Madeleine Wells

Elective Report-Kitwe Central Hospital, Zambia

Introduction

I undertook my elective in Kitwe, the second largest city in Zambia, situated in the northern part of the country in the Copplebelt region. I, together with 4 other colleagues organised our placement at Kitwe Central Hospital (KCH), which is an entirely government run hospital, reliant on state funding. I personally spent the majority of the placement in the Casualty department, which dealt primarily with surgical problems and trauma. I also undertook some time in the medical outpatients, surgical wards and labour ward.

The Hospital

KCH as previously mentioned is a government hospital and resultantly has poor resources due to lack of funding. It is staffed mostly be locally trained staff, that is Zambia along with the surrounding countries such as the Democratic Republic of Congo and Zimbabwe. However, in the surgical department especially there were a number of ex-patriot medical staff for a number of countries including Russia, Egypt and China. Kitwe itself has a large Chinese influence due to the mining in the area and there is an on-going programme of Chinese surgeons paid by the Chinese government to work at KCH. There are a number of associated nursing schools in the area, which results in a large number of student nurses in the hospital, as well a many Clinical Officer (much like physician's assistants) Students.

The catchment area of the hospital is large and it is a tertiary referral centre taking on cases from the smaller mining hospitals as well as local clinics. However, despite this it is itself very basic. Throughout our time there the was problems with investigation equipment in that there was no LFT or U&E available. Additionally the X-ray machine as out of use for over a week. There was no more advanced imaging available at anytime, and indeed there is no CT machine outside of Lusaka (the capital of Zambia). The hospital also struggles is a lack of pharmaceuticals. There is commonly no analgesia stronger than diclofenac available, which makes managing post-operative pain extremely challenging. Other medications were also in short supply, for example the hospital ran out of anti-hypertensive and TB treatment in the time we were there. There was also a lack of functioning surgical equipment, for example a diathermy, which resulted in some operations being indefinitely delayed, others being unnecessarily prolonged and risky. Basic items, such as gauze, tape, pen torches, blood bottles and cannulae, were also in short supply, which resulted in the staff being extremely creative at times.

Although many of the staff were really dedicated to their work, we did find that many of the medical staff would leave well before the end of their shift (commonly around 11am!), making initiating any treatment in the afternoon extremely challenging as the were no seniors around at times.

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My duties in the Hospital

Before I left for my elective I planned to spent half my time in the O&G department and the other half in the A&E. However, like all great plans things changed a bit when we arrived. I initially spent time in the medical and surgical outpatients, which due to the lack of primary care, functioned as a combined A&E and GP. The patients were divided into surgical, medical, paediatric and O&G patients when the present to the hospital and sent to the appropriate department in the outpatients department 1. I spent most of my time in the surgical outpatients or casualty room (also known as Room 14, although no other rooms were numbered so this was a bit of a mystery) as this deals primary with trauma patients, which is one of my particular interests. The department is comprised of three rooms the first of which has three desks and chairs to see patients (there is no confidentially here), the second room has a trolley for undertaking procedures or intimate examinations. The third room has three beds and is use for the major trauma patients, although there is little beyond the beds in there or as overspill from the second room. In the department saw patients, often with another colleague, and undertook a history and examination, before ordering appropriate investigations (e.g. X-ray) and coming up with a management plan. There was a junior doctor in the department, which was open 24 hours a day, at all times who was able to assist me in forming and executing management plans when appropriate. There was also a number of seniors on call, including an SHO and a consultant, although at times it was tricky to get hold of them due to a lack of bleeps or similar. In the department as well as having a chance to practice history and examination skills, along with interpretation of results, especially x-rays, and formation of management plans, I also got the opportunity to sharpen a number of practical skills such suturing, giving IM injections, cannulation and venepuncture. The majority of the patients we saw were due to minor trauma, ongoing surgical problems such as hernias, new surgical emergencies (e.g. PR bleeding) or as a result of assault.
Another aspect of the department was major trauma management, which in large part was RTA's. This was the area that perhaps differed the most from the UK. These patients were usually managed at least initially by only very junior doctors and ourselves, with extremely minimal equipment. There was no oxygen available, no spinal immobilisation, no continuous monitoring, no portal imaging, no better analgesia than IM diclofenac. When we were involved with such patients we helped with the initial ABCDE assessment, something that didn't seem to be standard protocol, gained intravenous access and organised for x-rays when required. We also got involved in documentation, which we found quite challenging in the trauma environment.

I also spent time on the surgical wards. Every day we attended the 8am meeting in the surgical department which was a chance for all the surgical team to be kept up-to-date with admission and the ward patients. There are two main surgical wards, Kafue that caters for women and children, and Zambezi which has the male patients. There were also a number of wards that housed surgical patients as outliers, along with the ITU. The surgical team dealt with all surgical problems, including orthopaedics and paediatric surgical cases, so the workload was large and diverse. Following the meeting, I would attend the ward with one of the interns as they conducted their daily ward round of their patients,

