OBSTETRICS

Elective report
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Chris Hani Baragwanath hospital, Soweto, Johannesburg, SA

I spent 5 weeks in Chris Hani Baragwanath hospital in Soweto, Johannesburg. This hospital is the largest hospital in the southern hemisphere. It has over 2900 hospital beds and the grounds cover a whopping 173 acres. It is the sole hospital covering the 3.5 million people of Soweto and is an extremely busy place. I spent my time in obstetrics as that is where I see my career in two years time. Obstetrics was awesome here. The hospital has 300 obstetric beds and delivers over 25,000 babies a year. There is also a perinatal HIV research unit at the hospital and in 1997 the hospital was selected as one of 9 sites worldwide, selected by UNAIDS to conduct research into HIV with the aim of producing a vaccine against the disease.

The hospital is huge and sprawling and maternity covers a vast area to the right as you enter from the main road through Soweto. I spent my time doing the job of an intern in obstetrics, which meant clerking, and examining patients and then assessing where they needed to go next, i.e. whether they were in the early stage of labour and could wait 4 hours to be reviewed again to see whether the labour had progressed, or whether they were over 3 cm dilated and thus in the active stage of labour and should be transferred, if a bed became available, to the labour ward. There was also a third option of High care, which was where the pre-eclamptic or eclamptic women went. This area consisted of 6 beds and was staffed with dedicted nurses. Ward rounds led by the registrar would take place every hour/2 hours and would cover this area alongside labour ward. Labour ward itself had approximately 20 beds and then there were two operating theatres for caesarean sections, one of which was open 24 hours a day, 365 days a year.
I loved every minute of it. It was crazy busy almost all the time and on entering the admissions ward there would be 10-15 women waiting for clerking and assessment. From a learning point of view it's is hard to imagine a better place. My examination skills came on leaps and bounds, from having virtually no practice in examining pregnant women before I undertook this placement, to having the ability to assess the position, length, consistency and dilatation of the cervix with a good degree of accuracy, noting whether there was any moulding or caput on the babies head and assessing whether the membrane were ruptured or not. This sort of experience is sadly lacking during medical school training in the UK and medical students get a raw deal as a result. The medical students at the hospital were leaps and bounds better than any equivalent UK students and the interns there (equivalent of FY1) I would say were equally excellent and far more adept than equivalent FY1's in the UK. They are given more responsibility on their placements and much more is expected of them. As an example, interns in SA have to deliver babies and have to do caesareans. These are fully supervised of course, by a senior registrar, but once the intern can demonstrate that they are comfortable suturing and tying surgical knots then they can commence closing the skin. After a few demonstrations of this they can then progress and end up doing the cutting and closure of the uterus. They were achieving skin to skin times of 35 minutes or so, which is pretty good for an intern straight out of medical school. I also saw a great deal of complications, assisted deliveries, intrauterine deaths, preeclampsia and eclampsia, antepartum haemorrhage and approximately one third of women presenting had HIV. This was a most interesting experience.
I delivered babies, assisted in c/sections, closing the skin often, and almost, almost getting the opportunity to do the cutting myself (the only thing stopping me being long emergency list when the registrar that was mentoring me was on call) and sutured up many episiotomies, although I would let the midwifes suture the lacerations on the inside of the vagina as I felt that I lacked the training to be able to suture this area with confidence, as it is not always easy to see where the tears are due to the constant pooling of blood in the vagina. The actual episiotomy tear though is very straightforward to repair and is repaired with interrupted sutures (with continuous sutures being used on the inside).

Johannesburg itself was interesting. It is a large city and has a reputation for being violent. It is very ethnically divided, with Soweto exclusively black and the northern suburbs being home to the majority of white people. Downtown is the no-go zone and is home to the rough districts of Hillbrow, Joubert Park and Berea. These areas us to be relatively bohemian and trendy in the apartheid days, but folioing the collapse of apartheid, the area changed and is home to the new immigrants from Zimbabwe and Nigeria. I drove around there during the day, wanting to take photos but i have to say felt that it wasn't a good idea to get out and walk around with my camera. Indeed I remember watching a Louis Theroux programme on Johannesburg as part of his 'Law and Disorder' series. He was in Hillbrow on that programme and was talking about the buildings that get jacked there, a consequence of companies vacating these office blocks and abandoning them to flee to the northern suburbs as the crime rate escalated in the area post apartheid. Now the posh companies have their shiny offices to the north in Sandton and Rosebank. The Johannesburg stock exchange (the largest in Africa) similarly relocated to the northern suburbs and that is where the wealth is concentrated in the city. Driving around Sandton you see Ferrari, Lamborghini, Aston martin and Porsche dealerships. The city is very green as well, and this came as something of a surprise to me. In fact it is often known as the urban forest as every street in the northern suburbs is tree-lined, with 100 year old trees. Everyone live behind a security fence though and you constantly see armed security guards driving around their pick-up trucks belonging to the many private security companies that exist today. People pay a good chunk of their income for private security and that seems sad. There is a huge gap disparity between the incomes and wealth of the poor and rich in South Africa. The poor still live in tin shacks in townships like Soweto and Alexandra and walking around Alexandra was a real eye opener. This area is to the north of the city and is not too far from Sandton, on the other side of the M1 expressway. Indeed if you climb the hill near to the township you can see the shiny towers of the self proclaimed Sandton City a few miles away. Perhaps the most widely used measurement of income and wealth inequality is the Gini coefficient. This statistical tool has a number between 0 and 1 and countries are ranked between these two values, with perfect income equality equating to a Gini coefficient of 0, with the higher the value the more unequal the society. South Africa has a Gini coefficient of 0.6, ranking it amongst the most unequal societies on earth. By comparison, the Scandinavian countries have a figure less than 0.3. It is often postulated that this divide is one reason for the crime rates that befall the country. Certainly cities like Mexico City and Rio de Janeiro and Sao Paulo in Brazil also have large problems with criminality and the divides in these cities is vast as well, with poor suburbs nestled in close proximity to richer ones. Social security in South Africa is also almost non existent and unemployment is high meaning that there are many desperate people living there. Despite the stories that you often hear from SA, I found the people to be lovely and found the place most welcoming. Indeed I would love to work there after my FY2 job and am investigating the possibility of this even now. It is an awesome place and the elective comes highly recommended.