ELECTIVE (SSC5a/b) REPORT (1200 words)

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

Describe the pattern of presentation in an acute setting, in Dar es Salaam.

The main difference I found in presentation to the acute setting was the appreciation shown towards medical staff, this was amazing. When the doctor enters the room the patient's family members take it upon themselves to stand and leave and they come to see the doctor later to ask any questions they may have.

In terms of the presenting complaint this tended to be a lot more serious than what people tend to present with in the U.K.. These patients present late with around 40% of patients presenting with immunodefeciency syndrome (IDS) secondary to HIV. These patients present with opportunistic infections and normally have low CD4 counts. I also found that many patients presented with complications of diabetes which mostly included ulcers and gangrenous feet.

Many patients presented with extremely low heamoglobin levels, requiring blood transfusions. These could be due to upper GI bleeds and malnutrition. One of these patients, whilst I was present had an acute reaction to a blood transfusion due to wrong blood being transfused. This demonstrated to me the importance of the stringent checks we have in place for any medications prescribed by us to eliminate errors but in particular when transfusing blood products.

Describe the pattern of health provision, comparing the UK to Tanzania, Dar es Salaam.

I found acute care very similar to the care we provide in the UK. The knowledge level of the doctors was very good however the clinicians were bound by the financial implications to the patient. Hindu Mandal hospital is a private hospital trying their best to benefit patients whilst trying to keep the costs down for the patients. Most patients are found to be on the national health insurance fund however some patients must pay with cash, here costs of both investigations and drug treatment have to be taken into account. Doctors try their best to give the best method to patients to save money e.g. by sending patients to outside pharmacies to buy drugs as the hospital pharmacy would be more expensive for them.

Investigations are not as readily available as we find in London. Each hospital I have worked in London has their own biochemistry laboratory, pathology department and imaging is all available on site. However in Dar es Salaam I found that patient have to be sent of to different diagnostic centres where CT scanners are found. Histopathology takes more than 2 weeks to get results whereas the time taken in London is a lot less.

Despite this the doctors work so well together to diagnose and treat patients as quick as possible with a lot more emphasis being put on the clinical examination rather than investigations. This placement has allowed me to experience how to work in an environment where resources are scarce and therefore has given me the opportunity to learn how healthcare professionals deal with issues relating to this.

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Describe the procedure of prescribing and health management in an lower economically developed country.

The main issue in Dar es Salaam is patient education. Patients are not educated as to issues surrounding their condition and what I found was that patients who had diabetes (sukari) would be having 5-6 teaspoons of sugar in their teas due to their lack of knowledge about the disease. A lot of the management plan was based around counselling patients with what they can do to lessen the disease burden on themselves and prevent future complications.

The method of prescribing is completely diffferent here when compared to the U.K.. We are told that we must not prescribe using trade names unless necassary, rather to prescribe all drugs with the name of the drug itself.

This sometimes led to many problems with taking the medications. Some nursing staff are not aware of the fact that aldactone is spironolactone. This was then prescribed as aldactone and another practitionor had prescribed spironolactone. The treatment book therefore had the same drug written twice and hence given twice at the same time, essentially doubling the dose.

The other difference I found in prescribing was the fact that not all the information we require to give in an FP10 are required here. For example many prescriptions would just have IV cefotaxime 5/7. This may be because there is one dose available, however the prescriptions written by us must have the dose, duration and all of the patient's details. Here I saw that sometimes just the name and age of the patient was enough for the drug to be dispensed.

The hospital prescriptions were also done on a daily basis for every patient. In the U.K. we have a drug chart which is essentially an order form which allows release of drugs from the pharmacy and into the wards. Being a private hospital, what I found was that some patients were cash paying and drugs can occassionally be cheaper to buy from other pharmacies. Patients therefore have a choice as to where they buy their drugs from and therefore have the option to buy a cheaper preperation of the drug.

To gain confidence in practice, with non English speaking patients.

This was by far the most difficult aspect of my elective. Having worked in Whitechapel I found that most patients who didn't speak English spoke a language which I was able to understand, at least partly. Also patients who were not able to speak a familiar language to myself, were still able to bring with them an interpreter, whether this be a relative or a professional interpreter provided by the National Health Service.

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Despite having been to Tanzania many times in the past I found learning the language very difficult. This put me outside of my comfort zone and I had to rely on doctors interpreting for me or sometimes, learning what is wrong with patients from their actions and the little Swahili that I could understand.

I was quick to learn the simple words one of which included pain (nauma). I was surprised that I was diagnosing patients with literally just the patient's hand gestures and where they were pointing. I was able to find renal colic without the doctor explaining what the presenting symptoms were of the patient. Being outside of my comfort zone helped me to build my confidence in dealing with patients who do not speak the same language as myself.

However the precise nature of medicine has also reinforced to me the importance of having an interpreter. I sometimes assumed that a patient had said something but once the doctor explained to me what the patient had said I realised that I had painted a completely different picture in my mind.

Working in a non-English speaking country has been a challenge for me. It was an enjoyable experience and has definitely built my confidence in dealing with patients who do not share the same language as myself.

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