GENERAL MEDICINE

How are the population's lifestyle different to the UK'S in terms of diet and exercise and how does this have an impact on prevalence of certain medical conditions.

In Belize obesity is very common. In particular, it was noted that the majority of women in Belize are overweight. Due to this, the incidence of diabetes is increasing as well as other obesity related complications. A typical diet in Belize consists of rice and beans with their biggest meal being at lunch time. Eating big feasts is more cultural in Belize as well as in the UK. Obesity is also an issue in the UK and diabetes has a high prevalence here so in this aspect both Belize and the UK have a similar trend. However I believe education and ways to tackle obesity are more thorough in the UK.

In many clinics I saw doctors try and educate their patients on how to eat healthier and exercise more in order to lose weight,and therefore reduce their health problems related to them being overweight. Doctors often became frustrated as patients did not accept the fact that they needed to lose weight and did not gain motivation to lose despite telling them. I think in the UK there is more of a stigma to being obese and people are generally more health conscious, which is helped by the media and public. In Belize however, obesity is not seen as a negative thing to most people, and so dieting and regular exercise is not commonly done. There needs to be better education to the population about the outcome and risks of obesity and how they can be dealt with.

How have I developed my communication skills as a doctor to patient's that do not have the same first language as me?

In Belize I sat in many clinics and numerous ward rounds and I observed the interaction between patients and the doctor and communication. Even though Belize is a British colony many of the people speak Spanish as their first language. So when I sat in clinics I didn't understand what was being said but I observed the interactions between the doctor and patient and the level of non-verbal communication. What I realised is that the women usually come to see the doctor with their husband's, who play a big part in the decisions of their health care. I have realised having an interpretor is important, but during the consultation it is necessary to still speak to the patient instead of to the interpretor. It is vital they understand exactly what is being said and that their concerns are also being fed back correctly. A few differences I noted were that permission was not gained for having a medical student in the room during the consultation.

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What are the prevalent medical conditions in Belize and how do they differ from the UK?

The most common condition I saw in Belize was malaria. Other tropical diseases in Belize such as Dengue fever occurred but were not as common. The majority of cases are of the P. vivax variant. Other common cases I saw was cholera and hepatitis A and B.
In the UK, tropical disease such as these is very uncommon, with malaria and dengue fever being very rare cases only being seen with recent travellers. This is due to better hygiene and sanitation. Another important factor is the difference in weather conditions being different such that there are no or very few mosquitoes in the UK.
In addition in the UK, better medical facilities and expertise means those precautions can be taken to prevent these diseases. Malaria tablets are common and hepatitis vaccinations are readily available which plays a big part in the prevention of these disease. In Belize, due to the lack of medical resources, and mosquitoes, the prevalence of these tropical diseases is very high. HIV is also quite common in Belize. I saw a handful of patients with it, admitted with opportunistic infections or lymphoma mainly. They referred to the patient as having "CD20" to refrain calling it HIV due to the stigma attached to this condition.

What is the system of secondary referrals and how does this differ from the UK?

In the UK primary care involves GPs who refer on cases to the specialist needed known as secondary care usually in a hospital. However, in Belmopan there isn't a distinction between primary and secondary care and in most cases patients present in the hospital first, in a walk in centre situated in an outpatients department in the hospital. If the doctor thinks that the patient may need admitting then they can so it straight away in the same hospital. So therefore, primary care and secondary care are both situated in the hospitals. In addition he doctors who sit in in walk in clinics tend to be from the same team as that involved in the secondary care of the patient. In some hospitals tertiary treatment is also provided by the same hospital. The advantage of this was the efficiency of treatment delivered to the patient as there was no time delay of waiting for the secondary referral. There were times when the walk in clinic was extremely busy, but most of the time the number of patients waiting to see the doctors was manageable and so this wasn't a problem.

In the hospital I was working at, the concept of different specialities was very vague. Most surgeons were not specialised like in the UK, for carrying out specific operations, they did everything. Operations that one surgeon did in a typical day varied from an amputation of a toe to an appendix in a child.

In addition, ward rounds had very varied patients. One doctor would see patients from all specialities. This is due to the lack of staff in the hospital as well as a different healthcare approach compared to the UK. In England, a doctor would become specialised into a field of medicine which they are interested in and advance into that field, whereas in the hospitals in Belize the doctors seemed to prefer having a varied interest.

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