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Elective Report

As I have been interested in trauma surgery for a very long time, I wanted to go on an elective that would expose me to a high volume of variable trauma. After consulting seniors and classmates, I easily settled on going to Chris Hani Baragwanath Hospital.

Although I have only been here for two weeks so far, the sheer volume of trauma patients that I come across has given me some idea of the patterns of and how trauma care is like in South Africa.

In South Africa, one is able to appreciate a wide variety of trauma. This ranges from penetrating injuries (stabbings, gunshot wounds) to blunt trauma (motor vehicle accidents, pedestrian injuries, falls). It is worthwhile noting that a significant number of people and drink and drive, accounting for the large number of motor vehicle collisions, which may result in the department receiving a huge load of patients at one go!

In the UK, the etiology of trauma is similar, although the number of penetrating injuries is significant less. Unlike what I've been exposed to in the UK, there is a significant amount of burn injuries too. This has made the experience even more worthwhile in acquiring knowledge in the treatment of burns.

Trauma care is provided by trauma surgeons, who overlook patient care from the moment they step into the door. Should any patient require input from other teams, the trauma team will then refer them on. This is unlike the United Kingdom, whereby the trauma patient is first assessed by a large team of medical professionals such as the Emergency Department consultant or registrar (as the team leader), general surgeons, orthopaedic surgeons, anaesthetist, and occasionally the neurosurgeons, plastics and maxillofacial surgeons.

This difference means that the team has more tasks to do, which could make it very challenging when the casualty or 'pit' as we call it here gets busy. The trauma doctor is not only responsible for overseeing patient care as a team leader, but also responsible for carrying out a wide range of tasks such as setting lines, doing the eFAST, and intubating if required.

It is a very demanding job, but the fruits of their labor can be seen easily. I was amazed to watch interns (equivalent to our FY doctors) easily intubate and insert central lines (without ultrasound!) with minimal guidance from their seniors. This is certainly a fast and effective way to learn new skills, since the doctors get a lot of opportunity to practice and hone their techniques under the watchful eye of a senior who is never too far away.

I think that an important similarity I would highlight is the high standard of care and teaching provided. Even though it is so busy in South Africa, the doctors are extremely committed and motivated to provide the best care available. Furthermore, a large emphasis is placed on educating the juniors, and the registrars and consultants are keen to impart new skills to the students and interns despite the time pressures. This is also seen in the UK, where the pace of life is arguably slower, and the staffing is more, making it ideal for the transference of skills and knowledge.

Both South Africa and the UK use similar protocols of treating trauma patients. Both countries integrate Advanced Trauma Life Support (ATLS) principles in managing patients. The initial assessment or primary survey targets to eliminate and treat immediately life-threatening injuries, the order of which is as follows: Airway + C-spine, Breathing, Circulation, Disability and Exposure. After ensuring that the patient is stable, a secondary survey is carried out by assessing the patient from top to toe to identify and treat injuries that could have been missed out initially. The ATLS principles standardizes trauma care throughout the world, ensuring that patients receive appropriate and timely care. I was also very fortunate to be able to attend an actual ATLS course as a student observer, which was extremely useful and interesting.

During my stint, I have been able to pick up nuggets of information on various complications that may arise, and how to treat them. One example that clearly stands out in my mind is a patient who was involved in a motor vehicle collision. I was given the task of setting lines and catheterizing the patient, but was having great difficulty in doing so because of his agitation and unwillingness to cooperate. What made it even worse was that the patient's c-spine was technically uncleared, yet he refused to lie still in the collar and headblocks and kept sitting up. I felt annoyed at his refusal to lay still despite having nurses and his relative plead with him. Eventually, the registrar decided to intubate the patient as it was felt that his uncooperativeness would make CT scanning impossible. Much to my own consternation, it was later revealed that he had a large extradural haematoma! This explained his prior restlessness and further emphasized the need to carefully evaluate all patients and not to simply dismiss them as being uncooperative. From this experience, I will assess future 'combative' or 'uncooperative' patients more carefully and be wary not to forget potential head injury.

In terms of personal development goals, this opportunity has provided a wealth of experience that would undoubtedly be hard to compete with in the UK. I think that I have become more assertive and confident in dealing with other health professionals and patients. Also, the many opportunities to carry out procedures has increased my confidence in performing them unsupervised. In order to further improve my knowledge and technical skills, I hope to actively seek out opportunities to learn and hone new skills, such as putting in drains, lines and suturing. Finally, as has been imparted to me, I hope to share with others what I have learnt from this rich and fulfilling experience.