



Experiences and Observations from a Rural Hospital in Orange Free State, South Africa

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Abstract

During the summer of 2004, I travelled to South Africa to volunteer in Boitumelong Special Needs School. The school is located in the small township of Thaba 'Nchu which is near Bloemfontein in the Free State. It was not long before I introduced myself to the doctors practicing in the local hospital and eagerly asked if I could attend some of the clinics. The health care system in South Africa has a much more developed private sector than the UK. In every major city both a public and private hospital can be found. Typically, only white South Africans have health insurance and comprise the patient population of the private health care institutions. The public hospitals serve the black populace who cannot afford to pay for their medical treatment. Many of the small towns and townships in South Africa are populated by a majority of blacks and so are served by Government funded hospitals. Such hospitals often face staff, equipment and medication shortages and frequently become the primary choices of newly qualified medical students who are keen to spend their first year practicing under a great deal of pressure and in a variety of different medical specialties simultaneously. The doctors I spoke with found that they developed a greater depth and quality of medical knowledge and understanding of tertiary health care than their counterparts who applied to larger public and private hospitals.

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ISSN: 2051-7580 (Online) ISSN: ISSN 0482-3206 (Print)

Res Medica is published by the Royal Medical Society, 5/5 Bristo Square, Edinburgh, EH8 9AL

Res Medica, Volume 268, Issue 1, 2004: 19-20

doi: [10.2218/resmedica.v268i1.1019](https://doi.org/10.2218/resmedica.v268i1.1019)

Experiences and Observations from a Rural Hospital in Orange Free State, South Africa.

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During the summer of 2004, I travelled to South Africa to volunteer in Boitumelong Special Needs School. The school is located in the small township of Thaba 'Nchu which is near Bloemfontein in the Free State. It was not long before I introduced myself to the doctors practicing in the local hospital and eagerly asked if I could attend some of the clinics. The health care system in South Africa has a much more developed private sector than the UK. In every major city both a public and private hospital can be found. Typically, only white South Africans have health insurance and comprise the patient population of the private health care institutions. The public hospitals serve the black populace who cannot afford to pay for their medical treatment. Many of the small towns and townships in South Africa are populated by a majority of blacks and so are served by Government funded hospitals. Such hospitals often face staff, equipment and medication shortages and frequently become the primary choices of newly qualified medical students who are keen to spend their first year practicing under a great deal of pressure and in a variety of different medical specialties simultaneously. The doctors I spoke with found that they developed a greater depth and quality of medical knowledge and understanding of tertiary health care than their counterparts who applied to larger public and private hospitals.

In writing about my observations of health care in Thaba 'Nchu hospital, I hope to elucidate what a medical student can expect to experience and witness should they choose a rural South African public hospital as a location for their elective. The publicly funded hospital was established in the 1940s as a teaching hospital and has approximately 150 beds. During the day the doctors are expected to operate out-patient clinics and attend to patients on the wards. In addition to their daily duties each of the doctors will be designated the duty doctor commencing at 4pm on a different day of the week and be responsible for the health care of the entire patient hospital population and any additional individuals who arrive at the accident and emergency department until the following morning. During this time the doctor can be called to any ward in the hospital and be expected to attend to medical problems that exceed the capabilities of the nursing staff. The doctors would often move from A&E to the maternity ward, to the geriatric ward, to the neonatal ward before returning to A&E to perform a consultation with a new patient. If the doctor on-call requires additional assistance, a second doctor can be summoned from home. The doctor can request that the larger public hospital of Bloemfontein to admit seriously medically compromised patients although this is not to be relied upon. I met several exceptional doctors at Thaba 'Nchu hospital who were very driven to ensure that patients living in these rural surroundings (who could not afford health care) would not receive sub-standard treatment. Each one was always happy to explain a medical condition or treatment to myself or the junior doctors. There was one doctor at the hospital who openly announced to each new member of staff that his business in the town was his occupation and that medicine was simply his hobby!

