Queen Mary University of London
Institute of Health Sciences Education
Faculty of Medicine and Dentistry
Room 1.10, Garrod Building,
Turner Street, Whitechapel,
London E1 2AD
www.smd.qmul.ac.uk

SSC5b 2024 REPORT SUBMISSION FILE

Once you have received formal approval for your SSC5b you should complete this document with all the relevant details of your SSC (and objectives but don't answer the objective). You should complete one file per SSC5b placement you have arranged. This file should be given to your SSC5b supervisor either by email prior to arrival.

The fully completed submission file must be given to your supervisor for assessment prior to completion of the Elective and uploaded as a PDF to QM Plus by 12pm (Mid-day) Monday 3rd June 2024. Please rename the file with your FULL NAME and COUNTRY, eg John Smith Australia.

Student Name: Rida Kherati

Student Number: 180027482

Dates of elective: 20th May 2024 To: 31st May 2024

Elective Subject: Emergency Medicine

Host Organisation: Muhimbili National Hospital

Elective country: Tanzania

Supervisor`s name: Mohamed Msangi

Supervisor's email: mohamed@worktheworld.com

Are you happy for this report to be uploaded to the SMD Electives website in its entirety? No. I have made the essay and reflections quite personal and would prefer if they weren't uploaded.

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Dear Colleague,

This letter introduces one of our undergraduate students who has been accepted for a period of elective study with you. May I take this opportunity to thank you for agreeing to take this student and to provide further information about the elective attachment.

Final year students of good standing on the MB BS degree at Bart's and The London School of Medicine & Dentistry course may undertake a short period of elective study. While we are anxious that our students should obtain the widest possible range of experience it is important that they should not be asked to undertake duties beyond their level of training. Invasive techniques should be carefully supervised by staff who have the appropriate competences themselves. Students should not be exposed to inappropriate hazards. **A hazard avoidance checklist is provided with this letter and should be completed with the student on arrival.**

The students are required to set specific objectives, which have been agreed in advance with the School. A list of their objectives is provided with this letter. At the end of their placement they are required to write a short report addressing these objectives (less than 1200 words) and we hope that you will be willing to assess these on our behalf. This will form a part of their overall elective assessment. Students are also required to provide proof of satisfactory attendance on completion of their elective study.

On completion of the elective an assessment of the student is required, and I would be most grateful if you or one of your colleagues would complete the attached assessment form. Please be open and frank in your assessment. We encourage students to read these reports and it is important that they should be as informative as possible.

The completed student report will be given to you by the student by either email or in person within one week of the placement being completed along with an assessment form and we ask that you reply by e-mail back to the student, within one week, with a copy to us, providing a score of between 0 and 10 (10 = excellent, 5 = satisfactory and 0 = unsatisfactory).

In order to assist with this process, we encourage students to write their report while on placement so that you are able to grade it before they leave. Please let us, or the student know if you are unable to assess the student's report so that we may make other arrangements to undertake the assessment.

Should you or the student need to contact us about the student in an **emergency** please email:
SSC5B-emergency@qmul.ac.uk

Again, I am very grateful to you for accepting one of our students and I hope that s/he will be a credit to the Medical School.

Yours faithfully

Dr Nimesh Patel
Head and Principal Internal Examiner of the SSC & Elective Programme

HAZARD AVOIDANCE FORM (to be completed upon arrival with host)

