ELECTIVE (SSC5b) REPORT (1200 words)

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

Elective report 2017: Primary care in Peru, Hospital del Seguro Cusco

Elective report

Introduction

The majority of my clinical experience in Cusco was based the general medical department of the hospital Del Seguro, a multi-story multi-discipliary hospital providing acute, as well as general medical and specialist medical treatment for individuals subscribed to an employment-based tax contribution toward healthcare. My placement involved working alongside general physicians doctors De Silva and Carlo, where I was able to sit in on medical consultations and perform observed clinical examinations. Both doctors were proficient in English, and despite prolonging consultations, that, as in the UK are time limited (to 12 rather than 10 minutes in Peru) would translate the main patient presenting complaints to allow me to perform focused examinations after which I would be quizzed on differentials for the patient's presenting complaint, further investigations and management.

An introduction to the healthcare system in Peru

On my first clinical attachment with Dr Silva, I was given a tutorial at the end of our morning clinic that taught me much about the healthcare system in Peru. I found it useful to gain this introduction at the beginning of the rotation as it allowed me to put into perspective a lot of the problems the patients presented with and also from the offset gain a perspective of the system in relation to our NHS. Dr Silva taught me that the Peruvian healthcare systems is a decentralized one consisting of 5 branches, the Ministry of Health (MINSA), which provides health services for 60% of the population; EsSalud, which provides for 30% of the population and three smaller sectors catering to minorities of the populations; the Armed Forces (FFAA) and National Police (PNP) and the private sector (mostly reserved for the super rich). The Hospital Del Seguro is part of EsSalud that provides primary and specialist medical and dental healthcare to workers in fulltime employment whose' employers pay a 9% tax solely directed toward healthcare. When Dr Silva first mentioned the 9% tax rate I was surprised to see how low it was when compared to the minimum tax contributions of 20% in the UK, however I soon realised that in the UK, revenue gained from taxation is not solely allocated to the health service, and on researching only around 5-7% of UK taxation is allocated the healthcare. The higher taxation allocations to healthcare in Peru may help explain why taxation from a single earner (in Peru, most commonly the male of the household) would also provide full medical cover for his/her spouse and children under 18, including all prescriptions free of charge. This system, that provides primary, specialist and emergency care potentially for an entire family from a single earner is therefore one that is highly sought after, allowing recipients to negate the 150 soles (£45) consultation fees and prescription charges associated with the MINSA service. MINSA is funded by tax revenues, external loans and user fees, and provides healthcare for the majority of the Peruvian population. Though high in quality, MINSA services are also high in cost at the point of care, leaving the most vulnerable in society the most at risk of healthcare inequalities. In order to cater to the poorest and most deprived in society non governmental organisations (NGOs) are present in Peru who work with MINSA to improve infrastructure and make changes to health practices and insurance

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programs to provide support to Peruvians, especially those in the most poor and least accessible areas and have worked to generally reduced mortality and improve standards of living in Peru. Nevertheless, despite measures taken to reduce disparities between the rich and poor of society, vast differences still exist; Peru's poorest citizens are subject to unhealthy environmental conditions such as poor sanitation and exposure to disease carrying vectors facilitating the transmission of, and resultant higher incidences of communicable diseases. Furthermore, poorer members of society are less likely to be affiliated with organisations paying into ElSalud schemes, and so, the accumulation of disease burden secondary to chronic illness is likely to be high in these individuals due to an inability to afford consultation fees, and despite being entitled to emergency treatment through MINSA, paying off these fees may bankrupt many. Such a realisation put into perspective for me the beauty of our healthcare system, and reinforced the importance of the preservation of our NHS.

The role of the doctor in Peruvian society

Where in the UK medicine has taken a move away from the paternalistic role of the doctor, moving toward a format of shared responsibilities for health and wellbeing between patient and clinician, my experience, (atleast in the primary care setting) in Cusco revealed that the 'all knowing' power of the doctor was one that was still prevaled. Sitting in on clinics I was able to see and understand (with the help of my spanish lessons) how many patients presented to the clinic asking the doctor ' what he could do' for them not what they could do together; my experience exposing quite distinctively the attitude of 'doctor knows best' that remained in this society. Intrigued by this, I entered into further conversation with Dr Silva with regards the role and status of the doctor in the Peruvian culture to allow for me to better contrast this with the role and status of the doctor in the UK (perhaps a discussion most pertinent now than ever before). Dr Silva told me how here in Cusco, and in Peru as a whole the doctor still palyed a central role in society; someone who patients looked to for solace, advise and as an example to lead by. It was interesting that at this point Dr Silva mentioned how many of his colleagues in the hospital were infact morbidly obese and lead quite an unhealthy lifestyle, this perhaps more dangerous in the Peruvian society (where patients who look onto doctors as a pillar to follow by) and may facilitate the attitude of a lack of concern or perhaps awareness that many patients displayed over their weight, hindering their understanding of it's contribution to their current health issues. Dr Silva also told me, and I too soon saw how his consultations were laced heavily with patients requesting advice beyond their presenting complaints and how in many cases patients were in many ways 'obedient' to any suggestions made by the doctor; a stark contrast to the majority of UK consultations I have been a part of. Nevertheless, despite the willingess of the patients to comply with doctors suggestions, I was able to witness good practice on the part of both Drs Silva and Carlo when initiating medication and treatment with patients; always making sure to council patients with regards side-effects and potential red flags. This was an example of good practice and a reminder that despite patient willingness, it is our role as clinician to act in the patient's best interests and always fully inform them before consenting to any form of treatment or procedure. In the general medical clinic at EsSalud, each patient was allocated a 12 minute slot with the doctor to cover their presenting complaint; where in the UK some GPs limit patients to the number of presenting complaints, here consultations were limited by time, with patients potentially presenting with up to 5 minor ailments, if all could be addressed within the time slot. Time keeping was an issue; patients had the tendancy to convey other worries onto the doctors, and on asking Dr Silva about time keeping he agreed that though it was difficult, he could not simply cut off patients mid-stream, especially when they come to him as a source of wisdom and advise alongside the fact that the waiting list for

