorders. Services at the Hospital have expanded to incorporate a Division of Liaison Psychiatry (a key aspect of our work is interfacing with other Depts in the Hospital), a Division of Neuropsychiatry (including a great deal of work on neuroHIV/AIDS), as well as a great deal of work in Addiction Psychiatry and Emergency Psychiatry. The Dept at Groote Schuur Hospital liaises closely with the UCT-affiliated general and psychiatric hospitals (Alexandra Hospital, Lentegeur Hospital, Valkenberg Hospital), as well as with other Divisions in UCT's Dept of Psychiatry and Mental Health, on providing services, ensuring teaching, training and undertaking research.

Pioneering services of the Dept of Psychiatry at Groote Schuur Hospital have ranged from primary care efforts (such as our nurse-led community based interventions) to unique quaternary work (such as our cross-disciplinary highly specialized clinics for treatment-refractory individuals). In a number of clinical areas, such as neuroHIV/AIDS, our work is internationally recognized for being cutting-edge. Together with our UCT partner, we have also pioneered teaching and training in psychiatry locally, establishing the first sub-specialty programmes in addictions psychiatry, liaison psychiatry and neuropsychiatry, as well as the first postgraduate diploma in addictions psychiatry on the continent. We have welcomed students from around the country and continent to our Dept.

Finally, we have also made pioneering contributions to a number of areas of clinical neuroscience research, including work on brain imaging and psychiatric genetics (e.g., the continent's only extant 3T brain-dedicated magnetic resonance imaging facility is a stone's throw from our home in the J2 block), as well as work in the areas of psychopharmacology (e.g., Prof Denise White's work on the relationship between malignant neuroleptic syndrome and catatonia) and psychotherapy. Such research has addressed our most pressing clinical issues (e.g., our neuroHIV/AIDS epidemic, and our substance use epidemics).

Our Dept of Psychiatry at Groote Schuur Hospital has been fortunate to have had the services, over many decades, of outstanding psychiatrists, psychologists, nurses, and allied health professionals. We have also been emphatically multi-disciplinary in our approach: for example, long running a range of inpatient and outpatient multi-disciplinary services, and with UCT's cross-Faculty signature theme, the Brain-Behaviour Initiative (BBI) led from our Dept. Based on our services, training, and research – as well as on associated grants and publications - our GSH/UCT Dept of Psychiatry can justifiably claim to being the leading academic clinical Dept of Psychiatry on the continent.

Profs Gillis, Zabow and Stein (3rd and current Head of Dept).

10. Department of Anaesthetics (Professor Justiaan Swanevelder)

"An institution that prides itself in its history will never be lost, because it has an anchor for the presence, and a reference point for the future." (Chin 2014)

The Department of Anaesthesia has played a major role in the development of anaesthesia as a specialty, in South Africa (SA), on the African Continent, and internationally. (Thomas, et al) Over the years our Department has been instrumental in the evolution of surgery, anaesthesia, critical care, and perioperative safety in adults and children. The history of the development of anaesthesia in our Department and in SA, is well described in the Dr Nagin Parbhoo History of Anaesthesia Museum, housed in D23 at the Groote Schuur Hospital (GSH). The present official curator, Emeritus Professor Peter Gordon, also proudly keeps documentation of the history of the Department, as it evolves.

The Department originated in the "old" Somerset Hospital, moved to GSH in 1938, and gradually expanded over the years to include New Somerset Hospital (NSH), Red Cross War Memorial Children's Hospital (RCWMCH), Mowbray Maternity Hospital (MMH) and others (Table 1). In 1952 the SA Society of Anaesthetists strongly supported the formation of a Faculty of Anaesthesia within the proposed College of Medicine of SA. The College was established in 1954 and the Faculty of Anaesthetists shortly thereafter. The first successful individuals to qualify as specialists from UCT graduated in 1955. Since then, GSH/UCT has played a prominent role in the College and was instrumental in the development of a semi-independent College of Anaesthetists within the reconstituted Colleges of Medicine of SA. Numerous GSH/UCT individuals have functioned as president of the Faculty and subsequently the College.

The Department of Anaesthesia was formally established in 1953 under the direction of Dr CS (Buck) Jones. Subsequently, Dr Arthur Bull took over as Head of Department and was appointed as the first professor in 1963. The Department was primarily a clinical service unit with less emphasis on research, but a good teaching track

record. A paediatric anaesthetic service was set up at the new RCWMCH in 1956, under Dr Bull. Subsequently, Professor Gaisford Harrison was appointed to the Chair when Professor Bull retired, and was instrumental in introducing a stronger research ethos into the Department while maintaining teaching and service excellence. The third incumbent of the Chair, Professor Michael James, maintained its all round strength during challenging and difficult times of decreasing resources and a difficult relationship between the University and the Provincial Department of Health. In 2011 Professor Robert Dyer successfully stepped into the role of Acting Head of Department when Prof. James became ill just before his retirement. When Professor Justiaan Swanevelder became Head of Department in July 2012, Professor Dyer continued to assist, guide and co-direct for the next 5 years until his retirement in 2017.

The position of Full UCT Professor and Second Chair was established in 1993, and its first incumbent was Professor John Viljoen, an eminent South African Anaesthetist, who came back from the USA to take up this position. After him, Professors Adrian Bosenberg, Robert Dyer and Bruce Biccard filled this position with great success. Prof Biccard joined our Department in 2016 to redirect research focus towards the field of perioperative medicine. In January 2016 the name of our Department proudly changed to "Department of Anaesthesia and Perioperative Medicine". After the retirement of Second Chair, Professor Robert Dyer (34 years loyal service in our Department) in 2017, Prof Biccard was appointed in the Second Chair position. Immediately after his retirement in 2017, Prof Dyer was reappointed for 3 years as a UCT Senior Research Scholar. This is a prestigious UCT position, which has been bestowed upon extraordinary Health Sciences Faculty members only a few times previously in the history of the University.

The integrated Department of Anaesthesia is part of the clinical service platform of the Western Cape, providing anaesthetic services at a group of hospitals associated with the academic departments as well as providing outreach and supervisory assistance to peripheral hospitals.

The Department since 1984 has responsibility for anaesthetic services across an extensive group of hospitals of the Western Cape, including GSH, NSH, Red Cross War Memorial Children's Hospital (RCWMCH), Mowbray Maternity Hospital, Princess Alice Orthopaedic Hospital, and Peninsula Maternity Hospital. The latter two have since been closed and their functions redistributed to the remaining facilities.

The platform serviced by the Department remains significant with full time commitments to the remaining 4 hospitals and part-time commitments to Valkenberg Psychiatric Hospital (for ECT facilities) and Maitland Cottage Hospital (mainly paediatric orthopaedics). Within the central group of hospitals, the Department carries heavy clinical and academic burdens with a wholly inadequate staffing structure for either function. At present NSH is a secondary hospital forming part of the Level 2 platform of medical services in the Cape Metropole. Dr Anthony Reed from our Department presently leads the Division at NSH.

Mowbray Maternity Hospital

The Department of Anaesthesia and Perioperative Medicine plays a crucial role in the safe delivery of an increasing number of patients at the Mowbray Maternity Hospital (MMH). This hospital is a secondary level institution, receiving referrals from the Midwifery Obstetric Units, including patients with uncomplicated severe preeclampsia. Strict criteria are in place for the referral of patients to the Maternity Centre at Groote Schuur Hospital.

Professor Robert Dyer previously directed obstetric services across the three sites, until Dr Dominique van Dyk recently took over this role.

RCWMCH

The anaesthetic service at the Red Cross War Memorial Children's Hospital (RCWMCH) is provided to children from the newborn age group to those in their 13th year of life. Many of the neonates are ex-premature infants,

so the anaesthetist will be expected to anaesthetise any baby, from <500g to >70 kg. In some of the special clinical services, children may, with special permission, have surgery when they are older than the stipulated limit. Some of the specialised procedures include open-heart surgery, major neurosurgery, urology, neonatal surgery, separation of conjoined twins, kidney and liver transplantation, and laser- and other surgeries to infant airways.

Teaching is an integral part of the daily activities of the anaesthetists in our Department, both at registrar as well at a consultant level. Students include undergraduate 4th and 6th years, paramedics in training, nursing students, and visiting trainees form other African countries. There is a Hospital Trust African Fellowship Programmeme, which provides some sponsorship for African anaesthetists to train in paediatric anaesthesia under our tutelage. The Department is in process of developing a UCT Postgraduate Diploma in Paediatric Anaesthesia, which will compliment a 1-year Clinical Paediatic Anaesthesia Fellowship. Over recent years eminent Paediatric Anaesthetists like Drs Tessa Lopez, Tony Butt, and Professors Adrian Bosenberg and Jenny Thomas have taken the academic lead and developed services at the RCWMCH division of our Department. When Professor Thomas retired as Lead in 2015, Dr Robert Nieuwveld was appointed into this role, which he is successfully fulfilling.

National Leadership

Many members of the Department of Anaesthesia and Perioperative Medicine have played significant leadership roles within the anaesthetic community in SA, predominantly through the Colleges of Medicine and the SA Society of Anaesthesiologists (SASA). The following members of the Department have served as President of SASA: Royden Muir, Thomas Fuller, Jack Abelsohn, Eric van Hoogstraten, 'Buck' Jones, Arthur Bull, David Morrell, Peter Gordon, David Linton and Michael James. Presently (2017) Prof Bruce Biccard is SASA President-Elect. A former member of the Department, Professor David Morrell, served as overall President of the Colleges of Medicine.

In 2006 the WC DoH initiated a system of co-ordinating clinicians for major disciplines. Together with a Provincial Anaesthetic Coordinating Committee, an opportunity was created for specialist practitioners to support services provided by medical officers, resulting in an improvement in the quality of equipment and standards of anaesthetic practice in district hospitals. In this role, Dr Anthony Reed was able to assess anaesthetic services in hospitals across the province. Presently the excellent work performed by Dr Reed in his role as coordinating Anaesthetist for PGWC's "Metro West" has allowed the Department to play a leading role in the development of anaesthesia within the Western Cape. The leadership displayed by associate Professor Peter Gordon in safety related matters as lead to the Department, also played a leading role nationally in the improvement of anaesthetic safety in various aspects.

Academic history of Anaesthesia at the University of Cape Town (Adapted from Thomas et al)

1912 – The first medical school in SA was opened at the South African College (only Basic Sciences offered)
1918 – UCT officially opened
1920 – 5 doctors appointed to NSH to administer anaesthetics: Drs GW Bampfylde-Daniell, AG Forbes, PWJ Keet, J Mitchell and JF Wicht
1921 – First lecturer in Anaesthesia – Dr GW Bampfylde-Daniell
1936 – Specialist register in Anaesthesia
1936 – Department of Anaesthesia separate from Surgery. This consisted of 9 members, a curriculum of 12 lectures and in-theatre instruction.
1937 – First Postgraduate Specialist qualification (diploma) in Anaesthesia established by the Conjoint Board of the Royal Colleges of Physicians and Surgeons of England.
1937 – Dr J Abelsohn became the first Resident in Anaesthesia at NSH.
1938 – GSH opened.
1951 – The Joint Agreement between the Provincial Government and UCT was introduced

1956 – RCWMCH opened.
1957 – Professor Arthur Bull introduced Halothane into clinical practice in SA.
1957 – Intermittent Positive Pressure Ventilation used for poliomyelitis and tetanus patients.
1964 – First separation of conjoined twins in SA at RCWMCH. Anaesthesia played big role.
1965 – Establishment of the first Chair of Anaesthesia – Professor Arthur Bull.
1967 – Dr Joseph Ozinsky provides Anaesthesia for first heart transplant.
1968 – Description of an animal model of malignant hyperthermia (MH) – Prof Gaisford Harrison.
1975 – Discovery of the treatment of MH with Dantrolene – Prof Gaisford Harrison.
1976 – Development of Pain Clinic at GSH.
1988 – Establishment of successful liver transplant programmeme at GSH.
1988 – Department moves to New GSH Building, Area D23.
1988 – Establishment of a Second Chair of Anaesthesia
2003 – Establishment of a Pain Clinic at RCWMCH.
2003 – Opening of the new coagulation research laboratory within New GSH D23.
2010 – Department rebuilt – expansion includes the development of the new lecture theatre, library and additional offices.
1988 – 2012 – Major drive under Prof Mike James to computerize Department and transform into a modern day institution, recognized as one of the best training Departments in the World. Collaborative research in Obstetric and Endocrine Anaesthesia, as well as Coagulation and Fluid Management, revolutionizes these areas of perioperative care.
2012 – Establishing short course teaching format in Department to develop clinical skills and theoretical knowledge: Point of Care Ultrasound and Echocardiography, Regional Anaesthesia techniques, Thoracic Anaesthesia and Lung Isolation, Airway Management, Managing Emergencies in Paediatric Anaesthesia (MEPA), Critical Care, Essential Pain Management, Simulation Teaching, etc.
2012-2016 – Major drive to establish Point of Care and Perioperative Diagnostic Ultrasound, as well as Echocardiography in Department (FATE, TTE, TOE).
2015 – Established 2-year Storz- (Airway and Thoracic Anaesthesia) and Draeger- (Simulation and Education) Academic Fellowships allowing academic time to develop research, and teaching programmemes.
2015 - Clinical Skills Simulation Laboratory opened at GSH. Department plays a leading role to establish strong Undergraduate and Postgraduate Simulation Programmemes.
2016 – Department's name changes to Department of Anaesthesia and Perioperative Medicine.
2016 – Reconfirming research focus in area of Perioperative Medicine by appointing Professor of Anaesthesia and Perioperative Medicine, Bruce Biccard. This includes a regular weekly "Critical Assessment of Perioperative Literature Evidence, Research and Publication" Programmeme directed by Prof Biccard.
2016 – Combining acute and chronic pain activities to establish holistic interdisciplinary Pain Management Unit, complete with Professor of Pain Management, Romy Parker.

Services

Groote Schuur Hospital has a total of 32 operating rooms / sites where anaesthesia is performed. It is imperative to recognize that the Department provides substantially more clinical service than merely attendance in the operating room. The central role of anaesthesia as a service provider to all of the major disciplines means that anaesthetists are in a unique position to make unbiased and clinically relevant judgements when it comes to allocation of scarce resources and appropriate utilisation of hospital facilities. Bi-annual SPMS evaluations of over 100 staff members across the Anaesthetic platform is very time consuming.

Anaesthesia provides an essential service and advisory management role in the maintenance and purchase of hospital equipment for the operating theatres and for the critical care units, as well as consumables. The Department has a fixed equipment subcommittee headed by Senior Specialist Dr Ross Hofmeyr. The Department

of Anaesthesia also plays an important role in evaluation of consumable equipment and in the drawing up of specifications of consumable equipment. Our members play a key role on the Tender Adjudication Meetings of the Province. A team of Clinical Technologists under Mr Grant Strathie, looks after equipment in theatre. They also attend to the blood gas analysers and provides equipment support for difficult intubations.

Professor Peter Gordon has been responsible for the efficient running of service delivery of our Department over the years, until Dr Richard Llewellyn followed him from 2011. Anaesthetists undertake a variety of other activities, the extent of which will vary from service to service, from hospital to hospital, as well as between practitioners. These services can be summarised as follows:

Theatre work

This is the basis of anaesthesia practice and takes the majority of anaesthetic time. It must be recognized that even the simplest of anaesthetic procedures demand the continuous and uninterrupted presence of an anaesthetist at all times. There is always one anaesthetist available for every anaesthetic that is performed. At all levels of care, some degree of training must be undertaken and a degree of supervision is required in the operating theatre. Some operating lists are of such complexity that 2 anaesthetists are required for every case.

The Department of Anaesthesia presently provides obstetric anaesthesia services for approximately 10 000 deliveries per annum across three sites (GSH, MMH, NSH). This amounts to approximately 5000 caesarean sections. In recent years the Department has been managing an average of between 30 and 40 caesarean sections every day. Epidural analgesia is available to patients in labour. The anaesthesia staff also assist the obstetricians with peripartum triage, problem solving and resuscitation. Assistance is also provided in critical care management in the 4 bedded Special Care unit, where up to 4 patients may be ventilated overnight, usually with complications of preeclampsia or hemorrhage.

Cardiothoracic anaesthesia is headed by Dr Sylvia Heijke. She is supported by a team of specialists who are interested in the specialty. The cardiac case mix includes on-pump and off-pump coronary artery bypass grafts, valve replacements and repairs (also minimally invasive), aortic root, arch and descending aorta replacements, aortic aneurysm repairs, ventricular aneurysms, pericardiectomies, cardiac tumours, grown-up congenital heart disease surgery, and heart transplantation.

Thoracic surgery includes inflammatory (especially pulmonary tuberculosis), neoplastic and degenerative lung resections. Two stage and three stage oesophagectomies and other palliative procedures, tracheal resections and stenting for tracheal stenosis, laser treatments, video assisted thoracoscopic procedures, mediastinal biopsies, thymectomies for myasthenia gravis or thymomas and trauma (e.g. post gunshot bronchopleural fistulae, haemothorax drainage etc), are some of the complex procedures performed.

Intra-aortic balloon pumps and left and right ventricular assist devices are used frequently when weaning patients with pump failure from bypass. The Department also supplies anaesthesia to patients in the cardiac catheterisation laboratory (e.g. insertion of implantable defibrillators, peripheral insertion of ASD closure devices, radiofrequency ablation for arrhythmia procedures, TAVI procedures, etc). Registrars rotate on a weekly basis through the cardiothoracic surgery ICU where they assist in the postoperative care of patients and learn donor management.

Endocrine anaesthesia services are presently headed by Dr Revyl Haylett, previously established by Prof Mike James, who has a worldwide reputation in the field of perioperative management of phaeochromocytomas.

Neurosurgical anaesthesia at GSH is headed by Senior Specialist Dr Anthony Reed. Trauma related brain injury operations place a significant load on the emergency services of the hospital and the department.

Heart Transplantation

Fifty years after the performance of the world's first successful heart transplant at Groote Schuur Hospital, the unit continues to perform heart transplants, although donor numbers have significantly dropped off.

Liver transplantation

In 1987 the Department was involved in setting up the first successful liver transplant programmeme in Africa at Groote Schuur and Red Cross Children's Hospital. For many years Cape Town was the only centre in South Africa providing this service. The anaesthesia liver transplant service was developed by Prof Peter Gordon, now continued by Dr Deidre Batty. All potential liver transplant patients are referred to the department for preoperative anaesthetic assessment as part of their work up for transplantation.

Renal transplantation

The department plays an important supportive role to the renal transplant team. A significant number of live-related donor transplants are performed. Postoperatively patients are managed in the renal transplant unit.

Emergency theatre

A 24 hour emergency theatre service is provided. The increasing trauma load and reduction in elective lists has placed an ever-increasing burden on this service. During the day the emergency theatre is serviced by the consultant on call and one or two registrars. Dr Felipe Luis-Montoya was appointed as a senior anaesthetist to decrease the bottle-neck for patients awaiting emergency surgery. He has introduced an initiative in which all patients on the emergency board are triaged by a senior anaesthetic registrar and classified according to degree of urgency. This works extremely well and contributes to easier throughput of patients.

Recovery Room

The recovery rooms for patients postoperatively has one anaesthetic registrar allocated to the area on a daily basis. This individual is responsible for the postoperative care of patients and for discharging them back to the ward. The registrar is also tasked with setting up Patient Controlled Analgesia (PCA) machines for appropriate patients.

Intensive Care

The Department plays a key role in the functioning of the Intensive Care Service at Groote Schuur Hospital. The ICU is headed by Prof Ivan Joubert and supported by 2 Senior Anaesthetic Specialists and 2 Junior Anaesthetic Specialists. The Department of Anaesthesia provides four registrars to the combined ICU registrar pool and one registrar to the Cardiothoracic Surgery ICU. Dr Anthony Reed and Professor Robert Dyer provide support to the Neurosurgical ICU and Obstetric High Care Unit respectively. ICU Anaesthesia staff continue to provide valuable support to Mitchell's Plain and Victoria Hospitals.

Theatre management

Our anaesthetists play a vital role in the management of efficient theatre services and they form an essential component of our efficient theatre management system. Anaesthetists have a unique understanding of how the various theatre users interact and how to obtain the best use of time within the theatre complex. This is particularly important in the management of the emergency and urgent lists that we are constitutionally obliged to manage.

The Department also plays a major supporting role to the hospital and province and has representation on numerous committees.

The administration allocation is minimal, as some administrative time is included in the 13 hours per week non-clinical time allocated to all staff. These provisions are essential components of our clinical service. Dr Richard Llewellyn is allocated 1.5 days per week for running our service. Dr Ross Hofmeyr maintains the clinical equipment portfolio and spends substantial additional time on this vital clinical function. The daily and weekly

roster allocations (Drs Caroline Simons and Adri Troski-Marais) require a minimum of one full day and frequently occupy more time than this as changes have to be made during the week to accommodate illness and additional operating time requests. Roster allocations for the planning of the consultant and registrar on call services are also allocated a minimum time of 1 day every six weeks. Dr Felipe Luis-Montoya has responsibility for the efficient management of theatres and the control of emergency and urgent lists and he is allocated 1 day per week for this purpose.

Premedication rounds

The duration and extent of pre-medication rounds will depend to some degree on the complexity of the anaesthesia required, and the underlying clinical problems of the patient. Consultative services to patients requiring surgery with difficult clinical problems, is a very important function. It has been internationally demonstrated that a pre-anaesthetic clinic can save significant amounts of hospital time and prevent unnecessary cancellations by allowing for appropriate pre-operative workup and optimization. Our Department Pre-Assessment Clinic has been established and developed by Drs Marcin Nejthard and Francois Roodt over the past 5 years. Risk Stratification, which includes Basic Exercise Testing and Focussed Echocardiography Assessments, is part of this service to facilitate surgical patient throughput and prevent last minute cancellations. Due to manpower availability, this service is presently still limited to 1 clinic per week.

Resuscitation and Airway Management

Anaesthetists are experts in resuscitation and fluid management and our Department is frequently leading, and involved in resuscitation and consultative services for difficult cases of fluid management both in the trauma unit and other wards in the hospital. Since 2014 Dr Ross Hofmeyr has taken charge of our Airway Management Laboratory. He has developed a world class `Difficult Airway Programmeme' which has spilled over to other members of our Department, elevating this Departmental skill to international expert levels in service, education, and research. This expertise is now shared with other institutions in our country, Sub-Saharan Africa, and the World. The Airway Management Laboratory is well equipped with adequate and modern facilities.

Critical Care

Anaesthesia played the leading role in the development of critical care and anaesthetists still dominate this discipline worldwide. Over the years eminent leaders like Professors Peter Potgieter, Lance Mitchell, Dr David Linton developed and directed the GSH Critical Care Units. In the earlier days the Surgical-, Pulmonology/ Lung-, Neuro-, and Cardiothoracic Critical Care Units were all separate, but more recently these services were amalgamated under the combined leadership of Professor Ivan Joubert. The first two specialists to qualify with critical care accreditation at Groote Schuur Hospital were both anaesthetists and our Department continues to provide the majority of the staff in the critical care units.

At present anaesthesia supplies the Lead of ICU (Professor Joubert), 3 consultants (Drs Jenna Piercy, Malcolm Miller and a rotational specialist from our Department), 4 registrars in the general pool and one registrar in Cardiac ICU.

Anaesthesia also makes a significant contribution to paediatric intensive care at Red Cross Hospital, with Drs Stephanie Fischer and Lelani Lampbrecht both completing their Paediatric ICU Fellowships and Accreditation there.

The Post Anaesthesia High Care Unit was an essential development that took substantial workload off the highly pressurised intensive care facilities. This unit is entirely run from a medical personnel point of view by anaesthetic staff. Dr Felipe Luiz-Montoya has participate in its development, and is presently leading this service, together with overseeing smooth functioning of anaesthetic trauma services.

Pain services

Anaesthetists have great expertise in the performance of nerve blocks, clinical pharmacology of analgesic drugs, and in the physiology of pain. Our Department is generally on the forefront of Pain Management in modern hospital services in South Africa. In 2017, an exciting new strategic development was the inclusion of Professor Romy Parker (PhD), an academic Physiotherapist, to become Director of the newly established multidisciplinary UCT Pain Management Unit as part of our Department. This introduced new energy with all of the service, educational, and research components of pain management (pharmacology, psychology, acute, chronic, adult, paediatric, and community pain) unified together.

Acute Pain Services: It has been extremely well demonstrated that an acute pain management team, headed by an anaesthetist (presently led by Dr Owen Porrill and a team of 7 other anaesthetists) with appropriate nursing support, as well as support from physiotherapy when appropriate, leads to greater patient satisfaction with perioperative pain care, reduced complications, shorter hospital stay, and prevention of chronic pain syndromes.

Chronic Pain Service: Our Chronic Pain Service is a multidisciplinary tertiary referral unit headed by a member of the anaesthetic department and involving anaesthetists, psychiatrists, physiotherapists and social workers. It is presently directed by Dr Janieke Van Nugteren. Our Anaesthetists play an important role in this unit through their knowledge of pharmacology and ability to perform regional blockade (often in theatre under fluoroscopy screening).

More than 1500 patients are seen at the clinic annually and more than 250 interventional procedures performed.

In 2017 Dr Rowan Duys and Professor Romy Parker won an educational grant to extend nurse pain education to all Groote Schuur Hospital wards through their international Essential Pain Management Programmeme.

Outreach, support services and social responsiveness projects

The shortage of anaesthetic services means that there is limited anaesthetic expertise outside of the central hospitals. It is imperative that our Department makes a major contribution to the maintenance and support of anaesthesia in the secondary and primary level services of the province, and our country. Outreach services and educational visits have been provided among others to Hospitals in George, Vredenburg, GF Jooste Hospital, Mitchell's Plain, Worcester, Kimberley, Nelspruit, Umtata, Bloemfontein, East London, and George Mukhari Hospital/Pretoria. Although it is not always possible to assist with service provision, an educational, research or teaching visit goes a long way to inspire collaboration and development.

Operation Smile (ENT/Maxillofacial), Operation Flamingo (Breast Ca surgery), Nelson Mandela Day Orthopaedic/ Joint Surgery are just a few examples of charitable projects where our Department plays a crucial role in decreasing waiting lists in a cost-constrained health service.

Our Department is also participating in the very important, cross disciplinary, one-week West Coast Surgical and Gynaecological Endoscopy Screening Project to Upington, Garies and Vredendal, in August 2017.

Teaching and Training

Teaching in the Department is performed at undergraduate and postgraduate levels for the University. Our Department also has training demands required of it for provincial services, including intern training and training of other health care personnel. Registrars, interns and medical students in their 4th and 6th years are taught basic anaesthesia skills in theatres on a daily basis. The department has an excellent record in teaching and training: 2 colleagues are the recipients of the UCT Distinguished Teacher award. Undergraduate training has recently increased markedly with the extension of anaesthesia training in the new undergraduate curriculum, with no additional teaching staff and an inadequate teaching platform. Over recent years undergraduate

training has been guided by dedicated leaders like Drs Robert Nieuveld, Anthony Read, Revyl Haylett, Estie Cloete, Brigid Brennan, while all members of Department are involved in day-to-day teaching and training.

Since 2007 HPCSA has required that interns do 8 weeks anaesthetic training. Our department is now allocated 10-12 interns every 8 weeks. Interns are continually taught and supervised by a registrar or specialist. Assessment is conducted at the half way so that interns having problems can be identified and guided appropriately. Generic skills learned can be used in emergency medicine, surgery, trauma, critical care etc. Tutorials are provided for the interns on a regular basis, also in the Clinical Skills Laboratory. The interns consistently rate anaesthetics as the best intern rotation at their final interview.

Postgraduate specialist training.

At postgraduate level, the Department has an excellent record of achievement in the training of specialist anaesthetists at Fellowship level. Anaesthesia specialization requires 4 years of certified registrar training in an appropriate institution, a Fellowship (Part I and Part II Examinations) of the College of Anaesthetists (FCA) of SA, or equivalent, and an MMed thesis/degree. The entry criteria for a registrar post at GSH/UCT require that the candidate has at least 6 months of anaesthetic experience and a higher qualification in anaesthesia, either the DA or the primary FCA(SA). As competition for positions in the Department is intense, most of the newly appointed registrars in 2017 have already obtained the primary FCA(SA) and arrive with 2-3 years of clinical anaesthesia experience. The desperate shortage of anaesthetic specialists in South Africa means that this is a crucial function for which adequate provision must be made. Specialist training in South Africa is of an excellent standard and it is essential that this level of training is maintained and that the numbers of training posts are at very least maintained, and probably substantially expanded. At GSH/UCT, registrars in anaesthesia are registered for the MMed(Anaes) qualification, which is a four-year, three-part degree programmeme in which the first 2 parts are by examination and the third part is by thesis. This means that a registrar wishing to qualify as a specialist in anaesthesia from GSH/UCT must pass part 1 (Primary) and part 2 (Final) of the Fellowship of the College of Anaesthetists of South Africa. Once registrars have completed the primary examination, they are eligible for the senior rotation which includes senior rotations to obstetrics and paediatrics as well as a rotation to the specialist surgical services such as vascular, gastro-intestinal and liver surgery and a rotation to cardiothoracic anaesthesia. The objective is for all of these rotations to have been completed before the registrar writes the final fellowship examination.

Primary Examination, Part 1 – Teaching: The teaching programmemes are designed to assist self-directed learning, providing guidance and explanation to the candidates. Formal teaching for this part of the qualification includes a regular, afternoon-release set of lectures that are delivered on a Wednesday afternoon. Primary candidates are also encouraged to obtain additional teaching in the in-theatre environment as this allows the practical demonstration of the principles of physiology, pharmacology and clinical measurement. This "Primary-teaching" is presently directed by Dr Kamal Bhagwan.

Final Examination, Part 2 – Teaching: The final examination is usually attempted after a registrar has completed 36 months of anaesthetic training. The bulk of teaching for the final examination is practical, in-theatre tuition provided by the specialist staff, combined with a run-through Departmental academic programmeme. During their 4 years, registrars acquire a broad spectrum of clinical experience across the range of anaesthetic practice. Formal teaching for the final fellowship is based on a 6 month morning-release course on Friday mornings. Additional teaching on a less formal basis is made available after hours with all consultants willing to provide additional teaching sessions after the normal daily work time. Some of these sessions take the form of clinical examinations at the bedside, preparing be candidates for the clinical part of the final fellowship examination. The Departmental Educational Programmeme is complemented every Friday afternoon with a 1-hour session of ICU Academic Grand Rounds, and a 2-hour Anaesthesia Academic Grand Rounds Meeting. This includes Internal Audits / Morbidity and Mortality Meetings. This weekly activity is attended by the whole Department as

an Educational and CPD session. The College of Anaesthetists supports an annual one week national refresher course for both the part 1 and the part 2 examinations, and these rotate every 2 years between Johannesburg and Cape Town.

MMed(Anaes), Part 3 – Thesis: Since 2014 all registrars finishing their training programmeme have to submit a successful MMed thesis to qualify as a specialist. This thesis component of the MMed degree requires the candidate to complete a formal research programmeme at the level that would be acceptable for publication in an international, peer-reviewed journal. The thesis level is currently set at that of a half-Master's thesis and requires considerable time and effort from both the candidate and the supervisor. However, those theses that have been completed have been of a very high standard and are marked completely externally to GSH/ UCT. Challenges in introducing the thesis include finding sufficient supervisors to oversee the research work and obtaining sufficient time for the registrars to complete a suitable level thesis.

Intensive Care

The Combined Division of Critical Care facilitates the training of registrars from all disciplines in intensive care. This includes anaesthetic, medical, surgical and emergency medicine registrars. The Division of Critical Care presently has four accredited training numbers for the training of specialists in Critical Care. There are currently no funded posts to facilitate this training process, although several candidates have completed their 2 years subspeciality training funded from their mother speciality department.

Clinical Skills Laboratory

A Clinical Skills Laboratory was opened in 2015 after generous investment by Draeger. Our Department was one of the first to embrace this facility to teach essential skills in a non-threatening environment with no risk to patients.

Dr Rowan Duys became the partially funded Draeger Fellow of Medical Education and Clinical Simulation in 2015, and has since then developed this programmeme to an international level, with trainees from across disciplines, nursing staff, as well as Allied Health. This facility now has a wide influence, not only limited to medical student undergraduates, but established nursing staff, interns, postgraduate registrars and even qualified Anaesthesiologists for CPD purposes.

