
# Pre-Physician Assistant Internship Program

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# Learning Medicine in a Resource-Limited Setting: My Internship at Coast General Teaching and Referral Hospital

Not knowing what to expect, I walked into the surgical ICU on my first day at Coast General Hospital. I had never shadowed in a hospital in the United States, much less in a different country. To say I was nervous would be an understatement. Within ten minutes of observing the patients and following the medical officer on duty, we saw our first code blue. There was no immediate movement from anyone except a single doctor who rushed over to assess the patient, start CPR, and call for a crash cart. The difference between seeing CPR being performed on a person as opposed to a practice dummy was an extreme shift that caught me off guard. Once the crash cart was brought over and many nurses crowded around the patient, they discovered that the crash cart had barely any supplies in it. The nurses began to scramble as the doctor was shouting in frustration, "Is there any sense of urgency here?" Though I had never seen a code blue in real life, I knew that it was an emergency and I was shocked by how slowly everyone was moving. After a couple minutes, the doctor tried to intubate the patient through the sea of blood that was gushing out of the patient's mouth. Eventually, she pulled what I assumed to be a large blood clot out of the patient's mouth. At that moment I knew this shadowing experience was going to be much different than I expected. She successfully resuscitated the patient, who remained stable. Everyone resumed their normal activities, and the silence that followed left me in shock as I tried to comprehend what I had just witnessed while also trying to prepare for what I can only imagine was yet to come.

Going into this internship, I knew that the operations of the hospital including the doctors, nurses, and medical cases I was going to see would be different. However, I did not expect the extent to which the economic status of the patients and doctors would affect the care received. After talking to various doctors and nurses, I learned that most of them work both at public and private hospitals in the area. Those that only worked at public hospitals did not make as much as one would expect, about $12,738 USD a year for entry level doctors and about $13,846 USD for mid-level doctors (Mutuku 2022). By working at two different hospitals, the nurses and doctors had burnout set in faster than usual, which sometimes resulted in a snappy tone with patients and high levels of irritability.

One thing I noticed while shadowing was the lack of interaction between medical staff and patients, most likely another side effect of their burnout. It was rare for a provider to go to the patient, explain their diagnosis and then proceed to inform them of the treatment plan. This directly relates to the gap in health literacy across all aspects of healthcare in Kenya. As this article states, "Health literacy is now the bedrock of an individual's ability to access health care and achieve an improved level of health and

wellness." (Gatimu 2018). Some of the largest areas of low health literacy rates are in women's health, those living with HIV/AIDS, and mental health of both men and women.

When women have low health literacy rates, it affects the entire family as most women serve as the main medical decision makers and typically are the ones to seek health information for the entire family. Mothers being the head of the family in terms of medical affairs is a commonality between the United States and Kenya. Having a low health literacy rate impacts multiple areas of an individual's ability to navigate the medical world such as; explaining their medical history, navigating the healthcare system, following directions such as frequency of medications, and/or making certain lifestyle changes (Gatimu 2018). Consequently, the absence of conversation and explanation between medical professionals and patients gives way to a sense of medical illiteracy felt by the patients. This can lead to increased emergency room visits because they wait longer to visit the hospital. As for the women's effect on their children, there might be instances where a doctor attempts to explain that babies must be breastfed for a certain amount of time, yet the mother may not understand the reasoning and ultimately give the baby solid foods before it is ready, which could be incredibly harmful to the baby.

All of this being said, being given the chance to actually go out into the community and help teach young girls about reproductive and menstrual health was amazing. Participating and leading the menstrual hygiene clinics was one of the most engaging and eye-opening experiences during my internship. When talking to the girls, it was apparent yet again that their knowledge of reproductive health was not where it should be at that age. The biggest barriers to reproductive education amongst young people, both male and female, are lack of comfort from their medical providers as well as cultural/religious views and perspectives (Diamond-Smith et. al 2020). Their misinformation was portrayed to us in multiple ways such as asking if a woman can still get pregnant if they had sex in the water. Although it was entertaining and fulfilling to be able to answer the questions that the girls had, there were some unexpected questions that came up. At my first menstrual hygiene clinic, one of the girls asked me personally about possible infection following a female genetalia mutilation (referred to as FGM) procedure. I was shocked that she had brought that up because at the time I had only ever heard of the procedure online, unaware that it happened in the area of Kenya that we were. The encounter helped me to realize how important it is to spread correct personal hygiene information, all the meanwhile being sensitive to cultural differences.

Before visiting Coast General, I was not aware of the prevalence of HIV in Kenya, nor how it affected the country as a whole. Though I learned that Kenya is one of the "high burden" HIV countries in Africa, it was still surprising that around 1.5 million people were infected and living with HIV at the end of 2015 (IMA 2024). It was more shocking that HIV/AIDS in Kenya accounts for more than 20%

of the maternal mortality rate, 29% of annual adult deaths, as well as 15% of deaths of children less than five (IMA 2024). Two of the main reasons for the very high transmission rates of HIV are lack of education regarding safe sex and the absence of prenatal care, with HIV prevalence among women in Mombasa, Kenya being 6.1% higher than among men (IMA 2024). Part of the reason that women are more vulnerable to HIV infections is because of the submissiveness that is encouraged by aspects of Kenyan culture (Siringi 2010). Examples of this culturally ingrained submissiveness amongst women are seen in practices like FGM, child marriages, and wife inheritance (Bhattar 2024). HIV infections are being controlled, however, by targeting HIV counseling and testing, as well as offering voluntary medical circumcisions for males (USAid 2020). For young females, HIV is being addressed by discussing HIV risk behaviors, transmission, and gender-based violence (USAid 2020).

