Emergency medicine in Zimbabwe

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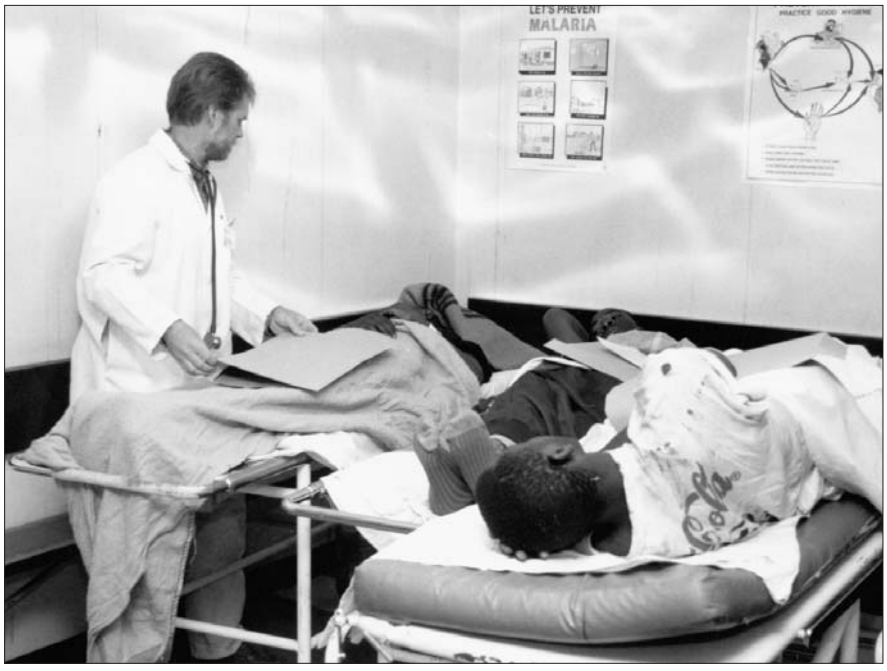
Moving half way around the world and practising emergency medicine in Zimbabwe rejuvenates an old Canadian emergency physician, taking one back to the 1980s. Aminophylline is dripped into asthmatics; skull x-rays are done to make doctors feel better when patients bump their heads, and the agonized wretches of ipecac-induced emesis resonate throughout the department. The only thing missing is a rotating mirrored disco ball on the ceiling.

Emergency medicine does not really exist here. There is no EM training in the medical school and there are no emergency (casualty) department rotations in the undergraduate or mandatory 3-year postgraduate training streams. The casualty doctors are either recent local graduates, physicians putting in time to build up a private practice, or foreign medical graduates (mostly eastern European) who must work in the public system or face deportation. Casualty doctors function primarily as triage officers, identifying the system of primary complaint and referring to the most likely involved specialty. As can be surmised, the professional status of a casualty doctor is not high and a long-term career option to practise emergency medicine is nonexistent.



Elizabeth Norton Photography; norton@bc.sympatico.ca

Posters plead for handwashing; physicians plead for soap. Privacy for the patient is nonexistent.

The Zimbabwe public health care system is in precipitous decline. With inflation topping 60%, once reasonable wages have become subsistence fare and have created shortages of doctors, nurses, pharmacists, technicians and technologists. The top professional salaries in the public health care sector are no longer competitive even with starting clerical salaries in the private sector.

Gross mismanagement and poor maintenance, combined with declining funding levels, have contributed to difficult working conditions. The camera flash obscures the darkness of the place, the result of burnt out fluorescent tubes. The boilers are more often broken than not, so there is never hot water and often no sterilized equipment, clean laundry or hot meals for the patients.

On the walls, public health posters graphically depict the fecal–oral trans-

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Received: Jan. 1, 2000; accepted: Jan. 14, 2000.

