ACCIDENT
+ EMERGENCY

ELECTIVE REPORT

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Subject: Neurology / Medical Accident and Emergency

Describe the pattern of disease/illness of interest in the population with which you will be working and discuss this in the context of global health.

In Mulago Hospital, in Kampala, Uganda I found that the many of the diseases suffered by patients were mirrored by patients in the UK. However, the presence of two conditions, Human Immunodeficiency Virus (HIV)/AIDs and Malaria provided the backdrop for a variety of conditions we may not necessarily see very often. For example, we encounter pulmonary tuberculosis (TB) relatively often in East London, however TB meningitis specifically was very common on the Neurology ward, simply because of the increased number of patients with co-existing HIV, the latter being the strongest risk factor to developing active TB disease (according to the World Health Organisation). Further, given the presence of the vector for malaria in Uganda, the female anopheles mosquito, it remains a high risk zone for malaria. Although I did not see as many patients with malaria as I did with HIV, the academic interest the doctors expressed at journal club and on the wards concerning which anti-malarials to use, as well as how and when to use them, highlighted the economical burden this condition has placed on the healthcare system. Nevertheless, this rings true for both anti-retrovirals for HIV and anti-malarials, as both sets of medication are very expensive and when provided to patients who are largely unable to pay, are provided for free - putting a strain on what seems to be an already dwindling healthcare system. Although, it seems that there are definitely positive movements in Uganda, especially in regards to providing ARV therapy to the country's poorest and therefore working to reduce the number of HIV sufferers not receiving ARVs - a number currently at 7 million worldwide. Unfortunately, this is true only to an extent, as once a country very open to discussing the HIV epidemic and successfully tackling it as a health issue, it seems Uganda has now become a country less willing to talk about HIV, adding stigma to the condition and therefore making more difficult to treat.

Describe the pattern of health provision in Uganda and contrast this with the UK. Comment on what you learnt about the health system in that country.

In a similar fashion to the UK, Uganda has the NHS or 'national health system' which encompasses all institutions which make it their primary aim to provide good healthcare for the population of the country. Similarly, it is split into a public and private sector. The public sector includes any government health facilities under the ministry of health, the army, the police and prisons, and the ministry of local government. In contrast, the private sector includes for instance private health providers, private non-profit organisations, and complementary medicine health professionals.

Given the hospital which I worked in was a government run hospital and the patients were being treated largely within the public sector - this is where my report will focus. In the public sector,

preventive and curative healthcare is free, since the abolition of the user fees in 2001 – although within private wings of hospitals where patients can afford them, they are still paid. Thus, to an extent there is a similarity between the free healthcare provided in Uganda and the UK. The difference becomes apparent when patients require care beyond the basic 'package of healthcare' that patients in Uganda are entitled to as a minimum i.e. extra tests not covered by this package such as ANAs or a CT scan – which patients have to pay the hospital for in cash, before the test can be performed. The ability for healthcare to be provided for the population is further limited by poor infrastructure which was evident in the capital city, Kampala as well as the low salaries of the doctors and the lack of accommodation for patients and their families as evidenced by the crowded hospital wards, all of which demonstrate an inability to handle the burden of disease on the system.

Further, in terms of healthcare provision there was an obvious difference between the NHS in Uganda and the UK in the distribution of healthcare across the board. In UK, the NHS is split into 'primary care' which deals with patients in the community i.e. GPs, pharmacists, walk in centres, and 'secondary care' which includes emergency care, mental health trusts and ambulance trusts. The care provided within the primary care trust and secondary care trusts is aimed to be as uniform as possible, within each trust with primary and secondary care professionals working together to provide the best healthcare as guided by the Department of Health which is responsible for the NHS. However, in Uganda the public general hospitals, are managed by the ministry of local government through local district governments. Thus, there is a huge decentralisation in Uganda, with districts and health sub districts taking more responsibility for the healthcare provided, which therefore leads to more variation in the level of healthcare provided i.e. based on funding and resources, in a particular region. However, the concept of VHTs (village health teams) has been introduced to act as the first link between the people in the community to formal healthcare professionals. They also have other roles such as community management of common childhood conditions such as CAP, malaria and diarrhoea – to reduce the number of hospital admissions by dealing with problems early on, within the community.

Was it what you expected?

