SSC 5c Report (Part 1)

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Subject: Emergency Medicine and Infectious Disease

I undertook an elective placement in emergency medicine and communicable disease at Mulago Hospital, Kampala. With a capacity of 1790 beds, Mulago is the largest healthcare facility in Uganda and functions as both a general hospital for the city and one of three national referral centres. Despite the significant emotional burden of working in a public hospital within a developing country, my overall experience of working in this intriguing setting was overwhelmingly positive. Here I detail some of my experiences and reflect upon the extent to which three predetermined objectives were achieved.

I undertook this placement with the intention of;

1. Developing my clinical experience by seeing cases present at a more advanced stage than they normally do in the UK.

2. Spending time in a community healthcare setting.

3. Becoming a more resourceful clinician by working a relatively resource-poor setting.

Spending time in the emergency department and on the infectious disease wards afforded me a fulfilling and varied clinical experience. I was able to witness a large and broad caseload of patients, who often presented with advanced disease. This is not surprising considering the inaccessibility of local primary healthcare services to the impoverished sections of the Kampala's population. Many patients' chronic disease goes undetected and undertreated and this often leads to advanced and complicated disease at presentation to hospital. I regularly encountered patients presenting to the emergency department with headaches with systolic blood pressures in excess of 200mmHg for example.

The high prevalence of HIV/AIDs, tuberculosis and malaria within Uganda was reflected by the large number of cases I saw whilst at Mulago. Although many government and charitable initiatives such as the free access to antiviral therapies in 1994 have helped lower rates of infection and AIDs-related mortality, HIV still remains a huge national public health problem. Many HIV-positive patients presented with opportunistic infections that I had not previously encountered in the UK such as cryptococcal meningitits and disseminated septic tuberculosis.

Spending time in the infectious disease and haematology departments was fascinating. Clinical examination was absolutely imperative to diagnosis as the most basic investigations were either unavailable or beyond their financial means of many patients. Seldom seen clinical signs such as massive splenomegaly and epitrochlear lymphadenopathy were frequently encountered on the wards. Regular consultant-led bedside teaching sessions were useful in building on these experiences and developing a more thorough understanding of the conditions concerned.

Many of the juniors were striking in protest over unpaid wages whilst I was the hospital. This coupled with the sheer volume of patients gave me ample opportunities to carry out a variety of clinical procedures including diagnostic and therapeutic lumbar puncture.

Although my overall clinical experience was varied and immensely stimulating, it was

emotionally challenging working with impoverished patients in such an under-resourced environment. Performing CPR (unsuccessfully) on a 17 year-old boy in the emergency department was a harrowing experience for all concerned. The patient had presented in severe respiratory distress secondary to presumed pulmonary embolism several hours earlier that morning. Resuscitation and investigation was attempted but severely hampered by the shortage of basic medical equipment including oxygen, fluids, and ECG machines. Despite the best efforts of the nursing staff and doctors he arrested, attempts at CPR were unsuccessful and he died in front of his mother as well as dozens of other patients and their families. The whole episode was shocking to witness, and the patient's outcome difficult to accept given his young age.

The emergency department was a chaotic environment in which to work, not least because of the large volumes of patients and lack of clinical staff. As in the UK, patients would be assessed on arrival by a triage nurse and sent to either the medical or surgical portions of the emergency department. Although there was usually at least one senior clinician on duty the lack of staff meant that it was sometimes left to me, another English student, a visiting American resident and local medical students to clerk all the 'medical' patients within the department, organise referrals to other departments and instigate basic management plans. We were forced to prioritise our attention and resources on the sickest patients as there were not enough staff or equipment to manage every patient adequately. This was an immensely difficult task given our relative lack of medical experience and knowledge of local protocol such as treatment guidelines and systems of referral and discharge.

I was also able to spend a day visiting a local community health centre in the district of Namuwongo, one of the poorest and most crowded urban areas in Kampala. The clinic, funded by the charity Keep A Child Alive, provides 24-hour care to over 11,000 HIV-positive patients, of all ages. Services provided by the clinic are comprehensive and include HIV-testing and counseling, prevention and treatment of opportunistic infections, psychosocial support and counseling, family planning, neonatal and infant HIV diagnosis, support groups and essential food aid. After meeting patients and staff we were given the opportunity to visit the local slum and spend time in the houses of some of the patients. This unique experience helped contextualize the immense importance of the work done by the clinic and highlight the considerable challenges of healthcare delivery to such a deprived population of patients.