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Elevtive report 2014

Mulago Hospital – Kampala Uganda

"Where are you going on your medical elective?"
"East Africa"
"Oh that's going to be harrowing"

I'd thought long and hard about what I wanted to get out of my elective placement and concluded a developing country like Uganda in East Africa was the most likely to provide me with slightly more "hands on" clinical experience I felt I hadn't yet managed to get completely confident with throughout my five years in the UK. I wanted to return completely competent at managing a critically ill patient and happy with procedures that I would be doing next year.

The medical placement I had chosen was based in the city centre of Kampala in the national hospital called Mulago. Mulago Hospital is the main referral hospital for the whole of Uganda, parts of Rwanda, Tanzania, Sudan and Kenya. The hospital was built in the 1960's by a large donation from the American government. However since then it was apparent no work had be done to improve the hospital or develop it further. The beds on wards were arranged with less than 30cm apart from each other and there were no curtains to provide the patients with any privacy. In a normal 6 bed bay there would often be up to 15 beds and the toilets and wash facilities on each ward were also being doubled up and used frequently as the sluice rooms. Mulago had an ICU with a total of 7 beds which throughout my whole time on placement there the beds were occupied. This meant most critically ill patients were left dying on the wards. On days where ward rounds attempted they were carried out in a very systematic way visiting every bed in turn in the order they were round the bay. Often seriously ill patents that needed prioritizing were left waiting and once my fellow medical student was on a ward round where they turned up to a bed where the patient had died in the night and no one had checked on him till the ward round. The rounds were chaotic and the number of people around each bedside often whelmed me. As well as a whole medical team and medical students often the whole extended family of a patient was in attendance. In Uganda patients were expected to pay up front for any tests or imaging they required and relatives were expected to pay, organize tests and imaging and collect results of tests from all areas of the hospital. Hence they had to spend the majority of time sleeping, eating and living on blankets on the hospital floors. They also expected to act as translators as all doctors training at Mulago spoke English due to there not being a national language of Uganda due to there being 56 tribal dialects.
When we arrived we were informed all the junior doctors were currently on strike throughout the whole hospital as they hadn't been paid in over 2months and the Attending or Resident doctors didn't currently work the afternoons as they too hadn't been paid and subsequently went to get private work in the afternoons in private clinics throughout Kampala. At times wards were left completely unattended for hours on end, a terrifying prospect for myself and other medical students as we often were left alone on wards with no nurses or doctors.

I was based on the pediatrics wing of the hospital but spend a week in the adult hospital as well. Throughout this time I spent the majority of time in the acute pediatrics assessment unit particularly in the "resus" area, which consisted of 2 beds, one cot, and a table with basic drugs, fluids and lines. I couldn't believe how basic and minimalistic this room was, oxygen could only be administered to 3 babies at a given time and even then it was only available via nasal canulae and with no greater than a flow rate of 2l per minute. I remember early on being incredibly frustrated

wanting to turn up a critically ill childs oxygen to 4l and being informed that this would waste the oxygen supply and no one else would be able to have any. The lack of equipment became even more apparent when I was told that within the whole paediatrics apartment there was one ECG monitor and only one sats probe. (Which belonged to an American doctor and was kept on his possession) This was such a frustrating way of managing patients as often the doctors or myself knew what to do but didn't have the supplies to begin management. In the UK, I feel we take the equipment and supplies we have for granted. In Uganda and Mulago imaging and tests were often not an option. Medical care and initiation of treatment was often solely decided by what had been identified by an initial consultation and a brief examination of the patient. This is something in the UK that only happens to life threatening cases such as meningitis and subarachnoid haemorrhage.

I also learnt early on that the phrase we are taught in medical school "common thing were common" actually was a universal phrase. Although British diseases were not the common diseases that affected the patients in Africa, over 80% of the cases I saw were malnutrition, malaria or typhoid. Often because patients presented late to hospital their symptoms of disease were bizarre and fraught with complications, but by applying this rule I learnt that the most important thing to do on admission was to rule out these common diseases. By identifying malaria, typhoid and malnutrition you were able to treat the underlying condition and then focus on the complications that had arisen from the disease.