Before starting at the hospital, I had a certain level of expectation about the kind of hospital Mulago was and the care they were able to provide. I had heard of Mulago as one of the best hospitals in East Africa at one time, and having perused their website, was given the impression that they had technologies that we utilise for diagnosis in the UK i.e. CT scanners. In terms of the resources available and patient conditions however, I was very surprised. For example, on the neurology ward although patients quite often had a CT scan, they were often limited by the fact that the hospital had run out of CT contrast delaying the test, and therefore hindering patient care. Further, the level of maintenance care for patients and their families was not what I expected for such a well known and large hospital; patients brought their own blankets, which raised the question of hygiene and perpetuating infection on the ward where many patients were already immunocompromised. Further, the lack of nurses on the ward I did not expect - were it not for family members, helping their own and other patients, which I thought was really lovely, I would imagine many patients would have deteriorated very quickly, without the family providing basic 'nursing' care.

Clinical Experience

My clinical experience was on the Neurology Ward and in the Emergency Department (largely medical). Overall, I thoroughly enjoyed my time in both settings.

In the Neurology ward, I was one of ten medical students – all of whom were training for 5 years at the hospital, and in their final year – which was very nice as having just completed finals I could relate to the pressure and responsibility one feels at this juncture in one's career. It also meant there were opportunities for me to teach them certain things that we focus on more so in the UK at this level i.e. ECG teaching, managing a myocardial infarction and neurological examination. I also realised very quickly however, that we were on the same page almost literally – we all used oxford handbook as our 'medical bible' and it was refreshing to see that continuity of knowledge between students entering the same profession in both Uganda and the UK.

Meeting the junior doctors on the ward was even more rewarding – their ability to make diagnoses based on clinical findings, along with differentials and a management plan was impressive. Further, their knowledge and ability to apply it was very good. Also, the style of ward round was very similar to my own experiences back home – in fact, it seemed more time was spent with students discussing the 'in and outs' of the differential diagnoses and I felt as a group we were put under more pressure to understand the concepts, which for someone such as myself, with an inherent interest in neuroscience was really enjoyable. The range of conditions although similar to the UK i.e. there was a lot of stroke and spinal cord compression, were also specific to Africa as a whole because of the underlying HIV status of many patients, such as Cryptococcal meningitis, CNS lymphoma and TB meningitis.

Overall, the experience in the Neurology department was that the staff were very friendly and the learning experience very academic in nature. Examination of patients was a lot more rapid and less detailed, than in the UK, but at the same time, no less effective in producing an appropriate management plan. The major limitation came again, in the limited resources. Only one patient on the ward, who looked extremely unwell was on oxygen, and although other services which I wasn't expecting such as an occupational therapist were present on the ward round, other rehabilitation services which are an integral part of care on a neurology ward in the UK i.e. rapid physiotherapy follow up following a stroke, was not made available to the patients. Consequently, the doctors, knowing what should be done, would have to provide the 'next best' affordable and available treatment for the patient, as their hands were tied by the system they work in – their ability to do this was commendable.

In the emergency department the experience was very different. I moved between the resuscitation room and the admitting ER ward. First of all, the emergency room was split down the middle, into seriously ill patients and those who were probably going to move on to another department or be discharged. It was also very busy compared to Neurology. As a result, I had a more active involvement here, as along with more patients, there were less staff members (often only the SHO, the staff nurse and myself were present), admitting and referring patients appropriately. In the ER department my role was varied and largely what I imagine my role will be as an F1 – examining patients and clerking them in, presenting them to my senior and writing up tests for the patient, or discharging them with hospital outpatient referrals or medications, or both. The main difference of course, was that if I wanted a chest x-ray done urgently, I would have to physically take the patient down there myself with the porter and request the test be done sooner, as diplomatically and respectfully as possible.

What did you learn about the people and the country?

The people of Uganda from my experiences in the hospital and in the local area, were that they were very friendly. In terms of healthcare, they seemed quite grateful for the level of care that they were receiving but at the same time, I felt their powerlessness to do anything about it, as did we all as healthcare professionals within the hospital. This was only highlighted by what seemed

to me at the time, to be the general consensus across the country, of discontentment and dissatisfaction with the government and their current acting president, Museveni, the fifth longest serving leader in Africa (having been controversially re-elected repeatedly since 1986). Overall, it seemed the corruption within the government and how it affects the common man was openly disputed in the newspapers, but that the same openness was not exacted by the people on the streets of Kampala (though riots between followers of Museveni and the opposition leader, Kizza Besigye, have arisen in the past in Kampala).

What were the best bits?

