My Student Elective

A centre of excellence in Africa

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Encapsulated in a naivety born of expectations and excitement, I'd given little thought to what my Africa experience would be like. One can talk too freely of "culture shock," but it existed for me in my slow attempts to adapt to my new environment. For the tourist or the professional an arrival in a new country can be smooth and untraumatic, but the student sees the differences more acutely as he is thrown unprotected into strange surroundings meeting new people, habits, sights, sounds, and smells.

Kenya is a country of contrasts. Nairobi stands at a high altitude and is a cool city in August. The people guard themselves against this weather, some in bright polyester cardigans and others in torn and ragged jackets, while the occasional Masai is wrapped warmly in large blankets. This is a modern city: the Kenyatta Conference Centre stands out against a skyline dominated by international hotels. The wide streets are always busy with traffic, and not only are the buses and taxis filled to capacity but each car seems intent on surpassing an overcrowding record. To travel by bus is always an adventure, and the danger of alighting as the bus moves off is ever present. Large cars seem inevitably to sport United Nations number plates. The shops with their expensive imported food among the innumerable Kenyan brands are a poor alternative to the colourful markets with their choice of lush tropical fruits.

In the streets the harsh contrasts between the rich and poor are apparent: on the ground the crippled beg while above them the prosperous walk with their hands over wallets or handbags. Away from the centre the small slums lie beside the affluent suburbs, where each house is well guarded with fences and dogs. At dusk the fear of mugging produces an artificial curfew for the Westerner without a car.

To leave Nairobi is a relief, and outside it the sun always

seems to shine—on the beautiful escarpment of the rift valley on the yellow grass savanna of the game parks, and on the unspoilt beaches of the coastline.

An empty new hospital and a full old one

The Kenyatta Hospital (the University Hospital) lies on a hill almost 3 km from the centre of Nairobi. To the casual observer it is a typical new hospital, but closer observation shows the differences. The new hospital building completed three years ago lies empty awaiting the materials to equip it. As a consequence the patients lie crowded in the old prewar building with rudimentary facilities. Inside are the wards, in which two or three patients share a bed and extra mattresses are provided on the floor. It is pitiful to see the patients lying on their green rubber sheets, resting on filthy pillows, and covered with minimal bed linen despite the cold weather. To watch as the nurses went through the charade of a bed-making round seemed to illustrate how misplaced Western nursing patterns are here. The wards had an unpleasant musty smell, and adequate hygiene was impossible as the few cold taps never carried a supply of soap or towels. The nursing staff were few, and what often seemed a disregard for their patients may be excused by the many demands placed on them. The wards were rarely adequately cleaned, and the domestic with his dirty mop made little impression on the stone floors. While money seemed to be available for the lavish ambitions of modern medicine (a new kidney unit was under construction), the most rudimentary equipment was absent from the wards. The signs at the entrance offered all the specialist departments, but when you arrived at your destination you were not impressed.

This is Nairobi's only free public hospital; all children are treated free, and adult outpatients are not charged but an admission costs just over a pound. This is where most of the population of Nairobi comes for medical care, and in addition complex cases are referred from all over Kenya.

The casualty department receives emergencies of all types and replaces the general practitioner of the British health system. Registrars in paediatrics and gynaecology supplement the normal casualty staff and are available 24 hours a day. Most patients come for a short consultation and inevitably leave with a prescription. To the Kenyans simple reassurance is inadequate as they have an implicit belief in the curative powers of medicines. Maybe this has its origins in tribal ideologies that claim therapeutic powers for the potions of traditional medicine men.

Problems of high fertility

The department of obstetrics and gynaecology is one of the largest in the hospital: each of the three firms has two senior registrars and as many as eight registrars. The explanation for the large staff is the determination to be self-sufficient in post-graduate training, thus removing the necessity to go abroad for a

specialist education. This was a busy department, and the patients in casualty showed the extent of reproductive problems in a highly fertile population. Most patients had similar presenting symptoms: amenorrhoea, sudden lower abdominal pain, and vaginal bleeding. Normally the women sat quietly in blood-stained wrappers and accepted that this was just another abortion. Some were more demonstrative, but their display of pain and collapse failed to alter their position in the line. The medical staff were more attentive, however, to the more acute emergencies—the daily ectopic pregnancies. But they too might have to wait several hours to be seen and then more hours to reach the theatre. There are high rates of pelvic inflammatory diseases in Nairobi, and this explains the high incidence of ectopic pregnancies. If blood was ever required for a patient her relatives would be asked to donate blood to supplement the decreased hospital stocks.

In the gynaecology wards women waited week after week for their operations: cancellations were common, and for some this meant a six-week delay. Those with non-emergency problems presented late: the fibroid was an abdominal mass before it came to the attention of the doctors. Ovarian cancers, always difficult to detect early, were huge and though removed surgically required long-term chemotherapy. Complications of pregnancy were also common, and many patients had postabortal or puerperal sepsis and vesicovaginal fistulas.

