I undertook my elective at the Oxford University Clinical Research Unit (OUCRU) based at the Hospital for Tropical Diseases in Ho Chi Minh City (HCMC), hoping to see the presentation, diagnosis and management of a range of infectious diseases I would not be exposed to in the UK. The hospital is a tertiary referral centre for the south of Vietnam, and therefore serves a theoretical population of tens of millions. In addition to the clinical experience, I wanted an opportunity to talk to academic clinicians working internationally about doing research abroad and how they had developed their careers. The majority of my elective was spent in the paediatric ICU and adult neurological infection ward, though I also saw patients in adult intensive care, the HIV ward and the infectious disease ward of Cho Ray Hospital.

On the paediatric ICU I saw the management of children with severe respiratory and diarrhoeal infections, alongside a number of conditions that are vanishingly rare in UK hospitals such as dengue and tetanus. The paediatric ICU was well equipped to care for these patients and the doctors had a huge amount of expertise in these diseases. Nevertheless the ward had challenges not seen in the UK, for example a lack of nurses and anaesthetists meant children were restrained, parents had to be consulted to see if they could afford medication before it was used, and other specialities such as oncology, haematology and indeed paediatrics were based at other hospitals scattered across the city. The financial difference with the UK was best demonstrated by parents taking their children home to die, once a bad outcome was likely, in order to avoid the costs of a hospital death. It was also very uncomfortable watching restrained children receive LPs without sedation or local anaesthetic.

Whilst I was at the hospital there was an outbreak of diphtheria in an ethnic minority community, which included at least 26 cases and a number of deaths. The most memorable experience of my elective was the ward round where a child with a tonsillar pseudomembrane, initially in a bed on the main ward under an AC unit, mentioned that other members of his family had a similar problem, along with a neighbour who had died. At roughly the same moment the doctors looking at his ECG commented on his complete heart block (a serious complication of the diphtheria toxin), and instantly masks went on, the patient was moved to a side room, and phone calls were made to start investigating the other cases. Over the last 15 years diphtheria cases in the hospital had reduced from over a hundred a year to none last year. As a result, though the more senior doctors were familiar with treating the disease, the younger doctors – like myself – had never seen a case before. Moreover, whilst the expertise to treat the disease was readily available in the hospital, there was no anti-toxin in the country. If this case was not already memorable enough, the patient then chewed through his pacemaker wires and pulled out all his IV lines so he could take a shower; somehow his next ECG showed a sinus ryhthm.

On the adult neurological infections unit I saw many cases of TB and cryptococcal meningitis, and encephalitis due to a variety of infections, including herpes simplex and Japanese encephalitis, including trial follow up patients. I was able to practice LPs (under close supervision) on this patient group.

In addition to my experiences on the paediatric ICU and adult neurological infection ward, I attended a number of academic talks at OUCRU, was able to speak to several researchers about their ongoing work, and perhaps most valuably, talk to academic infectious disease clinicians at various stages of their careers about how they had got into the field. I gained a lot of clinical knowledge during my elective and had a fantastic time living in HCMC and travelling the length of a beautiful and varied country with a fascinating history.