# *Royal Medical Society – Travel and Study Report*

## My Samoan Elective, 2018


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**Planning**
I knew I wanted to go to a developing country rather than a developed country. I have had an interest in visiting Samoa for a while, largely down to a rugby connection. It proved quite difficult to gain much reliable information from the internet about Samoa and I soon abandoned trying to organise much more before arriving.

Samoa is still a very traditional society, based on respect to elders in a hierarchal structure. They often live with their whole extended family within a stone's throw and dedicate their life to looking after the older members of the family. Religion also plays a large role in Samoan society. Most of people's disposable income goes towards their local church and Sundays are protected church and family time.

**First impressions**
My first few thoughts on the journey from the airport to the hostel were a) how hot it was at 06:00am; b) how many gigantic churches there were in seemingly small villages; and c) that Samoa was perhaps less developed that I had first thought. A lot of people were sleeping in very basic fales (Samoan traditional buildings), there were a lot of stray dogs and the general condition of the buildings, aside from the churches, were far from pristine. One of the hostel owners said that the reason for the basic housing was that cyclones were very common and so it was easier to rebuild a simple house.

I chose to stay at a hostel called Lynn's Getaway, famous for being sociable. Within the first day I had met 6 or 7 other medical students and a couple of volunteers who were all incredibly welcoming and funny.

The hospital had some interesting quirks that I noticed quite soon on. For example, patients' bedding and food would all be provided by the family. The family would also be responsible for washing the patient and no matter what time the ward round happened, there was always a member of family present. What was obvious was the great respect shown to the doctors from the patients and the families.

**Disease**
Diabetes as a comorbid factor played much more of a role than I had anticipated. There were three whole bays within the medical ward filled with diabetic patients who had wounds on their lower limbs (collectively named diabetic foot sepsis) that either weren't healing or had become infected and required debridement. Amputation in the UK is uncommon, whereas it was commonplace in the Samoan diabetic community. Half of the OT list comprised of 'sepsis' cases. This included diabetic foot sepsis requiring debridement or amputation, abscess incision and drainage, pyomyositis etc.

A lot of the pathology was very advanced, as the culture of healthcare in Samoa would usually consist of going to a traditional healer for any problems first before they would consider seeing a doctor. Alongside this, it can be difficult for people living in villages to visit the main hospital – there are no permanent surgeons on the island Savai'I, which

contains 24% of Samoa's population. This all meant that diabetic foot wounds would often already be gangrenous, tumours would often already be malignant/large in size, fractures may be weeks old at presentation, and they would often have several comorbidities that had not been seen before.

**Problems within Samoan healthcare**

A common theme with my hospital experiences was a lack of resources and subsequent tactics to navigate around this. The issue of a lack of consultants was dealt with by having the registrars doing the equivalent work of a consultant, the interns (equivalent of a foundation year) doing the work of a registrar and the medical students essentially being junior doctors. The fourth year (of five) medical students were much more practically useful than I had been at any stage in my medical training. The head of surgery complained a few times about how limiting it was not to have a pathologist on site. Currently they send all of their samples to New Zealand; however, this would often take weeks to return and for possible cancer cases this was too long.

One reflection I often felt was gratitude for the fantastic nursing care we have in the UK. There was often confusion about medication administration, a lack of attentiveness with PRN medication, deteriorations going unnoticed for longer than is safe and especially the lack of effective observations taken. There was not a single observation chart that had a respiratory rate quicker or slower than 20 bpm.

**Personal development**

I was able to explore two areas of interest for future careers during my time in Samoa. The surgeons in Samoa are the general surgeons of old, where just about anything could come through the door. I saw a lot of what would be plastic surgery in orthopaedics, with multiple machete injuries to fingers and tendon reconstructions taking place. There was also rudimentary skin grafting performed by one of the surgeons. One week I was able to indulge my interest in vascular surgery when a team of vascular surgeons from Brisbane arrived to perform fistula creation surgery. There were also many chances to watch amputations, which are usually done by vascular surgeons in the UK.

I had been correct about how much participation there would be in theatre. I was scrubbed in most days assisting the consultant and they would often let me suture fascial planes or close at the end. I was guided through undertaking my own abscess incision and drainage by one of the registrars (I think largely because he couldn't be bothered doing it that morning).

**Reflections**

I was constantly blown away by the pleasantness of the staff. If interpersonal skills in the UK were half of what they are in Samoa I think we would all be a lot happier. That being said, below the surface of smiles there lie a lot of difficult social issues. Plenty of our trauma patients, some with significant facial injuries, were from assaults, often as a result of infidelity.