ELECTIVE (SSC5a) REPORT (1200 words)

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

After spending half of my elective in the UK, I travelled to Tobago to work in the A&E department at Scarborough General Hospital for 3 weeks. Trinidad and its much smaller neighbour Tobago are located in the Caribbean, northeast off the coast of Venezuela.

Scarborough General is the main hospital on the island and serves a population of approximately 60'000 (Trinidad and Tobago Central Statistical Office, 2011). As in the UK, healthcare is funded predominately by government and taxpayers, but this is supplemented by private services. Furthermore, the healthcare system is largely modelled after the UK system, with primary and secondary care services. However, in practice most patients often present directly to A&E instead of attending regional community-based District Health Facilities. The reasons for this are likely multifactorial, although most may be traced back to issues with funding and resource constraints. From personal accounts, waiting times in District Health Facilities are often long and local clinics are understaffed. Many patients, therefore, hope to accelerate their treatment or referral to an appropriate specialist by presenting directly to A&E. This may further be compounded by patient health believes. While in the UK it is common for patients to think "GP (General Practitioner)" when they suffer from a bothersome symptom, patients in Tobago may see a hospital's A&E department as the best way to seek medical attention in the first instance. Given Tobago's comparatively small land mass and population size, it may actually be sensible to concentrate the majority of available resources in one place, instead of scattering them across many smaller community services.

Irrespective of the reasons of this phenomenon, the lack of a "gatekeeper", as exists in the UK in the form of the GP, means that many presentations I observed at A&E in Tobago would not commonly be seen in this setting in the UK. This included, chronic back pain, worsening vision due to known cataract, and long-standing heavy and irregular menstrual bleeding. Additionally, patients commonly reattended A&E for a review of their blood tests or imaging that was done previously. While in the UK imaging results are readily available, here, fewer radiologists are on site to report scans, and this results in patients having to wait longer or having to reattend. One extreme example of this was, when I found out that a patient with chronic backpain had waited over 2 months for their results to become available. This highlighted to me how resource constraints can have a negative impact on the quality of care that patients receive.

Another difference I have noticed pertains to the care of trauma patients, particularly those with penetrating injuries. While in London, pre-hospital teams, consisting of specialised paramedics and doctors, provide initial care on scene, the ambulance service in Tobago operates according to the "scoop and run" principle meaning that emergency technicians with limited medical knowledge primarily provide rapid transport rather than medical assessment or intervention. In line with this, when a trauma patient was brought in by the ambulance service the handover was limited to the patient's name and a brief statement of what had happened, as might be seen in a newspaper headline. The patient in question was a middle-aged man that had sustained multiple lacerations and stab wounds that were inflicted with a machete. From working in a major trauma center in London, I expected the ambulance crew to handover initial observations, assessment of injuries and any interventions that were done. Instead, these things, including placing IV access, was only done once the patient had arrived in A&E. This meant that almost all doctors available in A&E had to help with this patient. Further, there was no pre-alert system in place that would notify us of the arriving case. At the Royal London Hospital in London there are clear pre-alerts that when activated lead to the mobilisation of appropriate resources including senior emergency doctors, anaesthetists, nurses and, depending on the nature of the trauma, members of the orthopaedic, neurosurgical or maxillofacial team. Additionally a theatre will be put on standby and radiologists will ensure that a CT scanner is available. In Tobago, where resources are limited and there is a much lower volume of trauma cases per year, these systems have not been put into place. Therefore, I initially found that there was a lot less structure to the assessment and treatment of the trauma patient. Nevertheless, each team member knew what to do, found their tasks within their personal skill set so that the team was able to respond to clinical changes dynamically. However,

things may have been a bit more tricky if the patient deteriorated and crucial resources were missing such as having an anaesthetist available to manage the airway of the patient.

Tobago is a comparatively low-income country, that relies heavily on imports from its larger neighbour Trinidad. I learnt that through the COVID pandemic many people have experienced further financial difficulties. One patient, who presented with palpitations, told us how hard it has been so difficult financially that she couldn't even find much money to feed herself. This was an eye-opening experience and reminded me to think about the socio-economic factors that might underlie a patient's presentation. She told us how she has lost so much weight that her clothes won't properly fit anymore and this made us think that the pathology underlying her palpitations might actually be secondary to electrolyte abnormalities as a result of malnourishment. Unfortunately I was unable to follow up her blood works, but it would have been interesting to see whether this was actually the case. Regardless, it made me realise that some medical problems can be traced back to social or economic factors.

Overall, this elective has been beneficial to my own personal and professional development. I have revised a plethora of conditions, many of which I had never seen outside a textbook before. Additionally I got to practice my clinical examination skills on many patients and my suturing skills on the trauma patient. I strived to put the patients safety first. A specific example of this was when I made sure to clarify how many doses of a blood pressure medication a patient had received. Based on this information we were than able to avoid giving a further dose of the same medication which could have had adverse effects. Through working closely with the clinical team and by clerking many patients I have been able to practice my communication skills. At times it was difficult to understand patients due to the accent in Tobago but I made sure to ask again or find other methods of communicating whenever possible. One particular aspect that I found difficult was getting used to taking a good drug history. Many of the medications used here are named by their brand name, so it felt like learning pharmacology again all over. However, Google was very helpful with this. I also practiced using MedCalc, an App that might come in handy on the wards in 2 months time. And finally I also familiarised myself with the Oxford Foundation Handbook, which I will be having by my side when I'm on my job. I am happy to say that I feel somewhat more prepared to take on the job ahead of me.