assisting in reviewing patients, writing discharge forms, filling in drug cards and generally doing jobs alongside the intern. It was nice to spend time on the ward, especially when following up patients I had admitted via the outpatients department.
Whilst on my elective I also spent some time in theatre, was quite different from some of my previous theatre experience. I saw a number of operations but due to the diathermy not working whilst I was there, the majority of elective complex cases had been postponed.
I also spent some time on labour ward. The ward is midwife lead and definitely the most well organised in the hospital. The note and record keeping here was really far better than that else where in the hospital and resultantly the ward functioned very well. That said, it was not at all a busy ward as most women give birth at home or in local clinics, only attending KCH if problems arise. Therefore although I did not see a huge number of births, I did see some more difficult labours, including a natural breech delivery and a PPH, which I had not had the chance to observe in the UK. In terms of my gynae experience in KCH, I attended then manual vacuum aspiration (MVA) clinic, which deals primarily with incomplete miscarriages. Although abortion is legal in Zambia, many women still are forced into illegal abortions, which are often incomplete and MVA dealt with many of these. This experience was again wildly different from the UK (or indeed Australia where I undertook my O&G placement), in that women were enduring this procedure with only diclofenac as analgesia.

There were a number of cases which really stand out for me from my elective, and I imagine will be ones I remember for some time to come. The first was a 16 year old boy who had been brought in following an RTA. As there are no ambulances in Zambia, his father had brought him via car. On arrival he was minimally responsive and clearly had multiple traumatic injuries, including an obvious head injury. Having gained IV access, we noticed that the patient, who was complaining of neck pain, was unable to move his limbs. Being our first week, we were not sure of the resources we asked for triple blocks or a neck brace, neither of which they had. Eventually we tapped the boy's head to the trolley for him to attend X-ray and be moved to the ward. Later we saw the boy's father on the stairs of the hospital, who thanked us and said he was doing much better, but still couldn't move his limbs. We later visited him on the ward and found that his head was no longer immobilised and he had not received any more fluid, despite little improvement in his condition and had not been reviewed by the surgical team. We spoke to the nursing team about the fluids however were unable to locate the surgical doctor and eventually left for the evening. The following day we returned to ward to find that the patient had died overnight. We were extremely shocked and saddened that such a young boy should have died, and found it hard to except as we felt that he really hadn't received the best care. It was particularly moving to see his father again later that day, and for him to thank us again, which we found incredibly humbling.

Some time after the RTA victim, late on a Friday afternoon/evening, there was a large lorry crash involving predominately women and children, as the lorry had driven into a group on the roadside, in the surrounding area. All the victims were transferred from a local mining hospital to KCH. There were approximately 40

patients who arrived over 1 hour. Due to the timing, there were few doctors around and we really had to get stuck in, assessing acute patients until the senior doctors arrived. The injuries included fractured min-shaft of femurs, severe soft tissue injuries to legs with exposed tendons and multiple head injuries. Additionally there was a large volume of more simple fractures. We were all involved in a number of cases, initially assessing and requesting senior help, a later assisting in managing the patients when the seniors arrived. It was extremely busy work, and quite distressing due to the nature of the injuries, but an incredible experience to be so involved in assessing and help manage such acute trauma patients, something which we have minimal exposure to in the UK. The following Monday when we reviewed the patient who had been admitted for the accident, all of them were recovering well and we felt pleased to have been involved in their care.

Outside the hospital

Kitwe itself is an interesting town. It is obviously an industrial hub, so in terms of things to do outside hospital hours, it doesn't offer a huge amount. There are a number of lodges to have dinner at and you can pay to use their pool. We stayed in a local orphanage whilst in Kitwe which meant our evenings were very busy playing with the kids. This was so enjoyable and I would definitely recommend this to anyone planning on going to Kitwe as it gives you a chance to be involved in the community outside of the hospital. Through the orphanage we visited a local compound an number of times and became involved in the painting of a new women's centre.

We also spent weekends away from Kitwe visiting a safari park 4 hours from Luskaka, Kafue National Park, where we saw amazing wildlife including a leopard! We also journeyed down to Livingstone to Victoria Falls, which words really can't describe.

After our time in Zambia we travelled through Malawi and then got the train across Tanzania, culminating in Zanzibar for the last part of our trip where we met up with other Nottingham Medics and compared experiences which was great and really fun. The travelling after Zambia was amazing, even whilst we were there we started planning all the bits we would do when we come again, that we had to miss out this time!

My reflections on the Elective

Overall Kitwe Central was an interesting experience. I felt that I gained experience in dealing with patients, and enjoyed the amount of patient contact. However, at times I felt the staff's attitudes frustrating. Additionally, the lack of staff available meant there was a limit to the learning opportunities, especially in terms of skills, as there was no one to show us how to undertake new skills. I would also have to say that our supervisor was very rarely around, and one of the days we did see him, he drove us round to his private clinics and country club- not an especially useful learning experience and generally quite inappropriate. That said there were some doctors really keen to teach and get us really involved which meant we never felt too out of our depth. I would say there is a lot you can learn in Kitwe Central on an elective, but I am not sure there will

ever the be the resources to really facilitate it. Having spoken to other people who worked in mission hospitals in Zambia and elsewhere in Africa, I feel that you can gain more from you elective in such hospitals, as there is more supervision available to enhance learning opportunities. Kitwe was however, an awful lot of fun and I will have some really cherished memories from my time there. I would also recommend Funsani Orphanage as a great place to stay and get involved in another aspect of the community.

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If you are considering this elective, feel free to contact me regarding accommodation at the orphanage in Kitwe or any other aspect of the elective.

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