ELECTIVE (SSC5b) REPORT (1200 words)

A report that addresses the above four objectives should be written below. Your Elective supervisor will assess this.

What diseases present to the emergency department of Khayeltisha? Does this differ from the UK?

Khayelitsha has a high burden of HIV and TB. A high percent of the presentations in the emergency centre stem from these diseases. TB itself has a much higher rate of dissemination leading to preentations that I previously had not considered. I found a lot of the time that I was thinking in my UK hat so when I went to a doctor to present my case I had not considered some of the differentials. I quickly learnt and adapted my history and examination skills. Understanding the presentations of TB and HIV in South Africa has made me realise back in the UK that some presentations we see may be due to undiagnosed TB and HIV. I will endeavour to keep this in mind when working back in the UK.

What types of traumatic injuries does the department at Khayeltisha hospital recieve? How does this reflect the social situation in Khayeltisha? Does this differ from the UK and East London?

Khayelitsha receives a breadth of traumatic injuries. Mainly from assualts and robberies with a much higher incidence of weapon use compared to the UK. Generally speaking patients who have been stabbed receive multiple injuries with a much higher incidence of stabs to the face and head than back in the UK. Most of the knife crime in the UK is gang based whereas in Khayelitsha it is drunken violence, robberies and neighbour to neighbour violence. Khayelitsha also recieves many gunshot victims with a higher rate of unlicensed firearms in the community than the UK. Unlike the UK where guns are normally used to just threaten during robberies or by gangs to kill, in Khayelitsha guns are used to resolve arguments, muggings and by the gangs.

What social situations in Khayeltisha have an impact on disease incidence?

Khayelitsha is a very poor township with many people living in shacks and poor housing. This leads to a high burden of disease with a lower life expectancy than other areas of Cape Town and the UK. Poverty and violence in the community lead to a higher incidence of TB, HIV, miscarriages and pregnancies as well as chronic health conditions such as heart failure, MIs and respiratory diseases. I found that chronic diseases presented much earlier in terms of age of patient compared to the UK which might reflect the access to healthcare and lack of public health funding.

How is the South African healthcare system set up?

In South Africa, like the UK, there is a two tiered system with access to government funded and private healthcare. Broadly speaking government healthcare is set up in the same way as the UK with general practioners, family doctors based locally, local clinics providing other services and district general and tertiary level hosptals for more complex management. The DGHs in the government system are much less well equipped than the UK with the hospital we were working out having to refer to a teritary

centre for CT imaging. Access to the government system and means of payment is based on monthly income and is a tiered system.

What is the difference in provision between government and private hospitals? What percentage of the population are covered by private healthcare and does this differ from the UK?

Private hospitals are much better equiped and receiving far fewer patients with respect to the number of staff. Patients in the private system will wait for appointments for far less time. Private healthcare is provided by companies and bought by individuals by those that can afford it. Subsequently far more of the affluent population has private insurance.

What initiatives do the South African government have in place to reduce poverty? How do these differ from the UK? What initiatives do the government have to reduce the incidence of trauma?

From speaking to doctors and allied health professionals the government in South Africa is very corrupt. This makes any attempt at schemes to reduce poverty few and far between with schemes costing hundreds and thousands of pounds having very little impact on the ground. There is a lot of resentment in the poor communities towards the government and authority. South Africa still recieves a lot of migrant workers continually adding to the poor population. The townships have improved a lot since the apartheid with electricity, ground pumps, running water and toilet facilities being more common place. There is very little money to reduce the levels of violence and the police are very reactive not proactive. Simple measures such as wearing seatbelts and speed reduction are not well enforced due to overstretched police forces. It was commonplace to see overcrowding in cars and pickup trucks. The country has a strict no alcohol policy whilst driving with plenty of signs along the main road however this is widely disregared within the townships leading to a lot of road traffic collisions. The townships population appear to have little insight into the dangers or frankly don't care about the consequences and don't fear prosecution.

At times it feels the country has resinded itself to its fate of widespread poverty.

What initiatives from the UK could be used in South Africa and vice versa to reduce levels of trauma?

Given the UK has much more funding for these types of schemes it would be hard to implement in South Africa. However targetted police forces against gang crime in some townships and social workers to help gang members out of gangs would make a huge difference to the level of violence seen. Stricter enforcement of traffic offense given approriate funding would also help reduce injuries.

How can I improve my management of acutely ill patients? What clinical skills do I need to improve to improve my management of acutely ill patients?

The constant exposure to acutely ill patients greatly increased my confidence in the basic approach to the patient. My ability to undertake basic skills such as cannulation, taking blood and suturing have greatly I also learnt more advanced techniques under supervision such as the placement of intercostal drains, lumbar punctures and pleural taps.

What lessons from trauma management in South Africa can I bring back to the UK?

South Africa experiences a far higher incidence of trauma than the UK. The patients are managed by far fewer staff and resources. In our hospital there were patients being managed by one doctor and myself whereas the same patient in the UK would have a team number into double digits. I think in some ways there is a lot the UK system can learn. It is expensive and there are a lot of wasted resources throughout the whole of management in order to pick up that "one" case. I think there is a happier medium somewhere nearer the middle in terms of resource use. The team approach to shifts in Khayelitsha meant that the team was very well bounded and knew each others skills and weaknesses. I think the UK couple learn a lot from having that indepth knowledge and trust within members.

What gaps are there in my knowledge of HIV and its complications?

I found that whilst my therotical knowledge of HIV was appropriate knowing its complications I stuggled to put it into practice. I intially found it harder to recognise the complications as they were not at the forefront of my differentials. Towards the end of my placement my understanding and appreciation of HIV was greatly improved.