Written report for NFOG funds

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We arrived in Cape Town an early Sunday morning. The temperature was already reaching above 25 degrees. We picked up our tiny rental car and started driving towards town, with Table Mountain ahead of us, as our landmark. We had both been here before, many years earlier, but Table Mountain looked the same. So did the Atlantic Ocean. Ah, this country is beautiful, we said.

Once on the highway, we saw what we knew we would see - townships covering mile after mile along both sides of the road. We saw small children playing on the littered roadsides. We saw shacks made of tin, cardboard and plastic, all with separate electric cables hanging from poles like a spiderweb. We saw fires here and there, and newly washed clothes drying on lines in the exhaust gas. We saw mobile toilettes in long rows. A try from the government of South Africa to make some sanitary approvements in these disadvantaged areas.

The people we saw along the highway this morning where the patients we would meet every day the coming months. They would use their last few Rands to come to the hospital for checkups of their pregnancies and for their deliveries. Some of them had been closely monitored by midwifes at local obstetric units in these neighborhoods, but some had not had a single visit before time of delivery. The panorama of pregnancy complications was broad. Many came in with a perished baby inside.

The hospital we worked at is a tertiary public hospital in the outskirts of Cape Town. For patients with no means, the health care is free of charge. We were placed in the delivery ward, antenatal ward, postnatal ward, obstetric admissions, and operation theatre for both elective and emergency caesarian sections. The number of patients to see in one day was enormous. The way of handling such amounts of patients is to standardize, rather than individualize. This was hard do grasp. We are so used to tailoring treatment regiments for each patient, but now we had to accept suboptimal care to meet as many needs as possible.

In this setting, the junior doctors are allowed to make difficult decision independently. There are not enough consultants to make possible discussions about each and every patient. This is very far from the Swedish reality, where a senior colleague is always consulted in a difficult clinical situation, i.e. premature caesarian sections, severe preeclampsia or eclampsia, late abortions, stillbirths, induction of labor in a high risk pregnancy etc.

I experienced many difficult situations during my clinical rotation, but more importantly, the patients I met experienced very difficult situations in their lives. They have delivered dead babies, they have delivered very premature babies, mothers have died in our ward, patients with severe illnesses have declined care and gone back home due to economy and family. Many patients have experienced multiple stillbirths. Many have HIV, syphilis and diabetes. Despite all this, these wonderful people do seem to be more content with life than I have ever been and have an extraordinary ability to embrace the small joys in their everyday, always. This is what I treasure most from my extraordinary experience.