During a conversation I had with one of my fellow interns who worked in the psychology department at Coast General, we talked about the differences in coping mechanisms between Kenya, the United States, and Australia. In both Australia and the U.S., people who suffer from mental health disorders have a slew of resources at their disposal including but not limited to; multiple variations of therapy, mental health facilities, and hotlines to call. The challenges that Kenyan people face are not as common in more developed countries, which makes it hard for the psychologists to give feedback on certain situations, if they are even reached out to. Despite these difficulties that are frequently rooted in culture, the strategies that Kenyans are given to cope with their stressors are limited. Approaches to managing mental health struggles that might seem obvious or juvenile to those living in more developed countries, like journaling, are not widespread practices in Kenya. Their minimal knowledge in regards to signs of mental health disorders, seeking professional help, and coping are all due to three main issues; access to treatment, cost, and socio-cultural stigmas such as witchcraft or crying as a sign of weakness for men.

Unfortunately, I witnessed the lack of mental health resources and importance firsthand while shadowing in the Newborn Unit (NBU). There were a lot of common cases amongst the babies in the high dependency unit (HDU) including; asphyxia, meconium aspiration, and meningitis. On our second day there, there was a baby with anencephaly in the HDU. Seeing this baby immediately pulled at my heartstrings, both for the baby and the mother. The condition of the baby was not good, and it was apparent there was no saving this infant. Even though it was difficult to watch this baby suffer, this case served as a prime example of the importance of prenatal care. In parts of Kenya, 77% of women have their first antenatal care visit (ANC) after 20 weeks of gestation, which is around 5 months of pregnancy (Diamond-Smith et. al 2020). Anencephaly occurs between days 23 and 26 of gestation (Tafuri 2023), long before a pregnant Kenyan woman would have even thought of being seen by a doctor. Sadly, this baby passed away the next day. When the mother came up to visit her baby for the first time that morning and entered the HDU to find that the baby was gone, she was understandably

confused. I prepared myself to watch as the doctor told her the unfortunate news, but I was surprised when they just told her to go back to the maternity ward and that the doctor would talk to her later. My shift was over shortly after that, so I do not know when the mother was told about her baby, but I mentioned it to some of the psychology interns at the end of the week and they said they had never seen her. The effects that losing a child has on anyone is incredibly difficult, so I can only imagine what she was thinking and feeling in the moments following the delivery of the sad news. This is the sad reality of working in a system that simply does not have the funding to provide resources that are considered customary to most United States citizens.

From my time in Kenya, I learned so many valuable things, all of which apply to my professional and personal lives, ultimately improving the lives of the patients I will treat in the future. My biggest takeaways from shadowing at CGTRH are being able to understand and respect cultural differences in healthcare, learning the importance of teamwork in a professional setting, and realizing the benefits of speaking more than one language. As I discussed throughout this paper, there were many apparent cultural differences in every aspect of healthcare in Kenya compared to the United States, many of which I had never encountered before. Exposure to these differences in treatment and patient interactions as a result of socio-cultural beliefs helped to guide me on how I will treat and connect with all my future patients. I was able to watch how the staff within multiple departments collaborated, or struggled when they didn't. It made me realize that helping a patient is always a group effort and their life depends on the teamwork of the professionals around them. Lastly, the language barrier came as a challenge sometimes, but not because I was frustrated that they didn't speak English. At times, I felt inferior to those around me because I only speak English and conversational Spanish, whereas most Kenyans speak three languages and sometimes more. Being able to talk to a patient in their native language not only increases the efficiency of the exchange, but also makes them more comfortable. That being said, it was a great push to learn more Spanish and become fluent.

Also, I came to a couple of conclusions regarding my professional track. I have always loved children, so when I began to think about possible career paths for Physician Assistant's, pediatrics was my top choice. When I was in my accidents and emergency rotation, I was able to shadow in the pediatric A&E ward as well. My perspective on treating children changed in those two days I was there and I realized that working with children would be a lot more difficult than I expected. Seeing the pain and betrayal in their faces as their parents held them down while the nurse inserted a line or removed stitches from their finger was incredibly hard to watch. Additionally, I saw my first patient, a four month old girl, pass away in pediatric A&E and the grief that the mother felt made the air thick and hard to swallow as I stood there and shed some tears for both of them. That being said, it was clear to me that pediatrics was not where I was meant to be and instead I will be pursuing women's health, particularly obstetrics so I can work with mothers and their babies. Overall, I am incredibly grateful to

have had the opportunity to further my medical career and shadow health care professionals in Kenya. The experiences I had, things I learned, and people I met will forever be in my thoughts as I work my way through school and eventually practice medicine.

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