In the outpatients department I became aware of the problem most important to the women themselves—infertility. In this society infertility is a real disability: the husband may take another wife, and a single woman with several children is stigmatised. The wait for an outpatient appointment may be two years, and many were discharged immediately because of their age. They would stare back in disbelieving tears and plead with the doctor to reconsider his decision. Many others were admitted for extensive investigations; laparoscopy often preceded other tests to confirm that the cause was infective. The medical staff remained optimistic and often proceeded to operate, although the outcome was rarely successful even in ideal circumstances. The aspirations of the doctors went beyond the capabilities of the facilities, and consequently money and time were sometimes channelled in inappropriate directions. I was interested to see that the possible misdirection of resources was being investigated by the World Health Organisation, which was considering the efficacy of these operations.

Expertise well used

In contrast, in obstetrics the medical manpower is well used and more obviously successful. I was surprised to find that the women of Nairobi had assimilated the idea that the only safe place for childbirth was the hospital. The city was well served by council maternity homes, but the pregnant population regarded these as second rate and so joined the hundreds who attempted to book in each Monday at the Kenyatta. The weekly booking clinic could admit only 50 women, and so only those at greatest risk were considered. The senior registrar stood as judge, and the women had to satisfy certain criteria in order to be booked in: they had to be small and having a first baby; to have had many children; to have had a caesarean section, a stillbirth, or a young baby die; or to have a history of heart disease. The women who were refused were often indignant and would argue their case volubly, usually without success. Those determined to book at the Kenyatta arrived in labour, and for most antenatal care was the way to ensure that they had a hospital delivery.

The Kenyan women accepted the pain associated with childbirth without complaint; they were each given a prophylactic dose of pethidine on admission, but any pain was accepted silently. Each day there was a list of elective caesarean sections to be done, mainly for cephalopelvic disproportion. Beside the labour ward was a room in which patients with pre-eclampsia were nursed. They were under "close" observation, but the nurses regularly failed to keep any fluid balance charts.

The maternity wards were always crowded, with antenatal patients taking priority in obtaining a bed. The many patients with heart disease showed the high incidence of rheumatic fever in the population; for them each pregnancy was life threatening but they refused offers of sterilisation. Despite the high standard of obstetric care neonatal mortality was high. Premature infants were sent to the nursery, where they lay two or three to an incubator. Cross-infection was common, and any gastroenteritis spread rapidly. Despite all these problems the nursery could never be closed down as there was simply nowhere else to care for these children. Meanwhile, in the ward, the mothers of stillborn infants lay quietly in bed, their faces turned to the wall, weeping silently.

Evaluation

In concluding this report I want to give an overall evaluation of my experiences at the Kenyatta Hospital. Despite my initial horror of the physical environment of the hospital I came to appreciate the quality of the medical care being dispensed within these difficult working conditions. I understood that the lack of urgency with which the staff met each emergency was part of the general easy-going attitude of the Kenyan. It was unfortunate, however, that a poor copy of Western bureaucracy had been introduced into this setting; the staunch immobility of the officials placed unnecessary obstacles in the path of smooth management. To give an example, the hospital had had no supply of iron tablets for the last three months; when they eventually arrived in the pharmacy the antenatal clinic was unable to obtain them as the necessary requisition form was also out of stock. Perhaps incidences like this are no more than an irritation, but they combine to produce a hospital that is failing administratively.

The Kenyatta Hospital is a specialist unit and, while it is easy to criticise a misdirection of funds and manpower, perhaps a university hospital is the one health institution in a country where technological medicine is necessary. Kenya is not a poor country, but I feel that a good foundation of preventive and primary care associated with efficient district hospitals is necessary before the Kenyatta is a justified luxury. It is elitist to claim high medical standards as our own. If, however, these centres of excellence exist it is essential that there be improvements in administration and an upgrading of nursing standards. Why should medical expertise fail because of poor standards of hospital care?

I left Kenya feeling I had come to know and like the people of the country, I had learnt that my idealised standards were misplaced in this environment, for the people who use the Kenyatta Hospital praise it, and within the context of their daily lives this was not second-rate care.

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If an individual detained by the police in a cell is found to have tuberculosis what action should be taken?

An individual found to have tuberculosis should be seen by a chest physician, who will supervise his chemotherapy. If necessary this may be done while the patient is detained in prison. If he is already undergoing chemotherapy when admitted to prison this should be continued under the supervision of the local chest physician. Once adequate treatment has been started it is not necessary for greater isolation than already occurs in prison. Disinfection of cells occupied by tuberculous prisoners is no more necessary than disinfection of hospitals wards in the same circumstances. In any such cases the chest physician would arrange appropriate contact tracing in conjunction with the community health services.