Hazard	Problems	Y/N	Comment
Climatic extremes	Dry/desert, monsoon/storms, oxygen deficiency/rarefied air, sunburn/skin cancer, Tidal/water/wind considerations	N	Tanzania weather is moderately hot. Will keep water near. A+E department has aircon which mitigates risk.
Contact with animals (wild or domestic)	Allergies, asthma, (bites, dermatitis, rabies, stings, other physical contact)	N	No Contact with Animals.
Contact with insects	Bites/stings Lyme's disease, malaria, yellow fever, other	Y	Malaria risk- taking malarone.
Contact with reptiles	Poisoning, snakes, scorpions etc, remoteness, shock, availability of antidotes, medical back-up	N	No contact with reptiles.
Contaminated food	Allergies (food-poisoning, Hepatitis A	N	No contact with contaminated food.
Contaminated water	Diarrhoea, legionella, leptospirosis	N	No risk of contaminated water
Contaminated drinking water	Cholera, polio, typhoid, other	Y	There is a risk. Drinking bottled water to minimize risk. Not using ice.
Electricity	Compatibility of equipment and supply, safety standards (higher / lower / different)	N	No differences in electricity.
Emergencies (including fire)	Arrangements and procedures (first aid provision, 'help' numbers, contacts and response expected	Y	Numbers and emergency procedures explained during induction.
Environment (local)	Culture (customs, dress, religion)	Y	Covering shoulders and knees. Aware of customs and religion through induction.
Excavations / confined spaces / tunnelling	Permits to work (risk appreciations, safe systems)	N	No significant work risks.
Hazardous substances / chemicals	Antidote available (CHIP, spillage arrangements, transport requirements)	N	No interaction with hazardous substances.
Legal differences	Local codes / guidance (local standards, statutes, information & training)	Y	Have local guides to advise us.
Natural phenomena	Avalanche, earthquake, volcano, other	N	No natural phenomena risk.
Needles (contaminated)	HIV, Hepatitis B	Y	OH discussed at induction.
Stress	Accommodation problems, civil unrest, crime, vandalism and violence, extremes of heat/cold, fatigue, language/communication problems, lack of support (of family and peers), load/expectations excessive, loneliness/remoteness, sickness, unfriendly environment	Y	Support was offered from my supervisor whenever needed.
Transportation	Competent drivers, hazardous terrain, properly maintained vehicles, suitable transport	Y	Using Bolt and travelling with others to minimize risk.

ELECTIVE (SSC5b) OBJECTIVES

Please write out your submitted objectives below

OBJECTIVES SET BY SCHOOL (Objectives set by you when you submitted your application to the school)
Describe the pattern of critically ill patients in an emergency setting in Dar es Salaam and discuss it in the context of global health.
Describe the structure and functionality of the multidisciplinary team at Muhimbili National Hospital compared to other tertiary hospitals in the UK
To understand the impact resources have on patient care and observe the differences in resource utilization.
To learn Swahili and gain confidence in communicating with patients and people who don't speak English.

ELECTIVE (SSC5b) REPORT (1200 words)

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

Describe the pattern of critically ill patients in an emergency setting in Dar es Salaam and discuss it in the context of global health.

A large proportion of the critically ill patients have been involved in a road traffic accident, usually a motorbike accident. This is probably because there are multiple people who are on 1 motorbike, often without helmets, weaving through traffic which is not considerate towards them. This is similar to the UK, as there are road traffic accidents there too, but I think there is a lower incidence and frequency due to the higher safety standards and regulations. In a global context, education around motorbikes and precautions for safety, i.e. helmets, and a restriction on the number of people on a bike would be helpful as I know this is a problem across many less developed countries.

The other cohort of patients often seen are those with advanced diseases, more advanced than we would see in the UK. This is partly because when patients experience any symptoms go to a local traditional doctor first who uses herbs and various cuttings on the skin to heal. By the time the patients realise it isn't working, their condition has significantly advanced, making it difficult to treat and manage in resource depleted healthcare settings. Many patients present with late stages of cancer, and end stage renal disease. Even at that point, many are reluctant to go on dialysis or have medication which perpetuates their condition. Patient education is something that is important and under focused on in Tanzania which may contribute to reduced understanding of their condition, its implications and the importance of treatment. The last proportion of patients are those with infectious diseases like malaria, hepatitis and HIV.

Describe the structure and functionality of the multidisciplinary team at Muhimbili National Hospital compared to other tertiary hospitals in the UK

I found the multidisciplinary team structure in the emergency department at Muhimbili National Hospital quite interesting compared to the UK. Here they have 4 resuscitation bays in the emergency department, as well as ambulatory care area divided in 2 (one half for publicly funded patients and others with private health insurance). In the UK, there are also 4 resuscitation bays, as well as 2 large areas with approximately 16 rooms with individual beds. Although the space in real terms is similar, the resuscitation bays here function for all significantly ill patients, so in 1 resuscitation bay (which is approximately the same size as the UK), they fit up to 6 patients and use mobile barriers to provide privacy if needed. They have a flow system in place, where a doctor, nurses, students and HCAs are assigned to one resuscitation bay for the shift, and treat any and all patients coming in that bay. In the UK, doctors who are available take the next case, and move around the various rooms to see the patients wherever they are. The system in the UK works well for them as they have the space to provide individual bays, whereas here, due to space constraints, it is easier for healthcare professionals to focus on one area.

