ELECTIVE (SSC5b) REPORT (1200 words)

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

Objective 1

Before I left the UK, I was advised to take malaria prophylaxis, bring mosquito repellent and sleep under a mosquito net. Given the level of vigilance I needed as a traveller, I expected that in relatively poor rural communities, a lack of education around malara and limited access to resources such as nets would mean significant levels of infection and therefore suffering. While it is clear that malaria is a problem in the region (there are an estimated 2.4 million cases per year in Madagascar), the seriousness with which we view the disease here is not mirrored within the country. It seemed to me that malaria was viewed there very much in the same way that we would view the flu in the UK; it can be deadly in the young or old or frail, but there is treatment available and most of the time it works if you have access to it. Many healthcare interventions have failed because of this difference in perspective. An example of which is a story we were told regarding the attempted introduction of several hundred mosquito nets by a British charity to a community living in the rainforest to the east of Fort Dauphin. The locals made use of these, but they used them as fishing nets. At first hearing this sounded to me as a happy ending, the rates of malaria may not have been improved, but people were provided with a means to make a living. However, the knock-on effect was that local businesses involved in the manufacture of fishing nets suddenly had no one to sell to, and in turn, their families suffered. This taught me the importance of research and perspective in the way we in the UK attempt to promote healthy lives in countries we don't call home.

Objective 2

This was the problem that struck me most during my time in Madagascar. Contrasting the NHS, a healthcare service that is free at the point of delivery is unique to only a few countries in the world, to the healthcare system in Madagascar is really quite staggering. Patients in Madagascar pay to see a doctor, pay for their investigations, pay for their medications and if needed, pay for their hospital stay. If they cannot afford medical treatment, they go without. Indeed, families can be crippled by the debt of a chronic illness, and this in turn massively affects the way that doctors work. Chronic illness in the UK is diagnosed and managed constantly. We have whole screening programmes designed to detect chronic conditions early. It doesn't matter what the cost of your investigations or ultimate treatment will be; if you're unwell, we will do everything we can to fix it, and the state will pay to keep you healthy.

In contrast, in a place where the daily wage is similar to the price of a doctor's consultation and a 1-night hospital stay is barely affordable, acute conditions are treated if you can afford it, and most of the time, chronic conditions aren't. One example of the difference between healchare provision in the UK and Madagascar will stay with me throughout my working career. A middle-aged woman presented to the hospital with acute shortness of breath and treated with oxygen. Upon questioning it appeared that the shortness of breath was acute, but something chronic was underlying. She had been unwell for months with stomach pain and general malaise, being unable to get out of bed most days. She had very little appetite and looked clearly underweight. Her blood results showed a severe

anaemia. Her shortness of breath was treated, and she was then pronounced as ready for discharge. Coming from the UK, the fact that we hadn't diagnosed her underlying illness confused me. This patient was clearly unwell and without further investigation and management was likely to die within months if not weeks. I asked the doctor about the patient's management and she told me about the patient's social situation. Her family didn't have the money for investigations that went beyond basic blood tests. They also didn't have money for surgery or expensive medications, in fact, this hospital stay alone would have been a significant burden on them as a family. That ruled out a cure or treatment for whatever the underlying illness was, even if it could be diagnosed. The best that the doctor could do was give the family a realistic expectation of what would happen over the next few months, and allow them to make proper arrangements for their relative's death.

What struck me about this case was that not only would this patient die because she couldn't afford treatment, but also that she would die because she couldn't afford investigations, and no one would ever know why she died. We are pushed in the UK to not just to treat symptoms, but to diagnose. Every single patient has a working diagnosis, and if a patient dies without one, they have a post-mortem to make sure we can learn what it was they died from and how to spot it next time. It seems clear to me now that we are spoiled in the UK with the amount of investigations and clinical certainty that we have at our disposal. I hope that going foreward I won't take that for granted.

Objective 3

A community project that I supported during my time in Madagascar was the construction of an awning to cover the families' waiting area outside the emergency room at the local clinic where I was based. I was very proud to have been able to support it, and becoming more involved in the clinic allowed me to reflect upon the disparity in wealth between Madagscar and the UK. There is clearly a huge difference in the daily wage between the two countries, however I now reflect that the availability of public services is the biggest difference. In a country like Madagascar, the poorest members of the community don't have the government to lean on. In a family where one parent is working to support many children (contraception is not always used due to local customs), things that we get for free at home, for example education and healthcare, are the first things to suffer. We very much take these things for granted. Although the lives of the least fortunate aren't in any way easy in wealthier countries, in places where social care doesn’t exist, they are undeniably harder.

Objective 4

My knowledge in general medicine was greatly improved by my experience in Madagascar. As I have noted already, the diagnostic tests that are available within the country are very limited, and so there is much more emphasis placed upon clinical history taking and examination.

My knowledge of tropical medicine also vastly improved during my 6-week placement. During the placement in Madagascar, I saw patients with numerous tropical diseases including giardiasis, schistomiasis, malaria, typhoid and brucellosis. Having helped examine and treat these patients I now hope that I will recognise the diagnoses in the future, particularly during my emergency medicine placement. I will certainly always remember to take a travel history in anyone with new-onset infectious symptoms.