A medical elective at Kilimatinde Hospital

As my imaginative title suggests, I'm a medical student and the following will be a recount and reflection on my time spent at Kilimatinde Hospital, Tanzania.

At the time of writing I am in my fifth and final year of study at Nottingham Medical School. My elective represents my final placement as a student, running from 24th April - 4th June 2019. Finals were sat (and passed!) in late February, foundation job offer has been received and accepted; that bizarre overnight switch to 'Dr' awaits. I will receive no more formal training until I start working this August.

This fact was in part responsible for my decision to seek out what could be perceived as a more challenging elective. In Kilimatinde I saw an opportunity to test my clinical skills and reasoning in a situation where reduced availability of tests and imaging would surely render them more important, not to mention an inability to take a history (in Swahili). Also being a smaller hospital in a poorer region I, albeit tentatively, thought I might actually be able to help more people there than if I had chosen say a more developed country/hospital.

However, I was happy to accept that likely or not whatever preconceptions I had would go out the window on arrival. What I really wanted was a different, likely challenging experience, both medically and more broadly. This much at least I was confident my time in Tanzania would deliver.

I could write much more than I've included here. Multiple case histories, theatre and my relatively brief time on the obsterics side of the hospital I've decided to omit for brevity's sake.

The hospital

Kilimatinde Hospital is located in Kilimatinde, Singida region, Tanzania. If you haven't got google maps handy it's almost plum in the centre of the country. If like me, pre-elective planning at least, you can't say with 100% certainty where Tanzania is in Africa, it's on the East coast adjoining Kenya's southern border. Kilimatinde is 12 hours ~west from Dar es Salaam by bus and certainly a long way from any popular tourist routes of the country.

The hospital is a 'mission hospital.' It is only partly state funded therefore patients have to pay for treatment they receive either directly or by insurance, however there is an ethos of keeping costs only as high as required to provide the service.

It houses a busy out patient department (OPD - like A&E, GP and antenatal care rolled into one), male and female wards, a children's ward, labour/maternity/postnatal wards, 'chigonela' (where expecting mother's from further afield can stay in anticipation of labor), one theatre and a laboratory (where fundamental tests can be ordered - see photo). Physically it comprises multiple single story outbuildings linked by covered paths.

During my stay there were rarely more than 100 inpatients, at least half of which was accounted for by obstetrics. Male/female/paediatric wards were never even half full, which was fortunate. Certainly it was a far cry from the humanitarian crisis, Children in Need featured hospitals which I realised had subconsciously become the worst-case scenario picture in my mind.

A Day in the Life of a Kilimatinde Elective Student

7:55 alarm, roll out of bed into scrubs and flip-flops. Make the three minute walk to the hospital for the '8:00am' (8:10-30 Tanzanian time) meeting. New/ill patients are presented in English, indeed all medical

notes are in English, before Swahili is adopted to further discuss cases and points of issue, some of which is occasionally translated. Generally at this point the Swahili washes over me and my mind turns to chai.

Chai (breakfast) back at the Bungalow. Chapattis, mandazi, maiyai, kahawa…ninapenda chai. I have had 1-3 other students and 1-2 of the doctors staying with me in the bungalow. It made keeping in the loop with hospital ongoings very easy and allowed for fun insights into Tanzanian culture through conversation at dinner etc. 'Bride prices,' 'witchcraft' and 'Traditional names,' being some that come to mind.

The remainder of the morning would then be spent shadowing/accompanying one of the Drs either on the ward round or in the OPD.

Ward round involved seeing every patient in the men's, women's and children's wards. It lasted from 1-4 hours depending upon the number of patients that needed reviewing and which Dr you went with! There were definitely different approaches to medicine on show.

Lunch, the main meal of the day, might be taken anytime from 13:30-16:00 dictated by how busy the hospital was. It generally spelt the end of the day at the hospital for us leaving what left of the day to get to know the village and life in Tanzania better.

Outpatient Department

I really enjoyed time in OPD. It had the feel of general practise; you sat with the Dr in your clinic room and just saw whoever was next in the queue. The majority of attendances could be accounted for by infections, then obstetric/gynae/sexual health. More specifically:

Infections: viral URTI, flu, ?pneumonia (no CXR), malaria, typhiod.
Obs and gynae: STI symptoms, bleeding in pregnancy, reduced fetal movements.

