ELECTIVE (SSC5c) REPORT (1200 words)

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

1. The communities we visited could only be accessed by boat and medical professionals were at least an hour away in the best cases. This meant that western style medical care was irregular and many used local remedies instead. I saw a few tropical diseases and the impact they had. I saw a few patients who had caught malaria and still suffered complications; one woman insisted she had had persistent parasthesia ever since she was treated. The most troubling case was that of a 15 year old boy with filiariasis of the genitalia. He had suffered from the condition for several years, but had only been treated in a hospital once. The nature of the disease means it needs progressive treatments with 6 month follow ups: an impossibility for a family that needs every member to work and cannot afford the fuel for a speedboat to the local health centre. His genitals were so swollen that he could only wear loose clothing, and he was clearly physically uncomfortable and understandably embarrassed. We were only able to give him the first dose of medication, and hope that the next visitors to this community could bring the next.

The major public health initiatives seen were those in place throughout the world: childhood vaccinations, hand washing, sun protection. There were several posters in the health centres, in a simple style with large pictures and few words. This is because a large number of the populations were illiterate. I did see a large and complex poster about baby checks, presumably for medical professionals. These posters were only available in the main town, however. None of the villages we visited had a hospital and very few had a health centre with a trained healthcare provider.

A public health program that I believe would have made a big difference in the communities would be advice on how to lift heavy objects. Many of the men and women worked in the fields, carrying large amounts of sugar cane or root vegetables on their head, shoulders and backs. From what I could see there was no back protection in the method of lifting, unlike the 'lift with your knees' protocol we are taught in the West from childhood. By adapting the way they carried these large weights, I believe people could be spared the back and joint pain that many suffered early on in life.

2. Due to the distance from medical care and the cost of travel, many patients remained at home and consulted the local herbalist or shaman. The services of these specialists were paid for in trade as opposed to currency, or the shaman would offer services free of charge and would live on gifts and other sources of income.

Once every 4-6 months the villages were visited by a medical boat such as ours, carrying Peruvian and foreign doctors. The healthcare was free to the villages because the funding was combined from the Peruvian Ministry of Health, charities and funding from elective students and volunteers. This led to patients asking for medication that they had received from the last group, however each group arrived with different drugs and resources so many were confused or disappointed by what was prescribed. We could also not carry enough medication for prolonged prescriptions. This was most felt when prescribing pain medication. Many patients suffered from back pain, headaches and joint problems, but we could only prescribe at most two weeks' worth of analgesia and anti inflammatories. For recurring problems such as parasites, we could only give a stat dose for children and adults that asked for it, in the knowledge that they would become infected again soon

afterwards. We attempted to alleviate some of this burden by encouraging hand washing, but such measures are difficult in a community that does not have easy access to clean water.

3. The majority of patients had similar complaints to those seen in the Western world: headache, backache, colds and flu. However there were tropical diseases such as parasites that were very commonly seen. The main medication prescribed was analgesia and anti-parasitics, followed by anti-tussives and proton pump inhibitors. Malaria was a common worry, and there were many public health initiatives to combat the disease in the larger town, however in the small villages there were no mosquito nets and no prophylaxis, so the people used herbs and roots that were known to keep the insects away. Mothers came in looking for vitamins for their children; although I did not see any signs of vitamin deficiencies, many believed that the drugs were better than the advice to eat a varied diet.

4. I had not previously been able to learn much Spanish in the run up to exams, and this presented the largest problem in consultations. We were in pairs where at least one person spoke the language but even for those that knew it the consultations were still difficult. The accents were thick, the terms were confusing to both parties and often patients did not speak Spanish but a local language. I learnt a few stock phrases that were very useful, particularly when examining and when running the pharmacy. The problem became that I could ask questions quite well but I had difficulty understanding the answers. At this point I had to use many non verbal skills such as mime to communicate with patients. Surprisingly, it was easier to communicate with children, because they were more adept at non verbal communication.

The general health of the communities were quite good, however there were few elderly in the villages. The life expectancy was not very low, around 70, but the elderly were less inclined to seek the advice of western doctors, preferring the traditional healing techniques. I was also informed that in the more conservative communities it was not seemly to show outsiders the sick. It was considered disrespectful. Even the fact that we were doctors did not discourage this view, and we had to visit certain patients privately. The population largely worked as manual labourers, yet the high level of physical activity was matched by a high carbohydrate diet, so many were still overweight. Due to the flooding many fields were lost and the diet of many was reduced to basic sustenance without variation or adequate nutrients.

One case that worried me was that of a 70 year old man who presented with haemoptysis. His history suggested a sinister cause such as tuberculosis or lung cancer, but on examination there were no clinical signs. In the UK he would have immediately been referred for an X-ray and followed up, but in this setting that would never be the case. He did not have the resources to visit the hospital, and even if he had an X-ray and something was diagnosed, it is unlikely that the hospital would have the resources to treat him, particularly if the diagnosis was cancer. I asked the Peruvian doctor and he said that due to his age it was also less likely that he would receive treatment. I understood that the cost benefit analysis was harsher in this setting sue to necessity, but I still left worried about that patient.