ELECTIVE (SSC5a) REPORT (1200 words)

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

I divided the report into the four learning objectives mentioned above.

1. I have had the chance to see a wide variety of presentations during my time in Panama. While some presentations are not as common in the UK, many do overlap. The most common presentations that I have seen are headaches, rashes, diarrhea and musculoskeletal problems. I have also seen many patients with chronic health conditions, like diabetes and hypertension. All of these are also common to the UK. One difference I found between my UK primary care rotations and here, is that there are fewer acute presentations. This may be due to the fact that floating doctors only visits the communities every 3 months, so more chronic issues are discussed. In my GP placement in London, I was often seeing complaints that had been going on for just a few days. Here, it was common for things to have been going on for many months or even many years, due to limited access to healthcare. I had to remind myself that just because a symptom had been there for years, it didn't mean it was benign. In addition, the cause of the presentations was often different than in the UK. For example, headaches were mostly due to dehydration, as many people drink around 1-3 cups of water per day. Similarly, musculoskeletal problems were due to manual labour such as farming, building or washing clothes/cooking. Most jobs require long hours walking in the sun, which leads to both headaches and musculoskeletal problems. In the indigenous communities, people work without much rest in order to make a living, which aggravates MSK problems and leaves no time for healing. Another common presentation in the communities we visited was family planning. Floating doctors only carries Depoprovera injections and condoms, so these are the only options available. Unlike in the UK where contraceptive counseling allows women to choose many options, here the options are limited. Sometimes there are taboos around contraception, so it is important to address these issues sensitively and to allow patients to discuss them in a private setting. Overall, common presentations were mostly due to the environment the communities are living in.

2. The healthcare systems in Panama and in the UK are quite different. Floating Doctors provides care to almost 30 different Ngabe communities in the region around Bocas del Toro. As an NGO they are not affiliated with Panama's national health system but do have to operate under the same legislations. For example, pregnancy in 18 year olds and under is illegal in Panama and therefore floating doctors must follow regulations and formally report these to the police. Not following such protocols could compromise Floating Doctors ability to practice in the country. Although Panama does have a health system in place, Floating Doctors cover the gap in the indigenous Ngabe communities. The communities we visited almost always have a "centro de salud" (health center) available, but often it is not stocked with the necessary medications. Health centers are placed by the ministry of health and are designed to be a free or low cost service for people that are not insured and living in remote communities. However, when speaking to locals it is the health centers are viewed as a "marketing" campaign or a failed attempt by the government. Some communities health centers only receive a doctor or nurse one day a week and lack essential resources. Even though medications should be free, if they are not stocked, they will prescribe it for people to buy at the pharmacy in bigger towns. However, the people in Ngabe communities cannot afford to buy medications at pharmacies. For example, I saw a three month old baby whose family had traveled to the nearest hospital for medical care. The baby had been examined there and the hospital

provided them with a paracetamol prescription for them to buy at the pharmacy. The family could not afford to buy it, so they had come to our clinic for the medication. While in this case they were able to do that because it had happened to be the same week we were visiting, other times they would have had to wait the three months until floating doctors visits their community or to travel to the community that the team is visiting that week. In a way it does feel like the ministry of health has left these difficult to reach communities behind. Free healthcare in Panama is also available through the "caja de seguro" an insurance system by which workers are covered. In the communities we visited, I came across patients who worked at the local schools and were automatically covered by this insurance and could visit hospitals without any fees. However, most people were not insured since they work "informal" jobs where they do not receive an insurance or they earn so little that they ask their employers to pay them without the insurance so their paychecks are slightly higher. All of this is very different to the UK health system. Thankfully, in the UK there is an accessible and free at the point of access system. Almost everyone lives in close proximity to a GP or public hospital. Although the NHS has its limitations, it is a well functioning system allowing free healthcare for all that require it. This has allowed me to develop a greater appreciation for the NHS and the privilege of being able to access health care.

3. Social determinants of health play a very large role in the Ngabe communities. Not one community is the same, but there are some patterns in terms of social determinants of health. These can be divided into education and health knowledge, as well as economic power. In terms of health education, there is limited knowledge of what constitutes a healthy lifestyle. For example, it is common to see people drinking sugary sodas and pre-packaged sweets in the communities. Similarly, foods are often fried rather than boiled. This results in a population where obesity, diabetes and hypertension are all very common. There is also a very limited understanding of human anatomy and physiology making it difficult to empower patients. Due to this, I made sure to always take time for health education in my consultations. I will definitely carry that with me in my future as a doctor. Often we make assumptions of what people know and it is good to ask and explain things thoroughly. Some of the social factors that determine health here are heavily influenced by economic power and the external environment. For example, I came across a man that had headaches without any red flag symptoms and drank only 1 cup of water per day. When I asked why, he explained that he relied on water from the well but it had not rained in a very long time. It is quite sad to see the direct impact of climate change, especially, on populations that have had very low carbon footprints throughout their history. Furthermore the lack of economic power, means that one cannot simply resolve the lack of rain water here by purchasing bottled water from elsewhere. Another social determinant I have observed is that of culture. Socially it is not common for people to talk about sex or pregnancy; this is also a big determinant of adolescent health, as people become pregnant young without being fully aware of what is happening. Schools also do not teach reproductive health in detail. It is not rare to see 13 or 14 year old girls that are pregnant or people that became mothers at that age. Floating doctors has a doctor in charge of giving health education talks which can be challenging. Overall, health awareness/education, economic power, dependence on climate and cultural taboos all impact health.

4. This elective has definitely allowed me to develop my skills as a doctor. I have had the opportunity to practice medicine in Spanish for the first time. While Spanish is my native language, being in different communities I had to adapt the way I would normally say things, as there are local variations of how to express oneself. In addition, I found that people were not as in touch with their bodies as back home. Sometimes consultations were very vague which was difficult for me at first. I have definitely grown my history taking skills during my time here and will be able to apply a lot of what I have learned. While in the UK, open questions often lead me in the direction that I want to go. Here, people were less "chatty", so I

was forced to practice a closed style of questioning. This has allowed me to think of specific and precise questions in order to include/exclude differentials. In addition, by interacting with healthcare professionals from different areas of the world, I have been able to pick up on bedside manners that I will carry with me into my day to day. My history taking skills have also improved by being here longer, as at first it Is quite challenging to know whether the patients mean the same thing you do. I have also been able to examine many patients and practice taking vital signs. Finally, this had been a great opportunity for me to start thinking more clinically and using clinical reasoning to formulate a plan. Up until now I feel that I was often waiting for the answer, but now I am more confident in communicating my impressions and plans and asking for feedback. I remember finding it very difficult to think of management plans and just over a couple of weeks this has massively improved. I definitely feel this elective has started to bridge the gap between student and doctor.