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 Grenada, Saint Augustine's Medical Services

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Introduction

The majority of my clinical experience in Grenada was based with the general practice department of Saint Augustine's medical services (SAMS), a small private hospital providing acute, as well as general medical and specialist medical treatment for individuals on an ad-hoc or insurance subscribed basis in Grenada's capital of St. George's. The bulk of my placement involved working alongside Dr Amechi, a general practioner who qualified in the US and UK wherein I sat in on medical consultations and perform observed clinical examinations, after which I would be quizzed on differentials for the patient's presenting complaint, further investigations and management. On informing Dr Amechi about my interests in experiencing emergency medicine in Grenada, and my general interest in the medical speciaties of Gastroenterology and Neurology, I was fortunate enough too to be able to spend some of my time at SAMs shadowing clinicians in each of these departments.

An introduction to the healthcare system in Grenada

At the end of my first clinical rotation with Dr Amechi, to allow me to gain a better understanding of Grenadian healthcare, I enquired about the foundations of the healthcare system in Grenada. He gave me a whistle-stop tour alongside some further reading material that allowed me to better understand healthcare and its benefits and downfalls for Grenadians and the many tourists visiting and expats and students living on the island. Grenadian healthcare is funded primarily by taxation through the Ministry of Finance, with the government allocating approximately 12% of the country's annual budget towards the healthcare sector, proportionally greater than the estimated 5-7% of annual taxation contributions toward healthcare in the UK. Other contributors toward healthcare include international aid organisations and contributions acquired by the Ministry of health (MOH) from private user fees. The MOH, a subset of the centralized government regulates the finances and policy of the public and private branches of health care in Grenada respectively.

Historically, Grenadian healthcare was predominately publically funded, with 46% of all healthcare finances are directed toward Grenada's 3 public hospitals; the 240 bed General Hospital in the capital St. George's, the 40 bed Princess Royal and 56 bed Princess Alice. Although there is no national health insurance, all Grenadians are required to participate in a social security program, that provides cover for work-related injuries, however with an unemployment rate of over 40% the burden of occupation related illness is relatively small. Though predominately a public funded health system, the ever increasing number of foreigners settling on the island and ever expanding student population of St George's university has seen demand for private care facilities increase and currently Grenada's private care sector includes 5 acute hospitals and several single practioner, specialist or general

practice clinics of which St. Augustine's Medical Services (SAMS) is one of the former. To this end, primary health care services are usually offered free at public health centers.

Healthcare challenges and public health initiatives

Inequalties in healthcare and society

A central focus of Grenadian healthcare policy in recent years has been in the provision of easy access to high quality primary care, and as such, primary health care services are usually offered free at public health centres, with citizens incurring small fees for diagnostic tests that are waived for children, the elderly and other potentially vulnerable groups. To ease access further, the MOH also divided Grenada into 7 health districts each assigned a cohort of medical and multi-disciplinary team members located either in health centres or medical stations widely distributed along the island that act as the first point of medical contact, this layout meaning that every household is within 3 miles of primary healthcare provider. However, the referral systems from the primary setting to more specialist and emergency services available predominately at the 240 bed general hospital are limited, with the majority referred to the Accident & Emergency (A&E) department for admission prior to designation to a specialist service, potentially resulting in long waiting times.

Though the MOH has been relatively successful in promoting and achieving success with improved access and uptake to primary care services, specialist care provisions in Grenada are somewhat limited. Well publicised is the reality of the 'brain drain' prevalent in Grenadian society, wherein individuals achieving success academically leave the island toward greater employment and lifestyle opportunities in the US and Europe; this is much the case in medicine, where unfortunately Grenada lags behind in several key specialties, including heam-oncology and emergency medicine. Indeed, potentially life saving initiatives such as CT scanning and reno-dialysis are in short supply and largely can only be provided in the country's private care settings. With less that 9% of the indigenous population subscribed to private care services, this makes access to such services, if required by the indigenous, amongst whom a 40% unemployment rate exists a difficult if not an impossible feat. Due to the limitation of advanced care facilities, and the ever increasing number of tourists and expats, off-island care plays a large role in emergency and advanced medical treatment in the Grenadian islands; those patients with specialist secondary care needs often being flown to larger, more technologically advanced facilities most predominately in the United States or other larger Caribbean islands such as Barbados. As one can imagine, the financial implications of such services are vast and very much limited to the most wealthy of Grenadians but more commonly British or American expats or toursits who can afford to pursue their healthcare needs off-shore. This reality begs to question whether when the wealthy can afford to quite comfortably and relatively rapidly (my experiences with Dr Amechi exposing me to patients with minor fractures being flown of the US the next day) travel abroad to seek treatment or further investigations for minor and major medical ails, surely this reduces the impetus to promote the development of medical services in Grenada. If indeed this is the case it exposes the vulnerability of the majority of the indigenous Grenadian population to substandard medical care at times when they may need it most.