Research

It is vital that research and audit relevant to anaesthesia problems in Africa is performed. The Department of Anaesthesia has a rich legacy of research activity, dating back to the pioneering work of Professor Gaisford Harrison on malignant hyperthermia and the use of dantrolene as therapy. Under Professor James, these activities have been expanded and developed, so that the Department is now involved in many spheres of anaesthesia research. As an evolving specialty, research in anaesthesia has played a major role. In 1965 - 1967 the Taurus blood warmer – named after Professor Bull – to prevent hypothermia after major blood transfusion was developed. This device, still in use today, was one of the first to use radiofrequency induction heating technology.

Research on malignant hyperthermia (MH) put the department on the world stage. A porcine model of MH enabled elucidation of the pathophysiology of this condition in conjunction with the Department of Chemical Pathology. Later it was demonstrated that the intravenous use of dantrolene was life-saving in treatment of this previously fatal metabolic storm.

Magnesium was established as the treatment of choice for the control of hypertensive response to tracheal intubation in pre-eclampsia, haemodynamic instability in tetanus and in the peri-operative management of phaeochromocytoma. The first double-blinded randomised comparison of crystalloids versus colloids for resuscitation in trauma was the product of many years of research in the field of fluid management.

More recently Professor Robert Dyer has been a strong drive in Obstetric research, and with the joining of Professor Bruce Biccard, the focus has expanded to include other aspects of perioperative medicine such as surgical patient outcomes.

Despite the enormous clinical pressures in this busy unit, many anaesthesia research studies have been conducted over the years, involving fluids, neonatal outcome and the mechanisms of influence of spinal anaesthesia on maternal haemodynamics during caesarean section in healthy and preeclamptic patients.

There are ongoing interesting research topics in the department, including:- Fluid therapy; Coagulation (The opening of the department's thrombelastography laboratory in the mid-1990s led to significant contributions in the field of coagulation); Obstetric Anaesthesia, especially in peripartum haemodynamics; Paediatric Anaesthesia; Pharmacology of magnesium; Patient safety; Perioperative patient outcomes and Echocardiography (transthoracic and transoesophageal) and Medical Ultrasound (ultrasound-guided regional anaesthesia techniques, vascular access) has recently been introduced as everyday standard of care modalities in the workplace – this has been followed by extensive research in these fields, especially in point-of-care and diagnostic echocardiography in the Perioperative and Peripartum periods.

The world's longest longitudinal study into anaesthetic mortality over 3 decades was undertaken at GSH/UCT between 1956 and 1987; this landmark study documented a decrease in death attributable to anaesthesia at GSH, from 3.3/10 000 anaesthetics in 1956 - 1965, to fewer than 1/10 000 between 1977 and 1987. These advances went hand-in-hand with the establishment of pioneering national and international organ transplant programmemes for heart, kidney and liver transplants in Cape Town. This necessitated improved anaesthetic skills to provide peri-operative care and anaesthesia for critically ill transplant recipients (adult and paediatric). The liver transplantation programmeme, regarded by many as inappropriate for the SA environment, proved to be extremely successful in both adult and paediatric patients. Further positive benefits included the acquisition of point-of-care equipment in theatre, such as thrombelastography and blood gas analysers. More recent successful big data outcome studies directed from our Department and influencing our whole country and continent are SASOS (SA Surgical Outcomes Study), ASOS (African Surgical Outcomes Study) and SAPSOS (SA Paediatric Surgical Outcomes Study).

The WHO surgical checklist was first implemented at GSH and across the Western Cape (WC) Province by Prof Peter Gordon, and was adopted as a national core standard for hospitals by the National Department of Health.

Landmark studies on drug safety and errors in anaesthesia culminated in the first prospective multicentre study of drug administration errors in anaesthesia in SA.

Research in paediatric anaesthesia at RCWMCH in the management of conjoined twins, and the burned child, has gained international recognition.

The Departmental Research Committee meets regularly and assesses the scientific quality of protocols submitted by members of the Department, before submission for approval by the University of Cape Town Ethics Committee.

Recent Academic and Research Developments

The Hospital and Faculty approved the change of the name of our Department to "Department of Anaesthesia and Perioperative Medicine" in 2016. Professor Bruce Biccard, currently NRF C-rated, was appointed as the lead clinician and Head of the Clinical Unit of Perioperative Medicine in the Department. He is already involved in several multicentre studies, and will work in close association with the UCT Clinical Research Centre (CRC).

Two major Fellowships were established. Storz sponsored the first, and Dr Ross Hofmeyr was appointed to the Airway Fellowship. The Draeger Company contributed towards a Fellowship in Simulation and Remote Learning, occupied by Dr Rowan Duys.

Important international collaborations were continued and expanded during 2015, with Dr A Roscoe (Papworth, Cambridge, UK), Professor E Sloth (Aarhus, Denmark), Professor C Ortner (Medical University of Vienna), Dr V Krishnamoorthy (University of Washington, Seattle), Dr B Buddeberg (St Georges, London, UK), and Professor Alicia Dennis (University of Melbourne), amongst others.

Airway research

2015 saw considerable advances in the Difficult Airway Facility, under the leadership of the incumbent of the Storz Fellowship, of Dr R Hofmeyr. Dr Hofmeyr co-supervised an MMed project on a new airway device, the Totaltrack, a new device allowing for direct vision of the larynx during tracheal intubation via an LMA. This thesis was awarded a distinction, and published in the Southern African Journal of Anaesthesia and Analgesia. Dr Hofmeyr continues to collaborate with Dr D Miller, of Guy's and St Thomas' Hospital in London, who will supervise his PhD. Several further projects are under way.

Critical Care

In the field of septic shock, two projects are in progress. The first involves high dose Vitamin C in the management of haemodynamic failure, and the second relates to markers of oxidative stress in this condition. A further study on semi-closed loop control of blood glucose is planned, and will commence shortly. An international collaborative study is in progress on the attitudes of physicians to the withdrawal of therapy.

A further study will examine the efficacy of thoracic epidural anaesthesia in the Post-Anaesthesia High Care Unit.

Obstetric Anaesthesia

This remains an important area of investigation. The project on spinal anaesthesia in preeclampsia is complete. As part of this investigation, collaboration was initiated with the Department of Anaesthesia of the University of Washington. This aspect of the study examined the population characteristics of the adrenaline β2-haplotype in preeclamptic women.

The Department's specialist interest in obstetric anaesthesia has resulted in many research publications, covering various aspects of spinal anaesthesia for caesarean section. Particular areas of importance are fluid management, the haemodynamic effects of vasopressors and oxytocin in healthy and pre-eclamptic patients, and neonatal outcomes. There is on-going international collaboration in this field.

Laboratory Research

Dr Miller is the clinician in charge of the Coagulation Laboratory. Lizl Immelman-Loo, our senior medical technologist, has been appointed to a permanent post and is performing an important research administrative role. Ms Margot Flint was appointed as a Research Assistant in 2015. She graduated PhD in 2015. Ms Flint has made an enormous impact on academic activities in the Department, in her role as teacher, researcher and grant-writer. Ms Flint will work closely with Professor Biccard in the area of Perioperative Medicine.

There is considerable ongoing animal research. Dr Miller and Ms Flint participated in an animal study of coagulation in a porcine model of acute liver failure, in collaboration with Dr C Senden of UCL. Transoesophageal echocardiography is being performed in pigs and sheep undergoing valve replacement in the animal laboratory. Several anaesthetists have been trained in anaesthetizing animals as part of research on minimally invasive mitral valve insertion, in the Hatter institute, in collaboration with Professor Peter Zilla.

Collaboration

Once again, junior consultants and registrars were encouraged to participate in research activities wherever possible, and scientific writing skills were also improved in this way.

Interdisciplinary collaboration at GSH/UCT remains strong, and includes the Departments of Cardiothoracics, Cardiology, Obstetrics and Gynaecology, Neonatology, Paediatrics, Critical Care, Medicine, and the Hatter Institute of Cardiovascular Research.

National collaboration has been strengthened, in particular with UKZN, where the management of obstetric spinal hypotension, specifically in the South African setting, is a focus. International collaboration continues, and is constantly expanding. The Department collaborates with the University of Aarhus, Denmark, the University of Melbourne, the University College London Hospitals, the University of Leipzig, the University of Toronto, Stanford University, the University of Washington, and Glenfield Hospital, Leicester. In the field of echocardiography, there are ongoing collaborations with Professors E Sloth (Denmark), A Dennis (Australia), J Ender (Leipzig) and Andrew Roscoe (Papworth). In thoracic surgery, Professor Peter Slinger of Toronto is a world leader and collaborator with the Department. In the area of the difficult airway, ties continue with Dr D Miller of Guy's and St Thomas' Hospital in London, and Dr Ellen O'Sullivan of Dublin. In the area of acid base analysis and ultrasound studies in preeclampsia, there is ongoing collaboration with Dr C Ortner of Vienna, Dr V Krishnamoorthy of the University of Washington, and Dr B Buddeberg, of St George's Hospital, London.

Thirty-five Masters Dissertations are in progress, in Paediatric Anaesthesia, Obstetric Anaesthesia, Critical Care, Coagulation, and Simulation. The projects are listed below.

The Department collaborates not only with other national departments of anaesthesia, but also with international colleagues, from UK, Europe, USA and Scandinavia. Such collaboration included unpaid visits from Specialists from overseas, which contributed to teaching and patient care. These included Professor Erik Sloth, of Aarhus, Denmark, and Professor Alicia Dennis from Melbourne. The former was involved in 26 one day courses in Medical Ultrasound (FATE, advanced FATE [transthoracic echocardiography], lung ultrasound, regional anaesthesia, vascular access), training over 130 doctors at UCT and around the country. Medical student training in ultrasound was also introduced in the form of a research project involving on-line training. The latter carried out a research project in transthoracic echocardiography in obstetrics. Point of care ultrasound is now established at GSH, and is producing tangible improvements in patient care. Dr Don Miller from the UK also conducted airway research in the Department, again contributing to patient safety.

Higher degrees

The Department has played a leading role in national anaesthesia research, producing 13 doctoral degrees.

The GSH/UCT Department of Anaesthesia has grown enormously from an ancillary section of the Department of Surgery to a sturdy, independent department with a strong teaching and research record. The enormous demand for admission to our postgraduate programmes from doctors of a very high standard, together with a new leadership structure, presages a future of even greater promise for our proud organisation.

1. Derek Chin, Cardiologist - University Hospitals of Leicester, and friend of UCT Department of Anaesthesia and Perioperative Medicine, April 2014. St George's Hospital Transoesophageal Echocardiography Course, London
2. Thomas JM, Reed AR, Gordon PC, Dyer RA, James MF. Anaesthesia – what has the University of Cape Town contributed? S Afr Med J 2012;102(6):415-418.
3. Harrison GG. Anaesthetic contributory death - its incidence and causes. S Afr Med J 1968;42:544-549.
4. Prof Peter Gordon
5. Prof Mike James
6. Prof Robert Dyer

11. Division of Critical Care (Professor Ivan Joubert)

Intensive care began at Groote Schuur Hospital not long after Bjorn Ibsen established the first modern intensive care unit (ICU) in Copenhagen in 1953 as a result of the polio epidemics that were sweeping Europe and North America. Initially patients were ventilated using both positive and negative pressure ventilators in ordinary wards. Chris Barnard returned from the USA in 1958 and introduced critical care for his open heart cases. In 1960 Prof Val Schrire, with the help of technologist Bill Piller, equipped a room with cardiac monitors and a defibrillator to manage two cases of quinine-induced recurrent ventricular fibrillation. This was probably GSH's first intensive care unit but it was not a permanent feature.

A neonatal respiratory ward was established by "Boet Heese"- in 1962. He was supported by a young anaesthesiologist, Arthur Bull, who together with paediatrician P Smythe had established South Africa's first ICU in 1957 at the Red Cross Children's Hospital for ventilating neonates with tetanus.

In 1968 Dr Alex Ferguson returned from training in the UK and USA to become Groote Schuur's first acute respiratory physician and "intensivist". He initially began ventilating patients in the corners of the male medical wards of A1 and A5. By 1972 these had moved into dedicated rooms on the enclosed balcony section of Wards A1 and A5 in the Old Main Building. Again Arthur Bull was an active supporter and this was GSH's first multidisciplinary ICU. Early registrars who trained under Dr Ferguson were Peter Potgieter, an anaesthesiologist who later became head of the Respiratory Unit and Max Klein a paediatrician who became head of the respiratory unit at Red Cross Hospital. The technologist Don Capp provided considerable and ingenious assistance - designing and improvising ventilator equipment. Solly Benatar returned from a two-year training period at the Brompton Hospital, London and his combined anaesthesiology and pulmonology backgrounds gave considerable impetus to the development of critical care. Under Alex Ferguson's leadership the ICU's at GSH were never segregated paving the way to integrated general wards during the 1980's.

Following the first heart transplants a dedicated heart transplant unit was established in the refurbished B7 area - adjacent to the B floor operating theatres. Input into the design came from the microbiologist, Arderne Forder. Improved financing following the heart transplant programme enabled the building of the "10's block" which opened in 1977. Here new, purpose built and well equipped intensive care units for the Respiratory Unit, Cardiac Surgery and Cardiology were established. Pieter Potgieter became head of the Respiratory Unit in 1980.

General Surgery began providing intensive care for their post-operative patients on the balcony of Ward B1 during the 1970's. The Surgical Intensive Care Unit (SICU) was formally established in 1984 with 14 beds on the balconies of B1, B4 and the vacated B7 transplant unit. The unit was headed by Dr Bill Chapel, an anaesthesiologist, who had also trained in the Respiratory unit. He was succeeded by Lance Michell in 1986. Sr Ros Leach was the head nurse of B7 and Avril Gordon head nurse of B1.

The SICU and Respiratory units moved into the new Groote Schuur Hospital building in 1989. Initially the SICU had 12 beds and the Respiratory unit 10 beds, but with the increasing shortage of intensive care trained nurses and funds, beds were closed soon after the move, leaving only eight beds in each unit.

David Linton took over the Respiratory unit in 1993. He was assisted by consultants Richard Raine, Tom Ruttman and Sue Gardiner. In 1996 Prof Linton emigrated to Israel and Dr Raine took over the headship. At that stage the Respiratory unit junior staff were mostly anaesthesia registrars while the surgical registrars, in training for their FCS intermediate exam, rotated though the SICU at three monthly intervals. During the early 1990's Groote Schuur's first two subspecialists in critical care, John Turner and Janet Hammond were trained in the Surgical ICU.

Talks to combine the Respiratory and Surgical intensive care units began in 1993 but although the respective heads were in favour, no agreement could be reached between the parent disciplines. In 2000 the Surgical ICU began with assisting with clinical management in the cardiothoracic intensive care unit. Finally, in 2003 an agreement between Medicine and Anaesthesia was brokered and a Department of Critical Care which included the Respiratory, Surgical, Cardio-thoracic and Source Isolation intensive care units was established. Prof Bateman was the first head of the Department and he was succeeded by Ivan Joubert in 2008.

12. Pharmacy Department – Mrs Vanishree Naicker

The staffing complement in the Pharmacy department has stabilized after many challenging years when it was extremely difficult to recruit Pharmacists. This has allowed the department to shift focus from crisis management to innovation and process improvement.

The current staff complement consists of 1 x Manager, 2 x Assistant Managers, 7 x Pharmacy Supervisors, 21 x pharmacists, 1x Community Service Pharmacist, 4 x Pharmacist Interns, 32 x Post Basic Pharmacist's Assistants, 1 x Basic Pharmacist's Assistant, 4 x admin clerks and 2 x General Assistants.

The Outpatient Pharmacy services an average of 620 patients per day and dispenses 2630 items per day. There have been various initiatives over the years aimed at improving the Service offered to Outpatients. In 2008 the team was awarded a Silver award for the Premier Service Excellence Awards in recognition of their efforts to reduce the waiting times. In January 2014 the team once again embarked on a journey to reduce waiting times. The team adopted the Lean principles and introduced daily team meeting at which performance was reviewed. These efforts have led to the team sustaining an average waiting time of 1hr for medication.

The Inpatient Pharmacy issues an average of 373 inpatient scripts with 627 items per day and 202 discharges with 827 items. The recent drive has been to expand the clinical involvement of pharmacists with the focus on antibiotic stewardship. They have participated in stewardship rounds and assisted with the implementation of the GSH antibiotic prescription chart.

The A12 Pharmacy stores are responsible for procuring medicines directly from suppliers for the institution. Ongoing unavailability of essential medicines together with the need to comply with Supply Chain prescripts is a daily challenge faced by the team when trying to maintain a sustainable supply of medicines.

Despite numerous challenges the Pharmacy Department is focused on building a strong team that is able to make a valuable contribution to the service offered by GSH.

Pharmacy 1sts:

- In 1997 a group of 12 SASOs completed a training course offered by the South African Pharmacy Council and became the first group of SASOs in the Western Cape to register with the SAPC as Pharmacist's Assistants
- Introduction of an electronic dispensing system

Figure: Pharmacy staff - September 2016

13. Nursing Department

Compiled by Maureen Ross, Marel Paton, Martha Petersen, Nomafana Jakavula and Josephie Adams.

On 3 February 1938, 249 patients were transferred from Somerset hospital to Groote Schuur Hospital.

The first chief matron appointed in 1938, was Ms E.M.Pike, who remained in this position until 1946.
After Ms Pike, the following chief matrons were appointed:

Ms S.M.Marwick	1946 - 1949
Ms E.J.Fouche	1949 - 1966
Ms C. de Wet	1966 - 1968
Ms P.H.Brassell	1968 - 1980
Ms L.J.du Preez	1980 - 1988
Mrs A. vd Walt	1988 - 1997
Mrs M. Pletts	1997 - 2000
Ms C.J.Thorpe	2000 - 2009
Mrs M.J.H.Ross	2009 - 2016 (the first non-White head of Nursing at GSH)
Mr A. Mohammed	2016 –date (the first male head of Nursing at GSH)

It was during Ms Fouche's `reign' that non-White nurses were allowed access to training in 1963

a) Dress code for Nurses

Indoor uniform while on duty

Student nurses wore a White long sleeved uniform, grey and red cape (supplied and laundered by Dept of Health), White paper cap and brown lace-up Harley Street shoes {the latter had to be purchased by each respective nurse. There were no short sleeved uniforms at that time. Nurses had to roll up their sleeves neatly when attending to patients. The White nurses wore the same uniform except that they had navy blue and red capes.

NB. At the time, nurses were respected in the community and they could feel safe to travel because even the so-called "skollies" or "ruffians" would display respect and recognition to "the girls in White"

Outdoor uniform

An air force blue all weather coat with matching boat style cap with the GSH badge on same. This outdoor uniform had to be purchased by each nurse at a store called RINA's which was situated in the Main Road in Observatory.

b) Training Colleges

These included Carinus, Sarlie Dollie, Nico Malan, Otto du Plessis, Somerset Hospital, Conradie Hospital, UCT, Princess Alice Orthopaedic Hospital, Victoria Hospital and Woodstock Hospital.

Nursing education was offered as a 3 year diploma at the above colleges. The training system for nurses was referred to as the BLOCK SYSTEM whereby nurses were allocated to the Colleges from 08h00 till 15h30. This system of training ensured that student nurses could learn over the three years various nursing duties and modules pertaining to Anatomy, Physiology, Medical and Surgical nursing Social Sciences, Pharmacology and Ward administration.

On completion of the above, nurses were registered with the South African Nursing Council. (SANC) These registered nurse novices were given the title of STAFF NURSE. This changed when the two year bridging course was introduced in 1989. Only then all registered nurses were referred to as SISTER.

Then followed a one year midwifery course at either Peninsula Maternity, Somerset , St Monica's hospitals for non-Whites and Mowbray or Booth Maternity hospitals for Whites . The midwifery course was compulsory with a 1 year pupil nursing course and a 2 year bridging course which commenced in 1989.

With the introduction of the 4 year course in 1985 (R425), midwifery, Psychiatry and Community Health was included over the 4 year period. This resulted in a decision that midwifery would no longer be a compulsory course. However, only the nurses who followed the Bridging course were expected to complete a midwifery course.

It was compulsory for all student nurses to be resident at Carinus for Whites and the Nico Malan College for non-Whites, at least for the first two years of training irrespective of where they lived. The Nico Malan Building was also known amongst the nurses as the `koekblik'. The first group of `coloured' students to commence their nurse training at this facility was in 1969. Prior to that, nurses had to train at Somerset Hospital.

GSH created a Clinical Education Department for nurses to be assessed for competencies in the various nursing duties such as administration of medication, injections, changing underwater drainage bottles, full washes, swabbing, douching, removal of drains and sutures, simple dressings, etc

This department subsequently became the Nursing Education Department and later the Nursing School which is now a sub-campus of the HEI's.

Carinus Nursing College was accredited by SANC to offer post-basic courses. GSH was the accredited clinical facility for these courses. These courses included Oncology, ICU, T/E, Psychiatry, Neurology/Neurosurgery, Infection Control, Orthopaedics and Operating Theatre. The University of the Western Cape (for non-Whites) Stellenbosch and UCT (for Whites) offered Nursing Administration with either Community Health or Nursing Education courses over a period of 18 months. Staff were granted study leave to pursue these courses.

It was only later that GSH offered short clinical courses as an update in the various specialities, including ENT, Stomaltherapy, ICU, Operating theatre technique, Infection Control, Stroke care, Incontinence care, Dermatology and Diabetes Education.

All these courses enabled nurses to formulate a nursing diagnosis which enhanced nursing care.

c) Clinical placement of nurses.

Because Nico Malan Centre (NMC) was situated in Surrey Estate, the Dept of Health entered into a contract with Golden Arrow bus services, to transport day and night nurses to and from GSH and Conradie hospitals.

Because nurses worked shifts, either 7 to 4, 1—4, night duty, the bus would arrive at NMC at 06h00, and leave at 06h30 to transport nurses to the hospital for them to arrive at 06h45. The same bus would then transport the night duty nurses back to the college. At 13h00 the bus would transport the 1-4 shift nurses { off duty from 13h00 to 16h00} to the college until 15h30 then they would be transported back to the hospital to complete their shift from 16h00 until 19h00. This bus waited for the nurses who ended their shift at 16h00 and transport them to NMC. At 18h30, the bus would return to NMC in order to transport the night duty nurses to the hospitals to complete their night duty shift. The bus would remain at the hospital until 19h15 in order to transport the nurses, who completed the 1-4 shift, back to NMC. In the event that any nurse missed this bus, they had to find their own way home.

Initially, nurses' duties were allocated to amount to 44 hours, but following trade union intervention, this was reduced to 40 hours per week.

Upgrading training programmes were introduced on Saturdays (for ENA's). After the completion of these programmes, they were eligible to apply for the R2175 (EN Course). This was primarily a learning opportunity but it also boosted the morale of those nurses and this led to improved patient care based on additional knowledge gained. Nursing Administration students from CPUT were afforded the opportunity to do their practical for one week. The programme consisted of aspects of staff establishment, finance, HRM, support services, agency and overtime.

Achievement award ceremonies were held to acknowledge staff who portray good attendance and work performance.

During February and November each year, there were updates for sisters in charge in an attempt to improve their management skills.

Due to a shortage of registered nurses, Nursing together with HRM, embarked on a recruitment drive and visited Potchefstroom University, UWC, Nelson Mandela and University of Johannesburg in an attempt to attract nurses to join GSH. A formal orientation and induction programme was available to orientate these new staff. This programme ensured alleviation of anxiety and offered some form of stability which prepared them for their role and function.

d) The first black registered nurses

The first two black nurses, although fully trained and registered as Professional Nurses, were appointed into Housekeeper posts and expected to perform interpreting duties. These two nurses were:

- Sr Lulama Qenqua appointed on 1 October 1980
- Sr Lindie Mangaliso appointed on 1 October 1980

e) Other general information

- The linen and crockery was colour-coded in order to indicate what race it may be used for. Whites had blue blankets, patient gowns and blue-rimmed crockery. Non-Whites had red blankets.
- We had four separate kitchens for preparation of patient meals—a main kitchen, a Kosher kitchen, a Moslem kitchen and a Diet kitchen. During meal times, a trolley would be sent to the wards. All activities were stopped and all nurses had to roll down their sleeves, wash their hands and assist with dishing and serving of meals. After lunch, patients were made comfortable, the curtains were drawn and they had to rest. No medical students were allowed into wards during that time.

- Before visiting, all urinals had to be emptied, a bedpan round had to be done, bed linen had to be pulled straight, pillows had to be puffed up and patients had to be made presentable.
- Before the end of either the 4 or 1-4 shift, staff had to collect all the patient bedside records and present them for inspection to the sister on duty before the staff were allowed to go off duty. This ensured that no prescribed treatment was not executed. If however the sister found any discrepancies, e.g. omission of medication, incorrect totalling of intake and output charts, dressings, swabbings, vital signs or douches not done, the responsible nurse had to remain on duty to complete the respective task irrespective of whether they would miss their transport!
- It was compulsory for a ward sister or senior nurse to accompany doctors on ward rounds.
- The Occupational Therapy department would supply games such as Ludo, dominoes and cards to the wards in order to avoid patient boredom.
- The `Yellow ladies', a group of volunteers who wore yellow aprons, could be contacted to wash the patients' hair in the wards
- Long-term patients were allowed `week-end passes' where they could be temporarily discharged on a Friday and return on a Sunday. Their beds remained vacant for the week-end.
- We had lots of respect for our superiors. We never had a short-sleeved uniform. We had sleeves. And when it was mealtime, you rolled your sleeves down. When you went to see the matron you rolled your sleeves down. If a doctor walked in, you got up. if you were sitting in your ward and the doctors walked in, you got up. Ons doen dit nou nog. Ons is almal ou nurses.
- Our work ethic was second to none. When we talk about ward routine - in the morning there was a ruling that the night staff must wash the first two patients on the slate. The night staff also gave the first patient their premed. Today, the nurses don't do full washes – they give water; nobody strips the beds. In the old days, you weren't allowed to come into the ward if every bed wasn't stripped first. We first stripped all the beds before we did the washing.
- With the opening of wounds on ward rounds – this had to be communicated to the sister in charge the day before and they would then open the wound and place a fenestrated towel over it until the round and that is why the infection rate was zero. It was an absolute disgrace if your patient developed a bedsore in your ward. And we had to write a statement; jou matron het vir jou geskree en gesê watter slegte nurse jy is. And there was only one IPC sister.
- As the ward sister, we had to ensure, before we went off duty, that if you have 44 patients you must have 44 forks, 44 knives, 44 spoons, etc. And we had a ledger book that we needed to fill in daily.
- Some of the challenges faced by non-White nurses included the following: (These were not applicable to the White nurses)
- As student nurses allocated to operating theatres, we were not allowed to enter the theatre until the White patient was anaesthetised.
- Because of the separate entrances for the White and non-White staff, they had to only use their allocated entrance. If staff tried to enter by the wrong door, they were stopped by the porter. Ward F4 was the non-White Orthopaedic ward and C2 was the White Orthopaedic ward. The Zone matron had to walk from F4 to the A floor non- White side then had to walk outside the hospital to gain access on the White side in order to do the supervision of the White ward C2. The reason was that the non-White staff were not allowed to walk through corridors where White patients' wards were situated.
- If you were the sister on night duty, a parcel of sandwiches was sent down from the Doctors Bungalow and

was delivered to the night matron's office. The White sisters would eat first and when there were left-overs, they would send these down to the tea room, which was on the E Floor for the non-White nursing staff. The non-White nurses felt that this was disrespectful, so sent the sandwiches back to the matron's office. After that, they were summoned to Ms Brassell's office and reprimanded. They stated their case firmly and Ms Brassell agreed with them, so on the following night, two parcels were sent down from the Drs' Bungalow. However, things did not change during the day, where the White nurses went up to Carinus for lunch and the non-White nurses had to share the tea room behind the chapel with the General Assistants.

- Nurses were expected to stay at the Nico Malan College, but received a measly two slices of bread or one egg or pilchards for lunch. Supper was however good.
- In the Nursing Education Department, White tutors were allowed to mark examination papers from home. However, the non-White staff had to come on duty to perform the same function otherwise it would be documented as AWOL.
- Non-White staff were not granted permission for 5/8ths posts, two weeks' leave, sessional posts, etc. This was earmarked for White staff only.
- Initially non-White staff on maternity leave had to resign from their post and re-apply after 180 days.
- Study leave was denied to staff who had children under 2yrs of age.
- When entering nursing at the age of 17 or 18, all the non-White nurses had to first undergo a medical to check their status for syphillis and TB. TB checks were then done annually. This was not the case for the White nurses.
- Of all the matrons, Ms du Preez and Mrs Chaffey were very supportive of the non-White nurses, to do well and develop themselves by attending courses. They also encouraged the staff to apply for senior posts, thereby promoting their advancement in the profession.
- Some of the doctors were supportive and others not so, some bordering on blatantly rude. Some days were tolerable and other days made you feel as if you did not want to come to work anymore.

These were some of the experiences the nursing staff endured, but accepted with a smile and they used these to build their own strength. Despite everything, one of the nurses interviewed said: *"I say if I had my life over, I would do nursing at Groote Schuur again, really. The opportunities that we had."*

f) Nurses' role in the Planning and Commissioning Unit (PCU).

In 1978/1979, under the supervision of Dr F.vd Merwe, the following nurses were part of the PCU team: Mrs A. Louw, Mrs J. Adams, Ms V. Dettling, Ms J. Nathan, Ms G. Botes, ENA Cerfontein, Ms Engelbrecht, Mrs J. Daly, Ms P. Sexton and Mrs A. Coyle.

By 1986, the nursing representatives on the PCU had to give input into the planning for the New Groote Schuur Hospital building and commissioning. They were debriefed by the architects and engineers and regular meetings were held with senior medical and nursing staff of all departments to inform them of the location and lay-out of their areas. Each nurse allocated to PCU had a specific portfolio. Staff had to be part of decision-making with regard to space, equipment, bedhead services, lights, plugs and consumables, leading to the actual functions that would occur in that area. Staff were invited to attend presentations by various companies eg exchange cart, ventilators, instruments, pneumatic tube, etc. Nursing staff from the clinical areas were called to assess and evaluate the night lights for patients. The exchange cart , being an American concept, had to be demonstrated to all the ward, theatre, ICU and T/E staff.

PCU staff had to liaise with the fire department in order to identify the most suitable space for the fire hydrants.

Head Office received regular feedback and updates with regard to the progress of the New GSH and due to their success, PCU nurses were asked to assist Vredenberg Provincial Hospital with the planning and commissioning of their new hospital.

g) The Old Main Building (OMB)

In the OMB, wards had 44 beds but due to the burden of disease, those wards had to be fitted with camp beds to accommodate the extra patients. This led to a 44 bedded ward becoming a 50 or 52 bedded ward. This was not conducive to health and increased the workload twofold. Through consultation and negotiation with Head Office, by the then medical superintendent Dr Cato van Wyk, the camp beds were discontinued and instead alternate accommodation either within or outside the hospital, had to be found for those patients.

Following high profile consultation, permission had to be sought for non-White patients to be accommodated in the White wards, due to the shortage of beds in the non-White wards. Professor Solly Benatar was instrumental in allowing non-White patients to be accommodated in the White wards, where beds were available. "*All the doctors and especially the Heads of the Departments had such great respect for the sister in charge, that they listened. If you had the conviction to stand your ground, then they listened. That is the advantage I think, that we had. That relationship that you had and built up. I mean, even in Surgery, you know, Prof. Mendelson, Prof. Terblanche, Prof. Dent - they would listen to the sister in charge and they came to assist us. You had that relationship with the doctors.*

In the Emergency unit, Dr Aboo decided one night to close the entrance to the White side and only have one door open. This caused some disruptions amongst the patient who did not feel they should be there."

The first private ward at GSH was commissioned in F23 and was used mostly for surgical, orthopaedics and renal patients primarily. This ward was perceived by some as an elitist ward which caused some unhappiness among some medical staff. Despite the latter, the ward generated substantial finances.

In the OMB, radioactive patients were nursed in F4, J2 and A10 (gynae ward). Following discussions, it was decided to reinforce the stoep walls with lead in F4 in order to nurse the radioactive patients in a protective area. Subsequently, in the new, hospital there is a special ward, C9, to accommodate all radioactive patients.

h) The New GSH (NGSH)

The NGSH was commissioned in 1987 with the Oncology wards being moved over first and from 1988 onwards, the rest of the Old Main Building was moved to the NGSH. Before the Departments of Medicine and Surgery moved over, Prof. Benatar and Prof. Kirsch supported by an entire deputation went with the Dean at the time to Head Office and said that the medical patients would not move unless the wards could be integrated. Then when the message came through, immediately Prof Terblanche and Dent followed suit and integrated the Surgical wards.

