ELECTIVE (SSC5a) REPORT (1200 words)

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

I chose to do my medical elective in Tanzania as I wanted to understand how healthcare is delivered in different parts of the world, but also have the opportunity to immerse myself in a rich culture and experience the famous natural beauty of the region. This elective came highly recommended by a friend who had chosen t do theirs in Tanzania the previous year. Despite the anticipation and preparation, the initial culture shock was significant and it took time to acclimatize to the vastly different healthcare environment and living conditions. This experience was not only a steep learning curve but also an emotionally taxing journey that challenged my resilience and broadened my perspective on global health. This reflection will cover my thoughts on my elective experience as well as how each of my objectives were explored throughout my time there.

My first objective was examine how a certain disease or health issue which has a high prevalence in areas like Tanzania, affects the local population and how this could affect global health trends. I spent most of my medical elective in the emergency department. Here, I was able to see a vast array of illnesses which were prevalent in the area. I observed firsthand the high prevalence of trauma from road accidents and its profound impact on the local population. Road traffic injuries are a significant public health issue in Tanzania, contributing to high morbidity and mortality rates. The frequency and severity of trauma cases were alarming. Many patients presented with life-threatening injuries, often exacerbated by delayed access to medical care and limited healthcare infrastructure. The high incidence of road accidents can be attributed to several factors, including poor road conditions, lack of traffic regulations, and inadequate enforcement of safety measures. These factors are exacerbated by limited pre-hospital care and transportation challenges, which often result in delayed arrival to healthcare facilities. On a global scale, the high prevalence of road traffic injuries in countries like Tanzania underscores the urgent need for comprehensive road safety strategies and international collaboration. By addressing the root causes of these accidents and improving emergency care, we can reduce the global burden of trauma and its associated costs. Other than trauma, prevalent diseases like HIV, malaria, sickle cell, DKA, cancer and COPD had a high mortality rate. This was due to a range of factors such as limited staff and resources (such as equipment and treatment), socioeconomic factors and severity of disease (especially as they mostly presented in late stages). Tackling these issues at their cores, would consequently improve outcomes for patients that are admitted, as well target disease prevention.

My second objective was to study and analyse the healthcare services in Tanzania and draw comparisons and evaluate differences on a global scale, specifically with the UK. One of the most striking differences was the requirement for patients to pay upfront for treatments and even basic investigations such as blood tests and scans. This practice often led to frustrating delays, as family members needed to be contacted to gather the necessary funds. In the critical setting of the emergency department, these delays could be detrimental. I witnessed several cases where patients' conditions deteriorated significantly while waiting for payments to be processed. For example, one case I had was a patient who had suffered a stroke but treatment could not be started without him having a CT scan of his head. In cases like this, it is crucial to control bleeding if it is haemorrhagic or to target the clot if it ischaemic. The longer you wait, the more damage is done as the brain loses more and more function due to cells inadequately supplied with blood and therefore dying. This patient had to wait more than ten hours for a scan to be ordered which was very frustrating for me as I wasn't able to allowed to do anything else other than making sure he was somewhat stable. Contrasting this with the National Health Service (NHS) in the UK, the differences were profound. The NHS provides healthcare free at the point of delivery, ensuring that patients receive timely and necessary care without the burden of immediate financial considerations. This system allows for swift medical intervention, which is critical in emergency situations where time is of the essence. The ability to promptly administer necessary treatments and conduct investigations can significantly improve patient

© Bart's and The London School of Medicine & Dentistry 2024

outcomes, something that I realized I had taken for granted. Working in Tanzania's healthcare system made me acutely aware of the privileges associated with practicing medicine in the UK. The NHS, despite its own set of challenges, ensures equitable access to healthcare for all, regardless of their financial situation. This experience reinforced my appreciation for the NHS and the principles of universal healthcare that underpin it.

My third objective was to evaluate the differences in obstetrics, particularly in pre and post-natal care in areas where there are limited resources and compare that to more developed countries. As well as the emergency department, I spent part of my time in the obstetrics and gynaecology department. Here, I was able to work closely with the doctors observing and helping women in labour, with pre and post natal care, as well as seeing some complicated gynaecological conditions such as late stage cervical cancer. In contrast with the UK and other developed countries, I observed that pre-natal care often begins later in pregnancy and is less frequent. Many expectant mothers had limited access to regular check-ups, primarily due to geographic and financial, barriers, as well as lack of education. Not having early and consistent care can lead to undiagnosed complications such as gestational diabetes, pre-eclampsia, and infections, which were prevalent on the wards and which can have severe consequences for both the mother and baby. Another clear difference was the attitude towards giving birth. In Tanzania I found that both doctors and expectant mothers remained stoic throughout labour. There was no sense of privacy and, husbands and/or family members had to wait outside. This is vastly different to the UK were each mother usually delivers in a private room and can have family or partners in the room for support. C-sections were almost all emergencies which differs to the UK where mothers can choose to have an elective very early on in the pregnancy.

My last objective was to Develop confidence in speaking to patients who speak a different language whilst maintaining good bedside manner. Also, develop communication and teamworking skills by working with healthcare professionals who speak a different language and are from a different cultural background. As the doctors and nurses all spoke English, communicating with them was not as challenging as it was trying to talk to patients as they only spoke Swahili. This made is quite hard to elicit comprehensive histories, and therefore made diagnosis and treatment difficult too. I learnt common useful phrases such as ‘where is the pain?’ which helped when examining.
Overall, I thoroughly enjoyed my elective in Tanzania. It gave me the invaluable opportunity to experience healthcare in a developing country with limited resources and staff. I know feel more confident managing patients from admission to discharge and feel much more prepared to start work as a doctor.

© Bart’s and The London School of Medicine & Dentistry 2024