ELECTIVE REPORT

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NYANGABGWE REFERRAL HOSPITAL, FRANCISTOWN, BOTSWANA. 19/6/19 – 6/8/19

WHY BOTSWANA

I was clear from the outset that I wanted to see medicine practised in a resource-limited environment, but preferably also an environment where I would be given sufficient support to be able to both make a difference and learn. Add to that my requirements of an English-speaking country and a not-unbearably-hot climate and Botswana seemed an obvious choice.

As a politically stable long-time republic with a significant income from diamond mining, Botswana is often considered an African success story. The healthcare is almost entirely government provided and free, but the country was hit hard by the HIV/AIDS epidemic, leaving an adult HIV prevalence of 22.8% (Avert 2017). It is also an incredibly sparsely populated country, with a population of only 2 million people, spread over a land area more than twice the size of the UK. It was this background that intrigued and drew me to the country.

I travelled with Simon Brackley and we planned to spend 7 weeks at Nyangabgwe Hospital in the Internal Medicine department. Whilst trying to keep an open mind, I had hoped to gain clinical experience of infectious disease, such as TB and malaria and to see some of the social impact and clinical complications of AIDs, such as progressive multifocal leukoencephalopathy (which so far I had only read about in textbooks!). I also hoped that it would be a hands-on experience that would help prepare me for being a junior doctor, with more opportunities to practise practical procedures and be directly involved in patient care.

FIRST IMPRESSIONS

19/6/19 7:30am – Bleary-eyed we arrive by taxi at the large yellow-brick buildings that make up Nyangabgwe. It takes us a while to find the superintendent's office, but all the while doctors and nurses clocking in and out greet us with 'Dumela' as they walk by – Botswana really is a very friendly country! Turns out the superintendent wasn't expecting any elective students, but after offering us some elephants to take home (they apparently have too many), we are shown to the Internal Medicine morning meeting. This is a gathering of all the doctors to run through the statistics from the day before and discuss any complex cases. It's a multicultural group: there are doctors from China, Europe and all across Africa.

After this, we head to the ward for the 'Grand Round', where everyone gathers around one patient and we run through the case logically, with lots of teaching for the students. My first sight of the male medical ward is rather shocking. There are patient beds crammed into the corridor and the middle of bays and there are patients on mattresses on the floor. Some of the patients are clearly moaning in pain and the scanty curtains give only a hint of privacy. This is to be my 'workplace' for the next 7 weeks…

However, my nerves ease a lot once we start discussing the case – it turns out that Medicine doesn't change much, even halfway across the world! The same acronyms, the same scoring systems, the same basic medications…

THE HOSPITAL

Nyangabgwe referral hospital is the 2nd largest hospital in Botswana and serves as the referral centre for most of the north of Botswana. There are 2 medical wards (one male, one female), 2 surgical wards, the paediatric and gynaecology wards and an Intensive Care Unit with 6 beds. Each medical ward has probably 50 proper bed spaces, but whilst we were there, there were days when over 60 patients were accommodated there.

INTERNAL MEDICINE

I spent 5 weeks in total on the medical wards, half on female and half on male. Here, we were basically given the responsibilities of a junior doctor: scribing, making a job list during the ward round, then requesting and ordering bloods, making referrals and doing practical procedures such as ABGs, NG tubes and the occasional ascitic tap or lumbar puncture! At first, it felt like being thrown in the deep end – it was a lot more responsibility than I'd ever had in the UK, but we quickly got into the swing of things.

The differences to the UK quickly became apparent. Although technically most of the essential investigations and medications found in the UK were available here, getting them was a different matter. Less used blood tests (which included thyroid function tests…) were frequently sent to other facilities to be processed, which could take months. The CT scanner broke several times during my time there and the MRI machine apparently had not been working for years, so all patients requiring these investigations that I tended to take for-granted had to sent to 260 miles to Gaborone. In addition, important drugs seemed to often be out of stock. There was no N-acetylcysteine available when a young woman came in with a paracetamol overdose and whilst every patient with a slightly low calcium level received calcium gluconate, when a renal failure patient presented with a potassium level of 8mM, we had run out. These situations were very frustrating. I'd never actually seen a patient die in the UK; here, it was not infrequent. Many of them were young and the cause usually remained unclear.

In terms of infectious diseases, there was probably an >50% prevalence of HIV among inpatients and the complications of this were abundant: PCP, TB, meningitis, young patients with complex AIDS dementia, lots of anaemia. I never did see anyone with PML, but perhaps that's because diagnosis usually requires MRI… In addition, contrary to Occupational Health's advice, this was apparently a very low risk area for malaria!

I did, however, spend some time on the TB ward, which is located in a different part of town. Although they had no negative pressure side rooms, it was interesting to see good old Florence Nightingale principles being put into practice with open windows and hygiene.

Front of Nyangabgwe

TB ward

PRIMARY CARE

Most of healthcare in Botswana is delivered through community clinics. We sat in on one of these and saw a senior nurse essentially doing the work of a GP, prescribing a lot of basic medications.

Donga Clinic

A+E

I also spent one week in the Accident and Emergency department, which is usually staffed by one doctor and a handful of nurses. I clerked my own patients before discussing the management with the doctor. Whilst it is always said that in ED you never quite know what will come through the door, here this was especially true! One patient came in with multiple lacerations over his ear from being hit with a glass bottle by his cousin; I was the only one there to comfort another woman who had just had a miscarriage; another time, there was a 12-year-old girl who had been raped.

FINAL REFLECTION

Overall, no part of me regrets the decision to come to Botswana. I may not have found any malaria cases or enjoyed watching so many of patients die from preventable causes. However, I've certainly gained a lot of clinical experience, seeing more patients who are seriously sick than I ever have before and witnessing some of the most important and vulnerable moments of patients' lives, including my first patient death. In addition, I think I've matured and gained confidence in myself as a clinician – when responsibilities were thrust upon me, to my surprise, I (mostly) found myself able to rise to them. I fought to get my patients the best care that I could in a challenging environment (like going down to radiology everyday to try and request a CT chest for one patient), but when things went well, it was all the more rewarding. One thing is for sure though: when I return, I think I shall be infinitely more appreciative of simple things like normal saline!

For any future students, my advice is that elective is a time to challenge yourself and do something new. Botswana is a fantastic choice that I would thoroughly recommend: the people are all incredibly friendly and the support is there if you need it, but at the same time, you are also taken out of your comfort zone and given the opportunity to really grow as a doctor. In addition, I fit in lots of travelling at the weekends and in the week that followed, including lots of safaris and a visit to Victoria Falls!

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DETAILS FOR FUTURE STUDENTS

An idea of costs:

Application fee	£409
Tuition fees	£700
Flights	£750
Accommodation	£900 – claimable via NHS bursaries
Vaccines + malaria prophylaxis + PEP	£350
Insurance	£30
Transport	£20

+ food + trips

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