Fixed and dilated: A medical student's elective in a developing country

For medical students interested in global health, the overseas elective represents the first opportunity to volunteer as a health professional in a developing country. In many cases, as was mine, preconceived ideas and expectations are attached to the elective. I anticipated a rewarding transition from the vigilant student to responsible doctor, the first opportunity to be of practical value outside the comfort of a sugar-coated clinical school, to gain first hand experience of 'resource limited' settings, and, to see the world through a different set of eyes. How misplaced my expectations were: the most intense eyes I would see were those fixed and dilated.

Long interested in Timor Leste's history and health disparity despite proximity to Australia, I set about arranging a placement at the Hospital Nacional Guido Valaderes (HNGV), the country's only tertiary referral hospital. This proved challenging, as I later found out the HNGV had never hosted an independent Australian medical elective. Set in the back end of Dili, the hospital is comprised of a network of large inpatient wards, surgical, obstetric, paediatric, emergency and outpatient departments and various NGOs. Each ward is connected by a series of open air corridors and gardens, the flow of air essential to cool the otherwise hot and humid wards. Male and female wards are separated, with the Catholic influence clearly dotted along each corridor in the form of prayers and offerings.

As the hospital staff are largely Timorese, professional and patient conversations occur mostly in Tetun language. Local doctors typically spend six years in Cuba learning medicine in Spanish before returning to working in isolation in the districts and eventually, progress to the tertiary hospital. The remaining doctors are a mish-mash of those undertaking military service from Cuba, Nepalese mission doctors, Indonesian and Chinese-trained doctors and Australian volunteers. An an English speaker with basic Tetun and Spanish, conversing in and documenting management plans across several languages often felt like a medical circus act. This may be one of the only hospitals in the world where one can read the admission note in Spanish, ward round in Tetun, obtain a radiology report in English, and refer to a Cardiologist in Chinese.

The first half of my placement was on the female internal medicine ward. This involved ward work, outpatient clinics, assisting in theatre and with echocardiograms. Ward rounds took the team on a journey of long inpatients stays, many living with chronic infections we don't commonly see in Australia, such as tuberculosis, hepatitis B, sepsis and helminth infections. Communicable disease was often superimposed on a background of malnourishment, anaemia, heart disease, diabetes, and autoimmune complications. Others lay quietly, with inoperable cancers, waiting to die. On my clock, for every two women discharged, one would not leave. Often spending their final hours with a family bedside vigil, surrounded by other patients in a suffocating hot and crowded room. I was at first shocked, and then humbled at the grace and strength of these patients and their families in the face of death. However, I continued to struggle with accepting death as an outcome for otherwise preventable and treatable disease.

The remainder of my placement was in the emergency department. Patients would arrive by ambulance from around Dili or by community transport after long trips from the districts. Many obstetric, paediatric and trauma cases arrived in critical condition. Social determinants of health never spoke to me so loudly, where poverty, logistical and language barriers, late presentations, lack of education and lack of resources were the norm, not the exception. On arrival, we as providers of care often faced a lack of resources to offer timely diagnosis and appropriate management. ED was a place where there is no CT scanner, and at times no water to swallow medication. Antibiotics and analgesia are often out of stock, and laboratory testing is limited to waiting hours for a full blood examination and basic biochemistry. Without the usual toolkit of 'modern medicine' are trained to rely on as junior doctors, I was often confronted with the choice of working outside my comfort zone or leaving patients untreated. Again, the faces of morbidity and mortality loomed heavy.

One huge positive from the experience was the willingness of Timorese doctors to initiate discussion aimed at improving delivery of health services. I participated in collaborative education sessions on resuscitation, rheumatic heart disease, and emergency treatment of acute coronary syndrome. Despite their everyday challenges, I found local staff to be warm, optimistic and approachable. Their curiosity to draw

comparisons and learn from our health care system gave me impression there is a distinct fighting spirit and hope that defines the next generation of Timorese doctors.

Upon my return to Australia, I am reminded of how fortunate most Australian's are to access quality health care. I am taking time to reflect deeply on my experiences; how it felt to sit at the edge of my own limitations; how it felt to loose my first patient, how the health status of one of Australia's closest neighbours can be so vastly different from our own. These are not the questions I expected to emerge from my elective, but I am grateful for this experience and the opportunity to grow as a junior doctor, and as a fellow human. And to better prepare me for looking such future challenges in the eye.