ELECTIVE (SSC5b) REPORT (1200 words)

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

Objective 1:

To understand the pattern and burden of Traumatic injuries and presentations to the Emergency Department in a trauma centre in South Africa and how this compares to the UK and other more economically developed countries.

I was working in the Emergency Department at Khayelitsha District Hospital, Cape Town. Khayelitsha is one of the poorest townships in South Africa. The hospital services Khayelitsha and the surrounding area; a far greater area than was initially intended when the hospital was opened in 2012. This is due to recent fire damage at one local hospital and another that was shut down due to poor performance.

Compared with my experience in the UK there is a much higher burden of violent criminal activity as a cause for presenting to the emergency departments in at KDH. Be this beatings, stabbings, shootings, or a community attack (a type of community based 'justice' system). Like with the UK there was the weekly pattern to most activity with more injuries occurring at the weekend, especially the last weekend of the month (pay day) with a big fluctuation in our intake when the local bars closed. I remember one Saturday night 15 stabbings arriving within the space of one hour when the local bars closed.

While there is a steady stream of trauma throughout the week as well the majority of patients that present during the weekday will be medical patients. I noted some similarities and differences with the pattern of these presentations also. When looking at the burden, as I have already mentioned, KDH is draining a FAR larger area than was initially intended therefore standard operating ratio of patients to doctors is FAR different to my experience in the UK with one doctor for an entire area like majors, juggling upwards of 25 patients at any given time (with the support of only one nurse).

I also noted a vast difference in the type of medical presentations we were seeing at KDH. For example: where extra-pulmonary TB would be very far down my differentials for an abdominal mass, this was a differential that needed to be ruled out quite early in most cases due to the high prevalence of HIV with co-morbid TB in the area – this coupled with poor adherence to medication and late presentation to hospital due to a cultural reliance on faith healers. In three of the five instances of a lower abdominal mass I examined during my time at KDH, complications of TB was the final diagnosis.

Objective 2:

To understand how a Trauma department in South Africa functions in comparison to the UK in terms of streamlining, organisation and facilities and to understand differences in pre-hospital emergency care provision between the UK and South Africa

The Emergency Department at KDH was divided into 5 sections: Triage (ambulatory care), Asthma Room (Minors), Trolleys (Majors), Resus (4 beds) and Paediatrics. All patients arriving at the emergency department were initially triaged by a registered nurse and then graded in severity based on criteria (similar to a MEWS) before being diverted to the required area of the department. There aims to be one doctor in each area when they have available budget for a locum/sufficient volunteer support, but it is not unusual for one doctor to cover both minors and majors. Furthermore, due to the limited number of doctors if multiple patients present to resus at the same time/a case required the attention of more than one physician then doctors are pulled from other areas and their patients just wait until the incident is under control before their care continues. It is therefore not surprising that the wait time for patients in triage (the least severe) would routinely be between 6-12 hours before being seen by an out of hours GP (staffed by the equivalent of a foundation doctor) – not exactly the 4 hour target. If a patient in triage has seen a doctor within four hours the department is having a slow day. By no means do I mean to give the impression that the doctors are not working hard while they are on shift, needs simply overwhelm the resources. Not only is the only one doctor per 'pod' but there is also only one ECG machine and one Ultrasound to service the department – meaning that there are often large holdups in the patients' journey through the department.

In terms of pre-hospital care – this is vastly similar with one big exception. Often trauma patients would have presented to a primary care physician who would have already attempted initial resuscitation including cannulation and on rare occasion the placement of chest drains if required before coming to hospital. This is something I have never witnessed in the UK.

Objective 3:

To understand differences in the structure of the South African health care system and the NHS and to appreciate how this is influenced by poverty.

I think this is the objective I least met. I learned lots about the public healthcare system but in South Africa that is only half the coin as the private sector is utilised differently than how I have seen in the UK – in the UK my experience has been people will usually have an NHS GP and only go private to gain more choice rather than a better outcome per say. Whereas in South Africa is seem that going private is your first option if you can afford it which is hardly surprising given the under resourced nature of the public system.

Obective 4:

To integrate into a team of healthcare professionals and contribute effectively in a department where resources may be lacking compared to the UK. To improve my clinical skills including practical skills,

clerking patients, communication skills and management of acute presentations to the Trauma unit / Emergency department for preparation as a Foundation year 1 doctor in the UK

This objective perfectly sums up my experience at KDH. I was part of a team (team 3), working side by side as one of the 'doctors' – yes I still needed all my patients to be reviewed but I carried my own patient load and managed them largely autonomously. I would routinely present each patient twice, initially with my differentials and plan, then afterwards with my diagnosis and management/disposition plan – checking with anything that seemed too complicated/when I was not comfortable. I was even given my own situation in resus to 'lead' on (this was CLOSELY supervised – sometimes at my instance, the doctors forgot we are still students on occasion).