International Elective: Reflection

Some experiences in life I would not trade for anything. My recent elective to Uganda was one of those experiences.

My interest in international health was sparked while I was still doing my undergraduate degree. Therefore, when an opportunity for a unique international elective became available to me, I jumped at it!

My elective was two-fold, which is what made it particularly valuable.

My first two weeks were spent in rural mountainous Uganda, more specifically in Kabale, working with Bridge to Health (a group of volunteer physicians, nurses, dentists, and dental hygienists from Canada).

I was working primarily with a paediatrician, another paediatric resident, and my trusty local translator who was a nurse. We were seeing and treating children in mobile clinics, which was a new experience for me! Early every morning, we would travel 1-2 hours to set up our clinic in a different remote village.

Beautiful mountain ranges on the "commute" to work.

Our day would then start with lugging heavy bags full of medications and other medical equipment into our make-shift pharmacy, triage, and the medical tent.

Next on my to-do list was to set up my workstation with all the essentials – personal protective equipment, requisite reference books, and of course – stickers and a

candy station. When I initially started, having a “clinic room” on grass and school benches felt surreal!

This is what my workstation looked like at the mobile clinics. My favourite parts (and the kids’!) were the sticker book and the ‘candy station’.

Very soon however, the volume of patients drove away thoughts of grass and school benches. Numbered tickets were handed out to patients and we would see them all over the course of the day. Most days, we collectively saw hundreds of patients, although the majority of these were adult patients seen by the adult team.

These mobile clinics were “general paediatric” clinics in the truest sense. I saw patients with everything from tinea capitus and viral upper respiratory tract infections to severe failure to thrive with CP, malaria, severe bacterial infections, and night-blindness secondary to hypovitaminosis A (although I was unable to prove this due to lack of laboratory testing).

The most challenging part of my first two weeks in Uganda was perhaps having to evaluate and treat children with very limited ancillary testing. My laboratory tests were limited to doing a Haemoglobin (only for the first two days), rapid malaria testing, rapid HIV testing, and urinalyses. In terms of imaging, I could get an abdominal ultrasound although this was a limited resource as we only had one technician. For the majority of children, this was sufficient. However, some children required further testing and/or in-patient treatment. These patients were then

brought back to the local clinic in Kabale we were collaborating with for further testing and management.

Stickers got quite popular with the kids!

While I was in Kabale, I was initially very surprised at how healthy most of the children I was seeing were! They often presented acutely unwell with a disease process (usually infectious), but I can count on one hand the number of times a patient had a notable past medical history. I soon realized however after speaking to the parents of my patients that this was due to their high child mortality rates. Most children with significant illnesses did not get the treatment they required as they lived so far away from medical help. Emotionally, this was challenging to process, and further fuelled my desire to see and treat as many children as I could, although I was always aware of the fact that the difference I was making was but a drop in the ocean, if even that.

In Kabale, our team also visited a local medicine-man. The population we were serving at the time overwhelmingly subscribed to traditional medicine practices as well as modern medicine. Therefore, it was interesting to hear from the medicine-man (who often collaborated with allopathic practitioners) what the healing process was like. Dressed in animal skins, he painted an impressive figure as he outlined the various ailments he treated, and which ones he referred on to physicians.

The medicine man displaying an item that was to bring lovers together. This had been passed on to him from generations prior.

After two weeks, the next leg of my elective began! I travelled via local transportation to Kampala, the capital of Uganda for my three week elective in Paediatric Endocrinology. I was really excited to be going to Mulago Hospital, the national referral centre.

I had picked this elective as I am to soon start my fellowship in Paediatric Endocrinology. Learning how endocrinology is practiced in a resource limited setting was therefore an extremely valuable experience for me.

Prior to this experience, I thought I knew most of what there was to know about the management of type I diabetes. This misapprehension was shattered within my first day there. Counting carbohydrates and dosing rapid acting insulin is a "first-world" practice, I was told. In the land of "mixtard" and regular insulin, their regimes were completely different. Further, patients were often unable to afford test strips and ketone strips which made good glycemic control and monitoring for DKA much more challenging. Managing type I diabetes in the context of food insecurity was also a new challenge, especially in the absence of rapid acting insulins.

In addition to caring for children with type I diabetes, I saw patients with disorders of sexual development, hypoglycemia secondary to hyperinsulinism, short stature and precocious puberty. In general, I found that patients presented much later in their disease process when compared to Canada. Once again, diagnostic testing was limited – karyotypes are not available (the cost is prohibitive), and so for the first time, I learned of Barr bodies. Ultrasounds are available but the quality of reports can sometimes be questionable. Access to medications can also be challenging, and they often have to work in conjunction with neighbouring countries to be able to procure medications that are scarce there.

I was extremely impressed with the local team I was working with; they worked very hard to treat their patients. Despite the resource limitations, it was remarkable how much they were able to accomplish. I was particularly impressed when I saw a children with diabetic ketoacidosis and resultant cerebral edema walk out of the hospital a week after his presentation despite the fact that we had done only a single set of electrolytes during his stay (the turn-around time is one day) and had no access to blood gases at all! There had also been interruptions in his insulin delivery as on more than one occasion, I saw the drip had stopped and had to alert a nurse.

The above instance (and a number of other clinical encounters) forced me to critically reflect upon whether we over-order diagnostic testing in our clinical setting. I am definitely not advocating for once daily electrolytes in a patient with DKA and cerebral edema! There is however something to be said about being mindful of what tests we order and if there is room to improve in this regard.

On the whole, I would like to think that I have emerged from this experience as a stronger, more holistic medical practitioner. Learning from my counterparts in Uganda, I have a better appreciation for what the illness experience can be like in a resource-limited setting. This is of course important as we live in an increasingly global world. I also have an understanding of the challenges inherent in practicing medicine in such a setting.

Thank you for reading.

It was not all work and no play! Look at me white water rafting here in Jinja (the source of the Nile). The best part? I'm still free of schistosomiasis!