During the time I spent in the hospital I did observe an embarrassing number of shortages in both medication and equipment. Supplies would arrive infrequently forcing the medical staff to utilize what was available to them in the best way they could. It was not uncommon for the doctors to consult textbooks not because they were unaware of the optimum treatment plan but because they were forced to grapple with alternative solutions due to limitations in the availability of specific medicines. Late one evening, the doctor on duty examined an individual's eye for fragments of glass without the aid of fluorescent dye. The doctor was unable to perform an adequate exam and reluctantly discharged the patient telling

her to return if the pain persisted in the hope that by which time the necessary medical supplies would be delivered. In a separate incident, the doctors decided to make an incision in the infected hand of a man who had sustained a human bite in order to drain the pus. The team was faced by double equipment failure as both the machine used to occlude blood flow to extremities and an automatic sphygmometer were broken. One of the assisting doctors was forced to manually put pressure on the brachial artery. Following a car wreck, a woman had sustained an extensive laceration to her head. I was sent to every department in the hospital in search of appropriate sutures. The doctor irrigated the wound using an i.v. saline drip and proceeded to suture with the largest needle I have ever seen due to the lack of availability of more appropriate supplies. The doctors did find the inadequate logistical management of hospital resources extremely frustrating especially when the patient was very medically compromised, but were adamant that they learned to be more medically ingenious as a consequence.

An article intending to provide an insight into rural South African health care would possess a very narrow focus were it not to mention HIV/AIDS. Until recently the Government would not acknowledge the scientific fact that HIV causes AIDS and prevented either from being written as a cause of patient mortality on death certificates. As a consequence, no reliable data on the prevalence of the infection exists. A group of Accident and Emergency consultants took it upon themselves to conduct a very unethical and statistically dubious survey of the patients that entered their department. The consultants sent blood samples for HIV testing without patient knowledge or consent and argued that this method of collection would yield results that could be applied to the general South African public since they believed A&E admission to be essentially random. They discovered that approximately one in three black people suffered from HIV or AIDS and one in ten whites were infected. Whilst the study is flawed it does provide a general impression that a large proportion of South African patients will have HIV or AIDS. Upon hearing these figures I turned down the offers the doctors extended to me of participating in invasive treatment. Despite this, I very nearly received a needle-stick injury whilst one doctor attempted to sedate a violent patient. Due to a short supply of sharps bins, the doctors have developed the practice of pushing used needles into the hospital beds until they can take it to a room with an appropriate disposal receptacle. It may be wise to consider how likely you are to sustain a needle-stick or other such invasive injury given the level of your medical abilities at the time of taking an elective if you intend to travel to a location where HIV is prevalent. One doctor informed me of the incredibly uncomfortable side-effects of the anti-retroviral treatment he was forced to take after a needle-stick injury and of the prolonged wait before knowing for certain if he had contracted the infection.

At the moment, the majority of the beds in Thaba 'Nchu hospital are occupied by AIDS victims. This is not abnormal for a rural South African hospital and is placing a huge drain on the public health system. It does not require an expert to calculate that the prolonged retention of patients on hospital wards is less cost-effective than administering anti-retrovirals which would enable HIV positive individuals to remain within the community for longer. It will take many years before any anti-retrovirals reach rural hospitals like Thaba 'Nchu and they will no doubt be in inadequate supply. Questions have been raised about the patient congruence to treatment plans given the nature of the side-effects of such medication. Many of the patients who contract TB and who are treated will return time and time again with reactivation. Despite repeated

instructions by the doctors to complete the entire course of drugs, patients cease treatment when they become asymptomatic. Since anti-retrovirals are more efficacious in delaying onset of AIDS when taken early after diagnosis, some believe that anti-retrovirals will not have the desired impact on the health care budget.

Many of those at risk are aware of HIV/AIDS. They witness the death of friends, family, teachers or colleagues but continue to engage in high-risk behaviors. However, perhaps they are confused about mode of transmission, are in denial, suffer from youth immortality or expect to become infected. Unless the Government can develop improved ways of educating the public instead of erecting posters when many South Africans cannot read or stapling through condoms to attach them to medical referral forms, the crisis will continue. Anyone spending time in rural locations in South Africa should prepare themselves to observe the medical treatment of raped girls and even infants because desperation drives the perpetuation of misnomers about HIV/AIDS (such as having sex with a virgin will provide a cure).

I only observed the delivery of health care in one hospital in South Africa. Therefore, medical students cannot necessarily expect to share the same experiences. I am adamant that the quality of care and extent of medical stocks will be found to be greatly advanced in larger city public hospitals and as different again in private health care. The potential hazards of sustaining a needle-stick or other invasive injury with HIV contaminated blood is very real in locations such as South Africa where HIV/AIDS are so rife. Due to the misnomers about the disease and the nature of the culture, students can expect to witness the effects of extreme brutality and cruelty. However, despite the desperate shortages and great responsibility the majority of the doctors found practicing in Thaba 'Nchu to be extremely informative and phenomenally rewarding.

Mr Prince received funding from the RMS Travel & Study Fund which is available to all members of the Royal Medical Society. See www.royalmedical.co.uk for application forms.