In terms of the actual MDT, there are similar healthcare professionals in the team as there are in the UK, there are doctors, nurses, and HCAs. In the UK, there are emergency department assistants and physicians associates aswell, which are not a role in Tanzania, but on the whole it is similar.

To understand the impact resources have on patient care and observe the differences in resource utilization.

The resources available in the hospital in Tanzania are a lot more limited as compared to the UK. On my first day, the nurse was putting in a cannula, there were no tourniquets so she used a glove, and to secure it she asked me to get the tape- I was looking around for the clear covers we have in the UK, and she said no the roll of tape- it was a wide roll of tape, which was so sticky that it would probably be painful to take off! She then asked me to cut the tape, you could not rip this tape, unlike the UK, and they had no scissors, but they stocked

small razor blades which she used to cut the tape into little strips to secure the cannula, and then wrapped the patients whole ante-cubital fossa with the roll of tape. You could not see the cannula, which is something we are taught in the UK as it helps us identify if the cannula is infected etc, and they also did not put any date on it so there would be no indication as to when to change it. Similarly, there was another patient who came in with copious amounts of white frothy sputum. He came in with a bowl of sputum leaking through a plastic bag, and since there was nothing better in hospital, he continued using that! The doctors suggested using a glove to spit in, but the patient didn't have the grip strength to hold it. There were no glasses, or vomit pots available, which is unlike the UK. I then had an idea to use the plastic bottle they have for IV fluids, cut the bottle neck and that would create a cup shape that he can hold and spit in, and it would not leak. The doctors managed to do it and it allowed the patient to be more independent and enabled him to keep clean while he was spitting! It made me really happy that I was able to help the patient, even if in a small way!

To learn the basics of Swahili and communicate with doctors and patients, as well as observe the differences in communication amongst doctors and patients at the hospital.

The organization I am staying with organises Swahili lessons twice a week, which has been really helpful to get to grips with the language, understand basic greetings and phrases that are useful. On my first lesson, I was surprised to see how similar the Swahili words were to urdu and Arabic, which are both languages I am familiar with. I feel like it gave me a headstart and allowed the language to stick in my head better. I was also able to guess the meaning of certain words which helped me understand the gist of sentences. After every lesson I use the time in hospital to practice the language with patients and doctors. As the doctors speak English, there is not a pressure to speak Swahili but they were very sweet and able to correct me and add to my vocabulary. However with patients, they don't really speak English, which made it frustrating as I usually like talking to patients and building a rapport with them, and I feel like I couldn't do that, short of saying a few greetings. Additionally, the doctors and nurses don't really speak to the patients, short of taking a history from them, they ignore they are there during examinations, or ultrasounds. One of the doctors was explaining something to the nursing students, and started demonstrating on the patient without speaking to them at all, almost as if they were a dummy. This is quite stark to me as we usually don't have teaching right in front of the patient, and if we do, it usually includes them in some way, whether that's asking their perspective or just explaining the fact that we are teaching. I would love to know how the patients feel about this in Tanzania, and whether they don't mind as they are used to it, or if they would prefer it another way.

ELECTIVE (SSC5b) REFLECTION

This information will be used to monitor placements for safety and to provide useful information that we can pass on to students for the future. (Please complete the sections below).

Was it what you expected?

It was similar to what I expected, there was a good mix of going into placement but also being able to enjoy Tanzania. In terms of the hospital itself, I had gone in with no judgements or expectations. I wanted to purely experience their version of healthcare. As expected, resources were limited, and hygiene standards were not at the level that we have in the UK. Something I had expected but was still surprised by was the lack of privacy patients had. In the emergency department in the UK, you have a full resus bay for 1 patient, here it was for 6 patients, so someone could be having CPR less than a metre away from another patient with a flimsy privacy screen in the middle. Additionally, they often don't explain what they are doing, or the diagnosis or the management plan to patients, whereas in the UK we include patients in the MDT and have shared decision making with them, here it is very paternalistic and the patient is either not told or if they are, they are not given a choice.

Clinical experience?

