

External Rotation Groote Schuur Hospital, Cape Town, South Africa

January-April 2012

Report

Groote Schuur Hospital is a somewhat daunting building sighted to the right as you enter town from the airport. Here Christian Barnard performed the first successful heart transplant in 1967. The department of obstetrics where I spent three months between January and March 2012 monitors approximately 3000 deliveries per year. All women are assessed to be high-risk pregnancies or deliveries. The high-risk care also runs its own 4 bed unit of intensive care. The resident on call expertly calibrates the ventilator and anesthetic infusions.

The hierarchy of leadership, culture and to a great extent medical practice are based on the British model of obstetric care. Hence the tradition, unfamiliar to the Nordic uninitiated, of the grand teaching round. The professor's swooping eyes will suddenly land on you amongst the throng of 20 or so residents, interns, medical students and nurses and wish to be enlightened on the subject of pregnancy-induced hypercoagulability- which coagulation factors increase exactly? Or the immune system perhaps- how is the humoral immune defense altered and what modulations are seen on the placental level? Professor John Anthony is luckily also has an undergraduate in philosophy and can easily be digressed onto the subject of utilitarian ethics. Doesn't hypercoagulability after all have a philosophical component?

The patient amongst all this lays quiet. Sometimes she doesn't speak English but more often so it can be assumed she doesn't understand the terminology flying over her head. All patients are ethnically black or coloured (an instituted third race in South Africa) and too poor to afford private health-care. Having bore the brunt both of the apartheid system, with institutionalized abysmal education for blacks, as well as the present income-disparity driven system of poor education for blacks she is often uneducated and unempowered. She is none the worse however medically. I was struck again and again by the high level of care and expertise.

Early onset preeclampsia is represents the bulk of admitted patients. Most are admitted at diagnosis and remain in hospital until they are delivered at the latest at week 34+0. They laugh a little at me when I suggest a more restrictive policy in asymptomatic patients. Do they all really need magnesium sulphate upon admission? Could we wait to deliver? Their pragmatic argument of course is that neonatal mortality decreases only very marginally after 34 weeks. Also, this is still Africa they add. They mean this partly as a reflection of the demographics of their patient population, but also on some other superstitious, level having to do with the moon and general bad luck. Crazy things happen- eclamptic fits come out of nowhere (as we know they do but rarely see here), a uterus ruptures without any particular underlying risk factor.

This department offers a high level of care. They have highly advanced ultrasound, cardiologists specialized in obstetrics, neonatal care with cooling possibilities. But they still have patients who don't eat three times a day, who often have to wait for a fickle public transport system from the township to the hospital in case of emergency, who are very young, or very old with multiple

pregnancies, who are very often single mothers, who in 30% of cases have HIV. This has led to a pragmatic culture in regards to delivery- expectant management is something that requires a finely attuned sense of, not only of the patient's medical condition, but also her life situation.

Then you have the things you never see at home- a 30 year old woman walking seemingly unperturbed into the cardiology department with a hemoglobin above 200 and a saturation of 77%. She has pulmonary atresia and in essence only one heart ventricle but has managed a previous pregnancy well before. She'll manage this one too she says and walks slowly out the door- it's all in the hands of God.

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