Disease burdens

Prior to my elective I was under the impression that infectious disease would be the major contributor toward ill health in Grenada, however communicalble disease according to the most recent data account for less than 13% of all mortality in Grenada. With respect to quality aims for healthcare, the MOH works by a policy known as the 'Millenium developmet goals' (MDGs), of which MDG 6 aims toward the reduction the prevalence of commuicable diseases including malaria, TB and HIV/AIDS. In the period over 1955-72 Grenada successfully elimated malaria with the incidences of TB falling from the 90s to present however insufficient data exists at present to analyse the progress of HIV/AIDs goals. To this end however, the prevalence of unprotected sex in Grenada is high and the importnace of safe sex is not a message that I have seen to be one highly publicised, raising concers over the prevalence of not only HIV/AIDs, but also other, more common sexually transmitted infection. To this end, in a catholic country where abortion, though occurs (medically and surgically) is outlawed, the rate of teenage pregnancy and childbirth as a whole is high and concerns over mother to child transmission of HIV and other communicable diseases are very real ones, for which public health promotion and education are at present sparse.

Rather than the infectious disease, 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 Genadian population very much mimics that of the UK; with obesity and its primary and secondary health complications being the major contributors to ill health. Indeed, non-communicable diseases (NCDs) in Grenada accounted for an estimated 81% of all mortality in 2008, and Grenada is very much as affected as the UK by the 21st centuries lifestyle of excess, with 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 mimicked the presenting complaints of patients I met with Dr Amechi at SAMs 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 Grenada, of which I was able to see more through my experience with the community clinics, shadowing ursing staff at SAMs, and through a day I spent with the speech and language therapy (SALT) team.

Prior experience working oversease in the indian subcontinent and indeed still in the UK has shown me how mental health is still very much stigmatised and prior to coming to Grenada I believed this too was the case here, and unfortunately I am not too sure as to what extent my preconcieved notions hold true. Problems with addiction run high in Grenadian society, with recreational drugs and heavy alcohol consumption being culturally acceptable and for me, shockingly commonplace. Many patients coming in to Dr Amechi's clinic presented with complciations of alcohol excess, however his approach by and large was to address the medical ailment rather than broach the underlying cause. When I asked him about this, he metioned that as alcohol is so commonplace in Grenadian society and that indeed many people are very much brought up drinking alcohol, he prefers to attempt to broach the subject one or twice but is usually met by heavy resistance after which he prefers not to address things further. To me this seemed strange as addcition in itself is one of the most deadly of ailments, and opening the eyes of the individual and wder society to ways in which it could be challenged I think is one of the most important and potentially life changing public health initiaives that exist.

Substance abuse in Grenada is also very much prevalant and to this end the most commonly diagnosed mental illness in Grenada is schizophrenia; schizophrenic patients making up over three-quarters of the inpatient population at Mount Gay Psychiatric Hospital the only psychiatric facility in the country that is unfortunately poorly funded and supported. Interestingly, 24% of admissions in 2007 were found to have psychiatric disorders attributable to psychoactive substance misuse, though I suspect that the prevalence of recreational drug use namely cannabis in those diagnosed with schizophrenia would be substantially greater, though I do not know of any research conducted into this matter. Recently (April 2017) the MOH has addressed the problems of overcrowding in Mount Gay attributed to the influx of new patients and those existing patients requiring prolonged inpatient admissions, and announced plans for improving the quality of inpatient and outpatient care and provisions for the mentally unwell. Hopefully these plans will aim to reduce inpatient stays and aim to integrate the mentally unwell back into society, where in some parts of Grenada they are still relatively shunned.

The role of the doctor in Grenadian 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 with primary and seconday care physicians in Grenada revealed that the 'all knowing' power of the doctor was one that was still quite prevalent, even amongst western expats. Sitting in on clinics I was able to see and understand 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 Amechi with regards the role and status of the doctor in the Grenadian culture to allow for me to better contrast this with the role and status of the doctor in the UK. Dr Amechi told me how here in Grenada the doctor, to the indigneous at least still played a central role in society; someone who patients looked to for solace, advise and as an example to lead by. Dr Amechi 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, when it came to addressing problems associated with overconsumption of alcohol or cigarettes I saw how this paternalistic attidude very much fell by the wayside.