GENERAL MEDICINE

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My 5 weeks at Tintswalo hospital has been insightful, interesting, fun and a brilliant learning opportunity. The experience and opportunities have given me greater confidence and competence in my clinical and diagnostic skills as well as providing an insight into medicine in a resource poor setting and endowing me with a greater appreciation of the NHS and the quality of health care we enjoy in the UK.

The pattern of disease in the local area around Tintswalo was similar to that of most of sub-Saharan Africa. HIV was heavily prevalent in the population with more than one in three patients presenting to hospital having positive HIV serology. Many of the presenting complaints were a result HIV related immunosuppression. TB was also prevalent with many patients having to be admitted for treatment due to poor compliance and access to community clinics. Iron deficiency anaemia was endemic and a haemoglobin level below 8mmol/L was the 'normal'. However diseases often associated with western culture such as heart disease, peripheral vascular disease and diabetes were also common in the community. Due to the heavy presence of cheap foods such as fried chicken obesity is becoming a problem in South Africa which has led to this rise in lifestyle related disease. Conditions relating to poor diet were also common within the emergency department setting with large numbers of general abdominal complaints related to chronic constipation and gastric acid disorders. Within the obstetric department teenage pregnancy and HIV in pregnancy was common. Within gynaecology cervical cancer was the most common condition and loop excision procedures made up most of the case load.

Provision of health care in South Africa is better than that of some if it's surrounding neighbours. Health care is free at the point of access for the poor. In theory it works on a sliding scale and fees are based on level of income. At Tintswalo we did not encounter any patient that was paying fees which appeared to be a combination of the endemic poverty in the catchment area but also a lack of implementation of the income checks. Although access to hospitals and care was free the ability to get to the hospital meant that a proportion of society could not access the care they needed. This was particularly noticeable in emergency situations where lack of ambulances meant that severely unwell patients were often not able to make it to hospital and would die at home of treatable conditions. I encountered one patient who had waited 6 hours for an ambulance whilst in status epilepticus. Her seizures were stopped on arrival to the hospital 7 hrs after onset. This highlights the difference in access to care in this setting. A situation such as this would be very unusual and totally unacceptable in the UK. However, within wealthier communities and within the big cities there are a number of private companies that operate emergency as well as non-emergency care in hospitals of standards we would expect in the UK or US. In this respect health care in South Africa is very varied depending on what you can afford.

The availability of resources at Tintswalo was sporadic. At times stock would be good of certain things such as gloves, urine dip sticks and pregnancy tests. The next week they would have run out of those things and you would have to make do. The availability of standard blood tests and X-rays seemed to be quite good providing you could find the

correct blood bottle and X-ray forms. However maintaining hygiene and safety standards was difficult due to the lack of sinks, hand wash and towels. Disposable and/or sterile gloves were sometimes available. I found this lack of simple, cheap measures of infection control and safety shocking. There appeared to be a culture of 'make do' but it would be interesting to talk to hospital management about why these measures are not implemented given the relative low cost but high importance. A make do attitude was very much needed in theatre where although hygiene standards were high there was a lack of proper equipment often meaning patients were given inferior forms of anaesthetic, if any, and inappropriate equipment used for procedures. One issue that arose for me was the availability of sutures. The surgeon was often having to use an inappropriate needle/suture type which made wound closing more difficult and more prone to complications.

Other issues that contrasted with medical practice in the UK were the recording of patient details and note-taking. Names were often spelt differently or different names used on different forms, dates of birth were rarely compete/known and addresses were vague if any. This meant that identifying parents relied on doctor-patient recognition and continuity of care. On a number of occasion's patients results and folders were mixed up. No harm was done on these particular occasions but the potential risk was extremely high. This lack of accuracy was widespread and not just down to individual doctors. No guidelines appeared to be in place. Confidentiality, privacy and dignity were also areas in which huge differences exist between the UK and this particular hospital in South Africa. There were often two patients sharing a bed both in casualty and in the wards. Clinics were often done with the queue of patients in the consulting room and the lack of curtains meant that procedures were often in public view. Again this appeared to be more a result of lack of guidelines, poor resources and time pressure. Linked in with this was the culture of 'doctor knows best' and the fact that it was not expected that patients would complain or question doctors or nurses. Although this appeared appalling in the context of the NHS and healthcare in the UK the patients always appeared to be grateful that they were receiving any care at all. The doctors would argue that they were making the best out of the resources and time they had. I think it is hard to make judgement on this attitude when we work in an environment where resources for a more patient centred approach are made available.

Overall I had a fantastic time at Tintswalo hospital. Clerking and managing patients in casualty and on the labour ward was a steep but positive learning curve and I quickly became better at assessing patients and making decisions based on the limited resources available. Although standards were variable and certain aspects of the culture within the hospital was distressing, overall, it was a positive experience. Doctors appeared to do the best they could for their patients with what they had available and patients appeared to be very grateful for the care they received. My objectives were definitely met and the elective was beyond my expectations. I would thoroughly recommend this placement to any student.