The Trauma and Emergency resus room was moved from the front of trauma unit to the back because of the interference of gangsters who threatened staff. Security gates, cameras, and turnstiles were also installed for the same reason. High profile patients became difficult to manage again because of the gangsterism which prevailed. These patients had to be given false names in order to protect them as well as the staff.

TB was so rife that an isolation area had to be created in EU.

The management of Psychiatry patients was challenging. Prof Zabow kindly gave lectures to all categories of staff on how to manage these patients. Ward C22 was initially the short stay medical ward, but with the new Mental Health Care Act being introduced, GSH had to create a 72 hour assessment unit for Psych patients.

With any violence and unrest in the community, many nurses would voluntarily present themselves at the hospital to assist with the increased workload.

A laser suite was created at the entrance in ward C9. This does not intrude on the radioactive patient space. Part of C9 was also used as a lodging facility for patients who were awaiting up-country transport.

A first medical admission ward, C17, was commissioned in 1988. Later the admission ward was moved to C5 where both medical and surgical patients were admitted. Subsequently, C17 was allocated to National Health Laboratories.

Following the 2010 Health plan, GSH had to be divided into a Secondary and Tertiary hospital. A nurse manager (Mrs Martha Petersen) was appointed together with five L2 heads (doctors). The secondary level patients were accommodated in the third H on the G and the F floors of the new hospital. This pattern continued for 4 years until the 2020 Health Plan was formulated.

Wards D9, D18 and D19, were the Neurosurgery and ENT wards respectively when the new hospital was commissioned. Subsequently, these wards were allocated to create the UCT private hospital.

Ward G13 which was initially part of the medical wards, was allocated to UCT for the creation of a skills lab for medical students.

Ward F13 was initially part of the surgical wards. The ward was closed and subsequently commissioned as the Dietetics Department functions.

i) The zone matrons

The first non-White matron appointed was Mrs E. Lewis and the first non-White Principal Sister was Mrs Samsodien.

In 1980, the Zone Matron concept was introduced by Ms du Preez, whereby non-White senior sisters were allocated to supervise White and non-White wards. This was considered as a promotion but without any monetary incentives.

Some nursing staff members were dissatisfied with this system and some White patients did not respond kindly to this system. When these non-White matrons did ward rounds, some of the White patients would pretend to be asleep so that there was no need for acknowledgement per se.

j) Occupational Specific Dispensation (OSD) and Staff Performance Management System (SPMS)

Prior to the Staff Performance Management System to evaluate staff, performance was evaluated through a Personnel Assessment Questionnaire for Rank promotion, Merit Award System and the Notch Increment Questionnaire.

The OSD was created to improve staff morale and to attract registered nurses to the profession. The implementation and application thereof varied from Province to Province. The interpretation of this system was never clarified. Instead, this created dissatisfaction and anger amongst very senior nursing staff. Many requests were submitted in writing to review this OSD but there has not been any satisfactory response. The creation of a GENERAL stream vs SPECIALITY stream resulted in junior staff earning more than senior sisters (who had many more years of loyal service at GSH.) Currently there are still some staff who are disgruntled with this system.

k) The exodus of experienced nurses

The Pension rumour led to the resignation of many professional, enrolled and enrolled nursing assistants, despite efforts to reassure staff. This resulted in an increase of the utilisation of Agency and overtime staff.

14. Allied Health Professionals at GSH (Mr Lionel Naidoo)

Allied Health Services consists of various disciplines including audiology, dietetics, speech therapy, occupational therapy, physiotherapy, medical orthotics and prosthetics, social work and radiography. Some institutions may include clinical technologist and psychiatrist under the auspices of Allied Health. There are no clear definitions of which professions belong under the umbrella of Allied Health, something which could assist in determining the current workforce, service delivery and the potential gaps across the platform. It is unfortunate that in South Africa we have a board called Allied Health Professions which differs hugely from the rest of the world. Historically in SA the above-mentioned professions were referred to as Professions Allied to Medicine (PAM) by inference it means that we are allied to medicine.

The AHS functions as an integral part of clinical services rendered to the metro Geographic Service Area (GSA). Although often pooled in terminology as health or rehabilitation therapists, each of these professions has unique expertise, their own distinct scope of practice, professional boards and registration requirements with the Health Professions Council of South Africa (HPCSA) and South African Council for Social Service Professions (SACSSP).

Allied Health professionals are active in all aspects of health care and at every level from primary to tertiary care. The formation of the GSA allied health workgroup would be the first grouping of allied health services at this level in the Western Cape thus giving recognition to our professions, collaboration and representation of the services to be rendered.

Many allied health professionals feel undervalued and lack a sense of identity within the current health system. The only time there is mention of allied health it is within the context of disability and/ rehabilitation. What allied health professionals can offer is so much more than just rehabilitation.

For many years, the allied health professions have always felt as if they were an afterthought, but the creation of a Deputy Director post at Groote Schuur provided an opportunity to be managed by one of our own and this was a milestone in the Western Cape Tertiary services and GSH will be a flagship in this regard. AHP have expertise in a range of assessment, diagnosis, treatment and rehabilitation interventions that can be more fully exploited in health terms. Being managed as a group as never before may lead itself to us looking beyond traditional methods of providing services and engage in service redesign and role development that may create new models of service that reach across historical professional and service boundaries. This new impetus has aligned us to healthcare.

At GSH the Allied health team consist of 9 distinct professions

Audiology, Dietetics, Diagnostic Radiography, Occupational Therapy, Physiotherapy, Radiation Oncology, Social Work, Speech Therapy and Nuclear Medicine Therapists.

Audiology

Audiology is the study of hearing, balance, and related disorders. The purpose of Audiology is to determine whether someone can hear within the normal range, and if not, which portions of hearing are affected, to what degree, and where the lesion causing the hearing loss is found. GSH offers a range of tertiary services within Audiology.

Dietetics

The Department of Dietetics provides a specialised clinical nutrition service to both in and out-patients within the multi-disciplinary team, with a focus on specialised clinical feeding. A challenge through the years for this small department of 10 dietitians, together with its support staff, has been to provide effective evidence-based nutrition intervention in the face of malnutrition, the burden of disease, the growing awareness of nutrition and the demands for nutrition services in clinical areas. The impact of patient nutritional status significantly influences the outcomes of acutely ill hospitalised patients.

The role of the GSH clinical dietitian is to manage patients' nutritional care through assessment, prescription, and monitoring of nutrition support in patients requiring specialised nutrition intervention. General nutritional care also includes dietary education to patients and families.

The demand for clinical nutrition services continues to grow while staffing numbers, have remained the same throughout the years, leaving several clinical areas without a full dietetic service.

Historically, the tube feed service consisted of a tiny single room located in the old hospital kitchen in the 1970's, where powdered feeds were hand mixed, hand labelled and distributed in large glass bottles . In the 1980's this progressed to a small recon kitchen in the new main building together with the change to plastic compatible bottles. The introduction of a bottle recycling system in the mid-nineties required the move of the department together with the tube feed service to a refurbished J10 in the J block. The new millennium saw the worldwide introduction of ready to use products, and the development of more sophisticated disease specific enteral feeds. Once again the department and the tube feed service was moved to its current location in F13 in the New Main Building. The new hygienically safer and spacious environment enabled the department to upgrade the service by eliminating the costly powdered feed preparation and bottle recycling. A further introduction of ready to use oral supplements, as well as a more recent electronic ordering system has allowed for further growth and development in clinical nutrition care.

A daily feed outpatient feed dispensary also located in F13, is managed by the dietitians for patients discharged home on enteral feeds. The department also manages and administers the Department of Health's funded Nutrition Therapeutic Programmeme (NTP) from the feed dispensary. The programmeme supports and addresses problems of malnutrition.

Consultation is also provided to the Infant Milk Kitchen and Breast Milk bank, as well as to the Main Kitchen regarding menus and special diets with a close working relationship in these areas.

The department introduced a successful breast milk express room for staff in 2013, a first of its kind in Western Cape state hospitals. This service supports the Department of Health's Breast Feeding Policy to assist staff returning from maternity leave.

On- going training and development is an important focus of the department. UCT's Department of Human Nutrition BSc Med (Hon) students in their final year , as well as UWC's final year BSc Dietetics students, complete some of their clinical blocks in the department as part of their practical training programmeme.

GSH Occupational Therapy Department

"Occupational therapy is a client-centred health profession concerned with promoting health and well-being through occupation. The primary goal of occupational therapy is to enable people to participate in the activities of everyday life. Occupational therapists achieve this outcome by working with people and communities to enhance their ability to engage in the occupations they want to, need to, or are expected to do, or by modifying the occupation or the environment to better support their occupational engagement." (World Federation of Occupational Therapy, 2012)

The occupational therapy (OT) department at GSH renders services across various clinical areas within the hospital, including psychiatry, as well as out-patient clinics. The department is divided into four units' viz. Surgical (Hands, Plastics, pressure garments, Lymphoedema, Oncology), Orthopaedics (Rheumatology/ amputations/ Orthopaedics), Neurology (Paediatrics/Neurosurgery/General Medicine/Psychiatry) and Work Assessment, with services provided, on a referral basis, by 11 therapists to meet the in-patient and outpatient service. The remaining 3 therapists are based in the Work Assessment Unit (WAU) which is an out-patient unit, specializing in standardized assessments and work-simulated tasks. The department prides itself on the therapists' knowledge and skills of government and community resources, medico-legal procedures, performing functional capacity

evaluations and writing reports which are required to ensure appropriate referral for rehabilitation, placement or compensation. In-depth onsite work assessments are also performed to facilitate return to work programmemes. This requires excellent knowledge of job matching, ergonomics and occupational accommodations.

The OT department is also privileged in that it has a seamstress and two artisans to assist with the manufacture of assistive devices. The fully equipped workshop also doubles up as simulated work areas for WAU clients.

Physiotherapy

Physiotherapists provide services that develop, maintain and restore people's maximum movement and functional ability. They assist people at any stage of life, when movement and function are threatened by ageing, injury, disease, disorders or environmental factors. (WCPT)

The main objective of the Physiotherapy Department is to deliver a specialised, comprehensive, effective and efficient Physiotherapy service to both inpatients and outpatients.

At GSH, Physiotherapy offers specialised care in various units, such as ICU and the ASCI unit. They support all clinical tertiary medical services. This has necessitated that the physiotherapist have the necessary knowledge and skills to support these specialties. Physiotherapy service delivery provides care across the range from preventative, promotive to mainly curative management of patients.

The hydrotherapy pool at GSH is also only one of a few available in the public sector. Thus, the Physiotherapy Department has the infrastructure, knowledge and the clinical skills to rehabilitate patients who are unable to be seen at CHC's due to infrastructural constraints and the complex nature of the conditions that often require a broader multidisciplinary team approach that is only available at the tertiary level. Physiotherapists form an integral part of the multidisciplinary team across the various clinical areas in the hospital.

Speech Therapy

The core business of speech therapists is to provide comprehensive care and management, that is to assess, diagnose and treat a diverse range of communication, feeding and swallowing disorders along a continuum of ages from neonates to geriatrics. These include speech, fluency, voice (benign and malignant disorders), cognitive, language and learning impairments and feeding and swallowing dysfunction, that are often the direct consequences of acute or significant medical incidents, such as stroke, traumatic brain injury, progressive neurological diseases and dementias, head and neck tumours and resections, as well as consequences of tracheostomy and ventilation.

Radiation Therapy

Radiation Therapists, otherwise known as therapeutic radiographers are Allied Health Professionals who use computer systems to graphically plan the treatment machine arrangement so that a radiation dose is delivered to the tumour and avoids treating normal and critical tissue. Radiation therapists also use expensive high tech machinery that administers ionizing radiation to treat disease such as cancer, with the aim to either cure or ease pain. A radiation therapist together with a multi-disciplinary team makes use of relevant patient information such as imaging information, any tests or radiographic scans such as x-rays, CT and MRI the patient may have had, to determine where the tumour is located.

A radiation therapist works under the guidance of a Radiation Oncologist and other health team professionals to ensure the patient receives the highest standard and quality of care, thereby walking the journey side by side with the patient. Radiation therapists work only in their department and rotate through the various sections of CT Scanning, Simulation, planning and the treatment floor. Referrals of patients are received by the Radiation Oncologist who in turn, through a combined clinic with various other health professionals, determines the best approach to treatment for the patient. Should the patient, require radiotherapy, the Radiation Oncologist will book a planning slot for the patient with the radiation therapist. The radiation therapist has to have an empathetic nature and one that is intuitive to the patient's needs.

Radiotherapy is ever-changing and over the many years at GSH has developed into using technology of the highest quality through the purchasing of multi million rand treatment machines so that the prospective patients have access to quality care within GSH. It has evolved to faster radiotherapy treatment times and reduced waiting lists. Radiation therapists need to continually develop professionally on a consistent basis to keep up to date with the newest radiotherapy techniques and methods in treating cancer.

Years ago, a C Arm intensifier was used to localize a lesion. This procedure would generally take about 1-2 hours per patient. It also meant that all staff doing the procedure had to wear radiation shielding garments such lead rubber aprons which were heavy and exposed staff to ionizing radiation. In 2005, our first simulator was purchased - using a simulator to localize a lesion, takes 15-30 minutes. Staff now screen in a controlled area and do not wear lead rubber aprons.

Diagnostic Radiography

Diagnostic Radiographers provide an imaging and interventional service to patients referred from all hospital departments, to assist the Radiologists and clinicians with diagnosis, treatment and further patient management.

The diagnostic radiology department consists of different units, most of which need to provide a service over a 24 hour period, 365 days a year. This includes General Radiography, mobiles in ICU, Maternity Block, Isolation Units, Theatre screening, CT scanning, MRI, Angiography, Fluoroscopy, Orthopaedic and Cath lab. Certain areas are complex and require skilled training therefore staff from other areas cannot be rotated to these specialized areas on a daily basis.

Social Work

The aim of the social work department is to provide a comprehensive service to patients and families who access Groote Schuur Hospital. We aim to enhance and restore the bio-psychosocial functioning of patients through various methods of intervention. We provide a service to all in and out patient areas of the hospital as part of the multi-disciplinary team (MDT).

We provide crisis counselling to patients and families who have received bad news and require immediate assistance to cope. This is done through family meetings with the view to discuss and plan for future care of the patient.

We undertake psychosocial assessments of patients for transplantation and discuss these assessments with the MDT with a view to further treatment or counselling if the patient is denied treatment. The social worker is integral in dealing with issues of loss, bereavement and death. We further counsel all patients diagnosed with life threatening illnesses, intervene and plan future care with patient and families and if necessary introduce palliative care as part of the treatment.

We also undertake to assist in all referrals for intermediate care and rehabilitation of patients. The social worker is integral in the discharge planning in the wards to ensure quick turnover of beds. They are also called on to investigate and assist in dealing with homeless and unknown patients.

The social work department has been part of the development and growth of the palliative care programmeme at GSH and is part of the writing of the palliative care policy for the province. This service has been a success with the employment of two auxiliary social workers.

The social work department coordinates all the SASSA applications within the hospital and liaises with SASSA regional office. We have a designated clerk for this service which runs smoothly.

The role of Nuclear Medicine Radiography at GSH

Nuclear Medicine radiographers are health professionals working as part of a team which uses radioisotopes in the diagnosis and treatment of various medical conditions. Nuclear Medicine radiography is one division under

the Radiation Medicine Department at GSH. Nuclear Medicine services are provided on all working days and a 24-hour on-call emergency service after hours and weekends.

History: In the early 70's, Nuclear Medicine radiography consisted of diagnostic radiographers, medical technologists and medical scientists as no formal training was required. In the mid 70's, Ms Jane Gatt, a diagnostic/nuclear medicine radiographer was appointed as a tutor and a formal Nuclear Medicine course was established in 1977 under the auspices of Cape Technikon. The Nuclear Medicine radiography department was run by Mrs Patricia Freedman and Ms Idafay Madeisky. In 1982, Mrs Geraldine Philotheou took over the tutorship until she retired in 2015 and Miss Carolyn Lakay was appointed. The radiography headship was taken over in 1983 by Ms Gaseeda Boltman and Mr John Boniaszczuk until the present.

The department is reasonably well equipped with two dual head gamma cameras, a SPECT/CT camera, electronic image processing and archival systems, two intraoperative gamma probes, an automatic gamma counter, a laminar flow cabinet and an ECG / treadmill machine.

15. Department of Engineering (Mr Denton Smith)

In the early 1930's Groote Schuur Hospital was first brought to life in the form of engineering and architectural drawings. These drawings showed a new and extremely modern hospital that was to have on site a full Teaching Hospital, Doctors' quarters, numerous clinics and Out Patient Facilities housed in the Clee estate area located between the hospital building and the Main Road as well as a Nurses' College and Nurses' Home. The New Groote Schuur Hospital was to include a "Private Hospital" as this was already on the site.

In order to build the Groote Schuur Hospital all of the Cape Administration Engineering minds got together to ensure that the hospital engineering services were designed into the architecture in a way that would allow for ease of maintenance through simple robust engineering that to this day allows us the ability to easily and cost effectively maintain the older sections of the hospital.

This engineering fore-thought in design may be seen in the numerous service ducts and shafts as well as the rabbit warren of service tunnels that allow access to all services - be they electrical, mechanical or building all over the Old Main Buildings.

Built into the design of the older buildings are some tried and tested designs as well as some "new" ones. The design of the wards was based on the nightingale principle of high ceilings, large opening windows and verandas. The high ceilings and thick walls of the original hospital ensured that there was always a relatively constant temperature within the building. It is only since the verandas and windows were closed up and the ceilings dropped to create office space that there is now the need to air-condition areas of the building.

The original layout of the building had all of the main services like the Engineering Services, Laundry, Main Kitchen, Sterilising Department, Exchange, Main Entrance and Patient Processing on the ground floor as well as the basement. In order to get the services like food, files and linen from the Kitchens, Linen Stores and Records Rooms there were a series of utility lifts and dumb waiters that serviced the upper floors and patient areas. These lifts were not the manned type but rather were operated in this manner - a telephone call was made to the Support Service by the ward and the relevant lift would then be loaded with the requested goods and the correct floor button was pressed. The lift would then ascend to the relevant floor, be unloaded and be sent back to the basement.

As it would be at the time, some of the design team were employed as the first Engineering staff for the hospital. Many of the rest of the staff complement came from the staff of the contractors who built the hospital. It can therefore be said that the Engineering Department at Groote Schuur Hospital has been there right from the start,

from pencil on paper stage to the build stage to the commissioning stage to the maintenance stage where we have been effective ever since.

The Engineering Department consisted officially of 50 staff members employed to maintain all engineering and related aspects of the Hospital. By the 1970's the Engineering Department had a staff complement of 370 staff and these staff members provided an Engineering Maintenance service to the surrounding health Institutions, including Red Cross War Memorial Children's Hospital, Somerset Hospital, Mowbray Maternity Hospital and other such institutions.

In the early 2000's, due to budgetary restraints and a reorganization of the hospital structure, staff numbers were cut. In 2010, the Engineering Department had 75 staff and this has been further reduced to 70 now in 2017. This is particularly due to a difficulty in attracting suitably skilled staff into posts that have been graded at a low level through the Occupational Specific Dispensation process. The staff of the Engineering Department are responsible for the maintenance of all engineering and associated services to the hospital as well as all maintenance of health care technology (Clinical Engineering).

The Engineering workshops were located in what is now the Q-Block next to the boiler house. The Boiler House has always been located in the same position however the smoke flues and chimney pipes, originally passed through the hospital and into the central tower where it was vented from the dome at the top. Historically, this dome has always been painted black to hide the soot that fell out of the chimney onto the dome. The hospital incinerator chimney exhausted out of this tower as well.

Making reference to the sewer reticulation in and around the Old Hospital and surrounding buildings I would like to point out that there are some truly lovely designs that have been used to ensure the smooth and constant drainage of the hospital sewerage. Some of the more exciting designs are the surge tanks and over-flow containment tanks. The use of surge tanks to control water and sewerage has been in building and city design since the time of the Romans. The operating principle of the Sewerage Surge Tank is simple - many sewer lines terminate in a large subterranean tank that has one small bore outlet pipe. As the multiple sewer lines empty into the tank it fills a little and drains but at times when all of the pipes are draining a lot of water, then there will be a high volume of sewerage discharge that drains into the Surge Tank. This surge does not last long and as it carries on it fills the tank, when the discharge stops then the out-flow pipe will drain the tank in a controlled and constant manner.

In the basement of the Old Main Building can be found the sewerage over-flow tank. This tank is at the centre of the back end of the hospital basement at the focal point of a number of main sewerage pipe out-flows. This tank is a cement construction with raised manholes in the middle. From these manholes, the sewerage is directed out and to the municipal sewer system. Should this sewer out-flow be interrupted by a blockage the sewerage would then overflow from the manholes and into the tank allowing about 6 to 8 hours for the blockage to be removed before any flooding would occur. With normal sewerage flow restored, the liquids drain out through a French Drain System embedded in the floor of the Surge Tank and once drained the solids could then be removed by means of shovel.

Built into the basement on the Old Main Building can be found the emergency generator that was installed in 1936 and is still in use to this day. The Boiler House has a Rolls Royce generator dating back to 1934, also still going strong.

The same building techniques were applied to the design and build of the Out Patient's building and Maternity Block. The motifs on Balconies, walls and roof ends were carried over to all buildings built pre 1970 but sadly from then on, the design took on a more "industrial block" style. This style is easy to build with as the majority of the building can be pre-fabricated on or off site. As for the Old Main Building, the Maternity and Out Patients

buildings were constructed with:- Generator and associated substations along with the main section or riser electrical switchboards; Chillers and heat exchangers for generating hot and chilled water for domestic usage as well as air-conditioning purposes; domestic potable and fire-fighting water as well as sewerage main lines; Medical gas main lines and finally, all Communications lines (Building Management, Intercom and Telephone) located in a central service tunnel that runs the length of each building below the feet of the Patients and Staff going about their daily work without a thought of the services pulsating mere centimetres from the soles of their shoes.

All of the tunnels were interconnected and remain so to this day allowing for the free circulation of the Engineering staff as they perform the routine maintenance as well as attending to breakdowns. Like the inter linked basement tunnels the roof spaces are inter linked as well between the original hospital and the Out Patients building. This linking is to allow free access to water tanks and valves once more allowing the ease of maintenance that the Engineering staff are privileged to be empowered with. The fact that these links are there has allowed the Engineering team to deal with flooding, blockages, electrical failures and other such hospital threatening disasters often without the hospital even knowing that there is a crisis that is being dealt with.

In the later years of the 1970's the Groote Schuur Hospital was once more on the drawing board as the Hospital was in dire need for extra treating capacity and serious modification as transplant and orthopaedic operations were on the increase. Coupled with the increase in technology and complex operations the burden of disease had changed as had nursing techniques that had been pioneered in the pre-World War Two era. Post the Second World War technology and the introduction of Computer Technology had now changed the face of Engineering and health care.

This change in hospital Engineering Technology and Practise was now being used in the design of the new and high-tech Groote Schuur Hospital. The design centred around a central nurses station in the wards that enabled the nurses to monitor all 36 beds in their wards from a single vantage point that was equipped with all of the high tech amenities such as digital phones, under counter medicine fridges and fire-fighting equipment right at their fingertips.

The design also looked at the flow of the patient from the time the patient enters the hospital to the time that the patient leaves the hospital. This approached created a hospital that was to be built with all the different disciplines of treatment areas located in strategic zones from the A level for Stores, Catering, etc to the G floor where the wards are located and on the in-between floors, ICU, Theatre and Radiology services could be accommodated. The exciting part of the design is that the hospital was designed to have a services or interstitial areas between floors C and D, D and E, E and F, F and G, and then one more above G capped by the roof on which can be found six "towers" that house the Medical Vacuum Plant, Water Tank Rooms and the Lift Motor Rooms. The interstitial floors contain all of the Engineering Services required to keep a full service to a hospital capable of holding its own on the world stage of medical practice. Like the service tunnel and roof space principle that allows the Engineering Department to effect repairs and maintenance throughout the older buildings, the interstitial floors and services within the New Main Building allow the Engineering Department to effect changes, do maintenance and repairs without interrupting the patient services at all. Many serious disasters have been dealt with again without the hospital knowing about the danger.

The design of the New Main Building was unique in the days when it was built as it included in the design a number of features that allowed for the cutting of operating costs by controlling the `Power Factor' by providing separate tanks for toilet flush water. Additionally, there is pipe work that allows for the connection of water to water heat pumps that refrigerates the returned chilled water and the heat reclaimed from this process is then piped to the domestic hot water bank for use in the hospital. This is now installed on the existing system and the New Main Building gets all of its domestic hot water generated as waste product that would otherwise have been lost to the atmosphere by the cooling towers.

The Engineering team are currently in the process of re-directing clean grey water from the hospital to the flush water tanks in order to save water and to reduce the running costs if the hospital.

The Engineering Department has been on an intensive utility savings drive and have managed, through maintenance and basic engineering, to reduce the overall hospital water consumption by 54% since 2010 and the coal consumption by 48% also since 2011. For this achievement, the Groote Schuur Hospital Engineering Department was awarded and proudly accepted a National Award from the Centre for Public Service Innovation (CPSI).

16. SHERQI Department (Ms Milah Govender)

Groote Schuur Hospital took a decision around 2009 to consolidate previously separated services in Infection Prevention and Control (IPC), Occupational Health and Safety (OH&S), Risk Management and Quality Assurance (QA) under the umbrella of SHERQI. This was based on the premise that quality is everybody's business and is a transversal function, but links very closely to IPC and OH&S. IPC, although performed by nurses, affects all at facility level. Similarly, although Occupational Health staff have a key responsibility for occupational health, all health workers fall into this domain so a broader perspective was needed. Furthermore, within the National Core Standards, IPC and OHS were identified as functional areas and as indicators of good quality, thereby establishing Quality as the overarching framework, directly reporting to the CEO's office. This also allowed for an ability to meet the legislated requirements and accountability for these functions.

Benefits of Integration:

- Elimination of silos and duplication of tasks.
- Elimination of non-value adding activities
- Clear goals and direction to those components.
- Allows for an opportunity for building a sustainable management system.
- Operational efficiency increased and costs lowered
- The possibility of making quality ,environmental and health and safety part of every employees daily duties
- Enable fewer and /or decrease organisational risks

Furthermore, to achieve effective accountability, all staff have the responsibility for Quality of Care, IPC and Safety in their job descriptions. In 2013-14, based on the successes achieved by Groote Schuur hospital, the Western Cape Department of Health drafted a proposal to strengthen Quality, Infection Control and Occupational Health Management within the province based largely on the operational management structure, systems and processes implemented by Groote Schuur hospital.

The integration also allowed for a more effective management of these areas and huge potential cost savings through reduced adverse incidents; reduced health care acquired infections and improved productivity which was supported by current policies and initiatives.

Currently, the QA/IPC/OHS committees or forum includes: IPC practitioners, microbiological or infectious diseases expertise, clinicians, laboratory services, sterile services (SSD), waste management services and housekeeping services, health and safety Committee chairpersons and reps, safety officer as appropriate.

17. Groote Schuur Hospital Labour Caucus

Groote Schuur Hospital has a staff complement of ±3800 employees, consisting of various occupational categories, ranging from cleaners and porters to highly qualified medical professionals who are represented by no fewer than six trade unions with different confederation affiliation. These include, National Union of Public Service and Allied Workers (NUPSAW); National Education Health and Allied Workers' Union (NEHAWU); Public Servants Association (PSA); Health and Other Service Personnel Trade Union of South Africa (HOSPERSA); Democratic Nursing Association of South Africa (DENOSA) and Public and Allied Workers' Union of South Africa (PAWUSA). Thus, Groote Schuur Hospital is faced with a challenging labour relations environment.

The GSH Labour organizations were present prior to 1994. However, post 1994, a resolution, passed by the government resulted in the creation of the Institutional Management Labour Causus (IMLC). This forum is represented by members of the various trade unions as well as members from management. The main function of the IMLC is to promote a harmonious working environment, through monthly meetings to discuss issues that the employees face in the workplace. Labour Representatives are members of the different federations, which include, COSATU (Affiliation to the ANC) and FEDUSA (political). GSH Labour representatives are elected on a regular basis as and also act as Shop stewards. The IMLC meetings have become known for their healthy debates and heated discussions, but all work towards serving the interests of the employees. Apart from meetings to discuss agenda items prior to the IMLC meeting, Labour representatives also assist the staff with disciplinary and grievance procedures and when issues do arise at the IMLC that require further exploration, Labour representatives serve on the task teams to attend to challenges and timeously resolve them. Feedback is then provided at the following IMLC meeting. Labour representatives also serve as members of the Occupational Health and Safety Committee and the GSH Security Committee.

The CEO of GSH (Dr B. Patel) meets regularly with the Labour Caucus executives. If the channels of communication were followed and the matter remained unresolved, then the CEO intervened to assist with the process. Over the past few years, the relationship between Labour and Management has improved considerably. The CEO's `open-door' policy ensures issues are dealt with swiftly, which contributes to and enhances a better working relationship. Labour has seen a shift in transparency, which leads to improved communication in the institution and hence a better working environment.

The IMLC at Groote Schuur Hospital is one of the most successful in the Western Cape and we are proud to represent the constituencies at our hospital. We are equally proud to celebrate our 80th birthday with all those who have previously worked at GSH and those still working at this wonderful institution.

Groote Schuur Hospital Labour Caucus representatives.

Back row: Shahied Allie, Dini Jack, Patrick Teyise, Joey Hector, Mu-ammar Slamdien, Shuaib Abass.

Seated: Felicite Landsberg, Phumela Johnson, Zukiswa Qokoqa, Eleanor Roberts, Gretha Thys.

18. The Groote Schuur Hospital Benevolent Trust (Mr Lungi Hlakudi – Chairman)

The GSH Benevolent Trust evolved from the Hospital Benevolent Association, a welfare organization, formed in 1960, by former members of the Hospital Board, Mr Alfred Friedlander, as Chairman and Mr Henry Clarke as Secretary and Treasurer. The Association solicited donations to provide tea and biscuits to waiting outpatients as well as assistance to needy patients in the form of cash for the payment of clothes, food and rent. Funds were also raised through the trolley service selling various commodities to patients in the wards, which started in 1966. Over the years, there were constant concerns about meeting the needs of the patients with the available funds, which were often depleted, but somehow, the members managed to raise sufficient funds to keep the Association afloat and later flourishing.

The establishment of a Voluntary Aid Service resulted in a rapid growth of membership, who offered their support and dedication of the highest order, unselfishly giving to those in need and making the difference to others. Their services included hairdressing for the sick patients, an afternoon tea in outpatients and teaching patients handicrafts in Maternity. They were aptly called the `Sunshine ladies' and all the members who participated in the Association adopted the motto of `We Serve.'

A further income stream was gained with the establishment of a food outlet in the Hospital during 2000. The funds raised assisted the Association to sustain the good work done for the benefit of the patients. The members of the Association were constantly reminded of their good fortune in having a very unique relationship with Groote Schuur Hospital in that they are able to work exclusively for the patients who were disadvantaged and disenfranchised. The services provided included the provision of baby formula, Assistive devices, Financial assistance and funds were provided for transport. In addition, patients were also supplied with clothing and toiletries that were donated or purchased by the Association. A courtesy bus was purchased to transport patients to and from the main road, so that they would not need to walk up the hill to get to the hospital. Overall, the services changed depending on the needs of the patients and the amount of funds available.

Following the implementation of the Hospital Facilities Board Act, the role and legality of the Association was being questioned and measures were taken to change the status of the Association into a Trust under the auspices of the Hospital Facilities Board. On 24 February 2014, the Trust was established and continues to do the good work that was started in 1960.

On behalf of the Benevolent Trust, a note of thanks needs to be extended to all the previous CEO's of GSH, who had supported the Association and now the Trust, under the guidance of Dr B Patel, the current CEO. We are grateful for the opportunity to `serve.'

19. The Sports and Social Club

The Groote Schuur Hospital Sports and Social Club held its inaugural meeting on 13 April 1960 and was formally established on 7 September 1960, with a proper constitution. Since then, they were active in promoting sporting events, such as Table Tennis, Hockey, Netball, Snooker, Karate, Swimming, Billiards, Squash, Rugby and Cricket at Groote Schuur Hospital. In addition, they hosted the annual Christmas parties, Dances, Variety shows and played lunch time movies for the staff.

The club started out with 400 members and by 1970, this had increased to 550. Numerous sporting activities were enjoyed by all participants and spectators and from as early as 1960, the rugby team had won its matches, by 1965, the soccer team were noted to be successful, having won all three cups in the suburban matches during that year and the cricket team made good progress by 1968, having won the majority of their matches. However, interest in these different activities waned over the years and from time to time needed to be revived, with significant achievements being gained in many of the sporting league games, etc.

