GENERAL MEDICINE

Elective Report

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1. **What are the prevalent critical illnesses in Colombia? How does this differ to the UK?**

Neiva University Hospital receives a high number of patients who have experienced trauma. Because of the internal conflict within Colombia, and because of the position of Neiva Hospital being close to the conflict zone, some of these patients are soldiers. Secondly, there are many traffic collisions in this city, usually involving motorbikes, which results in a high degree of head trauma in particular. Most people, but not all, wear helmets, but often the traffic systems mean that the road can be very chaotic and dangerous.

Additionally, there is a high level of violent crime in Neiva. On my first shift in the ITU, 5 out of the 21 beds were occupied by patients who had either been stabbed or shot.

In London, particularly the Royal London Hospital, we see a disproportionate number of trauma victims because of its status as a Level 1 trauma centre. However, I believe there is overall a lower volume of trauma patients seen in London despite serving a larger population. The main differences can be explained by the presence of civil conflict in Colombia, and also by the public health initiatives in the transport industry. For example the use seatbelts, speed limits, safer cars, and licensing for drivers all help to reduce the number of casualties in road traffic collisions. There are differences between road trauma victims in London and from rural areas, as the speed that cars are able to travel at in the city is, on average, less than in other parts of the UK.

2. **What prehospital care provision exists in Colombia? How does this differ to the UK?**

The ambulances serving Neiva hospital are provided public services and by a number of private companies. The staff working on them can be paramedics, technicians, or volunteers. The latter are used because the supply of ambulances and staff often does not meet the demand of the city, and so people who have only time to give are used. It is possible to become a paramedic by one of two ways. Firstly, they can train vocationally, or they can go through the university route.

Patients come into the emergency room having been given a varying degree of prehospital interventions as a result of the disparity in skills of the staff. Some victims of trauma have been given cervical spine immobilization where others have not.

This differs to the UK, certainly in London, where staff working with London Ambulance Service are very tightly controlled in terms of their capabilities and expertise. There is no air ambulance working here in Huila province, as there are not the funds to support it. However, the Colombian military do evacuate many soldiers from the conflict zones surrounding the province. I believe Colombia has the second highest air evacuation rate after Iraq.

3. **How does the management of common critical illnesses differ from the UK? What are the groups frequently admitted to ITU and why?**

From my experience on this placement, broadly speaking, the management of common conditions is broadly the same as in the UK. Apart from drug choices, which would depend on institution in

the UK anyway, I could not see many major differences. The system here is based on the American system, and as such I believe that American evidenced based medicine is usually practiced more often.

As before, because of the high degree of trauma, the patients admitted to the ITU are often young, within 20-40years of age. The most frequent conditions, after trauma, that I have come across have been cancer and infections. The ITU here seems, logically in my opinion, to be the best equipped area of the hospital. I have wondered if this has changed the types of admission to the unit , for example patients who need monitoring rather than critical care. I wasn't really able to get to the bottom of this question during my placement. Of note, there were many patients with traumatic brain injury as a result of the various factors I mentioned above. On the whole, inside the intensive care unit, management was as it would be in Europe. The only thing to note was that 6 of the 21 cardiac monitors were defective, occasionally showing the patient to be in ventricular fibrillation when they weren´t at all. This seemed to be common knowledge, but it did cross my mind that this could lead to some confusion or endanger the patient if you were not aware of this and went to use electric cardioversion.

Also, the skills of the nursing staff were excellent and often performed procedures that senior doctors do in the UK, for example, placing arterial lines.

4. **How does the language barrier between me and the team affect "working with colleagues and in teams"? How did you maintain good clinical care in a new and unfamiliar environment?**

I hadn´t anticipated this to be as big an issue as it turned out to be. Because we had final exams in London right before we started elective, there wasn´t really any time to learn Spanish, and this impacted on the experience heavily. I suppose that over 6 months this would not be a problem, but with only a few weeks, it was a steep learning curve trying to improve to a conversational level.

On the ITU however, many of the patients were unconscious, so this proved to be less of a problem, but it was impossible to communicate with those that were awake. As a result, I think this had a negative impact on my experience here. During one night shift in the Ermergency Department, myself and the nurses did use an online translator in order to communicate which worked quite well and caused some hilarity along the way with the mistranslations.

In order to maintain good clinical care, I was supervised at all times with patients and so this was not a problem. So, where communication with staff was fine, patients proved to be more of an issue. According to the following requirements of the GMC´s Working In Teams, I believe that I was compliant.