ELECTIVE (SSC5c) REPORT (1200 words)

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

1. If I am completely honest, a placement on critical care medicine was not at all what I expected it to be in Belize. Before arriving at the hospital I understood Belize to be a developing country that would not have all the extravogant resources that an intensive care unit in the UK has the great fortune of housing. I believed the hospital to be a small one and so imagined the critical care to be a small room with a few beds and limited (maybe one or two) ventilators or machines. When we arrived and were given our induction on the first day, we were given a tour of the hospital which included a small emergency bay and three general (internal) medicine bays with 4 beds each. We then visited the obstetric and neonatal wards which were the largest in the hospital. I later asked where I would be placed in critical care, after which it became apparent there was no dedicated area for this. No separate room with private space and those few machines. Instead the intensive care unit was more of a set of equipment that would be used on the general medicine wards when required. Naturally this unfamiliarity made me a little nervous. However, throughout my placement it became apparent why this might be the case. In the UK, there a number of different circumstances requiring intensive care including, post-surgery, major trauma, acute disease complications etc. In Belize on the other hand, these events are all dealt with at neighbouring hospitals as are difficult obstetric cases. But for those obstetric cases that had unforseen complications, or for asthmatic patients that had particularly bad exacerbations, which was more common than I expected and probably due to the climate, critical care played a major role. However, due to the intermittent nature of critical care within this particular hospital setting I spent a considerable amount of my time there working in general (internal) medicine. During this time it became evident that complications of chronic diseases such as diabetes, hypertension and asthma, as well as HIV/AIDS, tuberculosis and other infectious diseases formed the mainstay of hospital admissions. It is my opinion, which was later concurred by some of the senior doctors, that this was due to limited medication compliance by patients and a lack of patient and population education.

2. Belize uses a health insurance scheme which allows its patients free healthcare provision at the point of delivery, making it somewhat similar to the NHS system used in the UK. However, due to the lack of resources mentioned above in addition to a relative lack of staff to patient numbers meant that clerking patients, carrying out investigations, and instigating management plans were all delayed thereby somewhat compromising optimum patient care, However, regardless of this it seemed every patient seen by the hospital, whether on the wards or in clinic, were extremely appresciative of the time and management they received from the doctors and treated the staff with the greatest of respects. This was really nice to see as the doctors, nurses and other staff really did work as hard as they could for their patients and cared for each of them as if they were family. I guess this may have been a positive reinforcement circle of sorts where the greatful attitude of the patients allowed doctors to care for them in a more personal nature without the fear of complaints or restrictions introduced by fear of litigation that can sometimes impact doctor patient relationships in the UK. Overall, considering the relative lack of funding put into the hospital I found that patient care itself was not particularyly compromised, but could not be compared to the care provided by the NHS with all its relatively unlimited resources.

3. As described as part of objective 1, there is a considerable lack in the local systems of critical care delivery in Belmopan hospital in Belize. In particular, I felt that post-operative care suffererd as a result of this short coming in intensive care provision, especially as there was no doctor that specialised in intensive/critical care within the hospital. The main point of care was provided by the same nurses that looked after the rest of the patients on the general medicine ward, unlike the one to one care that is valued in the UK. In addition, it is known that anaesthesiology plays a vital role during intensive care, however, this particular hospital only ever had one anaesthetic doctor working in the hospital at any one time. This proved to be challenging if the one anaesthetist was in surgery when a patient was deemed to require the skills provided by the anaesthetists during critical care. For example, on more than one occasion did I assist in intubation and manual ventilation of an acutely asthmatic patient on the ward whilst waiting for the anaesthetist to be free from surgery. It goes without saying that this is not the optimum situation when a patient crosses that scary line of requiring intensive care on the ward. Having said this, the nursing staff and other members of the team always handled these situations with the up most professionalism and efficiency. Finally, although I had not personally witnessed a situation that required a crash call, a colleague had explained to me that there was no general crash call service like in the UK to contact when in such a situation, and that if such an incident was to arise the team would contact the specialty the patient was under, i.e. respiratory or cardiology directly.

4. In summary, i got the impression that critical care in no way plays as a big a role in this community as it does in the UK, where many resources are made available to maintain optimum patient care. This may have been due to a combination of lack of funding and lack of need by the population. For this reason I didn't manage to gain as much experience in intensive care as I had originally hoped for but this did not in any way impede on my experience as a whole. I left this placement feeling very happy that I was given adequate experience and opportunity to practical both my clinical and practical skills in both general medicine, and when required, critical care medicine in a hospital setting. As mentioned I was encouraged to get hands on, even in insertion of endotracheal tubes and laryngeal mask airways when necessary and was made to feel as part of the team. This made me feel more confident and also probably improved my competence in performing such tasks which I feel would be important skills to have when beginning to work as a foundation doctor soon. In addition, the fact that the patient population and staff all spoke English it allowed me to practice my history taking, examination, and diagnostic skills comfortably within a completely different community and patient group, allowing me to build rapport with patients and colleagues alike. I do feel that public health could play a bigger role in Belize to aid preventing exacerbations and complications of disease, and thereby the overall health of the population. Relieving some of the drain on resources and funding in the long run.