Membership increased steadily as the club became more stable. By 1980, this had increased to 940 and reached 1295 by 1990.

Interest in the Sports Club has decreased since then and the membership is now significantly less. Despite this, more recent achievements have been in Cricket, Soccer and Netball.

Notable achievements:

1. **Cricket:**
   The GSH team reached the finals of the Provincial Games two years in a row since 2014.

2. **Soccer:**
   2012 ADMINISTRATION SPORTS UNION (First Division)
   - First Round League Champions
   - Grand Challenge Champions
   - League Champions
   - Knock-Out Champions
   - ASU Team of the Year
   - Golden Boot Award YUSUF ARMIEN (Fees Radiotherapy)
   - Semi Finalist Better Together Games

   2013 ADMINSTRATION SPORTS UNION (Premier Division)
   - Runners up Premier league
   - Winners Better Together Games

   2014 ADMINISTRATION SPORTS UNION (Premier Division)
   - First Round League Champions
   - Grand Challenge Champions
   - Overall League Champions
   - Knock-Out Champions
   - Golden Boot Award GURSZHON JOOS (Medical Records)
   - Winners Better Together Games
   - Cape Town Corporate Games Runners Up Representing Western Cape Govt. - Metro Region

2015 ADMINSTRATION SPORTS UNION (Premier Division)

- Runners Up Premier League
- Cape Town Corporate Games Winners Representing Western Cape Govt. - Metro Region
- Better Together Games Semi Finalists

2016 ADMINISTRATION SPORTS UNION (Premier Division)

- Runners Up Premier League
- Third Place Cape Town Corporate Games
- Third Place Johannesburg Corporate Games

2017 SOCCER 5's

- Winners Century City Fives 2nd Division League
- Winners Century City Fives 2nd Division League Cup
- Most Goals Scored: 93
- Least Goals Conceded: 31
- Top goal scorer YUSUF ARMIEN (Fees Dept.): 41 goals
- Runner up ISHAAM ISMAIL (Fees Dept.): 37 goals
- Semi-finalist SILVER BOOT TOURNAMENT Century City
- Cape Town Corporate Games Runners Up Representing Western Cape Govt.- Metro Region
- Reached the quarter finals at the Corporate Games in October 2017
- Reached the semi finals at the Better together games for 2017

3. Netball:

The GSH Netball Team started off in 2014, after being inactive for more than 10 years. Age group of the ladies ranges from 28 – 53 years.

2014:

- Reached 4th place in the ASU league out of 9 Netball teams

2015:

- The team reached the Semi-Finals against City of Cape Town.
- Ended 3rd place in the league out of 8 registered netball teams.
- GSH Netball also got the award for 'Team of the Year 2015'. For their remarkable camaraderie, discipline and love for the game.
- Zaneth Persence was awarded with title 'Manager of the Year 2015'. For her continuous support on and off the field. For being the teams' spokesperson, cheerleader and counsellor, whenever it's needed.

2016:

- Reached the Semi-Finals in the ASU League, but lost against Tygerberg.

2017:

- Inactive (struggling to get younger players on board)

GSH Sports Exco - 1991. Nathan Maalie, Joseph Auffrey, Ebrahim Isaacs, Matron E Lewis, Paul May, Denise Michaels, Ricardo Burns

Nariman Rylands (Victrix Ludorum), Nazeem Sait (Team Manager), Dawood Botha (Victor Ludorum)

20. Other

19.1 The Pastoral Care service

The hospital had always depended on the full time and part time chaplains at the hospital, whose day-to-day program was visiting, counselling and supporting patients, families and the staff. Their focus was on helping to understand the spiritual and emotional aspects of healthcare, which they accomplished through the lectures to both students and staff. The service has continued over the years with other religious leaders also assisting when needed.

19.2 The Photographic Service

Provided a service to the hospital for graphic design and photography

19.3 The Hospital Library

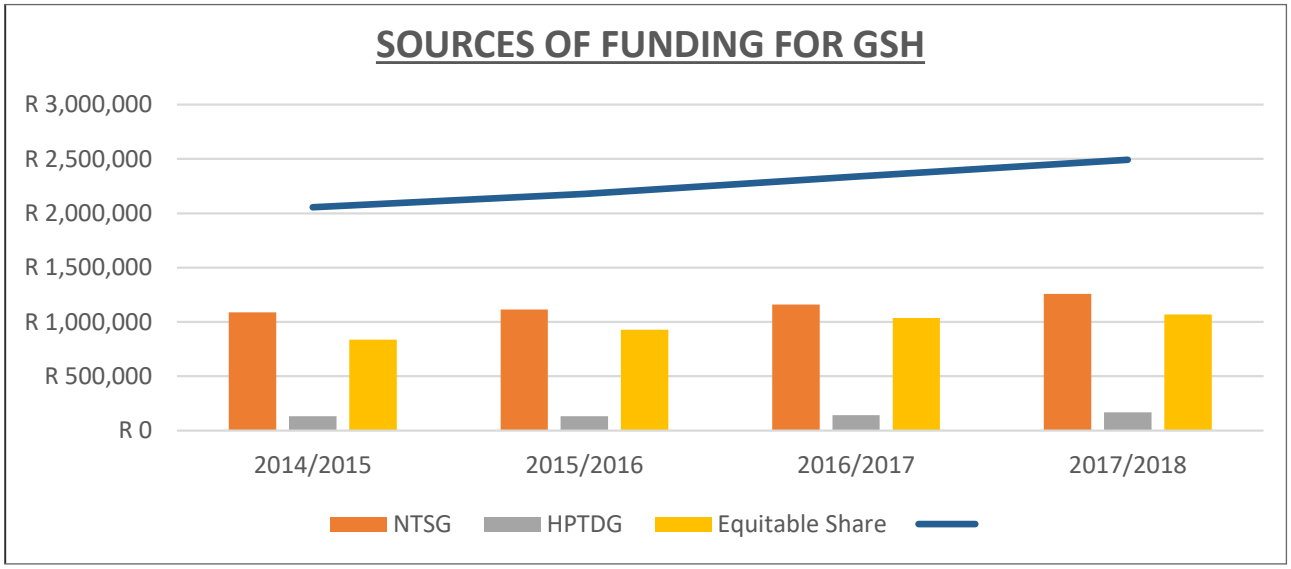
Provided by the City of Cape Town, where books were distributed to the patients

GROOTE SCHUUR HOSPITAL PATIENT, BUDGET AND EXPENDITURE STATISTICS

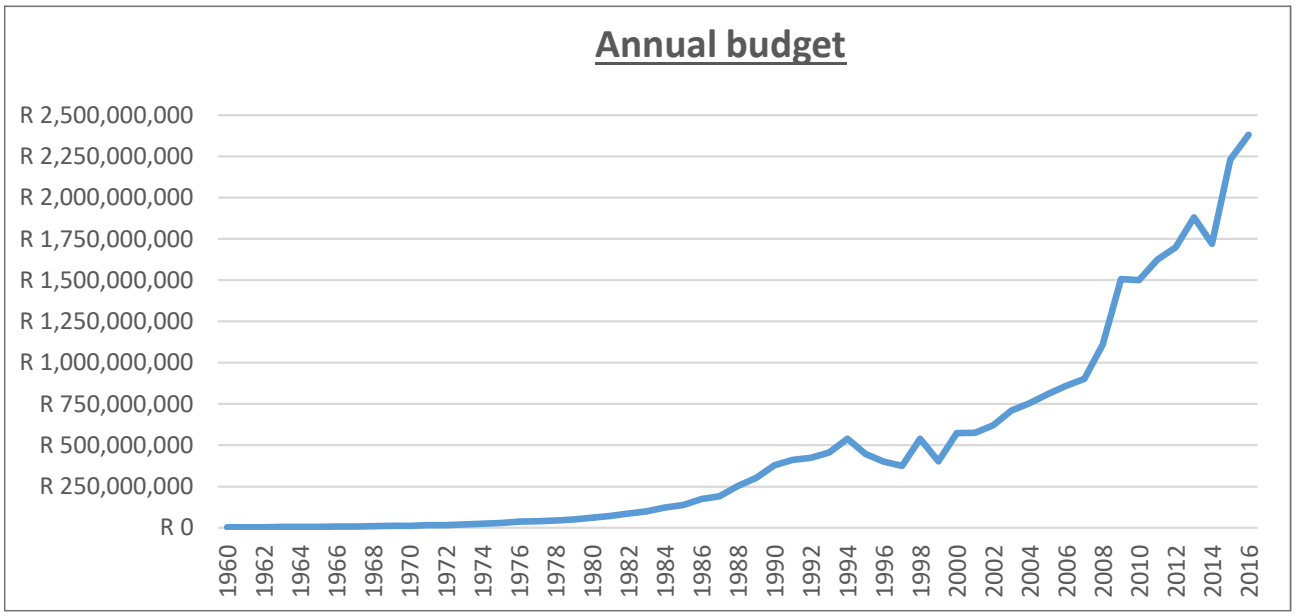
1. Annual budget

While the budget shows a steady increase in nominal terms, the percentage escalation is usually not in keeping with the rise of inflation and in particular, medical inflation (10-15%). In addition, staff salaries are negotiated for this current three-year cycle at 7% per annum, but this increase is above the annual growth of the grants. Specifically, the growth of the Health Professions Training and Development Grant was only 4.3% from 2015/16 to 2016/17. National grants account for 60% of the hospital's budget and the baseline is reduced annually, resulting in the Provincial share having to increase annually in order to sustain the work of the hospital. These National grants include:

The National Tertiary Services Grant (NTSG) and the The Health Professions Training and Development Grant (HPTDG).

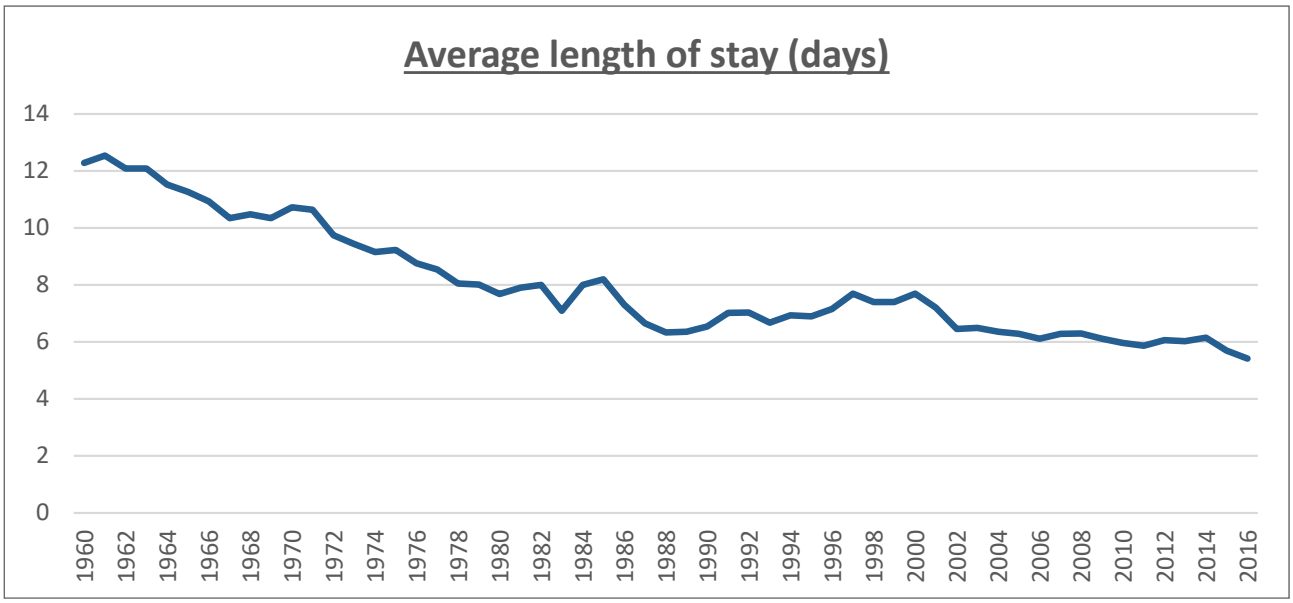


Thus, the annual budget of the hospital is decreasing in real terms.



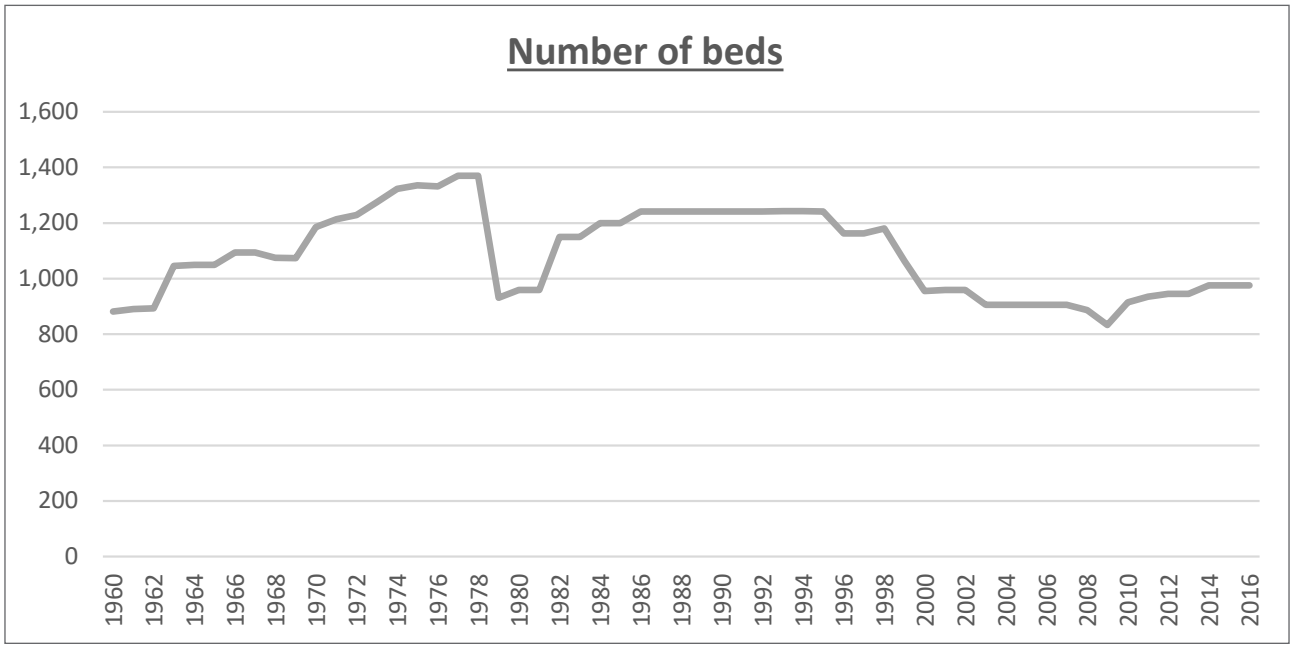
2. Average length of stay

The steady decline in the Average length of stay is a reflection of the increasing burden of the patient load being experienced at the hospital, requiring the staff to discharge patients earlier in order to accommodate the more ill patients. In some instances, length of stay has reduced due to technological advancement and less invasive procedures that require less hospital stay.



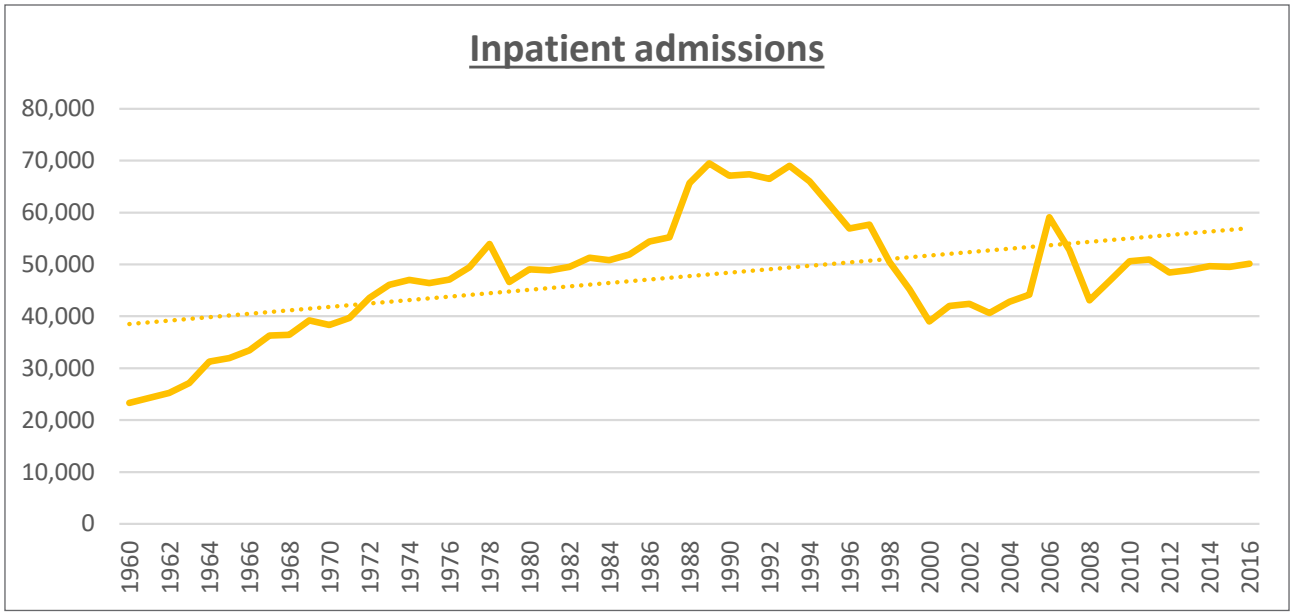
3. Number of beds

The number of beds have never reached the full capacity of the hospital as it was intended when built. Since the 1990's, bed numbers have reduced to it's current 975, due largely to the budgetary pressures, but in the face of increasing demands on services.



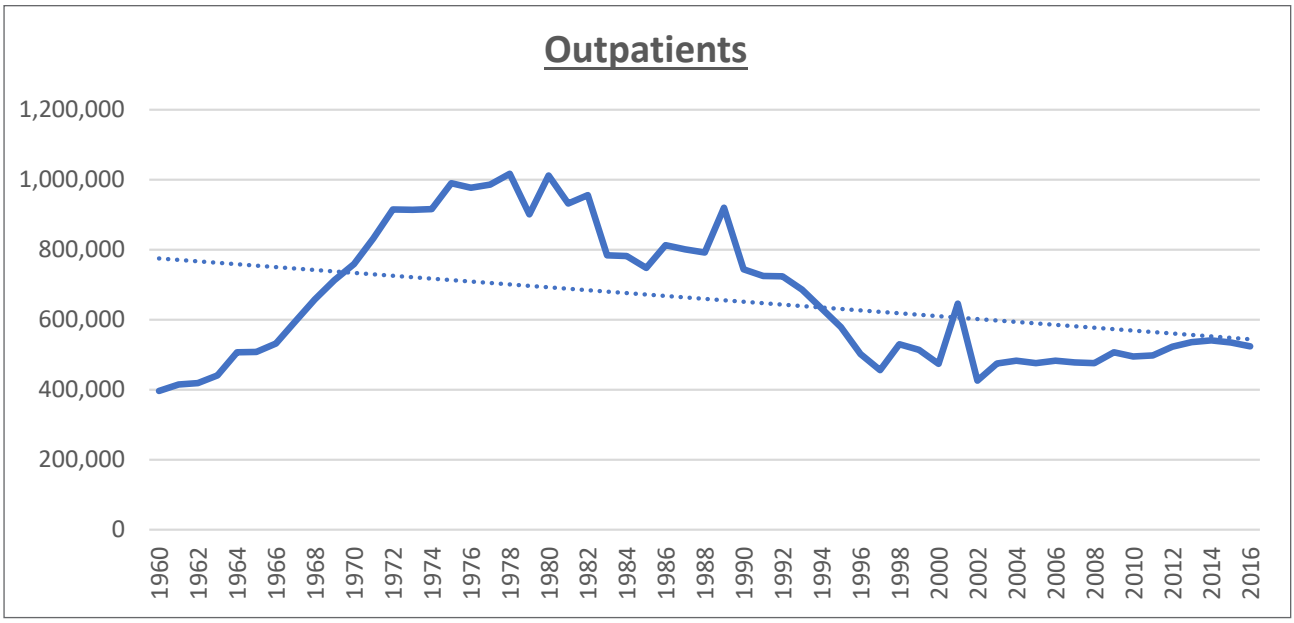
4. Inpatient admissions

The trendline reflects a steady increase in patient load on the hospital and while this is not measured, it is noted that many admissions in the latter years have a higher acuity, but are still discharged early due to the pressures on the beds. There is thus a significant mismatch between the number of admissions, the length of stay and the budget provided.



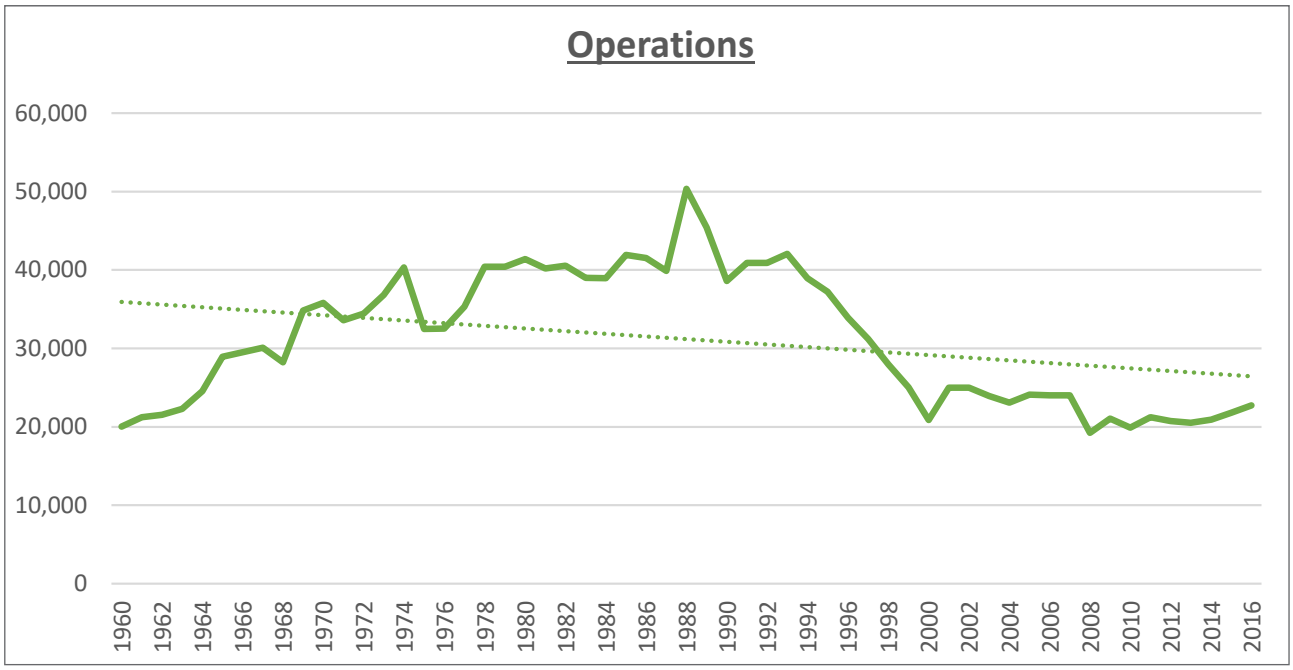
5. Outpatient admissions

The number of outpatients steadily decreased as the Primary Health care services were developed. It is hoped that this trend can be sustained to ensure that only specialist and subspecialist level patients are attended to at Groote Schuur Hospital. However, this will only be realised over the next few years as Primary Care is strengthened



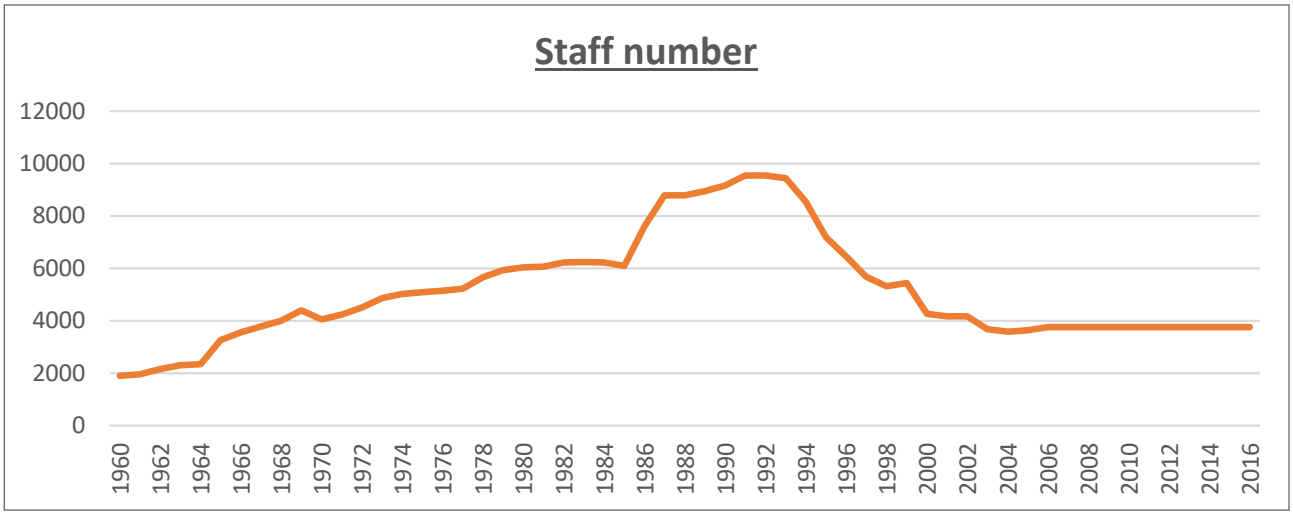
6. Number of operations

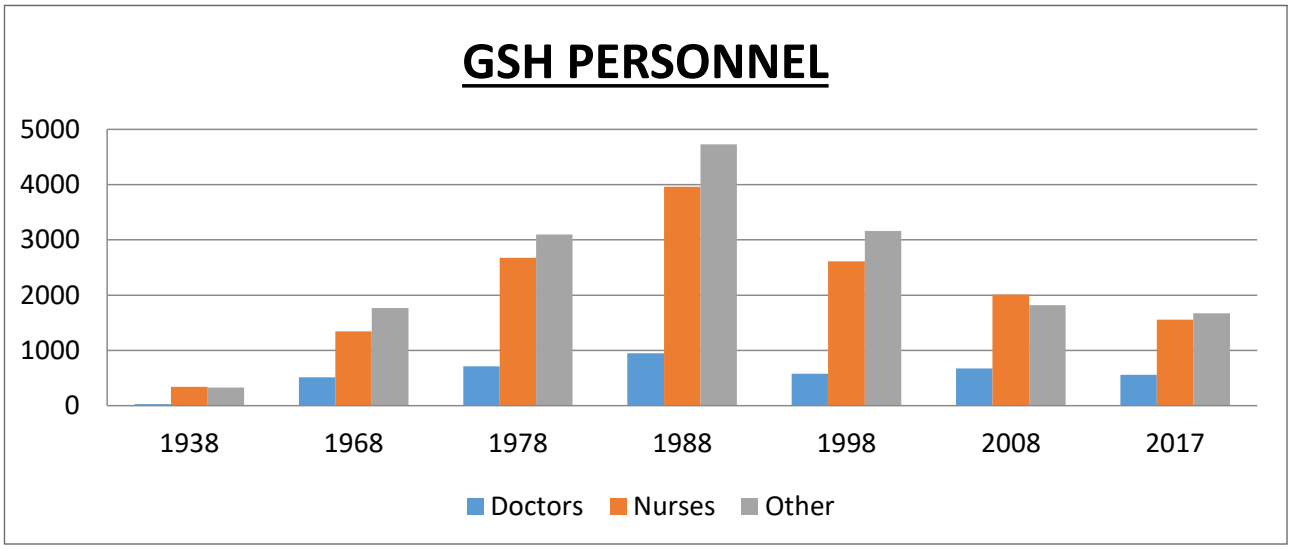
The decreasing trendline is due to many factors, including the opening of district hospitals; the management of patients medically rather than surgically; more non-invasive side room procedures; the shortage of skilled nursing staff and the reduction of theatre time due to budgetar constraints.



7. Staff number

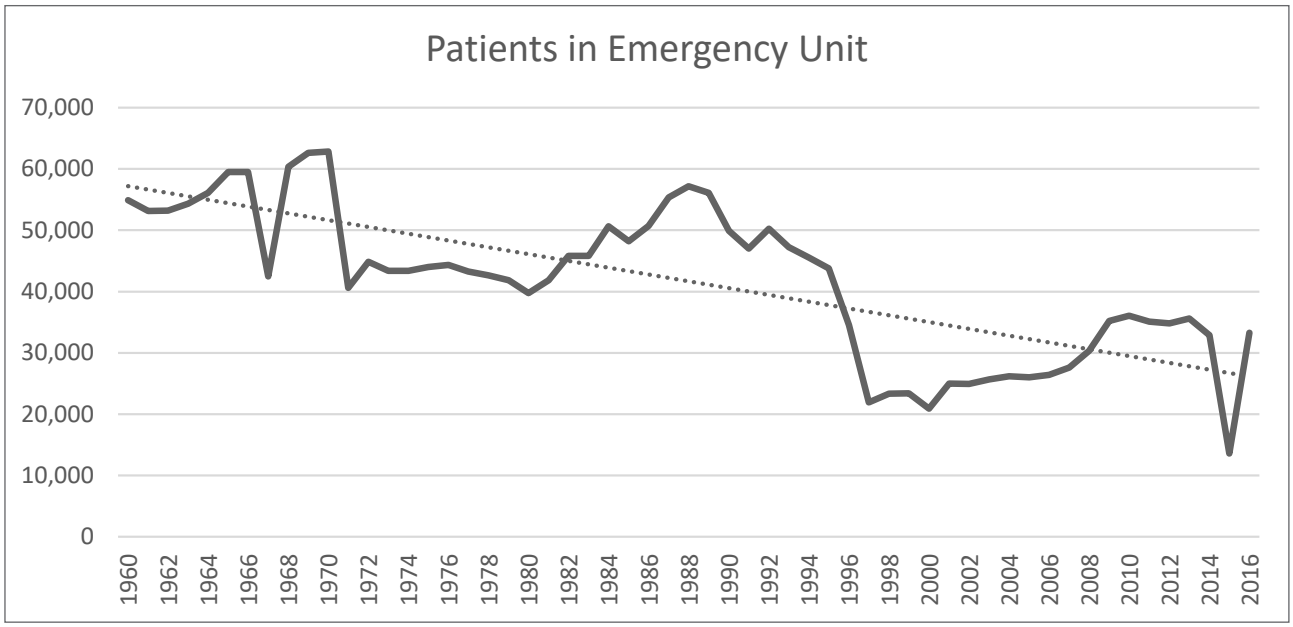
With greater budgetary control, staff numbers had to be curtailed in order to allow the hospital to continue functioning. The decrease in staff numbers for specific categories is seen mostly amongst Nursing and the Other staff categories.