I quickly found that the most frustrating and challenging hurdle of medical treatment in Uganda was addressing how late it was in a patient's illness they presented to hospital. There is no real primary care set up in Uganda and the majority of health care has to be paid for by patients. This combined with poor public transport and vast distances patients have to travel from rural areas to Kampala, to patients often presented incredibly late to hospital. Also due to the tribal influences on health care a large proportion of the patients visited a "witch doctor" from their tribe before attending the hospital. Often these visits to "witch doctors" would involve the patient taking herbal remedies that actually could poison the patient if taken in large amounts. It was frustrating to see how sick patients had become from relative treatable diseases just by not presenting to hospital sooner and receive treatment. This is something we take for granted in the UK. A better public health campaign needs to be done to improve the education of general public in Uganda to make sure the come to hospital earlier. I was curious about the health care provisions from the government so asked a bit more about the funding of the health care system and was unsurprised to hear it was still pretty chaotic, although they are trying to make advances in attempt to sort it out. I learnt that the government spends about a third of what it needs to meet its minimum target health care packages. Uganda spends only US$14 per-capita on health and out of this is $9 comes from the patient's own pockets and $5 comes from the government and donations from countries like the USA. The government is failing to reach the minimal targets to achieve a sustainable health care system. As a consequence of this doctors haven't been paid for over 2months, provisions within the hospital are scarce and equipment and medical management is heavily dependant upon donations from overseas doctors. The public health campaigns throughout Uganda however are a promising indication of work that is starting to be done to counterbalance this lack in funding. The United States currently donates almost $500million each year to Ugandan's HIV/AID program from this money every HIV positive patient in the whole of Uganda receives free anti retrovirals and treatment. Something that I hope will continue however we have recently learnt whilst out there that this is currently being withheld due to the recent anti-homosexuality campaigns throughout Uganda. My time at Mulago was eye opening, although practical experience didn't live up to what I hoped it would I definitely learnt far more than I though I would. The hospital is currently in a state of limbo with diminishing funds and incredibly frustrated medical personal. The

Ugandan Government cannot afford to keep allocating so little public funding to health care and without important contributions from developed countries places like Mulago will not be able to function.

SSC 5c Reflection (part 2)

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Doctor Dr Opoka

Subject: Acute Care Paediatrics
General internal medicine Adults

Was it what you expected?

Sort of, my knowledge of infectious diseases has been improved and my understanding on the importance of taking a good history and examination has been drilled into my brain. Mulago hospital even though it's the main referral hospital for the whole of Uganda, some parts of Rwanda, Kenya and Sudan was incredibly understaffed, very minimalistic and at times a challenging and hostile environment for administering medical treatment. Having said this, the things I have learnt are invaluable to my training and I believe have helped me in becoming a better clinical doctor.

Clinical experience?

In truth I wanted to go on this elective so that I could practice lots of procedures and get better at managing a critically ill patient. I felt after finals I would be more confident in examinations and basic clerking of patients however I wanted to improve on my clinical skills in preparation for FY1. Mulago was like many hospitals in Africa understaffed and under equipped. For the first month of my placement all the interns were on strike and senior doctors only attended the hospital for a few hours every morning, the majority of the wards were being run by residents and medical doctors from over seas such as American doctors and Belgium Nurses. I realised early on that Clinical procedures experience was not going to be falling into my lap as often procedures were determined on whether supplies were available and whether the patient could afford to have them done. Considering a CT scan cost almost 150000 shillings (£50), more money than people earn in a year, procedures were not done frequently. This proved disappointing at times as there was often only one needle and trained staff only had one attempt to get it right. Having said this, if you persisted you were often rewarded with practical opportunities. I was often presented with patients that had to be diagnosed and treated based on pure clinical examination and history taking. Signs that you read about in textbooks were common