ELECTIVE (SSC5b) REPORT (1200 words)

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

Trauma has become an epidemic in South Africa with approximately 60,000 deaths per year being attributed to it. Injury-related deaths are six times greater than that global average, the largest proportion of these deaths come from injuries due to road traffic accidents. On South Africa's roads, it is estimated that 1200 people are killed each month, double the global average. In the 12 months preceding March 2016, there were over 18,500 murders in South Africa, this is eight times greater than global rates. Western Cape hosts the second highest homicide figures in South Africa with 52 deaths per 100,000 people per year, this is a stark contrast to the 1 death per 100,000 people per year seen in the UK. The UK has recently experienced a change in major trauma population, moving away from the young due to road traffic collisions and towards the elderly with the main mechanism being related to falls.

These figures are impressive and hard to comprehend. During my placements in London, I had not seen a single patient with a gun shot or stab wound, I had been in the resus department for one high speed motor vehicle accident and had seen multiple fracture neck of femurs in the elderly. During my first shift in Groote Schuur Hospital I had 9 patients with gunshot wounds, 6 patients with stab wounds, and 5 patients involved in road traffic collisions.

In the UK, there is one A&E department which caters for all medical and trauma emergencies. In my experience, the majority of patients presenting to A&E are for medical reasons. However, in Cape Town there are separate departments for medical and trauma, this is fundamentally down to the huge number of trauma related injuries South African hospitals have to deal with. This division has its advantages and disadvantages,

The advantages are that patients are immediately streamlined into the correct department resulting in more specialist care earlier, the trauma department is better equipped to deal with major trauma - for example the use of the lodox machine in resus, suture packs and minor op theatre – because they do not need to prepare themselves for medical emergencies.

One disadvantage is a loss of continuity of care for patients who may present with both medical and surgical needs. For example, there was a patient who suffered a fall due to loss of consciousness (LOC). The medical side insisted that the trauma department took the patient to ensure that the patient had not suffered a fracture, whereas the trauma side wanted the medical department to investigate the cause of LOC. In the UK, this patient would have been treated by one team as opposed to two.

Another profound contrast in the delivery of emergency services is seen in pre-hospital care. The paramedics in South Africa were far more advanced with their initial resus management compared to those in the UK. Often patients arrived already intubated – a procedure that only doctors (specifically those with anaesthetic training) can perform – cannulated with fluid running.

GSH trauma department had a triage system that assigned patients into three categories. Patients assigned to the green area were stable, were not in any immediate danger and could be expected to wait 6-8 hours in a waiting room before being seen, their injuries were mainly those of traumatic injury to the limbs. Yellow area was for patients who had more major trauma for example, a significant fall, road traffic accidents, neck injuries, GSW or stab wounds but were stable, these patients could expect

a 3-4 hour wait. Red area was reserved for the most sick patients, these patients required immediate resus and would have sustained major trauma to the head, chest or multiple areas of the body, these patients were seen immediately. By using this triage system it ensured that patients who were in need of the most help received it first and only after that was under control did the yellow and green wards get attention.

During my six weeks at Groote Schuur Hospital I have seen the greatest improvement in my practical skills. Taking bloods, cannulation and ABGs have quickly become an important skill set to master out here. This improvement has occurred due to high numbers of these procedures needing doing on the wards, this was highlighted when during one night shift i was asked to do 5 ABGs in one hour period.

History taking in GSH has been very different to what I have experienced in London. In London, every patient who enters the emergency department gets a full clerking starting with presenting complaint moving through to social history and finishing off with a review of systems. Here, I was encouraged to take a more focused history, focused examination and order relevant investigations faster, this improved my decision making but I am very aware that this was only possible because I was in constant communication with my registrar who ensured that nothing more serous was missed.