GENERAC COHEN
SURGERY Josh

Elective Report

1. General surgical patterns of disease

By far the most common presentations in general surgery in Mnazi Mmoja hospital is haemorrhoids. Although also common in the UK it is the single leading reason for a surgical consult in Zanzibar. The second most common presentation was of hernia's. Most often inguinal hernias. The third most popular appearance in clinic was that of breast lumps and/or pain.

2. How is this different to the UK?

It is difficult to compare this to the UK like for like. In the UK we have, for example a separate breast clinic, where patients with breast lumps will have a triple assessment and sent home with a fairly good idea of the cause for their symptoms. Here in Zanzibar, the patients all attend the same clinic regardless of their presentation. This is mainly due to the lack of primary care health facilities in the country. 'Triage' so to speak happens at the clinic door. Furthermore, the investigations available in Tanzania are very different to those available at home in the UK. With no colonoscopy or rigid sigmoidoscopy, the diagnosis of haemorrhoids becomes a convenient diagnosis even in the abscence of visual evidence! The patients receive a treatment and go home fairly content regardless of the treatments efficacy. This is not a criticism of the health care but rather the reflection of a resource poor, culturally different society. In the UK a diagnosis is made more on evidence than convenience.

3. How to improve health/care of patients without a further stretch on resources?

This is, I think, the most important question to ask. In a resource poor system, the greatest asset a health practitioner has is the time with the patient. Time to take a full history, to really understand the symptoms from the patients perspective in order to arrive at the most likely diagnosis. My experience has shown me this tool, far from being maximised, is almost ignored! The communication between healthcare practitioners and patients is almost non-existent. In clinic, doctors would often jump straight to examination of the patient. We know that the majority of diagnoses are made from the history yet it is not really used to its full potential. This is one improvement. Another improvement, along similar lines is that of patient education. Culturally the patient here accepts what the doctor says and will take the medication given or have an operation but the explanation as to the causes and how the patient can avoid similar problems in the future does not happen. Prevention is the best cure but simple lifestyle changes, that could have big impacts on the health of the population here on the Zanzibar island go untouched. The strongest example of this is that sugar is seen as being very healthy and is added to every food here...there is also an extraordinarily high incidence of diabetes in Zanzibar. Although these two suggestions do not cost money, and would undoubtedly improve the health of the population, I think culturally they would not be popular or accepted. Patients don't expect to have a proper history taken so are confused when one tries. Health education is also seen as not relevant to the patient, for the doctor, not me! It would take time and much persistence to improve the picture but it would be well worth it.

4. What did I learn to put into my future practice?

The biggest learning point I derived would be the importance of consent and communication. I have experienced countless examples of medical practice without consent (for example a hysterectomy

post C-section with no indication!) and the repercussions of such practice. Communication is vital as well. Empowering the patient to make their own decisions about their healthcare having been presented with the facts is the ideal. It also allows the patient to see the bigger picture and have faith that their doctors are acting in their best interest. These things were lacking here and it did not always sit comfortably with me.