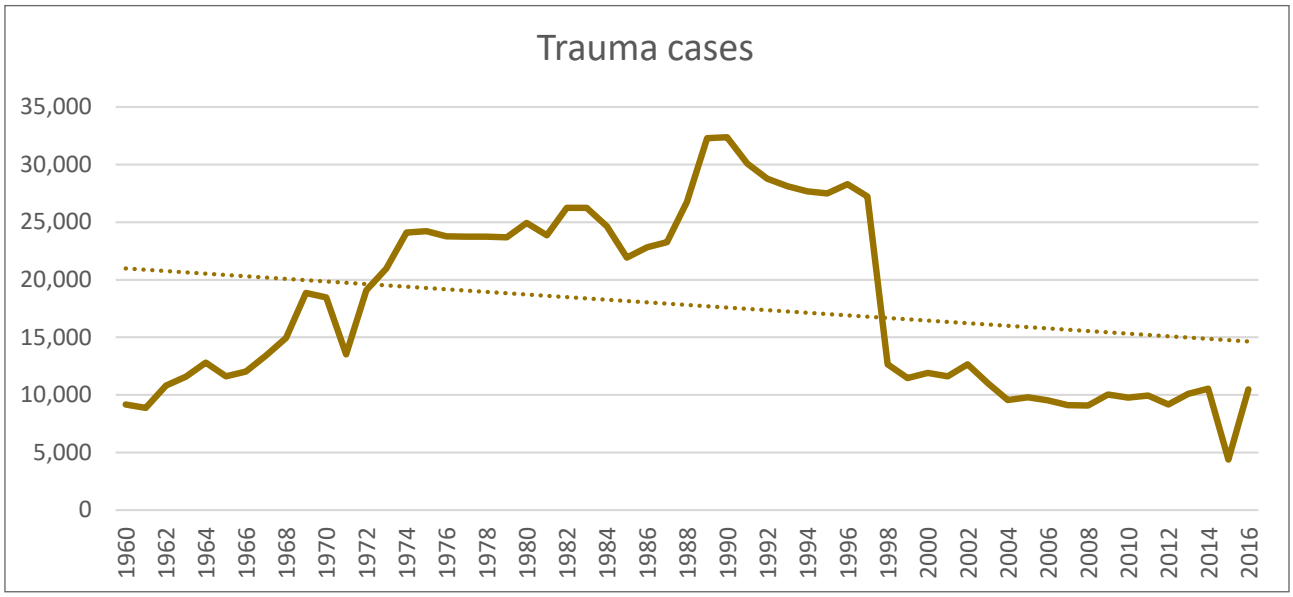
8. Patients in Emergency Unit

The decline is largely due to the opening of District Hospitals across the Cape Peninsula and the gradual strengthening of Primary Health care. However, as mentioned before, the pressures are still being felt on the services due to the higher acuity of the patients presenting for care. Of concern is the spike seen in 2016 from 2015 and the continued increase in numbers during 2017.



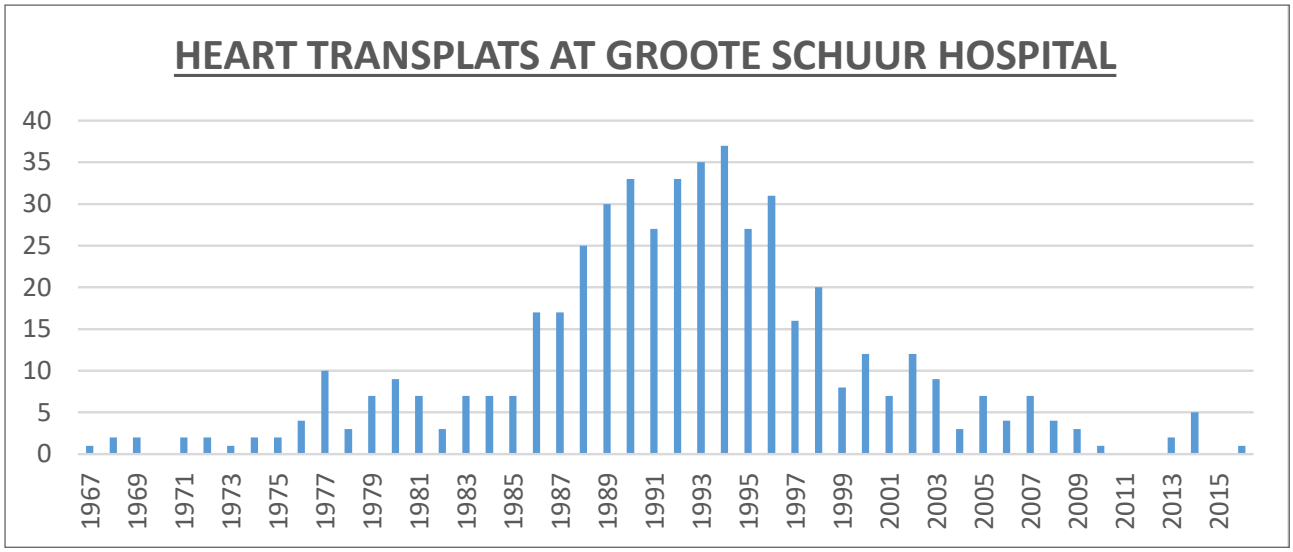
9. Patients in the Trauma Unit

The decline is largely due to the opening of District Hospitals across the Cape Peninsula. However, as mentioned before, the pressures are still being felt on the services due to the higher acuity of the patients presenting for care, with an increase noted in patients presenting with multiple gun-shot wounds and blunt assault, due to gang related violence in the communities as well as an increase in motor vehicle accident victims due to alcohol abuse. Of concern is the spike seen in 2016 from 2015 and the continued increase in numbers during 2017, which reflects a sign of our changing societal pressures and the possible future burden on our services.

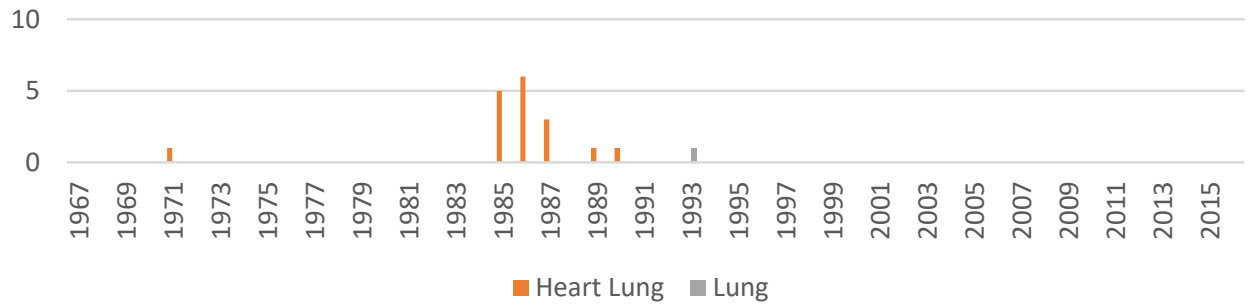


10. Transplant statistics

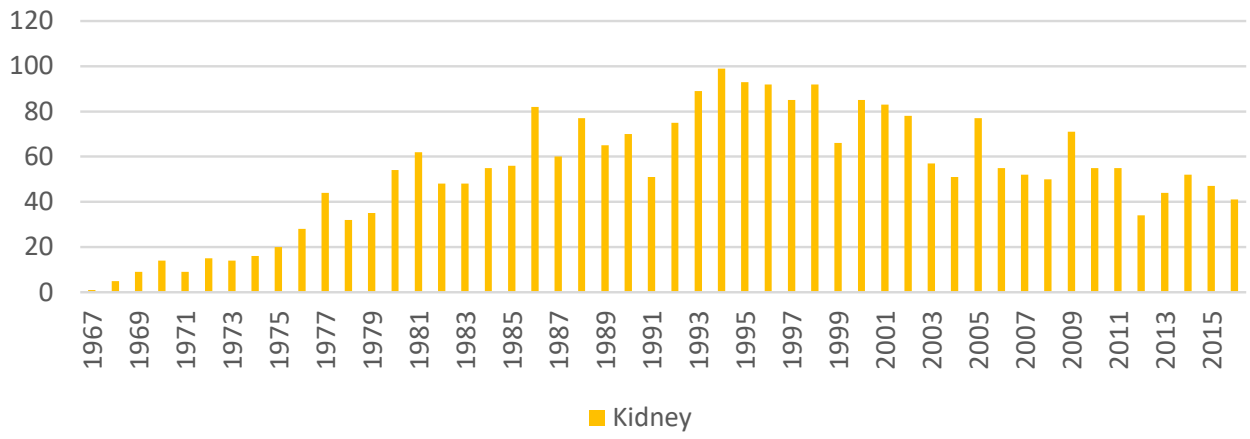
Transplants peaked during the 1990's, but have steadily decreased since the early 2000's. This can be attributed to a number of factors, including cultural beliefs, the burden of HIV related illnesses and the role of the transplant coordinators, among other reasons. The hospital hopes to re-start the lung transplant programmeme in 2017.



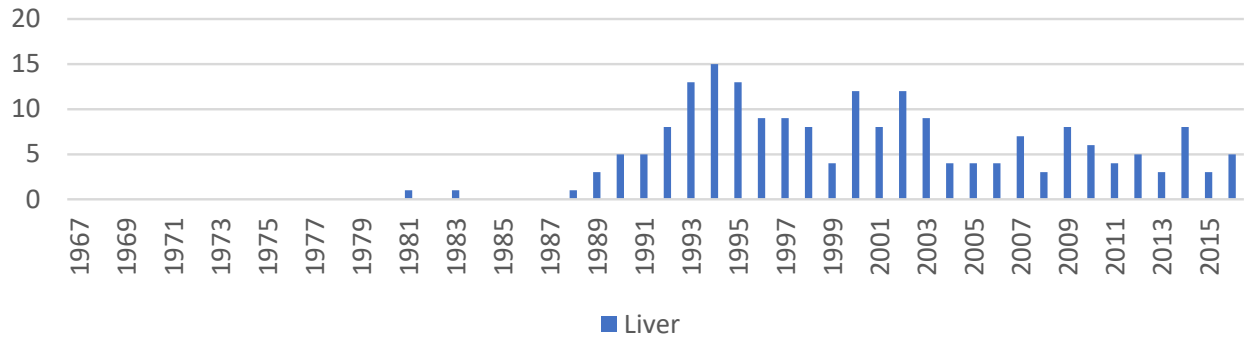
HEART-LUNG AND LUNG TRANSPLANTS AT GROOTE SCHUUR HOSPITAL



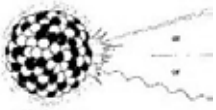
KIDNEY TRANSPLANTS AT GROOTE SCHUUR HOSPITAL



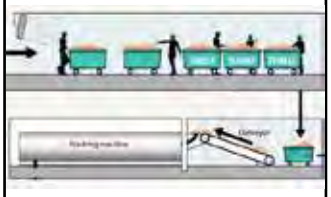
LIVER TRANSPLANTS AT GROOTE SCHUUR HOSPITAL



Some interesting annual statistics and expenditure – 2016

			
Telephone R2,079m	Blood and Blood Products R62,477M	Heart valves R15,012m	No of hospital beds 975
			
Cleaning R18,956m	Medical Gases R7,246m	Fuels R5,228m	No of Photocopies 4,453m
			
Medicine R111,194m	Medical consumables R205,484m	NHLS R83,294m	Workshop Maintenance R12,668m
			
Out-patient attendance 520 923	Electricity R36,163m	Radioisotopes R2,086	Medical Equipment Maintenance R25m
			
Total deliveries 2 816	Patients x-rayed 130 655	Meals served 1 038 810	Bandages/Dressings R7 408m
			
Staff 3762	Water R12,179m	Security R13,179m	Staff Cost R1 544,442m

Some interesting annual statistics and expenditure – 2016

			
Admissions 50 000	Surgeries performed 25 000	Lab tests 73 200	Payments to suppliers 40 000
			
Linen items turnover 3 240 000	Lighting devices (Bulbs and tubes) 4 603	Water 9 125 000 kilo litres	23 litres per patient per day
			
Number of generators 11	Electrical wiring 50 km	Diesel storage 35 000 litres	Steam lines 12 km
			
Medical gas piping 700 km	Coal used 2600 tons	Syringes bought 1 785 424	Needles bought 33 805
			
Toilet Rolls 285 737	Reems of paper ordered 17 791	Number of Computers 2 177	Wheelchairs issued 360
			
Walking frames issued 360	Elbow crutches issued 480	Number of Invoices paid 33 000	Average value of warehouse stock R25M

The Groote Schuur community has been a part of a changing South Africa over many decades, from the early colonial days with both the Dutch and the English, through apartheid to a new South Africa. While much has been endured in the past and many have suffered as a result of this, which cannot be forgotten, our efforts need to be focussed on a future that shares South Africa as a land for all. As we focus on such a future, it is important to recognise our history, because we can only appreciate where we are going to if we understand where we come from. Groote Schuur Hospital has a rich history that needs to be constantly told as it depicts the solid foundation that has been built up over the years and sets the scene for the community of today to continue to build, maintain, sustain and improve.

We at Groote Schuur Hospital are part of a diverse environment with all members of our community coming from a range of different backgrounds, cultures, countries and experiences. As such we interact with people who speak different languages in different dialects and all these differences need to be valued as part of our culture. We must embrace and respect these differences as we aim for greater cohesion. A large part of embracing and respecting involves an acceptance of people for who they are and whence they come from. This is the philosophy that is depicted in our hospital's behavioural principle of `I will respect you and you will respect me'. For Groote Schuur, this should be our mantra as we transform our environment. Respect should form the basis of all interactions, since it shows an acceptance of one another, without prejudice, without any discrimination of religion, colour or creed and without judgement. We loosely use terms like privileged, underprivileged or previously disadvantaged, but such stigmas will remain unless there is a change in the language we use and in the way that we relate to one another. We should not speak to one another based on our differences, but if we try to understand the context of where we have been and how we may see the world differently, we may understand one another better. Transformation is more about the conversations that we have rather than discrimination based on our differences, particularly related to the colour of our skin or whether we are male or female, etcetra.

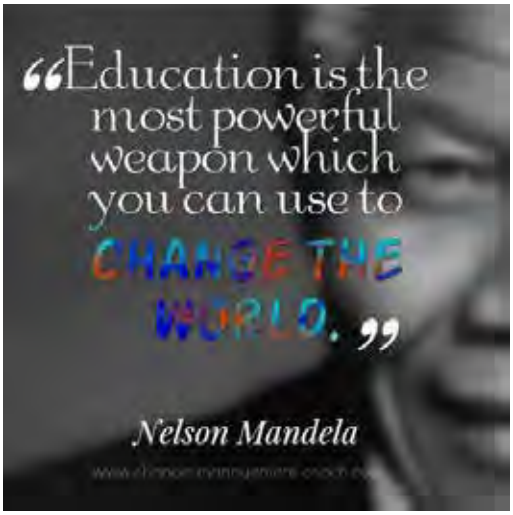
As we transform in our new South Africa, we also need to be mindful of the new generation of leaders. This new generation are part of the born-free community; they are part of the millennials and they are part of a rapidly changing environment that feeds off technology. Our transformation must include an adaptation to what this new generation needs to take our hospital into the future. Failing this could damper progress or create a situation where there is a stark division between the old and the young. Once again, this transformation is about the engagement and conversations that we have with this generation. Each and every person's opinion is valid and important, needs to be heard and needs to be respected. This requires the humility to listen to others rather than tell them what to do.

At the same time, we need to teach our young people about our history and also encourage them to learn from it. The hospital environment, and in particular the academic environment, believes in a hierarchy that has been perpetuated over the years. It believes in a paternalistic attitude from those who are supposedly more learned to everyone else. Junior staff are treated differently to peers and superiors. On top of all of that, our environment is filled with many strong willed personalities, further complicating these interactions. This attitude will have to

change, especially in the clinical areas, as we transform and this can be easily practised if we follow our behavioural principle of 'I will respect you and you will respect me'.

It is generally assumed that transformation is about fixing the differences of the past. Whilst this has to be done, it needs to build on what exists. However, if there is no fairness in 'fixing' these differences, then we are merely reversing what has been done to us before. With this in mind, transformation at Groote Schuur must promote equality for all the citizens that enter our premises. Equality in the treatment that we offer; equality in the criteria that we apply; equality in the way that we teach and train our students and most of all, equality in the mannerism and behaviour that we practise when doing so. Equality is a value and a right that forms the basis of transformation, but unfortunately, it has become a term that uses budgets, quotas and other targets to be met in the name of equality; It has become a term that is used as lip-service to endorse certain actions and as a band-aid to hide the injustices that still prevail. There is an understanding that this will take many years to evolve, but it must be done responsibly with an accountability to those who have come before us and to those who are our future.

Our country and our hospital is a space for opportunity and growth. Therein lies our transformation. To create this space requires leadership from every one of us who is part of the Groote Schuur community. Every little bit that we do to lead ourselves contributes towards the leadership of our hospital as we transform and build a Groote Schuur Hospital that will proudly survive the next eighty years.



by Bhavna Patel

1. Professor Solly Benatar

Fifty out of Eighty

I have been associated with Groote Schuur Hospital for 50 of the 80 years of its existence, beginning as a student, then intern, registrar, consultant, head of the Department of Medicine and presently through emeritus links. Interpersonal and institutional relationships of endless variety over this time provided enriching educational and clinical opportunities that contributed to a fulfilling career.

This period, from the second half of the 20th century into the second decade of the 21st century, was characterised by many spectacular advances in medical diagnostics and in medical, radiological and surgical treatments that were incrementally incorporated into our work at GSH. The nature of our country and of our health services also changed very significantly, mostly reflecting a changing national context, but also changes at the global level.

A turning point in the history of GSH was the progressive integration of racially divided services. Full integration of the old GSH presaged our transition to a constitutional democracy in 1994. Beginning in the ICUs in the late 1960s and early 1970s and continuing in the medical wards in the mid 1980s, it soon included the radiotherapy and surgical wards, and was largely completed before the move into the new GSH. Those were challenging days with many differences and difficulties that had to be overcome. But the spirit of collaboration to achieve these goals was unique and heartwarming.

Several characteristics of GSH stand out in my memory as a caring and socially valued institution, with its long-standing dedication to providing excellent care for each and every patient – although clearly achievement of this was not uniform throughout the hospital. I and members of my immediate and extended family benefited from such care both at GSH and elsewhere from doctors and nurses who had trained there. For me personally, providing such care to others under the guidance of superb senior colleagues, and later helping younger colleagues to do the same, especially within a highly effective 'firm system' that enhanced continuity of care, was one of the most rewarding aspects of my professional life. Administrative responsibilities of necessity diluted my clinical work, but never my clinical interests and passion.

GSH, as a centre of teaching and learning through its close partnership with the University of Cape Town, placed emphasis on clinical skills and teaching at the bedside. One of the goals of those who did not leave South Africa during the 'brain drain', was to ensure preservation of high quality teaching and patient care, with equal respect for the lives and dignity of all, and to carry this into a much hoped-for democratic and peaceful country. It is gratifying how far we have come and that current staff and students are building on and enhancing past achievements, although the path ahead remains challenging.

Medical leaders throughout the years included a growing number of female colleagues, who significantly influenced professional education, health care and medical administration, and served as powerful role models. For many decades, it was customary for colleagues in private practice to undertake part-time work at GSH. Their dedicated contributions to teaching, the care of patients in the wards and in out-patient clinics, and to supporting their full-time academic colleagues, were invaluable and it was a sad time when such sessional work was largely eliminated from the hospital.

The advancement of new knowledge through an expanding research programmeme and careful documentation and review of clinical results, through close collaborative and collegial work across disciplines, enabled many advances to be made. The spectrum included nutritional research, care of many chronic and malignant

diseases, life support care, organ transplantation, new surgical operations and successful implementation of antiretroviral therapy. The research record of UCT/GSH has been prolific and the work ethic of many exemplary health professionals inspirational.

The role of allied health professionals in health care, from nurses, physio-, occupational and speech therapists to research and laboratory staff, has also long been notable. I have vivid recollections of my introduction to Ward D1 as an intern on 1 January 1966 when I was informed in no uncertain terms by the senior matron that she ran the professorial ward and had clear expectations of me. Her insistence on high standards was enhanced by her unstinting support for all the ward staff, not least the most junior members of the medical team. My respect and admiration for nursing colleagues has grown over many years through working with them in the wards, operating theatres, intensive care units and outpatient clinics.

Hard-working, highly skilled technical staff in the ICUs, theatres, cardiac catheterization laboratories, radiology and radiotherapy services, renal dialysis, pathology and other services were additional stalwarts, without whom many of the advances introduced into clinical care would not have been possible. Their ability to work constructively and in close cooperation with their medical colleagues was most productive. In the early days of ICU work, competent clinical technologists invented and innovatively modified vital equipment for daily use.

Not to be forgotten were the many cleaners, porters and other support staff whose efforts to maintain a clean and effective infrastructure can be so easily taken for granted. A few years ago, I encountered in the hospital corridor a man who had risen from being a cleaner to being a member of the administrative team in one of the clinics. He reminded me of how he had taken pride in keeping the floors sparkling clean in the cardiac/ respiratory clinics (in which I had worked).

Major cut-backs in the funding of teaching hospitals in the years following the transition to the new South Africa were understandably motivated by the desire to spread health care more fairly across the country and with greater emphasis on access to primary care. However, the methods used were unrefined, poorly informed, non-consultative, unaccountable and lacking in transparency. Public criticism of damage to several expensive services led to the Western Cape Department of Health's approval of explicit, accountable, and transparent priority-setting processes. These were initially piloted in relation to some selective high-cost clinical procedures. Commitment to sustaining such priority-setting processes and to extending these to the hospital budget and to higher levels of administration, did not follow. Presumably this related both to the complexities of the process and to the reluctance of officials in management and politics to share decision-making with the clinical medical leadership, and to be accountable to the public.

I remain cognizant of the fact that my appointment as head of a nationally respected Department of Medicine in 1980 followed in the wake of the brain drain of a large number of excellent mid-career physicians in the 1970s, many of whom, had they remained, would almost certainly have been appointed instead of me. It was a privilege serving in a leadership position for almost two decades, in the early 1980s with colleagues who had been my teachers. Many who trained at GSH/UCT over its 80 year history have pursued distinguished careers in many parts of the world, and always with pride in the quality of their training.

As I look back over the past, I do so with hope that the legacy of the past 80 years will inspire current and future generations to sustain and develop new frontiers of progress, teaching and patient care. There is no more satisfying career than working as a health professional for the benefit of individual patients and for the broader society, and I extend my very best wishes for such satisfaction to all who work at GSH today and to those who will do so in the future.

2. Dr Aziz Aboo:

Student years at GSH (1964-1969)

We were a group of 10 "non-White" students in a class of 120 who were allocated to wards where we never came into contact with White patients. Prof R Hoffenberg (who had to leave under a banning order in 1967) was a kind, and skilled physician who taught us regularly and gave us extra tutorials on Saturdays. Dr L Vogelpoel, Prof Forman and many other clinicians were excellent teachers from whom we gained good clinical skills.

Working at GSH (1981-2008)

After working as a general physician at Kimberly Hospital for 5 years, I was fortunate to secure a post in the Division of Medicine, thanks to Prof O Meyers' support. I started working in the Emergency Unit (EU) in 1982 and was appointed Head of EU in 1984. In those days the EU was considered a "Transit" lounge by the doctors waiting for posts in various specialties. Emergency Medicine was not a specialty then. It was a crowded unit with rows of patients on trolleys waiting for hours on end for treatment and diagnostic procedures.

I was fortunate to have Dr Norman Maharaj as my deputy, various medical registrars and SHO's, as well as very dedicated nursing staff ably led by the head nurse, Mrs M Patton. A number of factors contributed to major improvements in health care and waiting periods in the EU.

- *The Provincial Health Dept. opened 24hours emergency services in Community Health Centres (CHC's) on the Cape Flats (our drainage area) and elsewhere in the city which resulted in a major decline in minor emergencies and benefited patients who could now use private transport to CHC's and improved the outcome of patients with acute disorders such as acute asthma, acute pulmonary oedema , epilepsy and many other disorders. We also started training MO's from CHC's.*
- *We received a lot of support from various specialties especially Cardiology (Prof P.J Commerford and his staff were in the unit whenever help and opinions were required), Neurology, Pulmonology, Gastro-Enterology, Radiology and various other units.*
- *Advances in Therapeutics and Technology: The pharmacological discoveries in the 80's improved the outcomes of many disorders with fewer relapses necessitating EU visits e.g. Heart Failure, Hypertension, Asthma, Ischaemic Heart Disease, Peptic Ulcer Disease and many others.*
- *Ultrasound made I.V.P's and Venograms redundant and various abdominal disorders could be diagnosed with reasonable certainty. Endoscopy replaced barium studies and the benefits of CT and MRI are obvious.*
- *Emergency Medicine became a specialty in the early 90's which attracted a lot of dedicated doctors who improved the standard of health care in EU.*
- *In 1996 the Provincial Health Dept decided to convert the GF Jooste from its post-acute status to a Regional Hospital with an EU. We agreed to assist on condition the city established drainage areas for all hospitals in the city; so that emergencies were always transported to the nearest EU except if facilities did not exist there e.g. Dialysis, Neurosurgery etc. Within 3 months the numbers in EU and other parts of the hospital declined by 30-40% and we could shed posts to GFJ and visit the hospital every day to teach and assist the staff. Many students,, SHO's and Registrars received their training at GFJ*

Many thanks to Dr G Parolis (Deputy Head of EU) for assisting all those years and who to this day is still working in the EU at GSH, other medical staff and support staff who toiled to make the EU such a wonderful and rewarding place to work.

3. Professor Abdul Wahab Barday and Dr Bhadra Uttam Chavda

OUR STUDENT EXPERIENCE

We were Medical Students from 1963 to 1969. This was during the heyday of Apartheid. We as "Darkie Students" had to apply to the to the Minister of Education and also had to obviously apply to the 'White' University, UCT.

Abdul W Barday was accepted as an Engineering student by the University and was registered in the Engineering Faculty for one week. When the permit for Medicine came, the Dean, Prof Bromilow-Downing, accepted him as a late registration. Bhadra U Chavda had a degree in Zoology and a Masters degree from Madras before commencing his studies in Medicine.

The Clinical years started in earnest during the 4th year. In the Preclinical years, we remember Prof Sloane and Prof Zwarenstein (Physiology) and the Prof of Anatomy. Prof Thompson(Patholgy) did not permit black students to attend post mortems when the body was that of a 'White' patient. The Black students then went to 'Card'iology – i.e. they played cards in the students' union!

Prof Walter Gordon, of Dermatology allowed everybody in his lectures and demonstrations – a far cry from his predecessor, Dr Lang (Lang of Africa!), who did not allow Black students when there was a 'White' patient.

Prof Raymond Hoffenberg (Endocrinologist) was banned from teaching and left South Africa on an exit permit, without the possibility of return. He took up a research and consultant's post in London offered to him by the British Medical Council. Later, on 23 April 1968, Prime Minister Vorster reiterated that he fully agreed with the restrictions placed upon him in South Africa. It was said that it was due his involvement with the Defence and Aid Fund. Most Clinical students including, Barday and Chavda, went to bid him farewell on his exit from South Africa on 30 March 1968, at the then DF Malan Airport. He returned to Groote Schuur a few years ago and it was an honour to meet him again.

During our sojourn at Groote Schuur, the world famous Heart Transplant took place in 1967. We were unaware of the work done by a gardener, Hamilton Naki, on animal experiments that contributed to this. An honorary master's degree from the University of Cape Town in 2003, was presented to him by Chancellor Graça Machel. The honorary degree was described as MMed (Master of Medicine) in some sources and MSc (Master of Science) in others.

Barnard was quoted as saying "If Hamilton had the opportunity to study, he would probably have become a brilliant surgeon" and that Naki was "one of the great researchers of all time in the field of heart transplants".

We were fortunate to be taught by the giants of Groote Schuur, Professors John Brock and Lennox Eales and Stuart Saunders. The latter became the Vice Chancellor of UCT.

Despite having done our clinical years mostly at GSH, we as black students, were not allowed to do the Internship at GSH because of the Apartheid Policy. We had to apply to Somerset or Livingstone Hospital.

The above views represent our personal experiences and other students will have other stories to tell. We are grateful to be able to contribute to this rich history of Groote Schuur Hospital.

4. Mr Steve Sumner

On 1 May 1972 I applied at Groote Schuur Hospital for a temporary job. In those days of undeserved privilege, I was offered a job in the Supplies office (Supply Chain) without any formal interview or any such thing and was shown to an office in the old Admin Block on the first floor where I was given on the job training in how to invite tenders.

It was here that I was able to excel, as I had always liked technical things. So drawing up specifications etc. came quite naturally. We did all our own typing on large manual typewriters. The office was strictly White. Across the passageway were the two coloured clerks who did the annual tenders. Apartheid was the way of things in those days. The Whites were able to be appointed as administrative assistants and received special salary enhancements such as double increments. Even our hours of duty were different. To the best of my knowledge at the time there were no black clerks. One of the clerks I met doing the annual tenders was Mr Gordon Reid who in later years became the Assistant Director for Hospital Fees.

In 1981, I applied for a job in the Planning and Commissioning Unit for the new Groote Schuur Hospital. I spent roughly 12 years in the Unit. This was a time of real growth and excitement working with Top Management, Head Office, Department of Works, Architects, Engineers, Quantity Surveyors, UCT Management, PenTech, etc.

Although I moved on as Assistant Director for Supply Chain and later for Services, I never really left being involved with Planning and Commissioning. Among the most memorable projects I was involved with were:

- *Haw and Inglis "donation" of the N-zone parking area upgrade as a trade-off for the use of the old Admin Block and Hockey Field during the upgrade of Hospital Bend for the World Cup Soccer Tournament.*
- *Topographical and architectural survey of GSH*
- *CAD Planning and Plan Printing System*
- *Conversion of the D-floor into the now UCTPAH formerly Rhone-Kilinikum.*
- *Co-ordinating the supply and installation of MRI's at GSH and TBH.*
- *Numerous Linac bunker installations in L-block. Cath labs, CT scanners, etc*
- *Restoration of the Charles Saint Theatre Suite funded by Mr Hennie Joubert. This project required very detailed contracts between the Board and the Works Department and between the Board and Mr Joubert. We ensured that the project would not be short-lived as it involved the longest user agreement stretching to the end of the land lease for the GSH Property with UCT in 2025!*
- *Installation of access control with chip-embedded custom printed ID cards*
- *Installation of a comprehensive CCTV monitoring system.*
- *Parking Control and Admin Systems.*
- *Pay for parking by patients and visitors with the Board still being the main beneficiary.*

If anyone requires to be acknowledged there are two persons who stand out: Dr Hannah Reeve-Sanders and Dr Joce Kane-Berman. These two women played a huge role in the vision and drive for the redevelopment of Groote Schuur Hospital. They also personally took a lot of flak from the politicians when the move from old GSH to the new GSH took place as they refused to separate the patients into racial groups. The new GSH was totally integrated from day one.

I was privileged in my forty years at GSH to meet and interact with many dedicated staff members. Not everyone was a person with a high profile but ordinary faithful workers without whose input GSH just could not work.

I humbly pay tribute to these unthanked and unacknowledged heroes for the roles they played.

Long live the spirit of GSH.

5. Ms Faldela Martin

Employee at Groote Schuur Hospital for 47 years. (29/1/1969 to 30/9/2016)

For me, Faldela Martin, to have been granted the opportunity to work at GSH for the above-named period, is a milestone, a unique event and an opportunity for life.

I thank the Almighty for granting me the health and the wisdom throughout my entire career. I also remember all my amazing family, friends, colleagues and Hospital Management who helped me on this wonderful journey, a memory to be remembered.

My career commenced in 1969 as a Salary Level(SL) 1 General Assistant until I retired as an Senior Admin Officer (SL 8) on 30/9/2016. I started working in the Central Processing Deartment as an operator in the Old Main Building for about 5 months. Those years we worked 7 continuous days, Day 8 was our day off. I vividly remember packing the instrument trays in prep for the Heart transplant cases that were booked in the B2 Theatre for the Prof Chris Barnard team. Month-end we stood in queues to receive our salary in cash, our documents were manual. My first salary payment was R39 per month. Our Uniforms were pink striped and I proudly wore mine.

On 1/6/69 I was appointed as an Enrolled Nursing Assistant, I worked in the T3 Orthopaedic ward, Orthopaedic OPD, Ward D7 Ear, Nose and Throat (ENT) Ward and the E10 Dialysis Unit. I was part of the team when the E10 Dialysis Unit opened. Our Operational Manager, Sr Hamied, was trained overseas and knew how to operate the Haemodialysis machines. There is a saying: "once a Nurse, always, a Nurse", I can vouch for that. I have been very passionate about patient care throughout my career. I applied to do the Pupil Nursing course, but my application was unsuccessful, due to my finger deformity. But, this did not deter me, I applied for a ward clerk post thereafter and was successful.

1-8-1971 to 31-1-1974: Ward clerk in Ward C5 Surgical. I enjoyed this period thoroughly. My duties comprised of a variety of ward clerk functions. However, I recall that we were responsible for stock-taking as well. Our functions were manual as we had no computers. I celebrated my 21st birthday in this ward, a small gathering of all my colleagues and a beautiful spread arranged by Matron Lewis.

On 1-2-1974, I was appointed as a 'non-White' (NW) clerk (as we were named in those days) in the Domestic staff office and performed a variety of Human Resource functions. If Blacks applied for employment, I furnished them with a letter to obtain a work permit at the Bantu Affairs in Langa. No permit: they could not be employed. This did not apply to the so-called "Coloureds" Those were the rules. Total General assistants employed was 545, females only.

