ELECTIVE (SSC5b) REPORT (1200 words)

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

My elective was split between Groote Schuur Hospital, a tertiary centre with significant inpatient and outpatient gynaecology services and Mowbray Maternity Hospital, a secondary centre dealing purely with obstetrics with around 10,000 births a year.

The first part was spent in gynaecology where I was attached to the urogynaecology and gynaecological oncology services. During this attachment I was able to clerk and examine patients as well as get some significant experience in the operating theatre. South Africa has both public and private healthcare, with public healthcare having limited resources in comparison to the UK. Some obvious differences that struck me initially were that items such as sterile gowns, drapes and speculums were all reused, whereas these objects in the UK are all single use.

The local population who use the public hospitals are mainly low income women from the 'township' areas on the Cape Flats and often have high numbers of children. This has led to a high rate of uterine prolapse with a large number of women in the urogynaecology ward awaiting surgery to have this corrected. I was able to examine and assess several of these women which was useful for me as a student in gynaecology as I had had limited exposure to this during our limited gynaecology block in our 4th year.

Surpisingly to myself, the surgical procedures carried out were equivalent to those in the UK although the women here have had to wait longer for the surgery. I was expecting there to be limited options available due to my perception of the public hospitals prior to starting. I was able to witness and assist in colposuspension, sacrospinus hysteropexy, vaginal hysterectomy and Mirena insertion. As in the UK, the Mirena has revolutionised care of dysfunctional bleeding in South Africa and is used more and more as it is in the UK.

The second part of my elective was at Mowbray Maternity Hospital where the head of obstetrics kindly agreed to have me for three weeks. During this period I was able to get hands on experience of obstetrics in a South African secondary centre. Obstetric care in Cape Town follows a model where women are typically booked in a Midwife Obstetric Unit (MOU), a hospital that is exclusively midwife run. Large numbers of women deliver here naturally. Mowbray is a referral hospital where the midwives anticipate a problem either at booking, at any clinic visit or during labour at the MOU and the patient is then transferred by ambulance services to Mowbray where they have high-level obstetric care. Typical referral cases I witnessed included preterm labour, pre-eclampsia, antepartum hameorrhage or LGA/SGA babies.

There were two main differences to the UK that struck me. The first was the antenatal care. In the UK, women rarely book late, are throughly screened with blood tests for infectious diseases, haemoglobinopathies and chromosomal abnormalities such as T21. Every woman in the UK is offered ultrasound screening for abnormalities and then further testing if there is deemed a high risk. In South Africa women are only offered abnormality screening if they have had previous significant problems, such as a stillbirth. The early booking in the UK means that women are able to be risk stratified and managed appropirately very early in the pregnancy, as well as having a clear idea of the estimated delivery date.

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Women at Mowbray who I had the opportunity to clerk and examine very often booked incredibly late by UK standards. It was not unusual to see a woman who was found to be over 30 weeks pregnant at her first contact with maternity services. This meant that dating the pregnancy was often done by the date of her last period or crudely with a late ultrasound scan and symphisis-fundal height measurements (SFH). Such methods have siginficant error margins and have implications for treament such as antenatal steroids for fetal lung maturation. It did mean that I was able to get a lot of practice in dating a pregnancy by examination and history which was excellent experience personally.

Sadly another significant difference was the HIV rate, and worse still was that many women only found out when they were offered a test during first contact with maternity services. The HIV rate in the country is around 15% which was about what I experienced at the hospital. On the positive side, antiretroviral treatment is completely free, widely available and counselling for these women was also offered. I had seen 2 confirmed HIV cases during training in the UK, both on treatment, in my first day in clinic at Mowbray I saw 5 cases. It was a good experience for me.

Pre-eclampsia which is rarely serious in the UK due to early booking, risk stratification and close screening was very prevalent in Mowbray which surprised me. I saw 2 women with suspected pre-eclampsia in the UK during my obstetrics training whereas at Mowbray the antenatal and post-natal special care wards would typically have around 6 beds with women suffering from severe pre-eclampsia each day I was there! Magnesium sulfate was used on a significant proportion of these who were at imminent risk of eclampsia, something I had never seen in the UK which has given me significant exposure and experience in the management of the condition.

An excellent part of my elective was helping to run a clinic with Professor Fawcus in one of the MOUs in Mitchell's Plain, a large area on the Cape Flats with a significant area of informal dwellings as well as some slightly better off areas. This was a great opportunity to witness the MOU setting, which had highly skilled midwives who needed to be competent in neonatal resucitation and obstetric emergencies as well as core midwifery. It was a low resource setting with one bottle of handwash shared about for everybody, and thermometers that went under the armpit. Women that needed a CTG trace had to be referred to the local hopsital as there was none available at the MOU. I was able to get practice in obstetric primary care, with plenty of history-talking, SFH measurements and assessment of the gravid uterus. I was able to practive using a Pinard stethoscope, a (very difficult) skill which as vanished from the UK due to the widespread availability of handheld doppler.

The caesarian section rate at Mowbray hospital is around 40%, which compared to the UK average of 21% is huge. However this is biased by the fact that it is a referral centre receiving emergencies such as pre-eclampsia and all the siginicant 'failure to progress' mothers which are both common indications for caesarian section. The rate in public healthcare in South Africa is around 20% however interestingly there is a national debate about the for-profit sector where some hospitals have caesarian rates of 90%! For comparison, the World Health Organisation targets a rate of 15%. As I was in a public hospital I was unable to explore this further.

This elective has been very interesting and a great learning experience for me as I embark on my career as a doctor.

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