ELECTIVE (SSC5c) REPORT (1200 words)

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

Having heard so much about Trauma in South Africa I expected manic emergency rooms, rushing doctors and nurses, perhaps some shouting, and definitely patients without beds lining the corridors. The patients didn't disappoint me, they indeed did line the corridors with bleeding bandaged heads, fractured limbs, and various penetrating wounds. But the overriding atmosphere was always calm. No shouting and no running. Even when a critically unwell patient was undergoing a failing RSI, the consultant remained calm and moved with precision. Sometimes this calmness is simply slowness. A very unwell child not 2 years old was peripherally shut down and deteriorating very quickly as no one was able to gain IV access. This child's dropping blood pressure was not monitored and of no great interest to the consultant when I reported them out of worry, and he continued to slowly look for more veins to try. Eventually an IO was procured after 90 minutes and after one failed attempt also abandoned. After another hour of slow attempts at access it was finally successful and the child transferred. Apparently it was the only IO in the entire hospital and it had to be delivered from the paediatric ward. How is that possible? In total it took 2.5 hrs to gain IV access in this unwell child, something I still find shocking. There was absolutely no urgency and definitely no targets to be met. Ultimately it's the sense of slowness that surprises me - it is trauma and emergency after all. Another noticeable difference is the number of patients: london A&E waiting rooms are forever filled with waiting people and the flux is constant and unremitting. Here it is not uncommon for the A&E beds to be filled with patients awaiting transfers elsewhere, but there to be no new patients for us or the doctors to clerk. I've never had as many cups of tea 'on duty' as I have had here. On the other hand, I've also never been so involved as I have been here.

A pleasant surprise is how friendly and enthusiastic the doctors are. They're patient when teaching and explaining, and willing to supervise us with procedures. I watched a few back slabs being put on and was allowed to try one myself (under heavy supervision). Similarly, once I'd seen a few chest drais inserted and demonstrated by single-handed reef knot to the consultants satisfaction, I was allowed to perform the next one. Simple cases that just required some cleaning and suturing, we were allowed to perform ourselves. It's a great feeling to be allowed some autonomy; something we've not experienced much during medical school. I've become much more confident in dressing wounds and suturing in the few weeks I've been here.

There was less variety in the types of patients and trauma encountered in South Africa. Most of the A&E cases were of the following kind: stab in the chest/neck/face/nose/ear/head, gunshot wound to the leg/shoulder/ankle/arm. Disappointingly, most of the stab to chest patients already came in with chest drain in situ, making it very difficult for us to find enough cases to learn the procedure on. I was shown the procedure a number of times and once I had practiced and demonstrated the relevant knots to the consultant's satisfaction, I was told I could perform the next one. However the rest of the placement passed without a further chest drain being required while I was on duty. I'm told I was incredibly unlucky for this to be the case.

The skills I did have the chance to practice however, I feel confident about. I was able to perform a few back slab casts for tib/fib fractures, one even grade 2 compound fracture. I leaned how to reduce

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the fracture, that the knee had to be bent at a 30 degree angle, and the ankle at 90. I learned that for a z splint of the wrist, if I had help, how I could use basic equipment to make it easier for myself.

Some suturing was particularly challenging: a knife wound across 3 fingers in the hand that sprung open despite a number of stitches, a depressed skull fracture, a dangling ear, etc. I feel confident in my suture skills, and in my hand knot skills.

At groote schuur, the environment was very different. The hospital more beautiful and the equipment more plenty. A ward at groote schuur looked just like a ward in England, and would be really no different if one didn't look out of the windows to see zebras grazing on the slopes of table mountain. The surgeons talked of the newest technologies, and used the latest equipment. The theaters alike were identical to what I was used to, with one singular difference: there were no sterile handle protectors on the mobile theatre lights. Thus surgeons would use their sterile gloves directly on the dirtied and bloodied handles and straight back onto the patient. I'm sure because everything else was up to a high standard, that perhaps the handlebars get disinfected and sterilized between each patient. At least I hope so.

At Groote schuur an entire ward was dedicated to ENT patients, but while we were there, there were always very few patients, as a few as 4 or 5, and ward rounds lasted only minutes. The rest of the beds were empty. A stark contrast to the crammed wards and bed-lined corridors of tygerberg hospital.

One of the most startling differnce I didn't expect was the quality of teaching during outpatient clinics. The consultants took teaching very seriously and always made sure students were learning from every case. Instead of limiting clinics to just 1 or 2 students, consultants and patients were happy to receive anywhere up to 8 students at once in a room in my experience. Teaching was interactive, between consultant, students, and patient, with dialogue going three ways. Patients enjoyed being part of student teaching. Students weren't afraid to ask questions. Consultants took pride in their teaching and clinic. When a procedure was being carried out, consultants made sure all students could see, and would allow us all in turn to look down the probe etc. It was a wondering eye-opening experience. One day I hope to also teach students in this way.

Ultimately, South Africa was a wonderful place to spend my elective. It had the best of all words. State of the art facilities and treatments as well as productive resource-restricted hospitals. It was wonderful to see the different ways staff 'make-do'quite successfully with what is available. Also refreshing was to see that patients were all generally very thankful for the care they received and never complained about anything, even when waiting times with severe unjuries was long. I have learned much, both about medicine, and what kind of doctor I would like to aspire to.

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