From 1-6-1974, I worked in Nursing Administration and performed a variety of admin functions and assisted the Chief Nursing Manager to implement the Nursing Admin Registry.

From 1988 to 30-4-1994: I worked under the Supervision of the late Paul Cleynhens, in the Envirnmental Hygiene Services Dept; he identified my variety of skills and granted me to grow within my career. A true leader.

1971 to 30 April 1994: These were the wonderful years that moulded my career within the Public service. During this time, I was also appointed as the Secretary of the Westcol Branch of the South African Nursing Association. Matron Lewis booked my typing training at a Private Institution and she paid my fees in full. What a kind gesture, I will always be indebted to her. I was also appointed as the GSH Secretary of PAWUSA and attended the Bargaining Council meetings.

From 2004 to 30 September 2016: I was also encouraged and nominated to serve on structures with the GSH Complex and this is where my health knowledge broadened.

I served as a Member on the following GSH Structures: GSH Transformation Committee; GSH Security Committee; GSH Quality Assurance Committee; GSH Integrated Management and Labour Caucus (IMLC) (Chairperson of PSA GSH from 2004 to 30/9/2016)

From the year 2013 to 2016 I served on the following Union/Departmental Bargaining structures: The PSA Employment Equity Consultative Forum Representative; PSA Representative and Member of Provincial Government Western Cape (PGWC) Employment Equity Forum; PGWC Member of PGWC Disability Forum, a position I still hold, post retirement. PHSDSBC: As Chairperson of PSA Western Cape, I attended this Bargaining Council.

In all my interactions with my friends, colleagues, members and Hosp Management, I always placed our patients first. My motto was: "An empowered employee is a productive employee". Eventually I migrated the Motto to our PSA GSH Branch as well as PSA PHSDSBC, Western Cape.

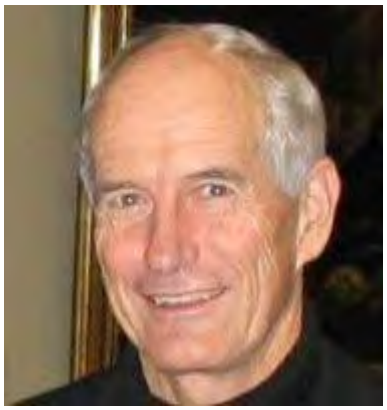
I firmly believe that if our morals, values and principles are intact and if we respect confidentiality, this world, including our working environment, will be a bliss.

The years 1994 t0 2016: These were the period of my employment as a Manager at GSH: Challenging times, but I enjoyed every moment. Would I have done things better if I could turn the clock, "No", I did my level best to build a harmonious working environment during my term of office.

I ran my marathon from 29/1/69 to 30/9/2016; along the way I experienced stumbling blocks which I converted to stepping stones, I refused to take the taxi or take a lift, consume harmful substances, I did not allow myself to be side tracked from my focus to build a successful career, I was not prepared to compromise my principles, even it made me unpopular. I wish all staff well and encourage them to build their legacy.

Post Sept 2016: I have retired and am enjoying this phase of my life and hope that I shall be spared sound health to enjoy my life with my family, friends and acquaintances.

Happy 80th Birthday to GSH, May she stand tall to serve Humanity, today, tomorrow, forever.



6. Professor Peter Gordon – An anaesthetist reminisces

I was appointed to the Department of Anaesthesia as a registrar in September 1979. Prior to starting, my wife and I came from Johannesburg to buy a house. On arrival we arranged an interview with the Chief Superintendent, Dr Reeve Sanders, to enquire whether we could stay in hospital accommodation whilst we looked for a house. Dr Reeve Sanders not only allowed us to stay in the hospital flats at Forest Hills but also arranged a job for Louise providing anaesthesia services at the Heideveld Day Hospital.

At that time Professor Bull who had played a major role in elevating the status of anaesthesia as a specialty in South Africa was about to retire and make way for Professor Harrison.

In the old hospital, theatres were spread around the hospital. There were no recovery rooms and patients were "recovered" in the passage outside the theatre. This led to problems, particularly after surgery in patients in renal failure, as the muscle relaxants in use at the time had a longer action than the reversal agents. This not infrequently resulted in some patients becoming re-curarised and having to be be re-intubated and 'Bagged" in the passage.

The anaesthesia machines at that time were primitive by today's standards. They had no disconnect alarms and could administer a hypoxic gas mixture. Monitoring was rudimentary. Pulse oximeters and agent analysers did not exist, arterial pressure transducers were not yet in use, and the first sign of hypoxia particularly in children, was the onset of bradycardia. I remember anaesthetizing a patient with a phaeochromocytoma with Dr Al Burman, and not being allowed to insert an arterial line. In the cardiac surgery intensive care unit the patient's blood pressure and central venous pressures was measured using water manometers that were nicknamed the "giraffe".

The Bird ventilator in use was powered by the oxygen gas supply and would therefore continue operating if there was an electricity supply failure. A failing of the ventilator however was that the tidal volume delivered to the patient varied enormously with changes in lung compliance. The Bird ventilator was noisy and if difficulties arose whilst ventilating a patient in the intensive care unit, the consultant on call could listen to the sound of the ventilator over the telephone, and make suggestions as to what knob to turn to improve ventilation.

The anaesthetic department, situated close to the urology theatre, was minute compared to today's suite. The Head of Department had a tiny office in the department and spent most of his time at the much larger office with support staff at the UCT Medical School. The anaesthetic workshop was situated next door to the department. This was a boon as the well-trained hospital technicians serviced all the anaesthetic machines, and were available to discuss any problems that arose with anaesthetic equipment.

The case-load in the old GSH Trauma unit was different from today. Gun shot wounds were relatively uncommon compared with stabs wounds. I went three years without having to anaesthetise a patient with traumatic cardiac tamponade, and then had three such patients in one night. The third patient was memorable in that he had to be re-opened for bleeding in the intensive care unit, and I ended up caring for him for 16 hours during which he received 38 units of blood.

Paternity leave for staff did not exist in the 1980s, and after my son was born at Mowbray Maternity Hospital at 05h00 in August 1983, I remember being congratulated by the theatre team, after arriving ten minutes late for my morning cardiac list.

One of the pleasures in working in the old GSH were the tearooms in theatres where tea and toast was provided and where surgeons, anaesthetists and senior nursing staff could interact, and discuss problem cases or the cricket. It was a great pity when the hospital stopped providing tea as a cost-cutting measure and this opportunity was lost. Excellent lunches could also be obtained at the doctor's bungalow for a nominal fee.

The anaesthetic department academic meetings were held on a Saturday morning. No roll call was taken, but Professor Bull would cast a beady eye at those present, and there were very few who dared to miss the meeting without a very good excuse. This required some anaesthetists to have to come into the hospital every day of the week.

After passing my specialist examination in 1983, I was appointed to a specialist post. In 1985 I, like several others of my colleagues, was allowed one year's unpaid leave to gain experience in the United Kingdom. My family and I spent a year in England, where I worked as a senior registrar at the Queen's Medical Centre in Nottingham and the Groby Road Heart Hospital in Leicester. It was a wonderful experience in which I gained an appreciation of the value of block training in subspecialties of anaesthesia, but also provided me with an opportunity to realise how good our training in Cape Town is.

On my return HIV/AIDS was starting to make an impact on health services and Groote Schuur was making a brave stance against the apartheid government by opening wards to patients of all races.

Professor Mike James succeeded Professor Harrison as HoD in July 1989 and made a major contribution in elevating the status of the department in the hospital and the university.

The move to the 1450-bed, New Groote Schuur Hospital, was of major benefit to the Department of Anaesthesia. Dr Ozinsky, as head of clinical services in the department, played a major role in the design of theatres, and in ordering state of the art equipment and anaesthetic machines for each of the 17 theatres in the main theatre suites. The centralisation of theatres, together with the provision of a large well-equipped recovery room, led to improved efficiency and patient safety.

The most stressful time of my career at Groote Schuur occurred in the mid 1990s and was caused by severe cuts to healthcare by government and the freezing of posts. By August 1995 the position had become untenable, with nine consultant posts and two registrar posts frozen. The department was expected to continue to provide a full service and morale was at an all time low. I attended numerous meetings with senior staff at the hospital and the university with no relief. Eventually in desperation I organized a Department Bosberaad that was held at Kirstenbosch on a public holiday in August 1995. At the meeting the acting HOD, Professor Viljoen reported that Dr Tom Sutcliffe, the Western Cape Director General of Health had offered to attend the meeting, and had stated that he would visit Minister Kriel to unfreeze our posts. At the Bosberaad a decision was taken that with their available staff at that time the Department could provide services for 20 lists per week and that any further reduction of posts would result in further cuts of 8 operating lists per week per post. Rotating cuts were introduced. The firm stance taken together allowed the Anaesthesia Department to retain staff, and morale.

On his return from sabbatical in Australia, Professor James instituted the emergency theatre whereby each department gave up time to provide staff and meant that elective lists no longer had to be "crashed" for emergencies.

One of the highpoints of my time at Groote Schuur was being involved in South Africa's first successful liver transplant programme. that commenced in October 1988. The success was largely due to the extensive planning that took place before the programme commenced, by members of surgery, the liver unit, anaesthesia, the surgical intensive care unit, and nursing. Protocols were set up and a rapid infusion device designed. The mean duration of the first ten cases was 10.25 hours with 80% of operations being performed at night.

Another challenge was then presented by the increasing numbers of females taking up a career in medicine and wishing to specialise in anaesthesia. The average young female specialist had been studying for 12 years, was in her thirties and wished to start a family. Paid maternity leave was now allowed. Solutions introduced included the creation of shared posts and the permission to use the overtime salary of women on maternity leave to obtain a locum for one day per week.

By 2001 the lack of clinical technologists in theatre had become a major problem. Equipment purchased for the new hospital was reaching the end of its life, leading to frequent breakdowns, intense frustration of staff, and was affecting patient safety. After several years of campaigning an arrangement was made with the Department of Critical Care for part-time support of theatres. This was formalized in March 2005 when the presence of a full-time clinical technology staff was appointed to support equipment maintenance in theatres.

In a high stress environment, it is important to maintain morale and collegiality in departments. For many years the department would organize a weekend away for families not on call. Another event was the annual hike up the mountain. One of the memorable hikes was leading a party of 17 members up the Right Face to Arrow Face traverse on Table Mountain.

Looking back on the thirty-three years I spent at Groote Schuur Hospital I realise what a privilege and joy it was to have been part of the staff that worked together with a common purpose of providing a service to the community. This was done whilst at the same time providing a world-class centre for training medical students, registrars and performing research.

If I had to live my life over I would have no hesitation in once again applying for a registrar post in the department.

7. Mr Howie Arendse

Howie is well known to Groote Schuur as the `singing messenger', who fills our corridors with harmonious melody, lifting the spirits of everyone who hears him singing famous Frank Sinatra and Nat King Cole songs. This is his story:

Ek het in 1972 begin hier by Groote Schuur werk as 'n messenger. Die atmosphere was baie lekker gewees. Daar was nou die 'blanke' en 'nie-blanke' gedeeltes gewees, maar die mense was vriendelik, en vrolik. Ek kan goed onthou vir Joelene, die meisie met geen arms en dan ook vir Dorothy Fisher – ek het hulle goed geken. Almal het gelag and was vrolik en so het ek mense leer ken. Mnr Booysen was my voorman and hy was goed vir my. In onse department was daar baie foreign dokters gewees, en hulle was goed vir my. Ek het goed klaar gekom met almal en ek het oorals in the hospital gewerk. Dr Goldberg was die hoof van X-ray department and hy was 'n baie lifelike dokter.

Oor die jare, het die mense verander. It was mooi gewees in die vroer jare. Die kos was baie lekker gewees. Vir die blankes was dit R1 en vir die nie blankes was dit 50c. Dit was goedkoop, maar baie lekker. Alles was mooi gewees, maar alles het nou verander. Especially vir die ouerige patiente, wat help soek, wat nie weet waar om te gaan nie. Vandag, is die staff soms nie so hulpsaam vir die mense.

Groote Schuur is nog altyd 'n help vir my. Die patiente was baie belangrik vir my. Ek het altyd vir hulle gesing en as ek sing, dan voel hulle sommer beter. Sommige was so depressed. Ek het leer sing by sing klasse in St Marks in District Six. Al die kinders het elke Donderdag St Marks kerk toe gegaan. My favourite is Nat King Cole en Frank Sinatra, maar ek het ook baie van Opera gehou. Ons het ook hier by die hospital gesing in die shows.

Ek voel altyd dat ek behoort hier. Al die staff is soos 'n groot famielie en al die jare, as ons 'n problem gehad, dan praat ons met mekaar. Daardie jare, het ons gevoel dat ons werk toe wil hardloop, maar dit is nie meer dieselfde nie. Die baase was baie strict gewees. As iets reg of verkeerd is, moes ons dit net aanvaar, en so het ons goed gewerk.

As ek nou moet iets verander, sal ek courses gee vir die staff, because hulle weet nie hoe on met die patiente te praat nie, en dit is baie belangrik. Mense hou nie daarvan as die staff kortaf met hulle is nie.

Ek voel nog altyd gelukkig en ek mis baie die hospital. My hele leeftyd was hier by die hospital. Ek was oorals welkom en ek ken my maniere en hoe om ander te respekteer. Respek is baie belangrik. Dit is hoe jy praat met mense. Vir my was dit 'n groot plesier gewees om 'n patient te help.

My boodskap aan die jong mense is net om ander to respek. As 'n mens lelike maniere het, dan is dit wat ander mense van jou onthou. Ek het gekom met liefde hier, die here het vir my die liefde gegee en daai liefde het ek deur my sang aan die patiente gegee om hulle te troos and hulle het baie lekker gevoel.

Die snaakste ding wat ek onthou was hoe die ambulance wat die patient hospital toe gebring het toe dieselde patient voor die hospital gestamp.

Almal die porters was baie lovable, en ons het lekker gelag, maar almal het hulle werk gedoen. Daai was so pragtag. Almal was so gelukkig gewees.

8. Mr Leonard Hoanne

Mr Hoanne started working at Groote Schuur Hospital on the 10 January 1983 in the Main Kitchen.

My duties included the delivery of food trolleys and mostly delivery of the milk. At the time there were three kitchen- Kosher, Muslim and Christian.

Things were very hard at that time, e.g. lunch times you could not sit on the lawn in front of Palm Court. All staff had to change their uniform before they went home. If you came 5 minutes late then you were in trouble and had to go back home and not get paid for the day. On the 26th we got paid and if you were off you had to come in and collect your wages. I started off with R190 per month. In 1986/87 I was part of the establishing of the Health Workers Union. In 1990 there was a strike that lasted 52 days and it brought about a lot of positive changes, e.g. Working hours were reduced to 40 hours. Over time, much has changed and I have now been promoted to an operator position, with great opportunities and staff development.

9. Mr Aghmat Slamdien

Mr Slamdien is currently retired after serving Groote Schuur Hospital for 49 years.

Ek was 14/15 jaar oud toe sê my pa ek moet gaan leer. My hart was nog altyd om by 'n hospitaal te werk. Toe sê ek eendag vir my pa dat ek sal daarvan hou om by die hospital te werk. Hy het hier gewerk daai tyd. Dis excitement vir 'n groot man om by 'n hospitaal te werk. So kan 'n mens jou op werk. Toe sê hy: my kind, okay en toe gaat ons. Maar toe ons die dag hier kom, toe is daar 'n Mnr Labuschagne. Ek kom toe in en hy vat my naam, maar ek was net 15 jaar oud. Toe sê hy net vir my: Meneer, as jy 16 jaar oud is, dan moet jy jou ID kry en dan kan jy terug kom. Ek wag tot ek 16 jaar oud was en toe bring ek my ID in. Daai tyd was daar about 20 supervisors en almal het 'n boekie gehad. Toe sê hulle my: Meneer, jy gaan daar werk. My eerste job was die staircase. Ek moet daai skoonmaak, maar hulle gee my net 'n uur. Nou is die supervisor elke dag agter jou. Jy skryf af hoe lank het jy gevat om die staircase skoon te maak, die aan die wit kant, en die coloured kant mos. Hy sê: come, you are finished now. Come we go to the main kitchen. Clean there for an hour, see what you can do there. From the main kitchen, go to the theatre, you clean there. Ons het gaan werk, amper vier, vyf, ses plekke op een dag. En daai het ek gedoen, okay. Ek was 'n cleaner vir amper 'n jaar.

Agter 'n jaar toe stuur hulle vir my cardiac clinic toe. Daai tyd was daardie clinic nog hier oorkant Maternity. Prof. Barnard hulle het daar gewerk en ek moes die buffs file. Prof. Barnard, en sy broer, Prof. Marius Barnard, as hulle iets wil hê, dan vra hulle vir my. Toe eendag toe vra Prof. Barnard vir my: Meneertjie, wat is jou naam? Toe sê ek: Aghmat. Toe sê hy vir my: Aghmat ek is Prof. Barnard en so werk jy hier by ons? Ek sê: Ja.

Ek het gewerk in theatre, main kitchen, maternity skoon gemaak, nursing skoon gemaak, linen bank gewerk, ek het orals gewerk in die hospitaal. Maar voordat ek 'n messenger geword het, daai tyd was ek mos 'n cleaner. Toe maak ek die pool skoon – hier was mos visse gewees. Dan moet ek daai lang stok vat – ja die fish pond – dan moet ek die blare uithaal, en daai was my werk – ek het oral gewerk in die hospitaal, daar was nie 'n plek gewees waar ek nie gewerk het nie.

Toe werk ek daar by Prof. Barnard vir 'n paar maande. Na dit, toe phone die office vir my: Meneer Slamdien sover het ons geen klagte teen jou en jy't nog nooit uitgebly nie of nooit laat gekom nie. Ons gaan vir jou nou 'n promotion gee. Jy moet nou gaan na records toe. Daai tyd was outpatients – dit was klaar gebou, maar

daar was nog niks clinics nie. Net H Floor was die records department. En toe wat ek daar kom, toe is daar net blankes wat daar werk. Die eerste keer wat ek inkom sê hulle vir my: Meneer, ons verstaan jy kom hier werk, maar u sien, die toilette, dis net vir blankes. Toe sê ek: ja, ek weet. As ek toilet toe wil gaan, dan moet ek maar anderkant toe gaan. Daai was mos nie 'n problem nie. Ek was die enigste kleurling wat gefile het tussen die wit mense daar. Almal was filing clerks, maar ek was not altyd 'n messenger. Toe het ek dieselfde werk gedoen wat hulle gedoen het.

Toe buite pasiente oopgaan, toe's ek die eerste ene wat elke oggend five o' clock moes oopsluit. Daar was niks securities nie. Die blankes en nie-blankes het in twee lyne ge-queue. Die ander mense het hier bo gestaan and daai queue was veel langer as die wit mense sin. Ek het 'n paar jaar by records gewerk.

Vir daai tyd het die dokters mos, as hulle jou ontslaan het uit die saal uit, dan vat hulle jou folder, summarise die goed, en dan neem hulle dit ward toe, of hulle neem dit huistoe. Maar daai professor, hy wou daai folder hê. Dan moet ek – toe wat ek in records werk, daai tyd, '97, to sê hulle hulle soek iemand wat die folders kan loopsoek vir die queries. Toe maak hulle vir my in charge nou om almal die queries te gaan soek in die wards, en maternity, en A1, en hier, hier was mos almal die sale. Dan moet ek gaan kyk. Kyk, môre het die pasient 'n appointment in die saal en ons het daai list gehet, maar hulle het nog nie computers nie. As die mense kom, nou moet jy gaan hardloop vir die folders. Maar okay, ek het dit gou gaan doen.

In OPD, by 7 o'clock dan kom die matrons opcheck of almal die staff op duty is, die dokters, nurses and clerks. Die mense was stiptelik.

Prof. Barnard en sy broer, hulle het vir my gesê: Meneertjie, die dokters en die nurste was, om die waarheid vir u te sê ok, maar dis net die matrons wat die ding saamgesit het, of jy skoongemaak het, dan kom hulle: Orderly! Dan moet jy gee pad: your tie is not right; of 'n nurse of sister kan nie saans uitkom nie. As hulle miskien uit die sale moet kom na pharmacy of so dan moet hulle 'n briefie gehad het. As daai matron vir jou vang, dan was daar moeilikheid. Ons het nie 'n ID gehet nie. Amper soos 'n ronde nommer, dan's jou naam daarop. Dan vra hulle vir jou as jy loop: waar werk jy? Come, come, come to the office. You are sitting here, you doing nothing, come.

Okay, wat ek sê, ons het seker omtrent 9000 mense hier gehad in daai tyd. Ons is nou omtrent 3800. So in apartheid, daar was verskillende uniforms wat die mense gedra het. Ek het khaki gedra en die wit ouens het wit jaste gehad. Almal het wit jaste gedra, maar ons het khaki kleur.

My salaris was R12 'n maand. Ons moes na die hall toe gaan om die geld te kry. Ons het dit ge-enjoy, maar nie vandag nie.

Ek is upset dat ek nie meer jonk is nie, want om met mense te werk en vir hulle to hanteer asof hulle onse guests is. Ons is die staff van GSH, soos by die huis. Ek praat lekker saam met hulle. In daai tyd moes jy nie 'n appointment kry, jy kom net. Jy't nie even nodig vir 'n briefie. As jy nie kan loop nie, dan kry jy 'n vorm voordat jy weggaan, en dan gaat hulle vir jou haal. In die aande bring hulle vir jou huistoe. Ons het duisende mense hier gehet. Daar was middag clinic Vrydag aande by buite pasiente en ons het six o'clock/seven o'clock huistoe gegaan. Die suster wat kyk na die transport, sy't eight o'clock huistoe gegaan. Die apteek het toegemaak heel week half sewe. Never mind of daar duisende mense hier gewees het in die middag het hulle sop gekry en brood. Elke dag!

My pa hulle was vyftien kinders; hulle was nege broers en ses susters. Ek het altyd my ouma gevra hoekom het my pa by die hospitaal gewerk en die ander broers het almal gaan bou. Toe sê sy: nee, hy was die baby, hy kan nie swaar werk soos hulle werk nie. Nes my, het hy ook oorals gewerk. My pa het hier gewerk die ou Slamdien, 45 years. My oudste broer Ishaam Slamdien, 38 years, dan's dit ekke, 49 years, dan's dit Anwar, 43 years. Dan is dit Faried, 25 years en dan is dit Nazeem Slamdien, 31 years. In total, my famielie het in total vir 230 jaar hier by GSH gewerk.

Agter 1994, so omtrent vier jaar later, maak hulle vir my senior registry clerk.

Om werk toe te kom, het ek quart oor vier, uit die huis geloop. Ek het seven o'clock begin werk. Die rede is, dan kom ek quarter past four op, die mense sit buitekant. En mens moenie praat en brag oor wat jy goed doen nie, maar wat in jou hart is – soos ek sê, die pasiente was my guests. Dan kom ek in, dan sit die patiente buitekant al, half vyf, something to five in die winter en die somer. Ek het maar altyd daai pakkies sop gaan koop vir hulle, en brood. Dan maak ek die venster ope, nou maak ek die plek oop, five o'clock, and sê ek: kom – hoekom, hulle kry mos 'n lift dan sit hulle daar binne en dan sê hulle: Mr Aghmat, het jy iets? Dan sê ek: nay moenie worry nie, dan maak ek vir hulle sop en brood. Tot nou nog kom hulle my visit by die huis. Hulle phone vir my, dan huil hulle, dan sê hulle dankie. Toe sê ek: nee, julle, die pasiente, was my guests. Dit was 'n eer om mense te gehelp het. As ek in J2 gewerk het, dan sê Mr Mohammed vir my: daar's twee mense kort daar, OPD soek weer folders. Dan phone hulle vir my, dan kry ek die folder.

In die apartheid jare was dit either jy wil werk, of jy wil nie werk nie. Ons was bang vir die wit mans en hulle sê vir ons - as jy nie wil werk nie, ons gooi vir jou deur daai venster, of ons jaag jou uit, een van die twee. Maar, aan die ander kant, as hulle gesien jy's ene wat werk, en jy bly nie uit jou werk uit nie, dan het hulle nogal baie respek gehet vir jou, maar net hulle was baie strict. Die pay was onregverdig. Ons het dieselfde werk gedoen wat hulle doen; jy het 'n bietjie gevoel dis nie reg nie, maar ek het altyd in my mind gesê, my pa het gesê: my kinders, bid net op daai bietjie. Julle sal sien een dag – ek het altyd daai in my mind gehet – ek was getroud met twee kinders, toe verdien ek maar R120. My liefde vir die hospitaal en pasiente was too much for me. Tot vandag nog, ek mis dit.

As jy nie lekker behandel is nie, dan voel jy maar seer binne in. Ek het seer gevoel, maar ek het nog altyd in my mind gehet, een dag, daar gaan changes kom, dit was altyd in my mind, maar hier gaan ek bly totdat ek retire.

Deesdae, as ek nou die eerlike waarheid kan sê - ek lyk somtyds nie hoe personnel met die mense praat nie. Jy praat mooi met die pasiente. Hulle kan soms kwaai wees, maar as jy mooi praat met 'n pasient - as jy uit 'n huis gekom het waar jou ouers vir jou geleer het, discipline en respect - dan moet jy mooi praat met hulle. Ek het eendag vir een van die nurses gesê - julle het 'n oath gevat hoe om te praat met mense, as jy mooi met 'n pasient praat en so aan, whatever jy is, but praat lekker met die pasient. En as jy verkeerd is, dan sê jy maar net: ek is jammer, ek is sorrie.

Ek mis die pasiente. Ek mis die hospitaal. As ek so loop in die hospitaal dan dink ek: daar is nie 'n plek wat ek nie gewerk het nie en ek het elke dag geniet.

10. Monica Cupido and Katrina Skippers – Worked in EHS for 48 years

Monica Cupido started in 1969 as a Cleaner, at the time called domestic workers. The recruitment and selection process was different in those days; she was brought in by an old lady who worked in Maternity and all she had to bring along was a reference letter and on the same day she started to work. She states that that she worked very hard and long hours, seven days a week, with only two days off. She further states that even though you were allocated to worked in the ward, if there was a need somewhere else, you couldn't refuse, you just had to go and help out in the other area. She mentioned that she was scared to come late or to stay absent, but she describes the working environment as pleasant and everybody being very supportive. They were family. They had respect for one another, and this kept them together. In 1985 she was offered a Housekeeper post. Prior to this she was also offered a Housekeeper post but because of fear for the unknown she refused it. She was a hard worker and in 1985 she was forced by her Supervisors to take up the responsibility as

Housekeeper. She mentioned that you had your pink book, and you had to go to the sister and write requisitions for everything that was broken.

She is also proud to mention that she received an implant at GSH and after the fourth attempt she delivered healthy twin daughters, now 30 years old.

Sr Nel was the Sister in Theatre and many times she cried because of Sr Nel, but at the same time Sr Nel also wrote good reports to EHS Management about her.

Today, there is no respect for the Housekeeper. But one thing she did mention is that there are many opportunities for staff to develop themselves.

Katrina Skippers, started in 1982. Ms Jantjies was the Housekeeper. She described the work place as 'Canan', because everything was in abundance. They received food, breakfast, lunch and supper. On Sundays, the dessert was a real treat. Support was good amongst the colleagues

During their lunch times they started to sing with Mrs Martin and they were called the Groote Schuur Choir. Memorable events linked to their role in the choir was when they went on to sing for President Mandela in Parliament and when they sang for Prince Charles just after he married Princes Diana.

Today, there is no support from the colleagues and it is definitely not 'Canan' anymore. However, she mentioned that they worked for " 'n apple en 'n uie", but today we receive "amper niks nie". Even up till today, the older staff still have respect for one another, but the new people have no respect.

11. Mr Hobbs

Mr Hobbs is currently a Chief Porter who started working at Groote Schuur Hospital in 1975.

I first worked in Casualty and later, was placed in Theatre, where I worked for 10 years - 7 nights a week. These were good years, a lot of interaction with patients. However the downside was that porters were not recognised by other staff categories, because some of the porters' behaviour was unethical and everyone was labelled as such.

In 1976, the riots caused a lot of unrest and the local neighbourhood watch had to patrol the outside perimeter of the hospital. Non-White porters could not transport White patients, but White porters could transport non-Whites. The non-White patients had to use red blankets and the Whites, the blue blankets.

The late Mr Peter Wilson was the first coloured porter to transport a White patient for X-rays (B3) in the late 70`s, permission was given by the Matron and the Medical Superintendent, because there were many patients to be fetched. Thus, in the 80`s, White patients could be fetched by non-White porters.

I was part of the decommissioning of the Old Main Hospital, by assisting with actual moving to the new Hospital. However, since 1994, a lot of changes have happened, but somehow things did not seem to get together; groups within the porters were formed, but service delivery was not affected.

Today, all porters are treated equally by the staff and porters are recognized. Some staff are still treating patients well and I get along well with the staff and really enjoyed all the wonderful years I spent at GSH.

For the 80th Birthday, I wish for the following to happen:

- *In 1965, I remember that there was a gold fish pond at Palm Court, but in 1975, when I started, it wasn`t there anymore. So I want to propose that the gold fish pond be resurrected and all staff must bring a gold fish and place it in a big bowl.*
- *Also, on the day of the Hospital's birthday, the oldest serving GSH staff member will throw all the fishes into the fish pond.*

12. Sr Brenda Blouws, Operational Manager in Ward E7, New Main Building.

"The first 'coloured' ward receptionist was appointed in 1971. I worked in F11 – a medical ward and was privileged to work with Miss Benting and Marlene Trimm (now Hendricks). The ward receptionist was the right hand of the sister in charge.

As a nursing sister, I never had to worry about:

- *Transfers of patients to other wards*
- *Admissions, bed status.*
- *Before the ward receptionist went off duty she would count the number of patients and give an update of discharges and expected admissions*
- *The sister would know about expected admissions from Casualty (now Emergency Unit)*
- *If a Muslim patient was admitted, the Muslim kitchen was notified. Similarly, with the kosher kitchen. Extra diabetic meals were also provided from the main kitchen.*
- *The ward receptionist would ensure that the stock room was neat and tidy and that any items that were short, were ordered after consultation with the sister.*

The doctors had so much faith and trust in the ward receptionist that they would feedback orders of patients to the ward clerk as well. The doctors would also ask the ward receptionist to contact family members.

I was extremely privileged to have worked with these competent, passionate and skilful ward receptionists.

As a Senior Professional Nurse, I was given the opportunity by Ms Samsodien, the night matron in 1991, to cover two wards in the new hospital as a night supervisor, as only two wards were functional at the time. Mrs Samsodien allowed me to do ward rounds alone in the old hospital as well. The new hospital required to be locked and unlocked and you were always accompanied by security.

I feel privileged to have been a Groote Schuur employee."

13. Ms Ann Catchpole – worked at GSH for 41 years

Ann has become a 'household' name for Physiotherapy services at Groote Schuur Hospital. This is her story:

During the 41 years and 7 months that I have worked in the Physiotherapy Department at Groote Schuur Hospital, being a period just more than half the approaching anniversary time, I have witnessed the life and times of an institution that has seen much change.

Against the backdrop of South African history, I have seen many changes in the Health Sector during the evolvement from the Apartheid era to the new South Africa. In addition there were also the changes associated

with the incorporation of the Acute Spinal Cord Injury Unit at Conradie Hospital in Pinelands as well as the Princess Alice Orthopaedic Hospital in Retreat as their services were transferred to Groote Schuur Hospital. In the early days work for the 4 Physiotherapists in the Transplant Team involved giving 4 hourly treatments for the first few days, namely at 07h00, 11h00, 15h00, 19h00, 23h00 and 03h00!

And then there were the physical moves around the GSH campus as the New Main Building was constructed and the Old Main Building re-furbished. This involved multiple moves for the Physiotherapy Department i.e. from the C3 Physiotherapy Department in the Old Main Building to the former Doctors' Bungalow (currently the HRDTU) for the Teaching and to a cream prefab building at 376 Main Road for the Clinical OPD. Later the latter moved again to the Moore Paragon Building which is currently the Cape Town Science Centre site before returning to the current location of E54 Physiotherapy Department in the Old Main Building. Included was a new feature namely the Hydrotherapy Facility.

As relatively few South African physiotherapists applied for clinical posts in the Public Sector at that time (preferring the Private Sector in South Africa or work overseas), the Physiotherapy Department was staffed to a considerable degree by foreign nationals from around the world! As the majority of them were using their profession to travel the world, they generally did not stay for lengthy periods but at least there were staff even if the turnover was high. Sometimes one even had to provide informal English lessons as part of the job!! The Physiotherapy Staff complement was approximately 35! It is now only 21. At a much later stage in the development of the Physiotherapy Department, there was opportunity for the training and appointment of Physiotherapy Assistants, some of whom even later upgraded to Physiotherapy Technicians.

