ELECTIVE (SSC5c) REPORT (1200 words)

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

OBJECTIVE 1

My initial thoughts about what I would see at CHBAH is that it would be completely different to the UK because of its socioeconomic situation and because South Africa is vastly different to the UK. In some respects this is true but surprisingly the general surgical workload and patient management is very similar to the UK. Even the training structure and hierarchy is the same as the UK. I was lucky enough to be put under the wings of CHBAH's Unit 1, the hepatobiliary unit. I was expecting to see that general surgery in SA would be a lot more general than it is in our super specialised units back in the UK but the units at CHBAH are no different.

There are some major differences between CHBAH and the UK however. CHBAH is a 3000+ bed hospital which serves the region of Soweto in Johannesburg, an incredibly poor area of Johannesburg. As such the hospital is placed in a deprived area and the patient demographic affected the provision of healthcare quite drastically. Patients often presented to us with very advanced disease or in a critical condition. There are probably two main reasons for this one being poorer health education and two being a different attitude to symptoms where patient's would have a higher threshold to pain or consider jaundice something that did not bother them. Some cases that highlight this would be the woman I saw who presented with a perforated peptic ulcer quite some time after perforation and the many people presenting with an obstructive jaundice months after symptoms first appeared.

Unit 1's workload included pancreatic masses, pancreatitis, biliary obstruction, biliary tree malignancies, cystic lesions and hepatocellular carcinomas though they seemed far more common than in the UK particularly HCC. There were many other factors that often complicated the management of patients including HIV, cirrhosis and hepatitis. The surgery and management of these patients was very advanced despite the fact that it is in a very resource deprived area.

OBJECTIVE 2

CHBAH is a state funded hospital and as such it has limited resources to deal with a very large population. Despite this it may not be the best representation of a state hospital as it is a very large academic hospital attached to Witwatersrand University and as such it attracts a large number of world class researchers and physicians. Some of the staff are international and some even pay for the privilege of working here. Saying that it does have some of same limitations of a state hospital and there have been occasions where it has been affected by a lack of resources, load shedding or loss of water supply which affects the way the hospital is run quite significantly.

Some of the time I had spent at the hospital was in what is known as the surgical pit. This is different to the UK as it uncouples medical emergencies from surgical emergencies whereas we have a more integrated A&E. The pit worked well as a triaging and referral system with an equipped resuscitation area and there are three tables which dealt with trauma, general surgical emergencies and orthopaedic emergencies respectively. It was however constantly plagued with problems of overcrowding and it's difficult to see how it can cope for a long time with such a large population.

Training and shifts on call in the pit are very intense and long with most shifts being more than 24 hours long with each of the three teams comprising of registrars and interns. It's clear from watching the doctors work that they are incredibly competent and experienced in regards to the numbers of hours training they get compared to ours but one can't help but wonder whether such long shifts affect patient care or the doctor's health. Saying that CHBAH does seem to be achieving very good outcomes. Perhaps there is a happy medium between the long shifts here and our much shorter ones back home in order to maximise experience and training without compromise.

South Africa also has a very advanced private healthcare system as well which many of the affluent have insurance for. There seems to be a higher propensity for doctors to leave state hospitals when they can to do more private work. There is a much greater divide between private and state care than there is in the UK.

OBJECTIVE 3

CHBAH being an academic hospital actually uses many of the same guidelines and resources we are used to using when treating HPB patients so there aren't as many differences between management.

Differences I did notice however tend to be differences in when the patients present and as such the general surgeons at CHBAH are well versed in the treatment of surgical complications such as perforated ulcers, ruptured appendices and very advanced malignancies. Newer qualified surgeons from the UK may not know how to treat these complications as effectively due to a smaller caseload of such complications and as such we have much to learn from our international colleagues.

Something that did bother me during my stay is that resources are sometimes scarce and this may not actually be a problem with funding but a problem with communication especially in such a vast hospital. Often lists had to be cancelled due to a lack of consumables. Other limitations on resources come from the country's general infrastructure to the point where load shedding affects to hospital and often theatre lists have to be cancelled. Other problems we had encountered was also limitations to the water supply which meant that elective lists were cancelled as scrubbing up was impossible.

I had also spent some time in the trauma department working alongside them in the pit. Trauma is obviously one of CHBAH's key strengths along with its general surgical departments and it's clear why they have to be. With the socioeconomic background of its catchment area, CHBAH receives a lot of trauma which ranges from assaults to RTAs. The trauma team are clearly well experienced and often have to deal with quite horrifying injuries with sometimes stretched resources. Gunshot wounds in particular are far more common here than back in the UK. This is well known already and many international doctors do come here in order to learn more about trauma care.

OBJECTIVE 4

I was fortunate to be under Unit 1 and also under CHBAH. As a major teaching hospital for one of South Africa's 6 medical schools, it has a large local student base and is therefore well equipped to teach. Speaking with the local students gave me an insight into medical training in SA which is not dissimilar to our own. However, it does seem that the students here have a greater responsibility in terms of ward work and clinical skills than we do and this can be seen in our competent and confident their new interns are. They appear to have a more standardised hospital clinical teaching timetable where there are scheduled on calls and I think we could benefit from having more structure like this back in the UK too.

The interns here at CHBAH have been very proactive in teaching me and allowing me some responsibility of my own in regards to procedures and skills. I feel like I am more comfortable and confident with my skills and how to take a quicker more succinct clerking. Ward work has been augmented by a weekly academic meeting timetable where I have some insight into how South African doctors think and work.

My time in general surgery in the pit has given me ample time to try and manage my own patients whilst also giving me plenty of theatre time which the surgeons were kind enough to let me scrub into. I assisted with the management of many acute surgical emergencies which has helped broaden my surgical logbook compared to the elective procedures I was used to seeing back at home. I have seen a few elective procedures in the HPB unit as well which exposed me to some very advanced ways of managing these patients.