St Mary's Hospital, London / Tygerberg Hospital, Cape Town

My elective was split between the UK and South Africa, working in Paediatric Infectious Diseases (ID). The Paediatric ID department at St. Mary's is a tertiary care centre, receiving referrals from across the country, as is Tygerberg. However, it is there that the similarities end. St. Marys' is a 'normal' NHS, UK Hospital – wards are clean and organised, numerous nursing staff are a noticeable presence on the ward. When we arrived at Tygerberg, and (eventually) located the ward, we found a dirty ward with numerous beds, minimal nursing staff visible and little equipment to maintain a hygienic working environment. Doctors were walking around with long sleeves, hair down and scarves dangling over the patients. We had to search for hand sanitiser, and most staff members did not make use of it. There were no monitored bays, or any indication that these children were having their observations monitored. Patients at St Marys are representative of the make-up of the UK population, whereas the patient population in Tygerberg consists of only the financially disadvantaged, mainly Black and some Afrikaner members of society. When we had orientation in Tygerberg, we were told where the nearest private hospital is; it was very clear that as Caucasian, Western women, we would never be expected to utilise the hospital services here.

The paediatric department is huge, and spread across 10 floors. Despite its' size, the system is clearly overburdened. However, there are no further services where children can be referred. *This* is the expert hospital. A senior registrar who had spent some time working in London, told us how the neonatal unit is lacking ventilators and equipment, and that many times they are unable to resuscitate premature babies, who would almost certainly survive in the UK system. Soon after, we encountered the backbone of the UK hospital system, the ward round. Firstly we were instructed to arrive at 10am, and when we did, were told that it wasn't going to start until sometime after, although this time could not be specified! The ward round experience was astonishing – not due to the patients' clinical state, but rather due to the absolute lack of organisation or structure. There was no patient list, or order in which to see the patient. No one wrote anything down in notes and there was no plan! Each distraction was embraced and I left feeling that nothing had been achieved.
From an ID perspective, South Africa is unfortunately a place to see a multitude of clinical presentations that are rare in the UK. The St Mary's department is responsible for patients with HIV, TB and other infections. Most of the TB and HIV patients are outpatients, and a few patients are occasionally admitted to hospital with a severe complication of their disease. Furthermore, most of the TB infections are drug susceptible and identified early on in the disease process. When arriving in South Africa, we immediately encountered numerous patients hospitalised with TB, not simple drug susceptible TB, but multidrug resistant (MDR) as well as extensively drug resistant (XDR). There were numerous cases of TB meningitis as well as TB osteitis. These patients are being treated for 12-18 months, on second or third line medication and often as inpatients for the entire duration. The HIV population in South Africa is around 12% according to the UNAIDS report of 2007, with the highest number of infected people in any one country. Although HIV patients may need hospitalisation in the UK, the proportion of patients on the ward who were hospitalised with HIV related conditions was astounding. The children have an extremely high rate of maternal to fetal transmission, with many children not identified as HIV positive until a late stage. The anti-retrovirals available in South Africa are far more limited than those available in the UK, and until recently, patients only began treatment when their CD4 count was below a certain threshold, unlike the UK where treatment is initiated as soon as possible after diagnosis. It was extremely distressing to see this, as their condition is a preventable one – with good antiretroviral treatment, transmission could have been prevented, or the HIV supressed in the case of HIV already transmitted.

We also did visits to a specialist hospital, The Brooklyn Chest. The only way to describe the appearance of the building is like that of an old army barracks, with numerous small buildings. These were draughty with no heating and ventilated by simply opening the windows. Many children were wearing 3-4 jumpers, with doctors often wearing their coats indoors. The doctors were some of the finest I had ever encountered, not only from a knowledge perspective, but also from their patient manner and the obvious devotion for their young patients. I was entirely out of my depth clinically, as I had no idea about some of the drugs that were used. I asked about the adverse effect that prolonged hospitalisation would have on a child's development, and was told that the care they receive, regular meals and intellectual stimulation from the other children and staff is superior to that where they live.

We had the opportunity to visit a healthcare clinic in Mfuleni, a nearby township. This experience was difficult in so many ways. I had never seen poverty like this, with people living in shacks, with no running water or indoor toilet. Animals and flies roamed freely inside the homes, and many patients couldn't afford the fare to the hospital. We were educating an obese woman about a good diet, and she simply stated that she could not afford anything other than bread. We had to teach a boy with numerous cavities how to brush his teeth with a piece of cloth as he couldn't afford a toothbrush.

The experience was informative in so many ways – exposure to new conditions as well as exposure to a different healthcare system.

I left extremely proud of the NHS, and disheartened to find that despite democracy, many inequalities remain within South Africa. There is so much to be done to correct this, much of which is far deeper than simply providing “better healthcare”. I realised that this is a beautiful but complicated country in so many ways. Despite the fall of apartheid, there is still an enormous divide between white and black. Segregation in living areas, although not legally enforced still remains. The white population is centred in Cape Town itself, with the black population on the Cape Flats. Young children beg on the side of the motorway, and there were so many basic need that people in the townships were lacking. When you observe this, there is an immediate and overwhelming desire to help. However, you have to stop and think. Sometimes, handing out money or simply buying an item for someone does not help. This encourages children not to attend school, and it is ultimately education that is going to break the poverty cycle, and provides no sustainable income for the beneficiaries. In the township, I saw abject poverty which was nothing short of devastating. This was emphasised when there were numerous generations living in poverty, as the system has failed them and not equipped them to rise from where they were born.

I felt that in the UK, the difference between socialised and private healthcare is minimal. Although the private hospital may be more aesthetically appealing and waiting times for a routine procedure or appointment shorter, ultimately, it is the same medicine being practiced with the same regulations. I got the sense that this is vastly untrue in South Africa. From what I was told, the private hospitals resemble Western institutions and the State run hospitals are entirely different, with significantly lower standards of care.

I felt that the students and junior doctors in South Africa were often superior in their clinical skills. The amount of information that they were able to glean from a simple chest x-ray was far beyond anything I could have noticed! In the UK, we would simply order a CT if there was a suspicious or unclear area, but these are in limited supply and therefore they have to take more from a plain chest x-ray. However, the inefficiency (which I am told from other students is not limited to the paediatric department) provides such a hindrance to delivery of care.

Despite large amounts of misery and poverty, some of the staff and services are truly inspiring. The healthcare they provide no doubt saves lives, and they are beginning to give people the opportunity to live healthy lives and remedy the inequalities that remain until today. I really feel that the change needs to happen on a deep, societal level. It is not a ‘quick fix’ or simply a case of giving money to disadvantaged people. Ultimately, the current healthcare provisions are better than what was available 30 years ago, and hopefully positive changes will continue to happen.

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