There was potential to get involved clinically. I was a bit more hesitant because their equipment was very different to back home. For instance I was asked to put in a cannula, they had the actual cannula, but they don't have tourniquettes, flush, clear tape, octopus, or alcohol wipes. So every step of the process was different which felt overwhelming at the start. Here they use gloves for the tourniquette, then use a cotton ball soaked in alcohol to wipe the skin, and after inserting the cannula, they don't flush, and then out of what looks like duct tape, they fashion it into a V-shaped strip and then wrap the rest around the site, as if you would with gauze, and you can't see the site at the end. And to cut the tape, there are no scissors so they say to use razor blades, but more often than not, they are not in that bay and you have to go hunting for it, or find someone who is able to rip it. I was slower than they were and initially was getting stuck on every step as it was all a bit different.

There are opportunities to do clinical assessments, and take histories from patients who speak English, as well as asking the doctors why they are choosing certain diagnostic investigations and management strategies.

What did you learn about the people and the country?

I learnt that often people opt to go to a local 'Witch Doctor' or natural medicine doctor before seeing

medical doctors. The 'Witch Doctor' often makes cuts on the body known as 'traditional marks' and then may fill the wound with various powders that have healing properties. Patients try this, and herbal remedies for a while. Seeing a medical doctor is often the last resort, and by the point they come, their condition that would have been curable has become irreversible and is difficult to manage. We did a local tour where the guide took us to a local herbalist, and explained the different plants and their properties. For instance, honeysuckle plant is mixed with honey and given to asthmatics, or using aloe vera soaked in water and drinking that for malaria, or use the quinine plant, which is what the anti-malarial medication is derived from! There is some wisdom in the herbs and it has been used for many years. I imagine it can be helpful for mild cases, but when it gets to a certain severity, then it probably is not enough to treat the condition.

What did you learn about the health care professionals you worked with?

I learnt that the healthcare professionals here genuinely do care about the patients but show it in a different way.

What did you learn about the health care system in that country?

I learnt the healthcare system is very paternalistic, with patients simply being told what they have, if that, beyond that most decisions were made by doctors and not always communicated. I learnt that there is a split public funded area and private area and the main hospital sees patients from both, but because it is often self funded, patients refuse many tests to save costs. Additionally, doctors rely on clinical judgement rather than investigations to confirm a diagnosis which is different to the UK, even if you suspect a diagnosis you still need to test to diagnose it officially (unless it is a diagnosis of exclusion or clinical judgement).
In Tanzania, there is also a greater understanding of herbal medication and the ways in which it is used as many patients go to traditional doctors as a first bet.

What were the best bits?

I enjoyed the hospital, it was interesting to see the differences and the unique cases that come through there doors. I would say the bike tour was eye opening and being able to see the local way of life, how their houses are and the emphasis placed on community was wholesome. During the second week, I felt like I got to know my housemates better which made it more fun in the evenings!

What were bits you least enjoyed?

I found the bed quite hard which meant I didn't sleep well for the first few nights. I also wish they had more Tanzanian food at dinner so we could experience it.

Were there any shortcomings?

Not really.

Would you recommend it to another student?

Yes, I think it is a great experience and is a good way to get out of your comfort zone.

Would you do anything differently?

Not really.

What did you learn about yourself?

I learnt that although I am happy travelling alone, I enjoy it more with friends and people I know. I also learnt I am quite curious about herbal and alternative medicine as it is so different to anything we have learnt at medical school, but there is a large population of the world, particularly in the East, who rely on it, so there must be something there to learn from and explore.

Where there any deviations from the risk assessment?

No.

How was your accommodation?

It was good, more traditional than I expected. It felt like first year again with the shared accommodation and meeting a bunch of new people, kind of like freshers. We got food provided, which was decent and there was a shop and some nice cafes nearby.

How were your travel arrangements?

Travel arrangements were good, took a flight to Dar es Salaam with a stopover, it was relatively smooth sailing. On arrival I was picked up at the airport and shown the city and hospital on the next day. After that we used Bolts to get to and from the hospital and other locations which was quite cheap, easy and generally safe.

Other experiences and information useful to future students:

In Tanzania, the bike tour around Dar es Salaam is a must do if you are not going to stay in the villages. It still allows you to get a glimpse. Additionally, I went to Kariakoo which is the largest market in East Africa, and got some fabric to give to a local tailor, it was relatively inexpensive and definitely an experience! You have to go with a local though!

Zanzibar was great fun and not too far away, just bring anti-sickness pills if you are taking the ferry (even if

you don’t usually get travel sick).