Family Medicine / HIV, Bethesda Hospital / University of KwaZulu-Natal, South Africa

Introduction

The 6 weeks I spent on my elective has been an unforgettable experience, one that has been invaluable to my development – both personally and professionally. I have learnt not just about medicine, but also about the culture and history of South Africa and in particular its Zulu people. On a personal level, I have met some truly remarkable people who selflessly dedicate their time and effort to their local community, an important reminder in modern times of the value of community.

I am grateful to be able to have met my personal aims from a medical perspective for this elective. I have become far more proficient in practical procedures, providing a great platform for a possible career in anaesthetics, which I am considering. Additionally I have seen first hand the multiple effects HIV and TB can have on patients and have learnt the numerous ways in which these patients are managed in a resource-poor setting.

Ultimately, this elective experience has allowed me to become part of an alien – but very much beautiful – culture, to practice their customs and even learn (some of!) their language. Every single person I met made me feel at home and I have no qualms in saying that I have developed some truly meaningful relationships. These few weeks have truly restored the humanity back into Medicine for me and I will apply all that I have learnt throughout my career

The Experience

My elective has been at Bethesda Hospital, which lies atop a mountain of the Lebombo range in Kwazulu-Natal (KZN), the north eastern province of South Africa. This is a district hospital specialising in family medicine, therefore all doctors working here are expected to be comfortable not only with general medicine, but also paediatrics, obstetrics and gynaecology (particularly caesarean sections) and minor surgeries. Indeed, this became even more impressive when on any given day they were only 7 or 8 doctors running the wards (with usually between 100 – 150 inpatients), outpatients department and have someone available for theatre – all of this with minimal resources (ie. the hospital's ultrasound machine has been defective for the last year). As a result there is a real emphasis placed on relying on clinical assessment and judgment – and therefore I feel far more proficient with regards to this after spending time at Bethesda.

During my placement I was allowed to move freely between wards, outpatients, theatre and community clinics. I was also given a lot of responsibility, in particular with practical procedures that would be deemed outside my competence level back in the UK, yet is expected of final year medical students in South Africa. Examples include: neonatal cannulation, lumbar punctures, epidural and spinal anaesthesia, intubations and assisting in caesarean sections, However, at no point did I feel out of my depth as the senior doctors were always more than willing to supervise during the aforementioned procedures.

There are multiple experiences I've faced that have been challenging. Many resulted in positive outcomes, though in some cases the opposite was unfortunately true. On my first day, the first patient I saw on the male medical ward was a 28 year-old gentleman with Stage 4 AIDS, active Pulmonary TB and Sepsis. I had never seen anyone so critically unwell before and the impression it made on me has long since been etched in my mind. The young man was but skin and bones, sweating profusely and totally confused with a CD4 Count of < 20 and a Viral Load in the millions. This patient was one of many whom I would go on to see throughout my time here. Each would follow the typical history of defaulting HIV treatment – commonly due to cultural reasons or community pressures – and go on to develop an AIDS-Defining Infection. Whilst some would go on to survive, many would not. A life filled to the brim with potential, ending so prematurely. The most frustrating aspect of this was that the barrier to treatment was not availability, but cultural attitudes to modern day medicine

Ultimately, the reasons as to why there is up to a 50% prevalence of HIV in areas of KZN is both cultural and educational. Many patients default their HIV treatment for years because as the virus enters its latent phase and they improve clinically, many believe they are cured. Additionally in Zulu culture it is considered a sign of weakness – particularly with men – to go to hospital or take medication. Another complicating factor is that men often have multiple partners (I was fortunate enough to meet all 6 wives of a gentleman during his 2 week stay at the hospital) – inevitably contributing to the spread of the virus. Many do not understand the importance of using barrier methods of contraception until it is too late. There is a real drive by the local government to try to engage with the Sangomas (traditional healers) and promote the value of preventative measures, particularly with HIV and other sexually transmitted disease. A survey in the outpatient department a couple of years ago found that 7 out of 10 patients saw a traditional healer before coming to the hospital. A Sangoma is a highly respected

member within the local community. Obtaining their support is the most critical public health measure to in controlling the HIV epidemic in Kwazulu-Natal. Sadly, this is easier said than done.

Whilst many Sangomas provide good advice to the community and encourage patients to come to hospital, there are some who do more harm than good. During my time on the Paediatrics ward, there were at least 10 cases of children as young as 3 months who had been admitted with severely deranged electrolytes and metabolic abnormalities. In all cases, the child may have had a relatively minor illness (i.e. gastroenteritis or an URTI) which the mother – often from the advice of a Sangoma – believed could be cured with the use of a home-made enema. In many cases these are harmless, but in the children admitted to hospital washing detergent and even bleach had been used. I could sense the frustration and sadness in one of the doctors when the new admission was a child with a history of herbal enema use, just after we had the spent the previous afternoon trying, and sadly failing, to resuscitate the aforementioned 3 month-old infant who presented with a similar history. Another relevant story involves a psychotic patient admitted by the police during my penultimate week. This patient had severely assaulted a distant relative of his and it became apparent that the local Sangoma had a major part to play in this. Mental illness is only starting to be better understood by the rural communities here, with many still referring to psychosis as 'bewitchment', often by someone a person has a grudge against. In this case, the Sangoma had reinforced this patient's psychosis and encouraged the patient to confront the relative who was already partly ostracized by the community and attempt to stop this bewitchment by violence. This was the only case I personally witnessed but I am told this is relatively common in these parts of the country.

Perhaps the most difficult adjustment I had to make was the allocation of time and resources to patients dependent on their prognosis. This is epitomised by a polytrauma case that arrived at the hospital late in the afternoon. It involved two patients – 35 and 63 years old respectively. They would both need transfer by helicopter to a trauma centre approximately one-hour flight away. However there was only enough blood in the hospital to transfuse one patient, a single ventilator in the resus room and equally only a single helicopter available to make the transfer. To me it seemed like such a enormous decision to make to decide which patient to focus resuscitation on, and which to ultimately let die. In the UK, we would likely throw all we could at both patients, but in this part of the world this is simply not possible. In the end the younger patient was stabilised for transfer. The older patient unfortunately passed away. Of course not all days were like this but this situation was a real reminder to me of the disparity in healthcare provision in the developed and developing world.

On a separate note – I was very fortunate in being able to organise a Shabbat dinner for some fellow members of staff (Doctors, Allied Health Professionals and Nurses) during my time at Bethesda. This was really exciting for me, particularly because many of the Zulu staff had no previous experience of Jewish culture and in my opinion Shabbat is the archetypal experience of it: beautiful prayers, being with friends and family and of course food! I was honoured to be able to share such an experience with the Bethesda community. Throughout the night there was a real sense of joy and unity. It was a reminder to me that religions appear so different on a superficial level, but ultimately the core values are undeniably similar. It was a truly magical evening.

Reflection

The experiences I have written about above may seem somewhat negative; in stark contrast to the positivity alluded to in the introduction. Perhaps it is because of our intrinsic negativity bias as humans that they stand out in my memory more so than the more numerous positive stories I had. Ultimately, I have written about them because it was from these experiences that I learnt the most, both medically and about my own, deep-rooted personal beliefs. It is experiences such as these that challenge us as individuals to critically think and reflect on what we value in life and how we can make a positive change for others during our lifetime.

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