SSC 5C: Elective Placment

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Subject/s: Gen Med and Palliative Care

Location/s: Mseleni Hospital, South Africa; Forest Holme Hospice, Poole Hospital NHS Trust

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Objectives

1. To observe the presentation of medical conditions in a part of the world with different cultural expectations of health care. (Mseleni)
2. To contrast resources available in a state funded hospital in South Africa with NHS funded hospitals in the UK. (Mseleni)
3. To develop my communication skills within cultures different than my own. (Mseleni)
4. To gain a greater knowledge of the range of palliative care services provided through the NHS; to develop my understanding of the role of the consultant palliative care physician within an MDT; and to note the value of palliative care in non-malignant disease. (Forest Holme)

1. Many patients seek medical assistance for exactly the same reasons throughout the world- pain, disability inhibiting their ability to work or care for themselves and their dependents. Meanwhile, the same familiar reasons keep patients from their doctors- expense of travel, time of work and doctors fees; patients fail to grasp the significance of their symptoms; fear, whether of doctors or of possible diagnoses and treatments with the potential pain of stigma they might bring. As these, plus other influential factors such as education, access to the internet and other sources of information vary between cultures, so the point at which patients choose to present to their doctors will vary. Of course, one of the most important influences will be the In Mseleni, primary care is provided mainly by nursing staff who refer patients on to see doctors, either in primary care clinic or in out patient department if it is deemed to be necessary. This inevitably filters out many cases from the doctors workload who would conventionally be seen by a GP in the UK i.e nurses may be able to adjust hypertension medication regimes or asses children with common respiratory infections. Another difference in the population of Zulu-natal is the prevalent beliefs in the value of traditional healers and the role of local religions in health care. I was surprised to find large numbers of the local population still treats this forms of traditional medicine as its first port of call, only seeking western medicine as a fallback option when traditional medicine is perceived to fail, or indeed, cause harm. This can result in a delay in patients presenting at critical points in their illness i.e. in septic arthritis and other infections, dehydration or malnutrition, and cause patients to present with avoidable problems caused by traditional medicine. One patient, a teenage boy, shockingly suffered from rhabdomyolysis and acute kidney injury after being beaten to drive out the evil spirit believed to be the cause of his learning difficulty. This is not unheard of in London hospitals but I was alarmed by how how many cases I encountered of this nature. Finally, the prevalence of medical conditions varies dramatically from that of the UK. Diabetes, stroke and heart disease are certainly problems here, with diabetes in particular on the rise annually. This coincides with a worrying trend of increasing obesity rates in the area which has developed with increasing affluence. However, the comparative rarity of advanced coronary artery disease was made clear when there was much excitement amongst the medical staff when a patient was identified as suffering from a STEMI in resus. The last STEMI was diagnosed several months previously. But whilst heart disease might be comparatively rare, the AIDS epidemic is all too

noticeable. It is estimated that 30-40% of the population are HIV positive, the highest prevalence within south africa. And with it comes a host of associated infections and conditions. TB is a major problem as are HIV associated malignancies such as cervical carcinoma and Karposi's sarcoma. Within paediatrics, malnutrition still presents a major threat to life despite a co-existent obesity epidemic. Also, worms have to be considered far more frequently amongst a differential for causes of infection as well as a common cause of asthma like wheezing. One condition which is unique to this area is the phenomenon, 'Mseleni hip'. In this condition, individuals present from teenage years with severe osteoarthritis-like degeneration of joints. Though most commonly the hip joints, it can include both small and large joints. '11% men and 39% women are severely disabled in young adult life'. (1)

2. Many of the resources which I take for granted as being accessible to doctors and their patients on the NHS are rare luxuries in mseleni. This does pose a problem with treatment, although normally an appropriate alternative is available even if the first line option is too expensive. Where the problem of of limited resources becomes really frustrating is with diagnostic tests. Endoscopy, CT, MRI and many other commonly used investigations in the UK require referral to a tertiary centre and the lists can mean patients with suspected malignancies can be waiting weeks or months for proper investigation. The only MRI scanner for the are is located in Durban. This is very frustrating as cases which might have been curable may become palliative in the time that it takes to confirm the diagnosis. It also prolongs the anxious wait for the patient to know what is wrong with them. In some cases, the wait for investigation is just not worth it. Some examples include diagnostic tests for many common STIs and serial beta-hcg measurements to confirm ectopic pregnancies. Where an STI is suspected, blind treatment is given for all common forms. In cases of ectopic pregnancy that is suspected on US but cannot be confirmed, patients can need to undergo laparotomy to investigate because it can take days for a beta-hcg result to be processed by the lab. Both of these are examples of the numerous situations in which patients have to undergo potentially unnecessary treatment due to the lack or inefficiency of diagnostic tests. Despite these difficulties, the doctors are very well trained and, I suspect, far better clinicians and generalists than junior medical staff in the NHS due to their inability to rely on specialists and sophisticated imaging being always on hand.

3. Communication with patients was difficult as the vast majority did not speak enough english for me to take a reasonable history without a nurse translating. It was useful to practice this though, as it is certainly not infrequent that a translator is necessary in consultations in the UK. It was also useful watching the doctors who were not fluent in zulu and observing how they made the most of the little language they had picked up so far. Picking a few choice expressions to learn enabled surprisingly clear communicated with relatively little vocabulary. An example might be learning the word for pain and combing this with sign language to ask the patient to point to where they were experiencing pain. This saves learning vocabulary for many parts of the body.

(1027 words)

References

1. Hip disease of Mseleni. Du Toit GT. Clin Orthop Relat Res. 1979 Jun;(141):223-36. PMID: 477111 [PubMed - indexed for MEDLINE] Online at: http://www.ncbi.nlm.nih.gov/pubmed/477111