ELECTIVE REPORT

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LOCATION

I chose (read: was persuaded into) Botswana because my accompanying colleague and I wanted to see a different healthcare environment and really wanted to do some travelling in Africa. We had also heard that Botswana was one of the safest African countries and that English was one of their secondary languages. Combining all of this with that fact that Botswana has over 130,000 elephants (!!!), gigantic and varied game parks and Vic Falls just next to the border it makes for a fantastic elective destination with potential for a holiday appended on.

MY EXPECTATIONS

Before travelling I was slightly unsure as to what my role would be in the hospital. I expected to be a part of the ward rounds and perhaps performing some basic clinical skills, much like in the UK, but I did not expect to be the one suggesting critical diagnoses and management plans that may otherwise have been completely overlooked by the clinicians. I also expected to see some rare and interesting cases such as complications of advanced HIV which are not seen in the UK – whilst these cases were present it was actually more interesting to see the patients with advanced stages of common problems such as acute kidney injury, sepsis, DKA and more.

MY EXPERIENCE

My time at Nyangabgwe was pretty much a rollercoaster of emotions, from excitement and triumph to frustration and disbelief. More on this later.

A typical day saw us arrive at 7.30am for a morning meeting where they presented statistics (admissions, deaths etc) and then either a short seminar or a "Grand round". The latter involved all the doctors within the medicine department crowding around one of the sickest or most interesting patients and being guided through the case in a logical, systematic manner. I found these very useful in terms of clinical exposure and diagnostic reasoning but I really felt for the patients who didn't know what was going on and were often scared by the audience. We then split off into teams over the male/female wards plus some specialities (Nephrology, Cardiology and a couple more) for the ward rounds. Depending on the team, ward rounds were often quick-paced and with limited explanation to the patient. The protected visiting time at 1pm saw a massive influx of relatives and efflux of doctors and then when the afternoon came it was virtually impossible for me to find a doctor (which was quite concerning at times…).

I discovered (on the second day…) that it was our responsibility to make a list and do most of the jobs from the ward round – whether it be organising scans, taking bloods, siting NG tubes or other basic investigations. At first this felt a bit daunting but we soon rose to the opportunity and this was a fantastic experience in preparing us for our upcoming FY1 jobs! Furthermore, we were allowed to perform skills which we are not given the opportunity to in the UK, such as lumbar punctures and pleural taps.

Unfortunately, some of my most memorable experiences (but probably most useful) were of patients who died. My first witnessed patient death occurred during a ward round. The doctor

suggested that we check the blood sugar on a patient with cirrhosis and upon doing so I discovered that it was reading “LOW”. The patient was drowsy and unable to take oral feeds. The nurse asked me to site an NG tube but I wasn’t confident without pH paper or a chest x-ray (this was my 3rd day) and I asked that a doctor could do it. The nurse tried syringing glucose into the patients mouth but she immediately choked. Without IM glucagon or buccal glucose sachets, we sought to obtain vascular access but after many peripheral cannula attempts (by myself and the doctor) we requested help from ICU to fit a central line. However, during this attempt somebody felt the pulse and the patient was pronounced dead. I was shocked, but I think I was the only one. Everyone else went back to their usual duties as if nothing had happened. I returned to my student colleague who asked how my cannula went and I just shook my head, unable to process what had just happened, “She’s gone” I said.

The visiting hour rapidly approached and I wasn’t sure what would happen next. The patient had been covered in a sheet but was still on the ward. Eventually I was called to the meeting room with my supervising doctor and a nurse and they had found the relatives to break the bad news to. This, in itself, was an experience. The conversation was the exact opposite of our communication skills training with the doctor using “the patient” because he didn’t know her name and then proceeding to talk at the relatives about the intricacies of attempting to place each cannula. Admittedly, there was a strong language barrier since neither the doctor nor relatives knew much English, but it was honestly one of the worst consultations I have seen. Whilst the nurse was talking in Setswanna to the relatives, the doctor interrupted to ask if “we” were done (referring to myself and him) and then we exited the room.

This experience was not a single occurrence. Throughout the 7 weeks, without fail, I had at least one patient per week who passed away of preventable or curable conditions including AKI (on a nephrotoxic drug for most of their admission), bowel obstruction, asphyxiation from aspirated vomit and more. As a medical student, these were very difficult cases to observe and be involved with, but on the flip side also demonstrated the importance of prompt, accurate diagnosis and treatment and also allowed me to see advanced clinical signs (acidotic breathing, uraemic frost etc). Of course, these negative experiences were also accompanied by many success stories. For example, we had a teenage patient with encephalitis who came in with a very low GCS whom we provided supportive management and eventually discharged with a remarkable improvement.

My Final Words

My elective was an experience of a lifetime. I could honestly continue writing about it for at least another 10,000 words and will be telling stories for many years to come. It allowed me to see exactly what type of doctor I want to become, to be able to fight for my own set of patients to get the care they deserve and to develop my clinical knowledge and skills.

I would highly recommend an elective in Botswana if you would like the clinical exposure in a completely different healthcare setting, with the responsibilities of an F1 (within your own limits) and to see some truly interesting cases. The country itself is quite amazing to see, with so many different animals and a government which really cares about their conservation. I also felt very safe walking the streets and found everybody incredibly friendly (literally everyone would say hello: “Dumela”). Their public healthcare system is definitely still developing but they actually have a lot of the basic medications (especially HIV and TB) and investigations.