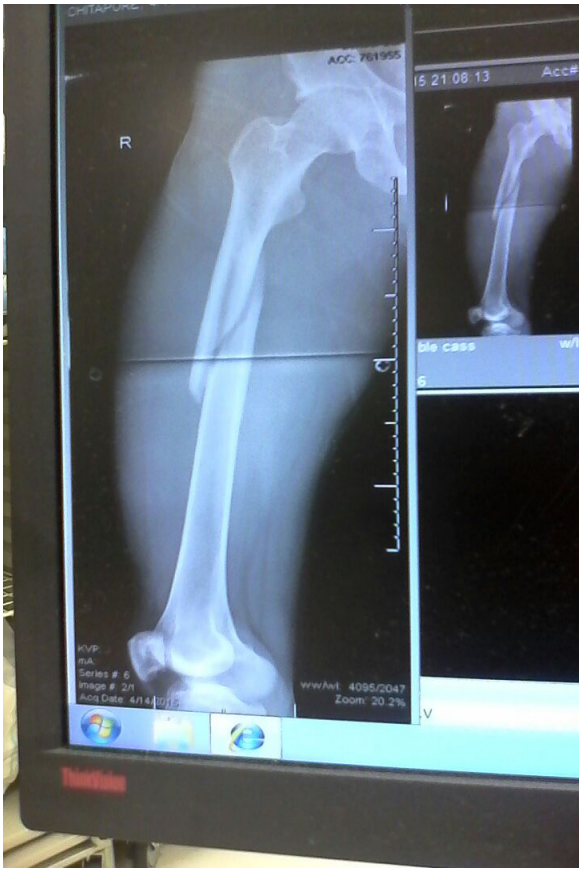
ELECTIVE (SSC5c) REPORT (1200 words)

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

N.B image taken with verbal informed consent of the patient

Objective 1: Describe the pattern of disease/illness of interest in the population with which you will be working and discuss this in the context of global health: What are the most prevalent presenting complaints in the Emergency Department in Tygerberg Hospital, Cape Town, and how do these compare to those in the UK and the rest of the developed world?

I was placed in the Emergency Department, across 2 wards; the "front room" which is the section of the emergency department where trauma cases are brought in by paramedics, and "F1" which is the ward where acute non-trauma patients arrive. During the time I spent in the front room, the trauma cases mostly consisted of gunshot wounds and stabbings, as well as a few cases of children falling off jungle gyms! The presenting complaints in the front room were completely different to what we see in the U.K, and I would imagine in most other first world countries.



To give an example, I saw a 35 year old man who claimed to have been mugged and stabbed in the anterior thigh. He seemed to be in an extreme and disproportionate amount of pain with relation to the injury, which upon examination I saw to be a 1 cm by 1 cm clean stab wound. He was a very difficult patient, refusing to comply with requests to straight his right leg to allow us to examine it. He kept asking for pain relief, and when we finally gave him some morphine and sent him off for x-ray without being able to completely examine the leg, we were somewhat shocked to discover a distal spiral femoral fracture! We couldn't understand how a knife could cause such a fracture, which would normally be associated with a high energy collision. He was referred to orthopaedics, for an ORIF with an IM rod. This was a type of injury I would never have come across in the U.K

In F1, I really enjoyed the work. In contrast with the U.K, where medical students are not usually the first people to see the patient, over here we were asked to clerk new patients that had just arrived, with similar conditions to those we might see in the U.K, such as Acute Coronary Syndrome or asthma attack patients. I saw some very interesting clinical signs, such as an asthma patient who had extremely loud expiratory and inspiratory wheeze, which was very concerning as a sign of severe airway narrowing. We were also in charge of procedures such as arterial blood gases, bloods and cannulas as well as setting up fluids for the patients. This was very good practice for work as an FY1. I also enjoyed presenting the patients to the doctors as they would ask us questions and it was a very good learning opportunity.

The prevalence of HIV and TB here is extremely high, therefore most of the patients we saw were assumed to be positive for both. This is very different to the U.K, where HIV and TB prevalence is very low, and the general health of the population is higher. Most people we saw were from Townships where malnutrition and alcoholism is high, therefore their baseline health is lower, and when you add traumatic injury on top of that, the chances of survival and prognosis is much lower.