Equally, there were a number of more unique cases. No session in OPD was ever the same.

The fundamental barrier to carrying out an OPD clinic independently was the language. The doctors spoke excellent English but most patients spoke as little English as we did Swahili. This made for an interesting dynamic when sitting in OPD. All the patient history, which we are preached from day one at medical school can give you 90% of diagnoses, is gathered, interpreted and then presented to you by another doctor. History taking was as a rule brief. Extra questions we inevitably had would be asked on our behalf and would often go something like:

(All in Swahili of course)

Me: 'Do we know how long they have had the cough?'

Dr: 'how long have you had the cough?'

Pt: Proceeds to talk for a long period of time in response.

Dr, to us: '2 days'

I often wondered what we'd missed out on.

We built up a really strong relationship with the doctors at the hospital and were consulted for an opinion on patients regularly. This was a refreshing change from the doctor-student relationship back in the UK. You felt, and were, able to have a say in the diagnosis and treatment of patients if necessary, which was very satisfying.

Furthermore the abundance of respiratory patients provided a fantastic learning opportunity to recognise and familiarise myself with the tricky and sometimes subtle differences between say crepitations, crackles or transmitted sounds from the upper airway during auscultation.

However, auscultation aside, I was surprised by the paucity of clinical examination and basic observations undertaken. This went for inpatients too, as I will come to.Patients in OPD who reported a fever had a fever; no temperature would be taken. Patients with ?pneumonia or asthma were not getting oxygen saturations measured despite the availability of pulse oxymeters. Blood pressure hardly ever done. It was hard to justify and a far cry from what I had honestly expected.

Perhaps the lack of clinical evidence gathering can be explained by the adjoined lab. Every patient in OPD would be seen twice - once to decide upon a ?diagnosis and order blood tests and once after the results were back a few hours later.

Antibiotic stewardship is not a concept really bought into at the OPD, which is not to say the Drs are not aware of the issue. It did feel like prescription pads should come with 'Amoxiclav' pre-printed. However the issue is less black and white than back in the UK. For many a journey to the hospital and the cost of medical fees is simply too high to return. In other words, the nice safety net statement 'come back if things get worse' you can rely on in the UK when denying antibiotics is often not so practical here. Nonetheless most colds I saw diagnosed as pneumonia and given amoxiclav could not be forgiven by this logic.

Inpatients and Ward Rounds

Every patient is seen by a doctor daily. During my time only two doctors have covered all the wards. There are no juniors running round doing jobs; there are no 'juniors.' Emergency C-section? Insurance paperwork to complete? Meeting in Manyoni? More often than not there is just the one doctor left to cover the hospital.

The shear workload they had to cope with daily was daunting and the attitude with which they approached it admirable. For the younger of the two, weekends were no different and any given night there was a decent chance of receiving a call for an emergency C-section. It really put into perspective my own concerns for what will be reduced free time when I come to work in August; my hours won't even come close. No Working Time Directive here. The truth is here dangers a fatigued doctor could pose to patients are somewhat less than the alternative; no doctor.

It's a problem that isn't easily solved in a poor hospital in an undesirable, rural location. On top of this, issues regarding staff payment came to a head during my stay resulting in varying degrees of workforce strikes further compounding troubles.

In short, all this inevitably affected the level of care some patients received, which was difficult to witness:

- A man with severe pneumonia who's respiratory rate and temperature have been suspiciously normal since admission. When double checked his supposed temperature of 36 degrees becomes 39.9, RR 22 becomes 44. The obs on the male ward were consistent fiction. They are only done once a day at the hospital and still they were often just invented. However, if you hadn't been paid for between 1-6 months, would you even be at work?

- A lady with oesophageal candidiasis secondary to AIDs who's been in 7 days and, when we ask doctors and nurses, we are reassured is taking her antiretrovirals. A few days later she is having an NG placed as she can't take any food. How has she been taking her tablets then? A different doctor directly asks the family - she hasn't taken any since diagnosis 3 months ago. It took 10 days in hospital for someone to actually ask it seems.

- A young boy with an irregular tachycardia and palpable heart murmur assessed at ~5pm. Lacking an ECG let alone echocardiography (the paediatric blood pressure cuff took 15mins to find) it was decided by the doctors to give the appropriate dose of atenolol to try and settle the heart prior to transfer. Midnight that night the doctor is called to say there is no atenolol. A 7 hour delay, the cause of which you could guess at for just as long.

