RURAL MEDICINE
CHARLOTTE TRAINER

Elective Report

Kenya (AIC Dispensary, Kajiado)

I left the UK immediately after my exams and travelled to Nairobi, Kenya, alone. I approached the city with some trepidation, having heard many things about the dangers and annoyances to be found there. In reality, I found very little hassle and settled in quickly. After a few days, I moved on to Mombasa by the scenic and notoriously unreliable overnight train to meet my housemates. We spent a very enjoyable few days on the beaches (getting burnt) before returning to Nairobi to be picked up for the placement. The company, IVHQ, was incredibly friendly and organised, and in steep contrast to the usual Kenyan way neither disappointed nor tried to extort us.
The placement itself was in a nurse-run Christian clinic in rural Kenya. Many of the patients still lived a traditional Maasai lifestyle and walked several hours to reach the clinic. An appointment cost 100 Shillings, which is equivalent to about £1.20, or roughly 10% of the average monthly salary, and medicines had similar costs attached. Treatments for few conditions, such as TB and HIV, were government-funded and free of charge to the patients, as well as childhood vaccinations. Days started with a prayer, and then any patients in the waiting room would be called to have their vital statistics measured before being seen by a nurse, who would diagnose and treat. Some blood tests were available in the clinic- malaria, typhoid and brucellosis- and patients could be referred to a small nearby hospital, but the nurses largely worked unsupported. The diseases we saw had a very different profile from general practice in the UK- malaria, hookworm and syphilis were high on the list of differentials, although a large number of patients still had coughs and colds or presented for contraceptive advice. One boy we saw frequently for wound dressings had been attacked by a hippopotamus!
The clinic was on the site of a rehabilitation centre for disabled children, and interestingly the head nurse at the clinic had spent much of his childhood there after contracting polio. The children either lived in one of the on-site dorms or came in for short-term physiotherapy classes, which aimed to educate the mothers and rehabilitate the children into the community. One of the major challenges in the setting was that physical or mental developmental delay was seen by the community as a magical curse, leading to denial by the mothers and stigmatisation by others. On the site there was also a workshop (run by Moses 1 (fat Moses) and Moses 2 (thin Moses)), which ingeniously produced calipers, orthopaedic shoes and wheelchairs suitable for the rural terrain from all sorts of old bicycles and chairs and metal tubing.
One weekthe clinic was visited by a team of ophthalmologists. During the week, they held an outdoor eye clinic to assess disease, and then they cleared out the children's recreation room to create a theatre. Incredibly, complex eye surgery was conducted with just an anaesthetist/scrub nurse, the surgeon, and his daughter (and us). The morning after surgery, we reassessed the patients' vision and I was amazed by the improvements.
The highlight of the placement for me was an outreach day. We examined several hundred children for signs of disease and tried to assess their home situation. Many of the children were incredibly shy to be confronted with someone so

obviously foreign, but towards the end of the line the nervousness had turned into curiosity. I learned a little about Maasai medical practice from some of the older children, who explained that some of the unusual scars and markings the children had were made by local healers to drive out illness. The other big impact of Maasai culture was the complete lack of response to pain- as warriors, even the children were expected to bear pain without so much as flinching, and cannulae, IM injections and abdominal examinations were met universally without response.
Outside of the medical placement, I would highly recommend the beaches of Mombasa for sunbathing (although you need a thick skin to fend off the various hawkers) and Nairobi to feel immersed in modern Kenyan life. We had some problems with our host family, who at points seemed to be capitalising economically on the opportunity of having mzungus staying, but on the whole they were very entertaining and made sure we were having a good time (and drinking our chai).

South Africa (Groote Schuur Hospital, Cape Town)

From Nairobi I moved on to Cape Town, where I met some more Barts students. I spent the first week exploring Cape Town and the surrounding area, which was both beautiful and surprisingly un-"African". Cape Point was well worth renting a car to drive to, I climbed Table Mountain four times in total, the quick walk up Lion's Head yielded spectacular views and a weekend drive around the cape to some tiny fishing villages was lovely. A Saturday morning market at the Biscuit Mill and an evening one at Hout Bay for a very enjoyable way to pass the time. I became very attached to Stellenbosch and the surrounding wine-growing areas, which I don't think could be beaten for complete relaxation potential, especially in the sunshine.
The placement itself was everything I had hoped for. I was quickly accepted into the team by my registrar (who was to become an ally against the barrage of very sick people and good friend) and put to work in the medical assessment unit (C15). One day each week, I saw patients as they came in, and clerked, examined, investigated, diagnosed and managed them. When I reached a sticking point, I would present them to my registrar, who would guide me. The rest of the week was concerned with managing the patients I had admitted until they were fit for discharge.
The factor I found hardest to adjust to was the sheer amount of HIV and AIDS in the population we saw. My first patient had a CD4 count of 8, and it just went downhill from there. Despite HIV treatment being available free of cost, it seemed many patients stopped taking the treatment and were lost to follow-up until they presented with a complication of AIDS. However, at first glance medical care seemed remarkably similar to the UK.
The medical students and junior doctors ("interns") had very different working conditions from those in the UK, working long hours so that the team's patients would always be attended by a member of the team (there were three interns). The final year medical students acted independently and as productive members of the team, as "student interns". Communication skills and breaking bad news did not form part of the medical school curriculum and palliative care was a minor issue, despite the advanced stage of many of the patients' illnesses. A

paternalistic style of medicine was still practiced, with the majority of patients accepting of whatever plans the medical team had in place and poorly educated about their own diseases. Presumably because of the living conditions many of these patients came from (GSH is a government hospital), they accepted levels of crowding and intrusion on personal privacy that UK patients would view as an unacceptable breach of their dignity.

I gained great experience (supervised, of course) in procedures beyond the scope of a UK medical student- drains, femoral stabs, and LPs. Overall, the experience was an unforgettable experience, and I hope one day to practice medicine in Cape Town again.