ELECTIVE (SSC5b) REPORT (1200 words)

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

Objective one

From day 1, I witnessed a stark contrast in the types of trauma that came through the emergency department at Groote Schuur. Gunshot wombs, knife attacks and violent assaults were commonplace together with numerous car accidents.

One particular patient that I remember was a 27 year old man that was the recipient of a vigilante attack. His injuries were extensive as he was assaulted to an inch of his life with a weapon that is not dissimilar to a machete. There were multiple stab and slash wombs all over is his body and especially to his head and face. These types of attack were not uncommon. They occur due to members of this man's community producing their own form of justice. Fortunately, this man survived and I was able to help with suturing a number of his wombs. The nearest I have seen to this was a singular knife slash to the persons back. But this was incomparable to what this man had. Furthermore, speaking to A&E consultant at the Royal London Hospital, the type of injuries this man had are incredibly rare in the UK. Moreover, they would be news worthy. In South Africa, this is not the case.

Gunshots injuries are a common presentation in Cape Town. One particular patient was a 17-year boy that had a point blank shotgun injury to his lower limb. Despite a large proportion of the calf and tibia missing, he was neurovascularly intact and the orthopods thought he could save the limb. This incident was a tragically fascinating experience.

Objective two

In South Africa there is a large amount of private health care, with the general hospital used primarily by the most poorest. The vast majority of the cases seen at Groote Schuur are typically from the townships of Cape Town.

When someone is injured, typically they declare whether they have 'Medi-aid.' The means they have private insurance and will then determine what hospital they will go to. If however, the patient is unconsciousness and there is no obvious Medi-aid ID found then they are directed to one of the general hospitals. From here they can then be transferred when their identity to determined. In Groote Schuur and other general hospitals, there are private wings in the general hospital itself.

This system highlighted the beauty of the NHS. It does not matter who the person is, what their social class is, what their wealth is or what they have done in the past. In NHS will be there to give them the same high-level emergency care irrespectively.

Poverty within Cape Town is very apparent with 66% of the population living below their poverty line. The vast majority of patients that I have seen at Groote Schuur are from a poor background. It became apparent that you could almost determine the poverty line by whether they have private insurance. This is because healthcare is prioritized incredibly highly amongst South Africans. In fact, 33% of the population have Medi-aid, the same percentage as those above the poverty line. Therefore, those that simply cannot afford it end up of the general hospital.

Objective three

The patient pathway typically is as follows. When person is injured, they are first triaged in their local hospital. These are located largely within the townships. These are basic hospitals, which takes care of the simpler traumas and the initial management of more complex cases.

If the trauma is more extensive, then they are directed to one of two major tertiary centres. One being Tygerberg hospital and other being Groote Schuur hospital. In addition to this, these smaller hospitals do not have CT scanners, therefore all head injuries together with other injuries needing that scan come to us. The local hospital are only open until 8pm and not opened on weekends or public holidays; therefore, a trauma outside of those times when are sent directly to Groote Schuur.

When a trauma comes in, in the UK there would typically be a representative from each relevant specialty plus a trauma or A&E consultant directing it. Here there a just specifically trained trauma specialists, who jobs is to stabilize and resuscitate the patient and then refer to the necessary department. I remember asking on the registers whether there is a MDT approach for the more complex cases and his reply was, "I am the MDT." I think this sum up, not only the strain on these doctors but also their high quality.

It is also important to note the amount the department was understaffed. Typically, there only two register to cover the whole department. Considering that GS is the largest general hospital in Cape Town, it highlights how understaffed they are. This proved beneficial to me experience as instead of feeling supernumerary I immediately became helpful.

The doctor-patient relationship is very different. It was very time efficient at Groote Schuur. What the doctor says goes. In the UK we get taught extensively to assess the patient ideas, concerns and expectations. But when I was clerking patients, they were almost confused by the questions. They treat your words as absolute and will mostly do what they are told without debate. However, I can only speak for the trauma department where perhaps time pressure is a huge influencing factor.

I only saw the consultants at Groote Schuur twice a day for both handover ward rounds. The registers do the majority of the work. Even if the patient's prognosis looks incredibly slim, there was no contact made to the consultant nor was there an equivalent to a 2222 call for help. However, one of my most fascinating experiences was during a consultant lead ward round. One of our patients was crashing and the consultant deemed it a necessary to undertake a thoracotomy. She splashed iodine over the chest and with just the blade of a scalpel proceeded with the procedure. Then proceeded to remove fluid around the heart and as soon as the patient improved slightly she continued with the rest of ward round.

Objective four

This objective was achieved in abundance. There was very little time sitting on my hands as the registers and interns actively get you involved and appreciate your help. I think having finished our final set of exams in England, they were happier to let us help in more ways.

All of the practical skills listed I undertook numerous times. It took a little bit of time to adjust to the differences in the equipment. The skill I most improved at was suturing. Due to the high level of knife attacks, there were plenty of opportunities to practise this skill. My first few, I took a long time over and as I did more and more I got more confident and my speed increased together with the fluently of

my technique. I now feel very confident to use what I have learnt in Cape Town in my career as a doctor.