ELECTIVE (SSC5b) REPORT (1200 words)

A report that addresses the above four objectives should be written below. Your Elective supervisor will assess this.

Situated in the lesser Antilles of the Caribbean Sea, Barbados is an island home to approximately 286,986 people. The island is divided in 11 Parishes; the capital city Bridgetown, is situated in the Parish of St Micheal in the southwest of the island. The population is composed of mainly of Afro-Barbadians, with White, mixed and indian population, as well as other ethnic groups. The populations of Barbadians is small compared to that of the United Kingdom at 65.64 million people. The Island is served by the government owned 600-bed Queen Elizabeth Hospital, as well as polyclinics, and other specialised facilities. The other hospital on the island is the privately owned Bayview hospital hospital.

The fertility rate in Barbados is 1.8, which is similar to the 1.81 in the UK; due to the considerable difference in population there are more babies born in the United Kingdom than in Barbados at only 9 births per day. Obstetric care is provided at both the government owned and the private hospital. Several Doctors in both Public and private sectors trained in the UK, and consequently much of their practice is British in nature. In the UK, the NICE guidelines for uncomplicated pregnancies are a standard for antenatal care. There are specific recommendations for complicated pregnancies, such as in gestational diabetes, venous thromboembolism and hypertension.

High risk pregnancies can be defined as pregnancies complicated by lifestyle, pre-existing medical conditions, pregnancy related conditions or a patient history of difficult or complicated pregnancy. These factors increase maternal, as well as Foetal, morbidity and mortality. The early detection and management of this high-risk group of maternity patients significantly reduces risk of complications. In Barbados, the care pathway provided by the national health system is like that of the UK, there are some differences however. For example, the anomaly scans for down's syndrome and trisomy 18 are not provided on their national health systems. Other checks are available with standards blood pressure, and urine checks at antenatal appointment.

It is recommended that high-risk pregnancies are managed by a maternity team which would include an obstetrician and other specialists. Antenatal visits would be more frequent with the usual basic checks of BP, urine and specific care for the complicating condition. This pathway is followed in the U.K. with provision of high risk antenatal clinics in centres across the country. In Barbados, there isn't a set pathway for high risk pregnancies, and neither is there a maternity team to provide the service. Patients are given more appointments to see the obstetrician and can call into the service if there are further problems. There are also differences between the antenatal pathway in the U.K. and Barbados. The combined test and anomaly scans are not provided on the national service; these are available via the private sector if there is a reasonable suspicion.

In the U.K., the RCOG maternity framework outlines measurable standards to monitor and regulate the service. These standards include but are not limited to; a variety of routes for a woman to access antenatal care, provision of antenatal clinics, the patient having a named midwife, a clear plan for

antenatal, intrapartum and postpartum care, and a clear referral system for women with complicated pregnancies. In Barbados, patients contact the hospital, relevant advice is given, and a care plan is discussed. The patients do not however have a named midwife; they are assigned the first available midwife when they present in labour. Women with complicated pregnancies are seen more often in the antenatal clinics by an obstetrician.

According to the WHO recommendations on antenatal care for a positive pregnancy experience, the following should be taken into consideration; nutritional interventions, maternal and fetal assessment, preventative measures, interventions for common physiological syjmptoms, and health systems interventions to improve the utilization and quality of antenatal care. Each section is subdivided into recommendations which aim to decrease mortality and morbidity. For example recommenations are made for iron, zinc and calcium intake under nutritional guidelines, whilst recommedations for asymptomatic bacturia, and intimate partner violence are coverd in the maternal and foetal assessment section. The document lists the known, common challenges during pregnancy which can benefit from monitoring and intervention. Many of thse conditons are easily treated yet can have a massive imact on mortality and morbidity.The documeny also highlights the importance of skilled staff, easy access to services, patient information and community based care provisions. This is a must read to potential and actual trainees as it spans the length, and breadth of obstetric care and highlight areas for research, and quality improvement.

During my time in Barbados I aimed to use the experience as an opportunity to transition into the role of an FY1 doctor. I managed the entire clinical experience of the patient from the history, examination, and recommendations for management under the supervisation of my senoir. I settled into the new environment by enquiring about the general population and the ususal conditions that were prevalent in the society, using the occasion to brush up on my clinical knowledge. I actively took on the role of advocate for my patients by enquiring about their ideas, concerns and expectations to relay this to the consultant. Taking the opportunity to educate the patient on the use of their medication and the course of their disease, I hoped to empower the them by encouraging an understaning of their conditions. I feel that this will be very useful approach as an FY1 doctor.

As I worked primarily in the private hospital, my exposure to the national health system in Barbados was limited. With respect to the operational aspect of the private hospital, it was very similar to the UK in the way that the clincal encounters were structured. The main differences were that once a treatment plan had been discussed with the doctor, the patient would need to confer with the administrative staff on the costs. It was clear that treatment would be delayed until payment was arranged; coming from the NHS system this experience was very new but understandable. I saw the same ethical and patient centered approach in the private hospital as I have in the NHS. On several occasions the consulant would discuss a variety of procedures with the patients, with an agreement at the end of the right treatment course at the right price for the patient. In the NHS, the range of cost effective or necessary procedures are provided and access to treatment Is a step wise process of conservative, medical, and surgical management in that order; anything above that would need to be sought privately. It was interesting to see the partnership between private ad public health care.

In conclusion, this experience was useful in the solidification and completion of my undegraduate medical training. When I return to the United kingdom I will have a plan of action for my foundation training. Having focused my report on obstetrics and gynaecology, I now have the firm belief that it is the speciality I would like to pursue.