One of the highlights for me in the hospital was upon admitting a young 12 year old girl into the ER with a large pericardial effusion. After both my SHO and I examined the patient (she did indeed have distant heart sounds), we discussed the need for an urgent echo and imminent pericardiocentesis. I raised the question of why we shouldn't just take the patient to cardiology ourselves, given that there was no porter but the patient was able to walk. As a result, we took the patient and her mother to cardiology, pleading with the busy cardiologists finishing their ward round to do an echo-guided pericardiocentesis before grand round. They agreed. During the preparation for the procedure, I asked the mother if she understood what was going on. She was under the impression that her daughter had, had a heart attack and was going to be treated for that. Given the mother and daughter both spoke English, I was able to explain to the patient that she had 'water around the heart' and that they needed to use a needle to remove it and to make her better. I tried my best to allay the patient's fears, as she was quite scared and warned her that although the needle was quite big, it was the only way to make her better. Before the procedure, the doctor briefly said a few words to the patient in Swahili which I did not understand, and proceeded to drain the fluid. The procedure was a success with one litre of fluid being drained.

For myself, having never seen a pericardiocentesis, no less a paediatric one, it was a great learning experience. However, more than this, the experience made me really value how I was able to put into practice the kind of communication skills I have honed at my time at medical school, to help the young patient through the procedure. This ranged from explaining what was going to happen during the procedure, to keeping the mother updated, to even just holding the patient's hand in a room full of doctors who were trying to learn the procedure as part of their training, and protect her dignity given the procedure involved the patient being fully exposed from the waist up and thus leaving her feeling more vulnerable.

What were the bits you least enjoyed?

I suppose what I enjoyed the least, was seeing patients not receiving the kind of healthcare they deserve, and seeing families not getting the kind of support they need to best care for members of their family who have to come to the hospital.

Would you recommend it to another student?

I would definitely recommend this hospital placement to another student – especially if they are looking for a placement where they can actually experience general medicine, and what it's like to be a junior doctor without all the resources that we often take for granted.

Would you do anything differently?

In retrospect I would have liked to explore the community setting a bit more, because the

potential for preventative healthcare in the community, seemed to be at the heart of tackling the healthcare issues in Uganda. The reason for this, is that during my hospital placement I visited 'Alive Medical Services' which was a very well run GP clinic which helps some of the poorest people in Uganda, wherever they may live, including those that reside in the local slum, which I also visited. It was very difficult to see the conditions which some very elderly patients and children were living in, in the slum. However, what was really nice to see was that because the clinic had external funding i.e. from the singer Alicia Keys, it was able to provide not only free regular healthcare to all patients with all kinds of medical complaints, but specifically, were able to offer antiretroviral therapy to every HIV positive patient that walked through their doors, as well as actively asking patients in the slum face-to-face, to come visit the clinic (which has an in-house laboratory) to get tested and treated for free. Additional provisions were also made to make the ARV therapy more useful, such as the monthly 'food day,' where patients could collect a bag of grain, rice etc to last the month – based on the premise that good nutrition will promote good health and work synergistically with for example the anti-retroviral drug therapy.

What did you learn about yourself? Has this experience impacted on your future?

Firstly, and most importantly I had a brief glimpse into what kind of doctor I will be, at least when I start out. The experience I feel has shown me that I will go above and beyond for my patient if it means they get the best care possible. It also informed me about my interest to work in Africa as a clinician in the future. Being a relatively good hospital in Uganda – Mulago is supposed to represent the best healthcare East Africa has to offer within the public sector, where I would personally like to remain as a doctor in the future. However, I realised how much having the knowledge and not being able to apply it in the form of management plans for patients, affected me emotionally – it was extremely disheartening and it made me feel that working in such a hospital would actually make me quite unhappy as a physician. If anything, working abroad may be more satisfying in a community setting where things like education and prevention can have a greater impact on the population as a whole rather than treating patients at a later point when they are so ill that the limited resources and the lack of money patient's have to get the required tests and treatment, are not enough to save them. The experience has also made me realise that if I should travel to Africa, in the future (very likely since I have been to East Africa twice in the last 2 years), that I would like to go as an experienced clinician with a real plan, and funding to set something sustainable in motion that can help the communities to manage themselves on the health front, as so many NGOs in Uganda and Africa are working towards already.

Any deviations from risk assessment?

No.

How was accommodation and travel arrangements?

I stayed with family friends in a house, so I cannot comment on hospital accommodation. Travel was straightforward as I lived quite close to the hospital – I walked to and from. For any visits to other placements i.e. clinics, a van was provided for students by the hospital to take you to and from.