The training of Physiotherapy Students was initially confined to those from the University of Cape Town(UCT) but over the years included those from both the University of the Western Cape(UWC) and the University of Stellenbosch (US).

Throughout my association with Groote Schuur Hospital, the one feature that has been and continues to be noteworthy, is the high regard that the community both local and further afield have for this institution. Truly, Groote Schuur Hospital lives up to its motto: Servamus-We serve. I have no doubt that this will continue to be the case in the future.

Well done and congratulations to GSH on the occasion of the 80th anniversary in January 2018.

14. Ms Gadija Benting – worked at GSH for 45 years

"I started in 1972 when I was 19 years old. I found this hospital very helpful, where I could grow. We were always one family. I started out with Ms Brassell, then Ms du Preez, then Mrs van der Walt, Mrs Pletts, Ms Thorpe, Mrs Ross and now Mr Mohamed. I worked as the clerk in the ward, but there were only good experiences. At first people would check me and I would cry, but I grew to be strong and I enjoyed myself. I used to leave home so early that I just greeted my mom and then came in to work. I did not speak to anyone, not even on the bus, but once I got to work, I spoke to everyone and I enjoyed myself. I'm grateful for the subsidy I got because that allowed me to own a house. In 1983, salaries were upped and housing subsidies were made available for single females. That is all the things I'm grateful for."

15. Mr Jeffery Eksteen – working at GSH for 41 years

Mr Eksteen is a senior messenger in EHS. He started at Groote Schuur in 1976.

I worked in the linen bank and then went to specimens. I left work because of the money in 1979 and then came back in 1983 because I kept in contact with Mr Horstman and he took me back. I was lucky to be taken back.

Those times were nice. I made a lot of friends. It was very strict in those days and very disciplined, but very very nice. I received 15 merits with Dr Sanders, Dr Kane-Berman and Dr Mitchell and it was good days. I am very grateful to Mr Horstman and Mr Cleynhens – they did everything for me. I'm also very grateful to Mr Rossouw for Rochester House and for helping me to get my life together.

The secret is that your heart must be here. If your heart is here, then you are on call for 24 hours. If the work is good to you and we stay 5 steps forward, the hospital gives back to you.

The difference today is that we are very upgraded in terms of technology. So nowadays, you come to work and start the machinery, whereas we used to prepare nicely before.

I used to stand in line for my salary, bonus and Christmas present. We used to eat at the cafeteria and this helped with the extra salary.

What I enjoy the most is dealing with people. I was lucky that I wasn't educated. I did try to go to night school to better myself, but because of my health I could not do this. If this did happen, I would not have this job I have today, which I enjoy. I would not have liked to work in an office.

The way forward is with respect, honesty, loyalty, calmness, forgiveness and peace.

16. Sr Maria Mc Donald worked at Groote Schuur for 48 years.

"Vir my was dit 'n experience. Dit was nie net van self-development, but I could help people in the community. All because GSH allowed me to do the ICU course and it helped me in my daily life. I am ever grateful to GSH vir die opportunities. Ek waardeer wat vir my gegee was. It really was not about money, but it was about the joy, the challenges. Ek het begin met R90 per maand."

17. Sr Pepe Cooper

My connection with the hospital is that both my aunts and my mom trained at Groote Schuur Hospital. When I started in Nursing Education (1986), my office was actually my one aunt's residence room.

Ms Hughes, the deputy matron recalled every year for the 26 years she visited our home, her impression of my mom walking up the tunnel to Clarendon House 'like a tired little bird' as she came off her last shift on duty. We children all rolled our eyes as soon as the sing song started! She used to arrive in the Morris Minor after the long trek from Cape Town first to the farm near Beaufort West and then Graaff Reinet.

Some of the memories that I have of my experiences include:

- *Many a tin of condensed milk that exploded in the autoclave making caramel*
- *Making peanut swabs by hand*
- *The nurses used to pull injection needles across gauze swabs to check if there were any burrs(rough tips) and if so they would be discarded.*
- *All nurses used to be in residence- all were weighed on a Friday*
- *You could phone 234 for a porter from casualty to accompany you to the 'J' block because the nurses were scared-they used to have to go and open the neuro theatre: rumours of phone ringing and no-one there when it was answered, or it would be found dangling off the hook*
- *One nurse recalled being asked to bring the bucket for an amputated leg, which she managed to drop as she didn't realise how heavy it was and then it rolled across the theatre floor*
- *One nurse stood on a chair to increase the gravity to hurry up a tube feed*
- *Miss Brassell would call the staff back – even if asleep –to complete charts*
- *A non-striper(1st year) was assisting an attractive 2 striper and a doctor with quite an ego to do blood culture for a patient. In cauterising the top of the bottles they caught alight. The innocent non- striper stood to attention and said' I'm a first aider and I've got it under control', which of course she didn't and nearly set the whole hospital alight.*

18. Ms Lulama Qengwa - retired in Dec 2011 as Assistant Director Nursing after 37 years of service to GSH.

I started working at Groote Schuur Hospital on 1 Sept 1974. Sr Lindi Mangaliso started 2 months before and we were among the first black nurses to be employed at Groote Schuur Hospital. I was appointed into Oncology, because the Professor there often went to East London and brought the patients back to Cape Town for further treatment. However, patients often refused treatment because they could not understand what the doctor was saying to them. Both Lindi and I were therefore appointed mainly as interpreters, but we also performed nursing functions, since we were fully trained and qualified as registered nurses. We were thus also the first black interpreters.

The welcome we received in Oncology was excellent. We were joined by the first black social worker Mr Themba Mtole. So we were the big three and worked in all the clinics and wards as interpreters. I did not understand Afrikaans, although I was born in Cape Town. I was raised in the Eastern Cape and was trained at Baragwanath Hospital, where we only spoke English. When I joined Groote Schuur Hospital, I was fascinated with culture, both in terms of religious and language differences.

I enjoyed being a cancer nurse. At Groote Schuur Hospital, patient care was priority number one – it was not about you as the worker. We remained second as long as we remained honest and totally committed to our job, and we accepted one another as well.

We came here during the apartheid years, but I had a totally different attitude. I was born black and when I was employed at GSH, I remained black and didn't expect any special treatment. I accepted other people who were Coloured, Indian and White. I was skilled in nursing management in Oncology and I had dynamic managers, like Mrs Vlotman and Mrs Davids, who soon realised that I needed further training on management. Hence I was placed in charge of the Oncology ward and ward F8 was the first ward to be opened when we moved to the New Groote Schuur Hospital. I worked with Mr Sumner for the first time and I was really impressed with how he handled the move at the time. At the time, people were scared that the hospital was going to be bombed, but fearlessly continued our duties.

I have experienced many problems during my years at GSH, but the most traumatic for me was the shooting incident in 2005. I was in my office and could not get any feedback from anyone. I went to reception and saw a porter who asked me to help her to get a patient to the Trauma Unit. We were told that the area was not safe since they feared that the gunmen would shoot again, but the porter and I pushed the patient out.

While we worked in ward T2, the Oncology ward, which was a prefab building near the Main Road, we admitted many Namibian patients and we had to learn their language and ways. Sr Mangaliso, cooked for them, because those Namibian patients wanted pap cooked in a certain way. We always made a plan to please the patients. Amazingly, the Oncology doctors even invited alternate medical practitioners to help the patients depending on what they believed in, but ensured that things remained safe in terms of medication. The patients used to come to Cape Town with escorts, and myself and Lindi, had to take the patients back. That was my first experience of being in an aeroplane and it was very exciting. It was a pity that when we moved into the New GSH, we were no longer allowed to cook food for the patients according to their needs.

I liked working at GSH as a manager, because GSH built me. I came to this hospital as an ordinary General Nurse from Baragwanath Hospital but GSH was the first hospital in the Western Cape to offer Oncology training and I was in that group in 1982. I had fantastic managers and they encouraged me to study Nursing Management at UWC, in 1990. I then continued to learn and completed my degree in Nursing Education and Management at UNISA. I therefore felt quite confident being a part of the Nursing management team at GSH.

We were privileged at GSH to be given so many opportunities because we were encouraged to promote and educate ourselves. We had a wonderful support system and we were exposed to all types of Management. We were even taught about Financial and Human Resource Management and therefore felt confident enough to manage large pavilions within Nursing. This factor is so important that it should actually be taught from Grade R. I learnt so much from the Engineers that I still preach to my neighbours today. I feel that because of this support system, we were the envy of many nurses outside of GSH.

What makes GSH so unique, is that everyone was accepted irrespective of culture and religion. I learnt a lot about Muslims, Jewish colleagues and all the other religions and we respected one another despite our differences. We were three blacks working in Oncology and we were closely observed, but also praised for what we were able to do. This made us feel like we were respected for our abilities.

People knew that I spoke my mind, because I would say things as I saw them without being scared of anyone. I made history to work in Oncology, because I loved it and I worshipped that place. We were admired because others were scared to work in Oncology because of the perception that cancer was contagious. Lindi and I were also the first black nurses to work in a White ward, both in Oncology J2 and we received a lot of respect because of this. I did like Oncology, but as I studied more, I realised I needed to move out of Oncology. There was a post in the Out Patients' Department. I was interviewed and was the successful candidate. I was already over the age of 50 at the time, but I saw this as an opportunity to teach others. Teaching has no borders, and one can teach and learn all the time. People had a lot of respect for me, like Ms Brainers and other zone Matrons, who had to go down to the buildings near T2 to have their tea. When they saw us, they often asked

us questions about what we did, our issues, etc. and we got along well. It was amazing and because we were the first to move from T2, I was a speaker at the opening ceremony. Mr de Klerk, Bishop Tutu were among the dignitaries present at the function. When I finished my speech, Mr de Klerk shook my hand and he asked me how my family was. I froze, thinking that this was the first time someone inquired about my family. I am not sure what I said in response. Bishop Tutu, who was always smiling, was very serious on that day, hardly smiling, but those were the times when many things related to apartheid were happening.

In the Medical wards, the professors used to see patients themselves and I needed to interpret. I did not feel bad, because I felt that I was talking for the patient.

The biggest joke at GSH that people find funny is that retired staff like Sr Orrie and Ms Adams still feed the cats. Those cats keep our hospital clean and keep the rats away so it is actually a blessing in disguise. Peoples' characters were funny, especially on Monday mornings at the Operational Management meetings. This was my weekly highlight – where managers used to tell it like it is. Issues often became heated and sometimes difficult for the chairperson to manage. People like Mr Paul Cleynhens knew what he was talking about, but nobody heard or understood him. Dr Rossi taught me all about Out Patients – from the toilets to managing the office. We worked very well.

I learnt something from them all.

19. Mrs Elaine Lewis

Interview with Mrs Lewis, who was the first `coloured' matron to be appointed at Groote Schuur. Through her determination and resilience, she motivated and supported many young nurses of colour to feel pride in their profession. Her stories are very detailed and have been included verbatim to appreciate her efforts towards advancing not only nurses, but all categories of staff. This is her story:

In 1970, I saw posts advertised for GSH nursing staff, so my husband got the Z83 and dropped it off the next day. I then received a telegram to say I must report for duty on the Monday. I insisted on an interview, so I came for the interview on the Friday. I sat on the E floor on the bench and after establishing where Ms Kotze's office was. I was told to enter through the lifts on the south side. So when I entered, the paige would not allow me into the lift because I was non-White. I stepped into the lift and he wanted to pull me out, but I used the lift. Then Ms Kotze conducted the interview and asked me if I could start on the Saturday. I was told to start in Jannie Louw's ward. Everyone was scared of him. One day when using scrap paper, I saw a page that said, Sr Lewis ex B1 to B4, so in other words, they thought I was a White person and when they discovered that I was not, they switched my appointment. In B4 I worked as a staff nurse, because even though we were fully qualified, the non-Whites were called staff nurses. We could wear the full epaulettes, but we were called staff nurse and the Whites were called Sister. Whenever he had a grand round, the previous sister of the ward would come to the ward and take over the folders. I then confronted her about this and she indicated that one of the doctors had asked her to do this, but she was apologetic about it afterwards.

One day, I came back from lunch and a patient was brought back from theatre. The patient was not breathing, so I asked the nurse to call the anaesthetist and he came and started resussing. When Dr Louw came to do the night round, he accosted me saying that I should have called him rather than the anaesthetist. I asked him if it was a respiratory problem or a bleeding problem. He then stormed out. The next day at the grand round, Prof Louw apologised to me and everyone could not believe it and saw that there was some humaneness in him.

I was on duty in C5, because I'd done my admin course and I was called to come to Ms Brassell's office and told to take over the personnel duties after a week of training. Three months later, I was in hospital for a procedure

and then Ms Brassell came to me and told me to apply for the advert for the non-White matron. I did apply, and got the job. The advert stipulated that they wanted a coloured person.

The Argus wanted to take a photograph of me, but I was denied to have a photograph inside the building, so it was taken outside next to a truck that used to come to GSH to sell pineapples. What I found offensive was the patronising attitude of White people, e.g. one of the White matrons used to collect all the caps of the nurses as they came off the bus from the Nico Malan College. They wore the caps because of the cold and rain. One day, after the nurses had written their finals, I told them to claim their caps before they left. They indicated that she had not marked them and this forced the matron to sort them out to give them to the rightful owner. When the riots happened in 1976, one of the nurses had to be protected from the White management because she was prevented from phoning home to check on her children to see if they got home safely. I felt that this was wrong and kept my ground to allow this, since White nurses were allowed to do this for other less important matters, but this nurse was being prevented from doing so, for the safety of her children. It was very difficult to handle and I think Ms Brassell may have regretted appointing me sometimes. I allowed the nurse to call whenever she needed to. Many of the matrons disliked me for my straight forward attitude.

With the hospital becoming very short staffed on the White side, some coloured nurses who were more fair skinned had to be handpicked to work in the White wards. I did this, so that the less pale coloured nurses would not be embarrassed by the White patients for touching them.

While on leave, I was called by the Medical Super to come in and meet Dr Francois van der Merwe, who had asked for me to be involved with the building project for the Rochester House. The next day, they did the implosion of the oven of the brickfields and I had to be present on that day too. I then met Mr de Wet, the architect that was in charge of the building of Rochester House. I had to then study the plans and determine how many curtains they needed, etc. Rochester was being built to accommodate the coloured nurses. Then UCT also was looking for accommodation for their non-White students, so they were also involved.

Nurses needed a medical when they applied to a hospital. Mrs Patton was 3 inches too short of the 5 feet that was required. She was then not going to be accepted, but I made a plan for her to stay.

When I was standing at the entrance to Rochester, I saw that the wall was skew. Mr de Wet was impressed with my keen sense and said that he was looking for someone who knew how to build arches, and I introduced him to the person I knew of who had built the St George's cathedral. I planted the pepper tree at Rochester House, which is supposed to be in my honour. The rubber tree was a pot plant in my home. I was responsible to get the furniture for the rooms, curtains, etc. Initially the PCU had recommended all the same curtains, so I called the owner of the company and asked him where they were manufactured and we managed to get a few colours of the same material. Rochester has about 1010 rooms.

One day I called a doctor back from the University to clean up the blood that he had thrown on the floor. He later said that I had taught him to treat everyone's job with respect.

The Matron used to check on us and daily, we were asked about the diagnosis of our patients. We had to know our patients out of our head. The respect was there, because everyone knew that you were the sister in charge. When I used to walk into a place, everybody stopped talking. I explained that you should never look as if you are lost. If you need to enter a room, you stand at the door, see where there is a chair and then walk towards it and sit down. This is the confidence that I had grown up with.

I was shocked when I came to Cape Town, because I found that the coloured people were themselves very racist. The GA's were called domestics. They used to be given an overall every morning, so on their way home, they used to throw it away. I then asked them to get a uniform for the Domestics that they could be proud of and managed to get them a pink uniform, because there was no colour left for them to choose, since all were taken.

I went to Dr Kane-Berman, and said to her that I have a problem to send number so and so to staff office. I told her that I felt uncomfortable that they were treated like a number and not as people. I then created name tags for them and the people were so excited. This was around the year 1973.

We used to pay the domestics in the office until someone was held up, and then the system was moved to Nico Malan. I said that this was very offensive to the staff, since the White staff, including the White porters, were paid into their bank accounts, but the others had to be paid in cash. I then asked that all staff provide their banking details and then this process changed. However, the domestic staff were still being paid in cash and many times, they complained that they were short of 20c or 25c, because clerical staff may have stolen this beforehand. It was said that they could not have bank accounts because they were 'under local rates of pay'. I then decided to ask the bank to open a mobile bank here at GSH. What was also wrong was that they had to first give their signature before they received their monies, so they were not afforded an opportunity to check their change before signing. I challenged this and asked some of the senior managers to join me when the domestics got paid and they saw what was happening first hand. After asking why these staff could not be paid by cheque, it was agreed that it could happen from the following month.

Mrs Jakavula joined GSH as part of the Education department in 1989– a White person was in charge and they were often asked to mark papers, but the White staff were allowed to take the papers home and the black staff were not allowed to do this and had to stay at work or be recorded as AWOL. They also selected the nicer modules to teach and left the less nice ones for non-Whites. After really assisting the students, they would not even say think you.

Even the SANC meetings were held separately and one day, the head matron asked me to tell the coloured nurses to join the meeting at GSH, because the White nurses were not quorate. I challenged this as not having been changed in the council's rules and I was in her bad books after that.

On one occasion, GSH hosted an international conference with delegates from India and Africa. The CSIR decided to have a gala dinner and prepared everything, e.g. invited a Muslim and Jewish priest to pray over the meat so that all could attend. This was to be at the Devil's Peak restaurant. The administrator of the Cape wanted to have a cocktail for the delegates, but when he found out that they were a mixed group of people, he said that non-Whites could not come to the Premier's residence. They then decided to buy me a new combi so I could take the 10-12 people to the Nico Malan (Artscape) and was also not told that there was an emergency meeting. While waiting in my office, I was asked why I was still there, because there was an emergency meeting in Ms Brassell's office. I sensed that I was not to be aware of what was being discussed. I then got a call from Ms Brassell's clerk and I then went to the office and when Ms Brassell told me, she advised me to place in the newspaper that the health department is racist and that this was GSH's reputation at stake. She left it to me – 'as long as its legal'. I then told Dr Reeve Sanders and other doctors and the R4000 was already allocated, but no-one went to the function and I was told to do what I wanted to do with the funds, and that was when I said we needed to use it for the crèche for the non-White side. The administrator was upset, but it was done.

I was the first to open up the crèche. The White people had a crèche in Clee Road, mainly supported by the Radiotherapy doctors, because they wanted the radiographers to work overtime. There was one little crèche in the main road. Just when I opened the non-White crèche, we took over the current location. I then got the Engineers to build the little chairs and toilets and basins, etc. Then they wanted the White and coloured children to be at the same place, but then divided it into the White (south side - Silvertree) and non-White(north side-Oaktree) side. White children would come over to check the non-Whites' veggie garden and this upset the White teachers.

The T2 and T3 prefab structures were built mainly to keep radiotherapy patients who could not go home, e.g. back to the Transkei. Sometimes, they could not wait for the ambulance to take them back to T2 and T3, so they

used to walk from the J block to T2. I would then be called that patients wearing pink gowns were in the street and could not be doing this.

The hospital also had red blankets for the non-White and blue blankets for the Whites. So much money was wasted because of this double needs. Grey capes versus black capes for the White nurses. When I started, non-Whites were given 12 uniforms and Whites given 14. Also there was only one company providing these uniforms, despite there being a proper tender system in place. Many instances were noted – 'because of having friends in the right places'.

There was a school in Rochester Road where they offered night school and I encouraged many of the GA's to complete their junior certificate.

When District Six closed down and staff needed to come to work on Saturdays, Sundays and Public Holidays, the hospital contracted with Golden Arrow to transport the staff for free. The management were not aware of this until I told them. Similarly, we were paying rent for rooms at Mowbray Maternity, so I compiled a list of all the rooms that were being used as part of the asset register.

When allocating the rooms, I did not mark them White/non-White and I showed them a picture of a room with a chocolate on the pillow – and when they agreed to which rooms they wanted, it was all mixed and they had no problem with this.

I managed to gather pianos from the Drs' Bungalows and from Peninsula Maternity Hospital and then placed them at Rochester. I saved money by doing this and got a merit award for this.

They wanted to build a tunnel from Rochester to GSH – which would need additional staff for security, so I decided to cancel it off the plan. ` Sometimes people agree with you because they are too lazy to think'.

The NMB is meant to have chutes for linen and patient body parts, etc – but what would happen to the linen, so I also cancelled this, otherwise we would need a way of cleaning the chute.

The first black nursing staff at GSH– Lindi Mangaliso and Lulama Qengwa – they were interviewed by me, and I had to get special permission to appoint them as interpreters in nursing posts for patients who were being used for research because doctors could not understand Xhosa.

I was also part of the Benevolent Association.

The GSH soccer club and the choir was managed by myself. The matron used to be very rude to them when they sang under the palm trees so I found a place at the nurses home for them to sing. When she was due to collect their uniforms from a company, they went bankrupt, but I got the uniforms anyway.

Mrs Patton notes that Mrs Lewis was very assertive and was not scared of anybody. Never rude, but assertive.

Mrs Maureen Ross notes that: – "it was only because of our seniors that we learnt how to behave and what to do. Because of this, every medical staff knew exactly who was in charge of the ward. On the grand round, we were asked for our opinions and we contributed on the round and this is how we learnt. Despite what we say about the past, I would come back to GSH anytime, but not the way that it is now. Nursing schools should be like the old days and the nurses must take back control of the ward. The block system produced more competent nurses. R425 used to be General, Midwifery and Psychiatry or General, Midwifery and Community health, which is now all mixed up. Now they come here only for a week and get no clinical practice. The cosnurses all state how much they have missed by the time they have to come to work.

Mrs Martha Petersen noted: "If I see further than anyone else, it's because I was standing on the shoulder of giants"

25. Other stories from the Three Musketeers.

A little bit of humour

- A funny story was when Mrs Ross was on duty as the matron over a week-end. She had to do ward rounds in one of the White wards, C2 in the OMB, an orthopaedic ward. The mother-in-law of Minister Botha was a patient. When Mrs Ross greeted the patient, the latter enquired what nationality Mrs Ross was. Mrs Ross, with her typical non-White looks and naughty streak, responded that she was from Spain originally but had come to South Africa to do a specialised nursing course. Only then was the patient prepared to engage in conversation with Mrs Ross. The patient was hesitant and anxious about her operation and thus not too eager to sign the consent form. Mrs Ross spent time explaining to the patient the nature of the op and reassured the patient accordingly. The patient wanted to know whether Mrs Ross would be on duty on the Sunday so that she could introduce Mrs Ross to her daughter and son-in-law (Minister Botha). Although Mrs Ross was on duty the Sunday, she informed the patient that she would not be on duty for fear of the patients' family discovering that a non-White matron had been to see their mom. Mrs Ross did not report this encounter. However, at the Monday morning management meeting, Ms du Preez enquired after the Spanish matron in her hospital because she knew full well that she did not have anyone in such a post. Ms du Preez informed the meeting that she had been telephoned by the minister's office who wanted to send the Spanish matron a thank you note for the manner in which she had reassured his mother in law and convinced her to have her operation!

- Ms Hardcastle, now Mrs Chaffey, was the night matron. She wore rubber sole shoes (which the nurses referred to as brothel creepers) thus staff could not hear her entering the wards when she did her rounds at night. One evening, a student nurse on duty in D7, the ENT ward in OMB, was sitting at her desk in the sister's office writing up the night patient progress reports. During that time, she fell asleep in the upright position. When she awoke, she realised that someone was standing in front of the desk and looking at the shoes, realised that it was Ms Hardcastle. Quick thinking, she made the sign of the cross lifted her head and told Ms Hardcastle that she was just finished praying for her patients. Ms Hardcastle was so impressed with this gesture!

- Over the week-end, many patients who presented themselves in the early hours of the morning to the Accident Unit (now Trauma unit), were inebriated. While waiting for either their x-ray or blood results, they would be stationed in the waiting room area. Often they would make a nuisance of themselves by continually moaning about the long waiting time, the incompetence of the service delivery, they would pass crude remarks about the nurses and doctors etc. Their behaviour was irritating and disturbing to staff. An ambulance arrived with a patient who had been involved in a train accident. The patient had his entire head severed from his body. As per policy, doctor and a registered nurse had to enter the ambulance in order to certify the death of the patient. Dr Chris Rudge, who was from England, picked up the patient's head, placed it under his arm, walked into the waiting area and asked the above patients whether they knew this patient (pointing to the head under his arm) the patients were horrified and fled out of the waiting room and ran down Groote Schuur Drive, never to be seen again! No-one knows whether there are still patients walking around with fractured skulls or pleural effusions or septic stab wounds.

- One evening, the doors of the Accident unit were flung open and eight young men were carrying an eighteen-year old indicating that the latter's toes had been severed following a gang fight where spades were used as weapons. The patient was placed on a stretcher and we could see the front of both of his shoes had been chopped off. Expecting to find severed feet when the shoes were removed, we were highly

amused to find both his feet in-tact! He had stolen his grandfather's shoes which were two sizes too big for him thus when his attacker chopped off the front of his shoes with a spade, it did not affect his toes because of the bigger shoes that he was wearing!

- As indicated, the outdoor uniform was compulsory for all nurses who were non-resident per se. During the cold rainy days, the non-White staff would wear a woollen cap (under which their hair was uncombed and instead had a part of a socking over their hair,) instead of the blue boat-shaped hat. One of the White matrons would stand at the entrance to the hospital, and would remove the woollen cap from these nurses' heads. An extremely embarrassing situation. She would then confiscate their woollen caps.
- Supper at Nico Malan was fantastic, but sometimes they cheated us with a thick slice of polony shaped to look like a chop. One day, because we were so naughty, we told everyone that we saw the cook stirring the soup with a mop. Toe eet niemand die sop nie!
- And then at night we used to play hide and seek because we couldn't go out. We only had one late leave and once a month one dance leave. Ons het nie boyfriends gehad nie, we were seventeen-and-a half years old. There was one nurse who came from a rich family and she used to bribe the housekeeper to allow her to go out with her boyfriend. So one night, we decided to play a trick on her and we dressed one of the nurses up in a black dress and a lacy black scarf. We switched off all the lights in H Block and then as she entered, the black dressed lady was standing at the door, giving her such a fright, and screaming that there was a ghost, since Nico Malan is built on a graveyard. Needless to say, sy het vir hoeveel aande nie uitgegaan nie. We always used to say that we don't think the nurses today have the fun that we had.
- One of the biggest jokes was the porter met die Jurgen susters. There were two theatres: B2 theatre was the main theatre; and then B5 was the gynae theatre on your way to EU. So this night we're in EU and we needed a size 12 cannula urgently because the doctor had his finger in the patient's chest. Hy sê toe vir die porter: Kom, jy's baie vinnig, dan hardloop jy om die draai – gaan gou hier in by die theatre, vra vir die Suster vir 'n size 12 cannula. So he goes, maar die porter bly weg, en die porter bly weg. We ended up inserting the size 14. Na 'n lang tyd kom die porter weer verby. So I asked him why he took so long. He was very upset and thought that we were playing the fool with him. Hy sê hy kom by B5 theatre en lui die klokkie. Suster kom daar en ek vra vir haar 'n size 12 cannula. Sy sê: luister klong, ek het nie 12 nie, maar gaan net hier op na B2 toe en gaan vra vir die suster daar. So when he got to B2, the twin sister comes out, the very same person. So he looks at her and says: suster moet vir my sê waar is daai secret passage. So I couldn't be angry at him and explained to him that they are twins. Hy kyk net so!
- These same twins used to perform with the surgeons. The one was very good with general surgery. The other one was exceptional with neuro, but they taught each other and sometimes when the one doesn't feel they want to come and scrub for Prof. de Villiers, the other one comes – one was Annetjie and the other Sannetjie - he thought it was the same person because you used to wear the mask. They used to walk the same. When they came to work, one morning Annetjie drives; and then the next morning Sannetjie drives. So one morning Annetjie didn't stop at the stop sign. The cop said to her: Dis nie 'n komma nie, dis 'n stopstraat. So he gave her a ticket. The following morning Annetjie is driving. And so she is about to go and the cop says to her: het ek nie gister vir jou 'n kaartjie gegee nie? Sy sê: nee. Hy sê: man, ek het gister vir jou 'n kaartjie gegee. Sy sê: Meneer, u het my nie 'n kaartjie gegee nie. Sy sê: as ek die kaartjie kan bewys, gaan Meneer vir my die kaartjie afskrywe? Hy sê: of course! En hy skeur dit net so op. and then the other sister says: u het vir my die kaartjie geskrywe; There are a lot of stories about them.
- Some of the nursing staff were genuine. They were the ones who taught us in theatre. They showed me how to do an AP resection. Once you were able to do certain procedures, it was as if 'you had arrived' and opportunities and doors opened for you. That is what I am saying with this hospital – that's how we learnt. We grabbed every opportunity.

20. Hilda Domingo

Ek was die head waitress by die Drs' Bungalows. Eendag was daar a workshop met baie belangrike mense, en ek moes die waitress wees vir hulle. Ek was toe nie bewus dat Mnr Spinner, die in charge van die kitchens, vir my dop gehou het. Hy vra toe vir die warden, Ms Smith, "Who is that girlie? She is neat, dressed nicely and fast. You need to use her appropriately." Ms Smith sê dak ek die head waitress is van die Dr's Bungalows. Hy sê toe vir haar, "As jy nie vir haar reg kan bebruik nie, then I will take her out and make something out of her".

Toe gaan ek op vakansie, en dit was nie eers 'n week nie, toe kry ek 'n telegram, dat ek moet onmiddellik terug kom werk toe. Ek sê toe vir my ma, "Ek weet nie waaroor dit gaan nie, want ek was nie in die moeilikheid nie. Toe ek by die hospital kom, sê hulle vir my dat ek die vorms moet invul, omdat ek 'n supervisor gaan word. Ek was mos nie bang vir werk nie. Ek het toe geteken en toe is ek 'n supervisor.

Ons het onse werk geniet. As General Assistant, het ek net R75 per maand salaris gekry. Maar, in daai tyd was kos en ander goed mos cheap and ons het goed klaar gekom met daai klein bietjie geld. As supervisor, het ek 'n bietjie meer gekry.

By daai tyd was ek al 21 jaar oud. Ek was 16 toe ek begin werk. Ek was nooit spuyt nie, want ek het baie geleer – van die Nurses Home af, tot die Dokters Bungalows.

Die werkers was meestal swart mense wat in die kombuis gewerk het. Die chef was nou 'n wit man and al die managers was wit mense. Die supervisors was blank and dan was daar ons coloureds.

Toe die Dr's Bungalows na die Rochester toe skyf, was ons na die sale toe gestuur. Ek het in al die sale gewerk and experience gekry in al die different sale. Ek het voor dit vir ses maande nag gewerk, as supervisor. Die susters was dan my supervisors and hulle het my baie geleer, van high dusting en so aan.

Daar het nou baie goed verander. Die mense respek nou nie meer die suster of die housekeeper. As jy die cleaner onder jou vlerk wil hê dan moet 'n mens baie streng wees. Nou se generation, hulle luister nie and wil nie gesê word nie, hulle sê vir jou wat om te doen. Die nuwe generation sê altyd – "Dis nie in my job description nie".

Eintlik, as ek mooi daarna kyk, dan dink ek dat dit was beter met die suster in charge van die general assistant. As die suster vir die cleaner kan control, dan develop hulle meer respek vir mekaar. Dan kan hulle hand aan hand werk.

Ek is nou baie gelukking met die werk wat ek nou doen. Die jare is nou te min om nog te werk, want ek moet nou retire in drie jaar se tyd, maar ek kan aanhou werk.

Dit sal 'n baie groot verskil maak as die mense kan nooit se 'Dis nie in my job description nie'. As die mense gewillig is om enige iets te doen, sal dit goed wees vir die hospital en dit gaan 'n baie groot verskil maak. Ek het baie met die patients ook gewerk. Ons het met hulle gepraat and goed vir hulle gedoen. Ons het baie geleer van hulle af. As die nurse short staffed was, dan het ons die werk ook gedoen. Dit was 'n lekker gevoel.

In die ou dae het ons baie voordele gehad. Ons het kos gekry, blyplek gehad, vir min geld. Die hostel was vir mense wat van up country kom. So ons het lekker gewerk.