Undoubtedly lives and suffering are saved at Kilimatinde hospital through a utilitarian approach to medical staff time. This ultimately results in scenarios like the above on a regular basis which was very hard to see, especially when there is no likely solution to the problem coming anytime soon.

'Medical Safari'

The opportunity was available weekly to head out with some of the hospital team to deliver vaccinations and antenatal weighing/growth checks at some of the surrounding villages.
During these visits we were able to take a much more activity role, weighing a seemingly endless stream of variably cheery babies and jabbing the thighs of certainly less cheery compatriots. There was something very satisfying in seeing how coordinated and effectively the outreach team worked together delivering such a vital service and being able to help them do so.

A village I visited, called Chugugu, was only accessible as a day trip via plane. Less than 10 years ago measles outbreaks, amongst other easily preventable diseases, had still been commonplace. Thanks to these outreach clinics that is no longer the case. Due to weather issues the plane was late only allowing 2 hours in the village. However, the number of children we could hope to vaccinate was calculated and the children triaged allowing those in most need to be vaccinated and those less so jotted down to be added to next month.
A shout out should go to our Medical Aviation Frontier pilot who allowed us to stay surely longer than he should have, jeopardising his return journey to Arusha. He quietly understood the risk of leaving any child unvaccinated for a month.

Beyond the Hospital

Whilst the nature of the hospital could at times be stressful and both physically and emotionally draining I found the Tanzanian approach to life to be a near perfect antidote to this. Things tend to happen when they happen; people are rarely governed by the clock. Indeed it's probably fair to say this culture suits down time better than hospital life.

Our bungalow is a little haven. Local grub is served up breakfast, lunch and dinner by our amazing housekeeper Rebecca, a tireless victim of our attempts to expand our Swahili vocabulary. It's set a short walk from the village proper allowing a bit of peace if you just wanted to sit and read.

Having said that, the immediately local kids have learnt our bungalow is generally equipped with stickers, bubbles, balls and SMART PHONES. They're great fun but can be difficult to shake if you just want to write your elective report in the sun…

Twice weekly Swahili lessons at the school have ensured my language efforts in the hospital and village became more common and, even better, understood. Noun classes will forever vex me though.

The school receives teaching assistants from around the world and they asked to hold a Q&A session with some of the older kids. It turned into a unusual mix of textbook biology/chemistry questions and sex education the latter of which it became apparent was not in the school curriculum.

I spent a good deal of time playing football in the village with the local team. I could undoubtedly double the length of my report comparing and contrasting Nottingham's Npower Sunday league football with the frantic, athletic brand on display in Tanzania. Perhaps another time. Tanzanian's are as a rule mad for football and it proved an easy way to get to know people outside the hospital.

During a six week elective I only ventured far from Kilimatinde (to Dodoma) once. I think that says it all about how content I've been spending time here. It is beautiful and peaceful.

Summary

My time at Kilimatinde has proved an invaluable learning experience. I've had the opportunity to practice the core medical skills of examination, clinical reasoning, teamwork and all in a completely different setting.

The emotional challenge of dealing with very sick patients day to day has improved my resilience in this respect. Furthermore I've discovered a more confident side of myself that is able to suggest that oral prednisone is a bit excessive for eczema; that this patients obs need repeating as they are clearly inaccurate. I don't think I'd ever been put in such a position whilst as a student yet I suspect that won't be the case for long once I start working.

I think what I've learnt the most from has been a new perspective from which to look at our healthcare system back home in the UK. It truly is hard to appreciate what you have till it's gone: some basic investigations and equipment, the availability of medication you want to prescribe and above all a full complement of hard working medical colleagues; the whole multidisciplinary team well coordinated by hospital management. Having seen how hard it is for doctor's to work with varying degrees of shortage in the above I'll be even more grateful for the help of my team next year.

Beyond medicine my time at Kilimatinde has passed faster the longer I stay. I'm leaving in four days time and have a couple of weeks to do with as I see fit in this amazing country. Despite this, a large part of me wants to stay. In Kilimatinde I know I've found a place I could return to and be made to feel karibu sana.

Footnote

I arranged my elective by simply getting in touch with the Ktrust having read about Kilimatinde Hospital on the Elective Network. They were very well organised never leaving longer than a week to reply to emails etc.