Objective 2: Describe the pattern of health provision in relation to the country which you will be working and contrast this with other countries, or with the UK: How are the emergency services organised and provided by the largest hospital in the Western Cape, and how do they contrast with the NHS A&E Departments in the UK?

In South Africa, less than half of healthcare spending is funded through taxation, with private healthcare insurance providing just over 40% of healthcare, and a small percentage around 10-15% through private payments by people. [1][2] The current government is attempting to move towards universal coverage, similar to what we have in the U.K, however there are several factors preventing this from happening. Firstly, the income inequality in this country is shockingly high. The statistic is something like the richest 10% of the population share about half of the total incomes, and the poorest 10% have less than 0.1% of the total incomes. [3][4][5] The health of the population varies hugely based on areas, as poverty and unemployment is very high in certain areas, which correlates directly with poor health. The problem is that private medical schemes account for the highest amount of health care financing (about 40-50%) but cover a small minority of the population. [3] Taxation revenue is used for the rest of the population that depend wholly on the public sector for their entire healthcare, and this is simply not enough money for such a large population. Hence, what I have seen in Tygerberg is understaffing and underfunding, with the hospital A&E completely overwhelmed.

Objective 3: Health related objective: What are the socio-economic and historical factors leading to the high rate of violent crime in Cape Town, and how does this impact on the general health of the population?

The apartheid government ensured that not only basic human rights were limited for black people, but also access to healthcare in all forms including emergency care. As a result, when in 1994 apartheid ended and a democratically elected government came into power, the provinces where black people lived continued to be underserved in terms of health services. The reality is, sadly in this country there is still a link between race and access to healthcare. Most poor black people depend on publicly funded healthcare, and a very small proportion of people, mainly white people and asians, can afford private health care. The very poorest of townships around Tygerberg, such as Khayelitsha, are so full of violence that the emergency services are afraid to go in. I spoke to a few paramedics that say there are certain areas they won't go in to at night, as they have been held at gunpoint several times. It becomes glaringly obvious then that certain members of the population simply don't have access to healthcare due to their living conditions and areas. As a result some of the patients from poor townships that I did see were often malnourished and unemployed, sometimes on drugs and mostly drunk.

Objective 4: Personal/professional development goals.: 1) To become proficient in clerking and managing patients in an unfamiliar setting
2) To take advantage of the learning opportunities in the potential contrasting spectrum of disorders presenting in the Emergency Department in Tygerberg, such as a higher prevalence of HIV and violent crime related injuries, to the UK.

I have had an incredibly eye opening and clinically relevant placement at Tygerberg A&E, and definitely believe that my ability to clerk and manage patients has improved substantially. From having increased autonomy in relation to what I usually have in the U.K, to having more patients to see with various clinical signs, these have all helped to improve my practical and clinical examination skills. The doctors are absolutely phenomenal and work very hard to ensure all their patients are treated equally, with respect and dignity, despite the lack of resources and time. They also love to teach, and have taught me a lot about the management of fractures, ACS and ECGs.

I also developed a greater resilience towards dealing with HIV+ patients, as before I was quite hesitant and nervous about the prospect of potential needle stick injuries etc. I have definitely learnt to be more aware of my surroundings and make sure sharps go straight into the sharps bin etc, and ensuring that washing hands and gloving up are happening not just for myself but also my colleagues.

[1] McIntyre D, Thiede M, Nkosi M, et al.A Critical Analysis of the Current South African Health System. Cape Town: Health Economics Unit, University of Cape Town and Centre for Health Policy, University of the Witwatersrand, 2007.

[2] Ataguba J, McIntyre D. Financing and Benefit Incidence in the South African Health System: Preliminary Results. Cape Town: Health Economics Unit, University of Cape Town, Working Paper 09-1. 2009.

[3] Ataguba, John Ele-Ojo. "Health Care Financing in South Africa: moving toward universal coverage." Continuing Medical Education. February 2010 Vol. 28, Number

[4] Mooney G, Gilson L. The economic situation in South Africa and health inequities: a comment. Lancet 2009; 374(9693): 858-859.

[5] Statistics South Africa. Income And Expenditure of Households 2005/2006: Analysis of Results. Pretoria: Statistics South Africa, Pretoria, 2008