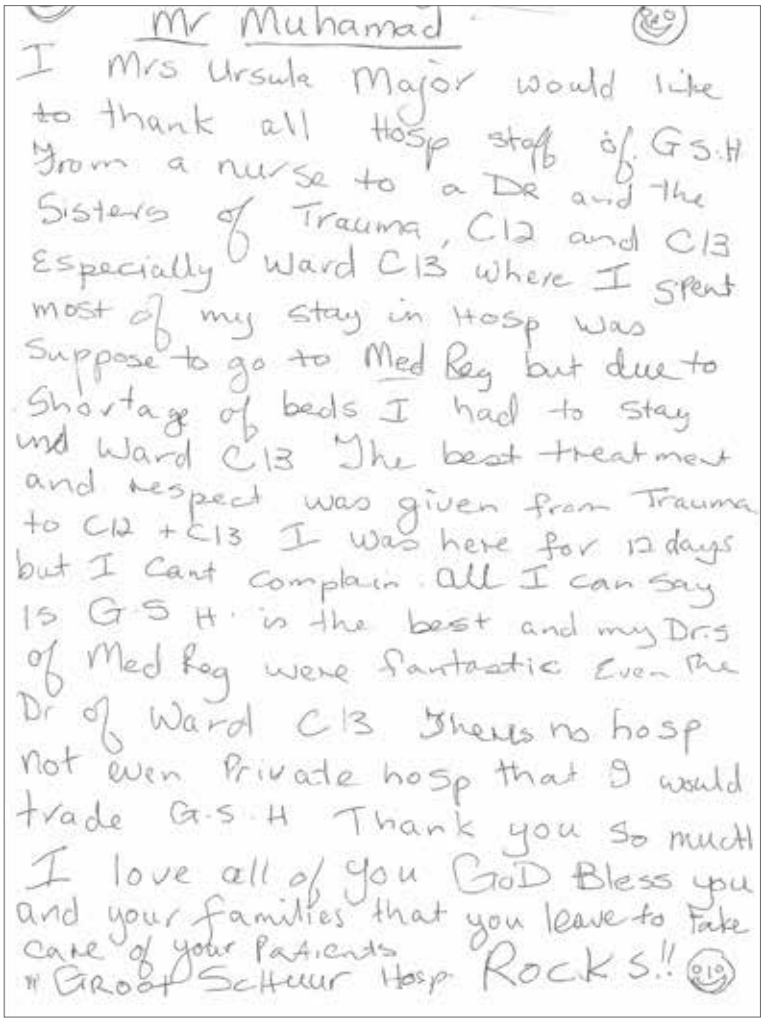
Van die baase wat ek gehad het – die professors raak mos gewoond daaraan om met ons te werk. Hulle wou net hê dat ek moet daar bly. Toe ek by Health Park gaan werk, toe werk ek met al die CEOs. Hulle was almal nice met my. Ek het hulle leerken en gedoen soos hulle daarvan hou. Ek het in hulle harte geklim.

As jy gewillig is om iets te doen, dan kan jy baie ver kom. Jy moet nooit sê dat 'Dis nie in my job description nie".

Patients were asked how they experienced Groote Schuur Hospital.

These quotes were taken from random patients lying in beds, sitting in waiting areas in the clinics and walking in the passages. They were all quite happy to offer an opinion on their care and we as the staff of Groote Schuur Hospital should continue to live by our motto, Servamus, We serve and do so with pride, because this is what our patients think of our care:

- In general, I find GSH very good
- No problems
- The hospital has been very good
- Sometimes it depends on who you speak to and how the doctors treat you. It's not so nice when you get a negative attitude from the staff
- They helped us nice.
- I've got a problem with the Fees Department. The care that I get is fine, no problem.
- So far, it has been good because they saved my life here at GSH, but I am still struggling with my back.
- I'm tired, but I will wait to see my doctor
- The service is very good. I was in hospital for 5 days and the service was excellent. I was diagnosed with high blood here at the hospital, which is a silent killer. Food is very good.
- I had my operation here. I'm 14 years old and they treated me very well here. I also liked the food.
- No problems. The experience has been very good and we are treated well.
- It's a good hospital
- I've been coming here for years and get very good service. We miss the clerk if he's not here. He's very good to us.
- No problem here.
- Can't complain. We wait a little, but the care is good.
- The administration people are very nice.
- Experience has been good, but the only problem is that I am feeling sick, that is why I'm at the hospital.
- In the EU, we need a proper shower available just to clean up. The service is very good.
- Bit slow, but not bad at all
- I was pleased to get such good care.
- We love Groote Schuur


Mr Muhamad
I Mrs Ursula Major would like to thank all Hosp staff of G.S.H from a nurse to a Dr and the Sisters of Trauma, C12 and C13 Especially Ward C13 where I spent most of my stay in Hosp was suppose to go to Med Reg but due to shortage of beds I had to stay und Ward C13 The best treatment and respect was given from Trauma to C12 + C13 I was here for 12 days but I Cant complain All I can say is G.S.H is the best and my Drs of Med Reg were fantastic Even the Dr of Ward C13 Theres no hosp not even Private hosp that I would trade G.S.H Thank you so much I love all of you GoD Bless you and your families that you leave to take care of your Patients Groot Schuur Hosp Rocks!!

Staff were asked what is it like to work at Groote Schuur Hospital.

These quotes were taken from random staff from the A level up to the G floor as well as Outpatients from all categories. They were all quite happy to offer an opinion on how they felt about the hospital and the heart-warming responses reflect a sense of passion, dedication and commitment to the work they do. It also reflects pride in the institution, but above all, it reflects Groote Schuur as a family that cares for each other. To many, this was an important value. These are some of their answers to the question: What is it like to work at Groote Schuur Hospital?

- Fantastic, Awesome, what an experience.
- It's a privilege. You learn a lot and everyday there's something new happening.
- Groote Schuur was like a family to me. I always had people around me who cared and I realised this especially when I lost my husband and how the Groote Schuur family helped me through those difficult times. I am very happy to work at Groote Schuur.
- It's a pleasure and it supplies most of my needs
- It's a privilege because of the esteem of what the hospital has achieved. I get a lot of support from the hospital.
- Yes, I like GSH because I see lots of people, students, professors, doctors and many patients. It's a nice hospital.
- Ek verdien my salaris, maar die mense is wonderlik and my doel vir die dag is on mense to laat lag en happy te wees.
- The best hospital in the world
- I have my good days and my bad days. I'm trying to enjoy. There should be some changes made to improve patient care, such as having more wheelchairs for the patients.
- It's challenging as an intern, but I'm enjoying it.
- It's quite a privilege. It just gives me job satisfaction, even though it's quite challenging. It is more good than bad.
- It's a lot of work, but it's a good learning environment. Sometimes it's too high tech, when some simple basic things could be used on patients. I'm a registrar.
- Priceless om by GSH te werk. Groote Schuur se naam gaan ver. Ek voel lekker om hier to werk.
- It's a privilege because we are very well known and we have the best doctors. Our patients appreciate it.
- It's a privilege for me. This is my home and it's everything to me. We work peacefully with our colleagues. This is home. The senior managers are down, they listen and you can say whatever you want to say, but just don't take advantage.
- I always dreamt of coming to work at GSH as a child. I used to be one of the ENT patients. It used to be nice, but some things now just don't make me happy, like how people address you. You pick up when people don't give you time and don't listen to you and they sometimes make you feel dehumanised.
- My patients come first. I started here in 1975 and from that time, Batho Pele.
- I've been here 17 years and it has been wonderful. No problems so far. I worked for 10 years here in the clinic and 7 years before that in Surgery, but now I'm enjoying this role.
- Very nice to work at GSH. I'm working at GSH for 38 years now. It's very nice to work with my colleagues.
- Makes me very happy. It's an honour to work here.
- Dit is 'n plesier om met mense te werk en te help. Ek geniet my werk baie en ek werk nou 34 jaar.
- Enjoyable to work at GSH. I love my job even though sometimes it's challenging to work here in Trauma Unit and Emergency Unit.
- I love my job and I love working here. That's why I'm still here.
- I've only been here 2 weeks, but it has been nice and a good experience. Very nice and welcoming staff.
- I enjoy many aspects of working at GSH, even as an Emergency Unit doctor

- At the moment good to work in the best Trauma Unit in the world, there's no question about it. I trained here and have been here for 15 years and it's the greatest institution in Sub-Saharan Africa.
- At work there will always be challenges, but if we can overcome these challenges then it's always OK.
- I feel very good and very much happy, because I'm enjoying myself because I'm working with staff that I feel is like my family. If I have a problem, I speak to management and they help sort out my problem, so I feel very blessed here at GSH.
- Patient care is important, but for myself, I can learn more and I do my work with a passion
- Die dokters vra baie vrae, en ek moet my goed ken, maar dis lekker.
- For 32 years I'm enjoying what I do
- I'm very blessed to work at GSH for 28 years. I enjoy my work
- Every morning when I travel by train, the first thing I see is the OMB, then I feel proud and I tell myself that I'm going to work now. On the train, I show people our beautiful hospital where I work. Everything is clean. Staff are friendly. Staff will escort the patients where they need to go. And my colleague here, when we have a challenge, I buy him a Coke and he buys one for me when I give him problems. It would be nice that we can be recognised in the public, because we feel proud to work at GSH. Outside, people call me Mr Groote Schuur Hospital.
- I've been here 35 years. I am part of the furniture and every Monday they dust me off and I'm good for another week. I like the open door policy of the managers and if they don't sort me out and I know that I can even come to the CEO to get help.
- We are family here. We listen to each other and we care for each other. It's an honour to work here.
- I love working here. I'm so proud to work here. I see the patients as my children and I care for all of them
- It's a privilege to work here. There are challenges, but they can always be overcome. We are all patient advocates.
- GSH is family
- My whole family was treated here and the way the nurses were with my grandfather in the ward, it inspired me. From there I wanted to help people – they come in sick and then walk out healthy and till today it's fulfilling.
- I enjoy working here
- It's fantastic. You have the opportunity to help everybody from all walks of life and you have access to incredible colleagues. I've worked here all my life and I won't work anywhere else.
- I enjoy myself for 33 years now. I'm happy to be here and won't change a thing.
- The fun and the games we have on a daily basis, because Engineering is always full of fun and entertainment
- I've been working at GSH for 21 years and I definitely enjoy what I do
- I enjoy the people, the dynamic teams, challenging at times, but enjoyable
- I like the sense of being part of a big family like Groote Schuur Hospital. The staff look after one another and care about one another. That's what makes my job enjoyable
- It's stimulating
- The excitement and change in attitude is very rewarding
- The good we do for others; Everyone shows us around
- Facing new challenges every day and you learn every day.

THE BEAUTY OF OUR HOSPITAL









THE BEAUTY OF OUR HOSPITAL

THE BEAUTY OF OUR HOSPITAL


Global
Day


#saFeHANDS


SOCCER FIVES

Chief Medical Superintendents / Chief Executive Officers

1960 to 1975	Dr J.G. Burger
01 January 1976 to 12 August 1976	Dr R. Nurock
01 December 1976 to 30 June 1986	Dr H.R. Sanders
01 July 1986 to December 1995	Dr J. Kane-Berman
	Dr G. Lawrence
01 January 1996 to January 2001	Dr P.J.Mitchell
01 February 2001 to 31 March 2004	Dr N.V. Maharaj
01 April 2004 to 31 October 2007	Dr J. du Toit
01 November 2007 to 31 Dec 2010	Dr S. Kariem
01 January 2011 to May 2013	Dr T. Carter
August 2013 to date	Dr B. Patel

Nursing Managers

1938 to 1946	Ms E.M. Pike
1946 ton1949	Ms S.M. Marwick
1949 to 1966	Ms E.J. Fouche
1966 to 1968	Ms C. de Wet
1968 to April 1980	Ms P.H. Brassel
July 1980 to 1988	Ms L.J. du Preez
1988 to March 1997	Mrs A. van der Walt
April 1997 to 2000	Ms M. Pletts
2000 to 2009	Ms C. Thorpe
2009 to 2016	Mrs M. Ross
2016 to date	Mr A. Mohamed

GROOTE SCHUUR HOSPITAL

EXECUTIVE MANAGEMENT TEAM

JANUARY 2018

Dr Bhavna Patel
Chief Executive Officer

Dr Edda Weimann
Manager
Medical
Services

Dr Hafiza Aziz
Manager
Medical
Services

Mr Denton Smith
Head:
Engineering

Mrs Annelise Bezuidenhout
Head:
Finance

Mr Vincent Rossouw
Head:
Support
Services

Mr Errol Brierley
Head: People
Management

Dr Tunc Numanoglu
Manager
Medical
Services

Dr Fahd Conrad
Manager
Medical
Services

Mr Lionel Naidoo
Head:
Allied Health
Services

Ms Vanishree Naicker
Head:
Pharmacy

Ms Miladevi Govender
Head: SHERQI

Dr Bernadette
Eick
Senior Manager
Medical Services

Mr Aghmat Mohamed
Head:
Nursing
Services

Dr Agata Krajewski
Manager
Medical
Services

Dr Belinda Jacobs
Manager
Medical Services

Mr Alaric Jacobs
Head:
Communications

Mr Garth Hankey
Head:
Improvement
Office

GROOTE SCHUUR `FIRSTS'

World Firsts

- Of significance is that Allan Cormack, who worked as a Groote Schuur Hospital physicist during the 1950's, had become interested in the mathematical problem of creating a correct radiographic cross-section in a biological system during his time at Groote Schuur. His work was used by a British computer specialist to develop the world's first Computer Scanning machine. The 1979 Nobel Prize was jointly shared by the two gentlemen
- 1965 – Of note is the development of a rapid warming device for massive blood transfusions.
- 1967 – First Human heart transplant in the world
- 1971 – One of the world's first heart-lung transplants was done by Barnard at GSH The patient only lived 18 days, similar to Washansky.
- 1974 – The heterotopic or commonly known in lay terms as the "piggy-back" heart transplant was developed in the UCT animal laboratory and the clinical cases were a world-wide first.
- 1975 – World's first vascularized Human Fallopian Tube Transplant performed by Dr Brian Cohen and his team.
- 1981 – Another world first for Groote Schuur Hospital came when a method for storing donor hearts by hypothermic perfusion was developed by Mr W.N. Wicomb and his colleagues. This method was used on four transplants performed at Groote Schuur Hospital, with the donor heart being stored for 7-17 hours.
- 1989 – A world first was the discovery of a technique to locate brain tumours without invasive surgery, with the use of a plastic head dubbed `Tom'. With the use of CT scanners, they were able to pinpoint the exact location of the tumour and thereby facilitate an accurate placement of the proton beam for treatment, without needing to constantly shift the patient.
- 2008 – HIV positive to positive kidney transplants
- 2015 – Aceso machine tested at GSH. World's first combined ultrasound and mammography device.
- 2017 – Brain operation through the orbit of the eye – World first

African firsts

- On 8 December 1955, an operation was performed as the first one in Africa to remove a tumour from the adrenal gland of a patient for a condition called Primary Aldosteronism
- 1981 – In March 1981 Prof Francois Bonnici (endocrinology), Mike Mann (Nuclear Medicine) and Dave Woods piloted the first neonatal thyroid screening programmeme in Africa.
- 1994 – First multiorgan transplant in Africa
- 2004 – Martin Singer – First in Africa to be awarded 'Pioneer of Hand Surgery'
- 2015 – Ashley Chin implanted the world's smallest pacemaker into a patient. First for Africa.

South African firsts

- 1955 – Prof James Louw introduced the pap smear to SA
- 1958 – South Africa's first successful open heart surgery was performed by Chris Barnard after his return from Minnesota, USA with a heart-lung machine, donated by the US government. 3 previous unsuccessful cardiac operations were attempted by Walter Phillips, in charge of thoracic surgery at GSH, in the year or so before Barnard's return using a more primitive machine and lacking the expertise Barnard had gained in Minnesota
- 1965 – First in South Africa, pre-birth blood transfusion in Dept of OandG under X-ray guidance.

- 1966 – The hospital performed the first triple heart valve operation successfully
- 1967 – First valve and pacemaker insertion in SA.
- 1974 – First SA Bone marrow transplant
- 1975 – Francois Bonnici established the first Paediatric and Endocrine Unit in the country. As part of the services of this clinic, the Growth Hormone was used first in SA.
- 1985 – South Africa's first removal of an air passage growth using Laser Surgery
- 1985 – The first successful series of heart-lung transplants in SA and amongst the first series in the world were performed by Bruno Reichart at GSH starting in1985 - till end 1989.
- 1986 – The Department of Haematology used for the first time in South Africa, a new technique to overcome the graft versus host disease in bone marrow transplants.
- 1988 – The birthday year was also marked by the surgical team, led by Professor Terblanche successfully transplanting a liver into a 48-year-old woman in October 1988. First for South Africa.
- 1991 – First for South Africa, Professor Scott Miller and Dr Ulrich van Oppel performed an Arrythmia operation
- 1993 – First Hand replant surgery in South Africa performed by Martin Singer.
- 2002 – First in the country to initiate ARV for children with HIV
- 2004 – Insertion of titanium bone into the arm. First in SA.
- 2006 – It was the only Pharmacology Laboratory in the country which is fully accredited with the South African National Accreditation System (SANAS) and the only public sector laboratory offering assays for antiretrovirals, antitubercular drugs and the immunosuppressive drug sirolimus.
- 2009 – First in SA to open a multidisciplinary adolescent ward
- 2013 – Surgery on a brain tumour using intra-operative fluorescence, a new technique that lights up the affected area of the brain. Pioneering neurosurgeon Dr Sally Röthemeyer of the Division of Neurosurgery.

First in a SA Public Hospital.

- 2014 – First in SA to use rapid arc technology
- 2014 – First pregnancy carried to term in a heart transplant patient in SA
- 2016 – The first successful pregnancy in South Africa in a patient with Glycogen Storage Disease 1 was achieved in a 22 year old patient.
- March 2016 – First in SA to do an aortic valve replacement through a keyhole size incision.

Groote Schuur firsts = Public sector firsts = First in the Cape

- 1961 - Another technique of total cardiopulmonary bypass with profound hypothermia was also developed in the laboratory at Groote Schuur.
- 1961 – The Cardiothoracic team performed a complete correction of a transposition of the great vessels. This operation was the fifth successful one of this nature done in the world, and in order to perform it, a new technique was developed in the research laboratory.
- 1962 – A prosthetic heart valve, the Lenticular prosthesis was developed in the Surgical research Laboratory and used on 7 patients as valve replacements.
- May 1963 also saw the first 'non-white' labourers department being inaugurated. This included Cleaners, Ward and Theatre Orderlies, Waiters and Cooks.
- Oct 1964 'coloured' nurses could train at Groote Schuur Hospital to service the 'non-White' patients so that they could treat patients of their own race and that this would provide more opportunities for employment to this sector.
- 1967 – First cases of peritoneal dialysis in the Cape
- 1967 – first kidney transplant in the Cape

GROOTE SCHUUR `FIRSTS'

- 1969 – First corneal transplant in the Cape
- 1969 – Marius Barnard started the Lung transplant programme
- 1972 – The year 1972, saw the Cardiothoracic team continue to innovate with the introduction of a new technique for the surgical treatment of infants with congenital heart disease. The process of Surface Cooling with limited cardio-pulmonary bypass, deep hypothermia and circulatory arrest allowed for much greater success with this type of corrective surgery.
- 1974 – First piggy-back heart transplant
- 1975 – It was also the year that Professor Gainsford Harrison of the Department of Anaesthesia discovered that Malignant Hypertension could be treated using Dantrolene.
- 1983 – First human liver transplant using the heterotropic technique in the world. First liver transplant for the Cape.
- 1986 – The Cook-chill system was pioneered at GSH
- 1986 – First test-tube babies in the Cape born at GSH
- 2011 – First bone-anchored hearing aid in public sector.
- 2013 – EBUS – first in WC. Only used at Albert Luthuli elsewhere.
- 2013 – First haploid mother to child transmission.

Nursing poems – written by nurses for the Hospital's first birthday celebration:

"THE NURSES'" IF

(With apologies to Rudyard Kipling)

If you can keep your smile, when all goes wrong,
And have that cheerful look the whole day long.
If you can make the beds, when there are only few of you
To finish that and dusting too.
If you can work and not be tired by working
Or being tired, give way to tears, though few
Or being late, do not give way to shirking,
But take those "temps" and chart them properly too.

If you can put your work before your pleasure,
And yet find time for your rightful leisure.
If you can keep awake the whole night through,
And finish all those washes in the morning too.
If you can keep a calm unruffled surface,
Nor lose your head when things are in a whirl,
Yours will be the conquest of your purpose
And which is more, you'll be a NURSE my girl.

Poem by Matron E.M. Pike

The first Matron of Groote Schuur Hospital sending a message to all nurses at the celebration of the first birthday of the hospital in 1939.

This is really to let you know
Of all the praise that I wish to bestow
On the people who with me did share
The honour of Groote Schuur's first year

The assistant Matrons all must know
Have helped the hospital to grow
Beyond anticipation
To say I could nothing have done
Without help from these fine women
Is no exaggeration

The Sister tutors also strove
To lessen the excessive load
Which was our common burden.
Our senior pupils were very few
Who could spare the time or even knew
How to "pass the word on"

Home sisters' tasks were never ending
All members of the staff must, blending,
Become one great community.
No person entered Clarendon House
Who could not air each flimsy grouch
Without impunity
Our Sister Crowe was always there
All complaints and request to hear.
Each took the opportunity.

Night Sisters helped to till the grounds
By keeping up their Constant Rounds
And guiding every pupil.
The Groote Schuur Hospital had to grow
Through night as well as day you know
And all its function fulfil.

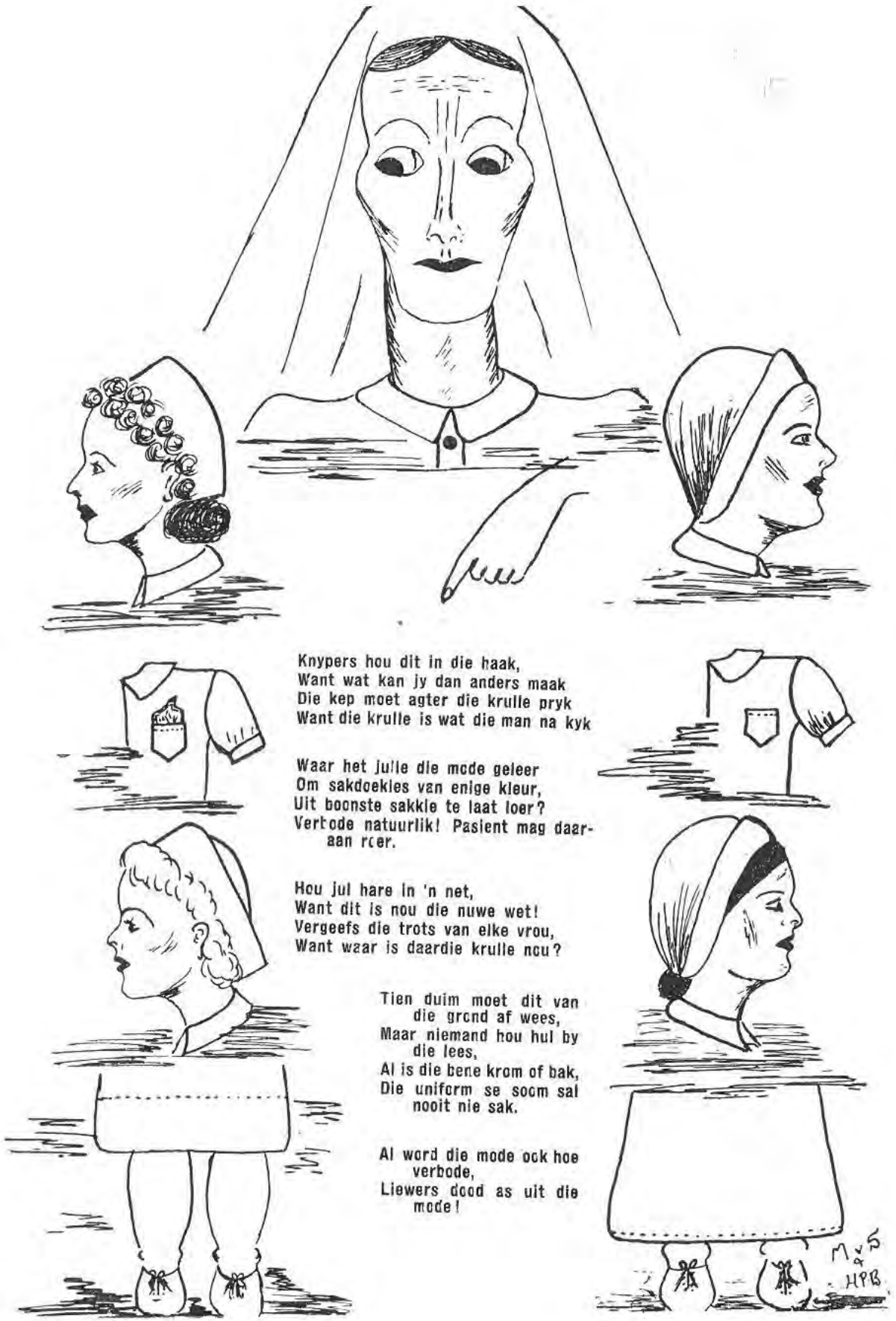
Sisters, O marvels of humanity
Though I've no desire to stir your vanity,
Have proved yourselves to be of the best
With which this Hospital has been blessed.
Your work, your tact, your tears, the strain
Have firmly built - were not vain.
How many there are who do not know
All that with a veil must go?
The responsibility, sacrifice and tension,
Do they wonder if you earn your pension.
If readers chance to pence conprendre
In these last lines in double entende`
Well gentle reader my responses is
Honi soi qui mal y pense.

Staff nurses came from far and near,
Some did not understand I fear.
Most of them were helpful and willing,
Hit the ground and did much telling.
Each one was a joy to know.
They certainly helped us "on with the show."
Birds of Passage most have been.
For Sister's Posts they were very keen,
It certainly is no mere platitude
When I offer to Canada our sincere gratitude.

Your student Nurses, children all,
Who have come to learn our "Service Call:"
Are privileged members of this High School.
I want you to make a big golden rule,
Take as your motto "No Grousing Please."
This you will accomplish with great ease.
Your building up will be blessed with Fame.
Your school will a fine reputation gain.
Stop – take time – do a little deep thinking.
Now Miss Inconsequence stop that winking
When things seem wrong don't cry in a passion.
We may as well be dead as be out of the fashion.

Remember the days are surely nigh
When you will look at new pupils and sigh,
"We had to do this in the lecture room."
Why can't these new pupils decently groom.
Uniform worn well, is a joy to see
But depends entirely on uniformity;
Don't go round with a monkey on your back.
A little introspection brings him down with a whack;
When you have him down at your heel
You'll be quite astonished what self-respect you feel.
Don't ask other people to help you win
But keep a stiff upper lip and stick out your chin.

Don't let us forget the 'Old School Tie.'
Remember what we need is what money can't buy.
Don't get distressed when you fail to attain
Don't let your lack of money keep you down.
A little cotton frock makes a pretty evening gown;
You can do what you really want is a true thing to say
If you want a thing sufficiently you will always find a way.
Remember Dick Whittington and just start again.
If the trundling of the wagon
Your peace begins to mar,
Don't allow yourself to forget your
Wagon is hitched to a star.



Knypers hou dit in die haak,
Want wat kan jy dan anders maak
Die kep moet agter die krulle pryk
Want die krulle is wat die man na kyk

Waar het julle die mode geleer
Om sakdoekies van enige kleur,
Uit boonste sakkie te laat loer?
Verbode natuurlik! Pasient mag daaraan roer.

Hou jul hare in 'n net,
Want dit is nou die nuwe wet!
Vergeefs die trots van elke vrou,
Want waar is daardie krulle nou?

Tien duim moet dit van die grond af wees,
Maar niemand hou hul by die lees,
Al is die bene krom of bak,
Die uniform se soom sal nooit nie sak.

Al word die mode ook hoe verbode,
Liewers dood as uit die mode!

271 | Page

DECLARATION OF REDEDICATION

We, the staff, friends and associates of Groote Schuur Hospital
and the Health Sciences Faculty of the University of Cape Town
rededicate ourselves, our knowledge and skills to achieving the
mission of this great hospital-
which seeks to function as a centre of excellence within a untary
and egalitarian health service committed to
providing comprehensive health care of the highest quality;
to offer teaching, research and specialist diagnostic and
therapeutic services that will continue
the proud tradition of past endeavours into the future.

We solemnly rededicate ourselves to the service of humanity, to
alleviate suffering and to promote health in a manner which
respects the dignity, the individuality
and the privacy of those whom we serve.

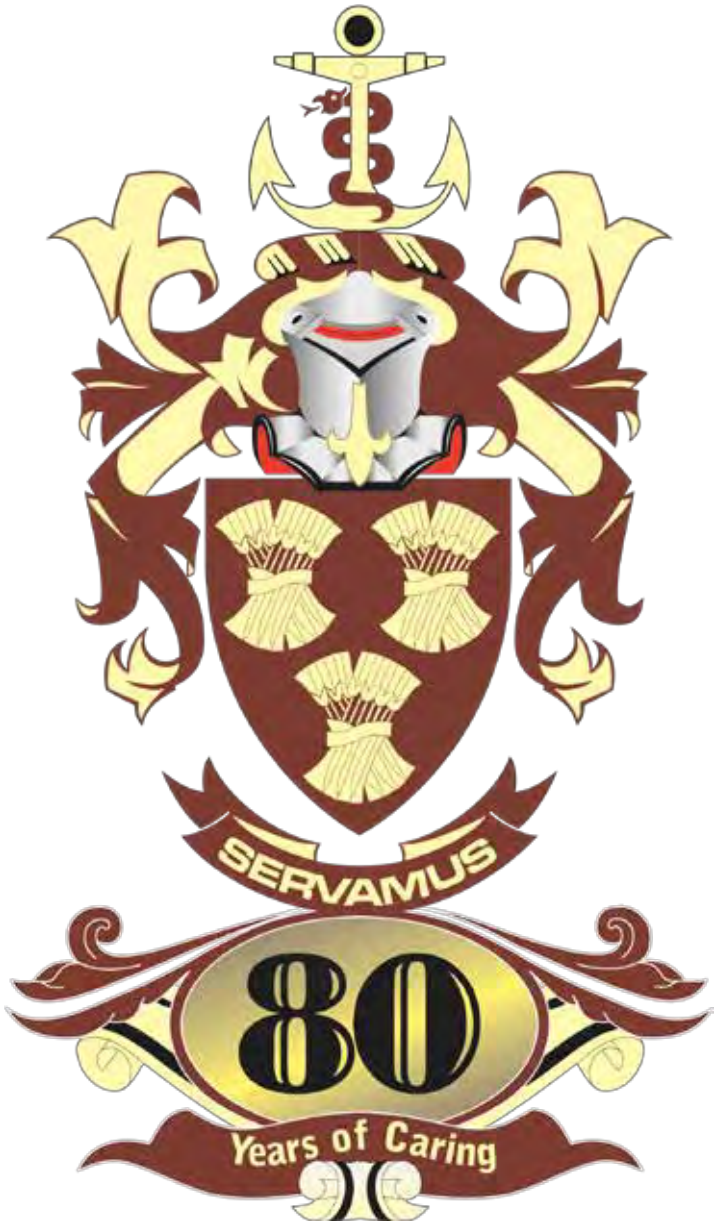
As members of the health care team we solemnly declare that we
will preserve and respect the honourable traditions and
obligations of our several callings for
the good of all people in our care, and for the common good,
regardless of any other considerations.

We will uphold the traditions and values of Groote Schuur
Hospital and promote its welfare, maintain its reputation and
constantly strive to improve on past achievements in all fields.
These undertakings can best be served
by observing our motto:

SERVAMUS – WE SERVE

References

1. Botha CG. 1950. The Cape Hospital Board 1913-1949. A survey of hospital development in the Cape Peninsula from early times. C. Blackshaw and Sons (Pty) Ltd Publishers.
2. GSH nurses. 1939.The Birthday Book. A selection of poems for the hospital's first birthday. Salesian Publishers.
3. Hospital and Nursing Year Book of Southern Africa. 1988. Groote Schuur Hospital 1938 – 1988. H. Engelbrecht and Co Publishers, Cape Town.
4. Hospital Annual Reports - 1950 to date
5. Cape Hospital Board reports – 1920 to 1949
6. Hospital meeting minutes; Newsletters and other Publictions.



273 | Page

SERVAMUS

80

Years of Caring