ELECTIVE (SSC5b) REPORT (1200 words)

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

1. → The top 5 causes of emergency admission in Cuba are Cardiac Insufficiency, Cerebro-vascular accidents, Myocardial infarctions, Moderate - severe asthmatic attacks and Acute exacerbations of COPD. Their equivalent in the UK are MIs, CVAs, Pneumonias, Acute exacerbations of COPD and Moderate - Severe asthma attacks.

This striking similarity is easily explained by the socio-economic model of health provision in both countries, namely healthcare free at point of consumption. Therefore, due to adequate provision of preventive services, the population tends to suffer with "rich-people's diseases" such as MIs, rather than gastro-enteritis.

Notably the only difference is pneumonia, being a more likely cause of admission in the UK, explained by the colder weather and ageing population. Meanwhile, Cardiac Insufficiency being the top cause of admission in Cuba due to the higher prevalence of essential hypertension, keeping with the higher demographic prevalence of Afro-Carribeans.

2. → While the epidemiology of encountered may be similar, the organizational frameworks are quite different.

There are two words of emergencies in medical Cuban Spanish - "urgencias" and "emergencias".

"Urgencias" are types of cases that are normally dealt with in the community and that do not require admission. Examples include mild pneumonias, mild gastro-enteritis and mild asthma attacks.
"Urgencias" are mostly provided in the community at polyclinics that are run by GPs. Urgencias, whose service is known as Cuerpo de Guardia has a similar format across the country. Namely, the clinical firm runs it for 24 hours and clinicians can only request basic investigations - urine dip, ECG, FBC, U+Es, ABGs, X-rays and US. More detailed or specialised investigations would render a referral to the "emergencia" services.
Urgencias, or Cuerpo de Guardia, are also provided at general hospitals, where service provision is split in between internal medicine and surgery. The two departments run two independent clinics that use the same laboratory and imaging services. The surgical Cuerpo de Guardia is further split amongst the surgical specialties, each having its own office and firm. The specialties are Opthalmology, General surgery, Max-fax, Neurosurgery, Vascular Surgery, Trauma and orthopaedics, Ears, Nose and Throat and Urology.
The specialists of these units may decide to admit a patient for observation to the "salas", or observation rooms, of which there are two - one run by Internal Medicine and the other

-ran by the surgeons. Examples of conditions that would require admission to the "salas" include, but not exclusive to, pyelonephritis, severe asthma and pneumonia, GI obstruction, appendicitis and acute hepatic failure.

More complex emergency cases may be referred to the wards for further investigation and management. Acute presentation secondary to a neoplastic disease and pyrexia of unknown origin would fall under this category.

In these general hospitals, life-threatening emergencies are dealt with at the emergency intensive care unit, aka UCIE. It covers among others, road traffic accidents, shock, MIs, and all acute cases that render intubation.

Finally, there are the tertiary specialised emergency centers such as the Obstetrics and Gynaecology unit, heart centers, lung centers and neurology units that cater to their relevant groups of patients who were triaged and directed there by the ambulance services.

This framework is quite different to the one in the UK. In my opinion, the advantages of the Cuban system include decreased waiting time and direct access to a specialist. Although the latter may imply faster, better diagnosis and treatment, it can sometimes create diagnostic bias. Moreover, a patient may end up being referred among the

specialties. The integrated approach in the UK does provide a better continuity of however would pave the way for errors by an inexperienced general emergensist. It would be quite interesting to devise a study and look at the performance figures at both countries, controlling for resources, to get a better idea of how they compare.

3. → Despite the fact that Cuban national expenditure per person per annum is $ 477 and the US expenditure is $ 5553, both countries have a similar life expectancy. Cuba is an exceptional case study of excellent prevention services, proving that prevention medicine is the best cure our profession can offer. The epidimiology center in Havana is the leading public health center in South America, running massive data bases, analysed for the public benefit. Recently Havan researchers provided a new vaccine for patients with non-small cell lung carcinoma, doubling life expectancy in terminal patients!

The immunisation schedule in the UK is: 1) 5 in 1 vaccine (diptheria, tetanus, whooping cough, polio and Hib (Haemophilus influenzae type b) given at 8, 12 and 16 weeks of age, 2) Pneumococcal jab (PCV) given at 8 and 16 weeks

and one year of age; 3) Rotavirus vaccine given at 8 and 12 weeks of age; 4) Men B vaccine given at 8 and 16 weeks and one year of age; 5) Hib/Men C vaccine given at one year of age; 6) MMR vaccine given at one year, at three years and four months of age; 7) Children's flu vaccine given annually as a nasal spray in Sept/Oct for ages two, three and four and children in primary school years one, two and three; 8) 4-in-1 pre-school booster against diptheria, tetanus, whooping cough and polio given at three years and four months of age; 9) HPV vaccine (girls only) given at 12-13 years as two injections; 10) 3-in-1 teenage booster against tetanus, diptheria and polio given at 14 years and 11) Men ACWY vaccine given at 14 years and new university students ~~given at~~ aged 19-25.

The Cuban government provides the exact same immunisation schedule, with the exception of rotavirus vaccination, which is not offered, and moreover, the BCG vaccine is administered in Cuba at birth. Due to compulsory immunisation, by 2006 there were no recorded cases of diptheria, measels, pertussis, polio, rubella nor tetanus in Cuba. This reflects the more prevalent and rigid structure of the Cuban healthcare system.

The breast screening programmes, the cervical screening programmes and colon cancer screening programmes in Cuba and the UK are exactly the same, boasting with similar mortality rates.

Finally, maternity screening services in Cuba provide more appointments and more rigid monitoring, contributing to Cuba's low maternal mortality rates.

4) → i) History taking proved a challenging skill to hone in, not just a different language, but also in a different accent. I initially struggled for the first few days finding it hard to understand the local accent and local format of note-taking. However, after a few weeks spent reading medical Spanish and adjusting my ear I found myself becoming increasingly confident. By the end of my placement, I can conduct an entire consultation in Spanish with minor struggles only, which feels very empowering!

(ii) My clinical skills on the other hand started to improve from day 1. Cuban doctors rely much more on clinical findings and are very proficient in their fields. I got to observe a lot and received much informal teaching and feedback that was very useful. I feel like I have more depth in the diagnosis and management of

the acute abdomen have built up on my suturing skills and have grown more confident in managing fractures.

iii) Team-work practice proved to be trickier than expected initially. Cultural framework is the unwritten flow of communication in any work environment. Even though I speak Spanish I struggled with the local language and was largely unfamiliar with local culture. I struggled with the bureaucratic nature of registering to various forms. In the end I realised that I just have to accept the local system and adjust my expectations. On the other hand I managed to work very well with the acute medical team, general surgery and orthopaedics. I believe, the reason was my willingness to engage and my genuine enthusiasm for medicine and the local culture.

iv) Patient management I fear was the area I struggled with the most. I believe that the reason is that I do not know enough about local life and the small details of medical service provision. In order to advise a patient one must know and appreciate the circumstances a patient faces and all the various constraints and options a patient has socially, politically and economically. Unfortunately

6 weeks is not nearly enough to appreciate a society and culture to such high degree.

Sources: NHS.UK., BBC.UK, WHO. com

Word count: 1310