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appointments at EsSalud being on average 3-4 weeks; another parallel between Peruvian and UK primary care.

Disease burden in Peru; experiences from my clinical rotation and further reading

Prior to my elective I was under the impression that infectious disease would be the major contributor toward ill health in Peru, and indeed whilst the World Health Organisation (WHO) deems the risk of infectious disease in Peru to be high (with common ailments including that of waterborne bacterial diseases such as typhoid, feco-orally transmitted viral infections such hepatitis A, and vector transmitted dengue fever, malaria and yellow fever). However, I was much surprised to learn from my experience from the primary care sector, and following further reading that infact the majority of disease burden in the Cuscan population and Peru as a whole very much mimics that of the UK; with obesity and its primary and secondary health complications being the major contributors to ill health. Peru is very much as affected as the UK by the 21st centuries lifestyle of excess, the most recent World Health Organisation (WHO) studies revealing the major cause of morbidity and mortality in the adult population to be that of cardiovascular disease and diabetes. This very much mimiced patient presenting complaints at hospital del Seguro, with the majority of patients with chronic illess presenting with complications of hypertention and diabetes. The prevalence of such conditions also allowed me to see the integral and increasig role of the multidisciplinary team in effective patient maagement in Peru. Many patients presented with complications associated with poor lifestyle, and seeked advice from Dr Silva with regards to changes they could make. Though he tried his best to answer questions nd offer advice it was clear to see that all the help the patients needed to effectively manage their condition could not be catered to in this one consultation, seeing a significant proportion of referalls made from the clinic to the nutrition and dietetics department.Two further conditions alongside those of the complications of HTN and T2DM combined to make up the bulk of patient presenting cases at hospital del Seguro; musculoskeletal and repsiratory. Musculoskeletal back pain was a prominent presenting complaint amongst patients, and in a surprisingly high proportion of patients the diagnosis was that of fibromyalgia. Prior experience working oversease in the indian subcontinent and indeed still in the UK has shown me how mental health is still much stigmatised and prior to coming to peru I had the preconception that medical practice here was more focused on the physical rather than the psychological aspect of illness, as such, it was refreshing to see and here Dr Silva consulting patients with potential psychosomatic pain about the importance of physical and mental wellbeing, and the use of referals to psychology as potential adjucts to the treatment for fibromyalgia was reassuring to see. I was also able to learn of the increased asthma burden in Cusco and Peru as a whole, which Dr Silva explained was a relatively new phenomenon in Peru secondary to the increased industrialisation of the country and the gas fumes relased from the ever increasing numbers of taxis and buses introduced on the Cuscan and Peruvian streets.

Cultural orientation

As part of my 3-week placement with Mundo Verde electives, it was arranged as part of the package that I would attend 10 hours of Spanish lessons in order to help my orientation in Cusco, but also aid my clinical experience. After my first two lessons I enquired with my teacher Patty as to the possibility of more lessons in my spare time as I found the lessons both interesting and very useful practically; when shopping, using taxis as well as in the clinic at the hospital del Seguro to which Patty gladly agreed. My lessons were two hour sessions covering basic Spanish, but on discussion with Patty, and following my first few days of clinical attachment at the hospital del Seguro we were able to tailor

some of the learning I did to aid my role in the clinics; learning some basic adjectives that were commonly used by patients as presenting complaints such as 'pain', 'tiredness', 'fatigue', 'phlegm' as well as colours and parts of the body. As with most if not all types of learning, I find it is best done being put into practice, and my practical learning of the Spanish language was very much enhanced and aided by Dr Silva and Dr Carlo whilst sitting in on their clinics listening to patient histories and performing examinations. For example, when performing examinations, Dr Silva would teach me phrases to aid patient understanding and compliance with examinations such as 'copy me' 'imitadme' in the case of musculoskeletal examinations, or in the case of respiratory exams, knowing how to tell the patient to 'breathe in deeply' 'omar una respiración profunda' or say '99' the Spanish equivalent of which was 33 'trienta y tres'. Learning the language alongside its practical application definitely made key phrases easier to retain, and to this end, using the taxis of Cusco helped me consolidate my learning of numbers and times, as well as my bargaining skills, a skill I believe was honed during my negotiations with the vendors of the Cuscan street markets buying souvenirs for friends and family back at home.

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