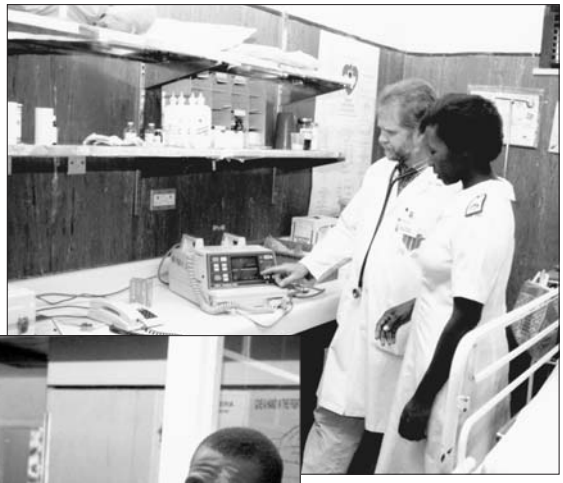
mission of cholera and plead for hand washing. The irony is that soap is rarely available and paper towels or any other means of hand drying (aside from one's white coat) are nonexistent.

The goal of many Zimbabwean doctors is to leave the country. For the vast majority of others, it is private practice. The public health care system has been left to wilt and die, and few seem to care.

The nurses (sisters) do the suturing, but drawing blood or starting an IV is a doctor's job. Suture material ranges from 2-0 to 3-0 silk; hence Zimbabweans display prominent stitch marks. Supplies are variably available, and some days you have the choice of starting your patient's IV with either a 24-gauge or a 16-gauge catheter. Other days it doesn't matter what you choose, because there are no IV fluids available. Attempting to manage unconscious hypoglycemics without D50, seizing patients without a benzodiazepine, and hemothoraces without a chest tube — medical malpractice anywhere else — is part of the daily challenge here. If you can wait 10 or 15 minutes, someone may be able to find an ophthalmoscope or otoscope in a locked cupboard, but mostly no one bothers. Oxygen saturation measures are the stuff of dreams.

This was once a different place. There is a disaster planning committee, even though the telephones rarely work and the pagers don't reach beyond the hospital grounds. An infection control committee glosses over the lack of soap for hand washing, disregards the infestation of cockroaches and rats, and actually concentrates on post-op infection rates. A quality assurance committee advocates the value of audits and clinical–pathological conferences. The absurdity is overwhelming: Being able to wash your hands and to provide patients with simple drugs and intravenous fluids are the real priorities.

Despite a 25%–30% HIV seropositivity rate, no one here has AIDS. Instead, they have "probable ISD" (ImmunoSuppressive Disorder). Yet Kaposi's sarcoma is the most common cancer, florid PCP pneumonia and disseminated TB are rampant, and chronic diarrhea and wasting are everywhere. It seems ISD is worse than AIDS.



Our modern defibrillator was stolen from the maternity ward. Without electrodes, all our patients are "flat-line."

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"Chloramphenicol or penicillin: that's the choice"

The official language is English, but many people are more comfortable with Shona. As a result, my patient histories are frequently obtained via a nurse or physician interpreter. When I ask my intermediary whether the patient has been tested for HIV, I always get a look that says, "Don't make me ask that inappropriate question." When I persist, the answer is invariably "Yes, I have been tested, but no, I don't know the result" — a sort of systematic denial. The patients are more comfortable with the topic of HIV and AIDS than the health care workers are.

For two months last Fall there was a strike by "junior" doctors. These are doctors in their first 3 years of postgraduate training, who show up for work about half the time and actually run the place. Their consultants usually appear much less frequently, but still claim their full-time monthly stipend. The strike was about money, not quality of care.

The strike was resolved, but did not resolve anything. Wages were doubled, but they have already been completely eroded by inflation. Shortages continue. Most recently, vinyl gloves and local anesthetics have been out of stock. Expensive sterile surgical gloves temporarily replace the disposables, and simple procedures are now performed without any freezing, using only "bruteaine" or referred for general anesthesia.

Soon we will meet our patients outside under the trees and move to more traditional African methods of diagnosis and care. We will search for patterns in the bones shaken from small wooden bowls and seek the guidance and wisdom of the ancestors.

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https://doi.org/10.1017/S1481803500004991 Published online by Cambridge University Press