Valuable training in South Africa

Adam Reid describes the benefits of surgical training in rural Zululand

It is a period of great change in surgical training in the United Kingdom. The European Working Time Directive, together with the New Deal, have imposed shift-style working patterns, giving trainees ample time to pursue interests outside medicine. However, we see fewer patients than our predecessors, spend less time in theatre, and the continuity of patient care has been broken. The role of surgical care practitioners has expanded to fill this workforce gap, which has led to competition for precious training. Hard on the heels of these changes is Modernising Medical Careers, which will shorten overall training time and base progression on competency assessments. While it is widely agreed that the long hours of service commitment done by our predecessors did not always offer high quality training, a broad base of surgical experience can be gained only by putting in the time and effort to see patients and be in theatre or clinic.

Knowledge but only basic skills

Having just completed my basic surgical training and passed my exams for membership of the Royal College of Surgeons, I was brimming with theoretical knowledge but had only basic surgical skills. I wanted greater operative exposure particularly in trauma, and I also wanted to experience living in a different culture and working in a different healthcare system. I found all this in abundance in my year in Zululand, South Africa.

Ngwelezane Hospital is a 550 bedded tertiary referral hospital in the heart of rural KwaZulu-Natal. It is staffed mainly by a team of young dedicated doctors and led by a small number of enthusiastic and extremely competent consultants. The busy surgical department deals with almost all surgical emergencies and elective operations, with only neurosurgery and a small number of other cases being referred to Durban for further management. The anaesthetic trainees are capable in many difficult circumstances. The other notable specialties are paediatrics and the expanding HIV clinic, which is currently concerned with the massive job of antiretroviral roll-out.

Busy week

I worked as a middle grader, which entailed a busy week. I was given a weekly full day theatre list where I was expected to supervise and teach other junior trainee surgeons. This list started with an elective caseload, but would gather any emergencies admitted as the day progressed. I gained proficiency in adult and paediatric hernia repair, orchidopexy for undescended testis, formation of colostomy, split skin grafting for burns and trauma, amputation for trauma and diabetic sepsis, as well as emergency laparotomies for sepsis and trauma. The rest of the week entailed a consultant led theatre list with more complex elective surgery, two endoscopy sessions, and a specialist clinic.

When on call out of hours, I was team leader for the hospital, covering all surgical emergencies and supervising the running of the resuscitation unit. Typical calls would see sepsis and trauma requiring debridement; penetrating and blunt abdominal trauma requiring laparotomy; orthopaedic manipulations, reductions, and tendon repairs; and burns patients requiring resuscitation. Most patients that I operated on would also be looked after by me postoperatively. This continuity of care was the greatest learning tool of all.

Underlying medical problems

I was privileged to work with the Zulu people, who are kind, uncomplaining, and have a good sense of humour. The nurses worked hard in sometimes difficult circumstances and sang beautifully every morning to welcome the day. Many of the patients travelled for several hours only to wait several more to be seen in clinic, and they were always grateful for their doctors’ time and medical opinion. Clearly, there were many underlying medical problems within the population: HIV, tuberculosis, type 2 diabetes, and malnutrition were commonplace. As a result there were some unusual surgical presentations, such as HIV related aneurysms in teenage patients, tuberculosis peritonitis, and frequent soft tissue sepsis in this immunocompromised population.

Since returning from South Africa, I have felt far more confident in my assessment and management of patients. My operative skills have developed further than those of many of my peers, and, importantly, I have a greater understanding of when to call for help.

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Opportunities for training with good supervision outside the UK are hard to come by, but it can be a tremendously valuable experience. Ngwelezane Hospital continues to look for well motivated UK trainees to spend a year with them. I suggest that the Modernising Medical Careers system should not only allow trainees temporarily to leave the system to develop their skills in other countries but should actively encourage them.

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