OBS + GYNAE

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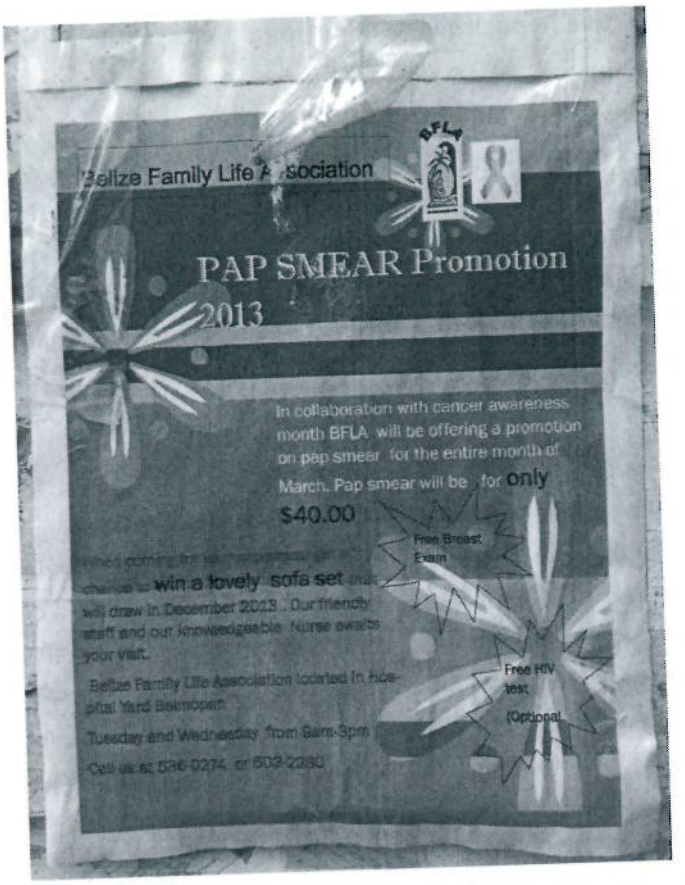
Medical Elective Report: Western Regional Hospital (Belmopan, Belize)

Objectives

1) Describe the pattern of health provision in Belize and contrast this with the UK
2) What are the common obstetric emergencies in Belize? How does this differ to the UK?
3) Compare and contrast the maternity services in Belize and the UK including antenatal, perinatal and postnatal care
4) Reflect on the experience and my ability to communicate with patients and healthcare staff whose first language may not be English. Gain exposure to obstetric emergencies

I chose to undertake my medical elective at the Western Regional Hospital, located in the administrative capital of Belmopan in Belize. Belize is a small but ethnically diverse country in Central America, with a population of only 312000 people. There are Caribbean/Rastafarian, Spanish/Mayan and colonial English influences which make visiting Belize a culturally rich experience. It is still a poor country however, and this was evident when we arrived at the public WRH. The small government hospital has only fifty beds, serving a population of around 70000 people. However, it has one of the largest obstetric and gynaecology departments in the country such that most women who suffer pregnancy related complications are sent either to WRH or Belize City. Additionally, there are two operating theatres, an A+E department, paediatric services, medical and surgical outpatient clinics and the country's only psychiatric unit. The doctors who worked there mostly came from Cuba, which apparently supply the majority of doctors to the Caribbean area.

The healthcare system is mixed, with both public and private systems available. In this respect it is similar to the UK, where some citizens may choose to have private healthcare insurance in order to access more advanced services without a waiting time. In Belize, these are mostly used by the expatriate community. Most Belizean citizens are unable to afford insurance, which can cost up to one hundred US dollars a month and so rely on the public healthcare system, which is funded by the government through social security- much like our national insurance. According to WHO, 5.7% of GDP is spent on healthcare compared to the UK, where it is 9.3%. This amount has increased in recent years as the department of health have been intensively reforming the health sector, focusing particularly on areas such as public health and education. This was very evident in WRH, where posters decorated much of the walls and covered a large range of subjects including breast feeding, cervical smear testing, safe sex, vaccinations and antenatal care. Leaflets were available throughout the hospital and outside clinics outlining health promotions and services including competitions to win sofa sets when attending for cervical smears!



Additionally, a digitalised online patient record and tracking system was developed which links all the public and private hospitals in Belize such that information can be rapidly. The doctors and nurses used laptops and handheld electronic notepads to record all patient information, which admittedly did look out of place in the often crowded, hot and basic hospital. It also took up a huge amount of time, which definitely reminded me of the administrational aspects of being a junior doctor in London. The hospital often experienced equipment shortages of the most basic medical supplies such as syringes, gloves, surgical scrubs and antibiotics, which was in stark contrast to the advanced electronic records system and I wondered whether government resources were allocated as efficiently as they could have been. Although it is a public health system, patients were required to pay very small fees for being hospitalised and for having any imaging or lab tests etc. Elective surgery is also not available publicly (apart from caesarean sections) however, when we were there, a team of American military ENT doctors were at the hospital providing free surgeries as part of a combined humanitarian/training program to anyone who needed it. We were told that specialists from other countries often came and offered their expertise and services free of charge for a week or so at a time.

I spent a large portion of my time in the O+G department where I was able to learn about the maternal services available to women in Belize and to see how these differ from the UK. The antenatal clinics were very overcrowded (not dissimilar to East London!) although the waiting room was extremely hot with no air-conditioning or fans in the thirty five degree heat. Lack of funding and resources was the largest barrier to care that I found. Ultrasound was not routinely available at every appointment, nor were the very routine blood tests that are performed regularly in women in

the UK. On the other hand, the process of care is much the same as in the UK, where hospital antenatal appointments are reserved for women with underlying medical conditions and therefore are at higher risk of complications. Free prenatal care is available to most women from public health nurses. As in the UK, obesity and chronic diseases including cardiovascular disease and diabetes are very prevalent in Belize and as such there was a high incidence of diabetes and hypertension in pregnancy. These were often poorly controlled, possibly due to more advanced disease, poor education and knowledge of disease, as well as cost and availability of medication. As such, pre-eclampsia is fairly common, which led to a high rate of elective/emergency caesarean sections being performed for this reason, something I did not see much in the UK. Caesareans are only undertaken in extreme circumstances, for example if the mother becomes eclamptic or there is a high risk of death to the mother, or if a baby is in the transverse lie. They do not routinely perform them for breech babies, or failure to progress in labour like they do in the UK. Caesareans were performed with vertical incisions as opposed to the routine pfannenstiel incision used in the UK. I was told this was for speed and lower complication rate. Although not an obstetric emergency, an interesting case I saw was of a young single Belizean woman who had multiple sclerosis (MS) and had become pregnant. MS is extremely rare in Belize and most of the nurses had never seen anyone with it. It was interesting to see how they went about the patient's management, using a similar multidisciplinary team approach used in England although the patient was told that she was most likely going to have to stay in hospital for a long period of time, as there are no systems in place for district nursing and home care.

Reflecting on my experience at WRH, I found it to be challenging, rewarding and at times frustrating. The set up and layout of the hospital was similar to hospitals in the UK, albeit on a much smaller scale. Ward rounds were very similar, with a consultant leading the rounds with a junior. They were often teaching rounds, and I experienced the same style of questioning by consultants around the bedside as I do here in London. The doctors were very competent, skilled professionals who did extremely well in light of the lack of basic resources and equipment available to them, although they too were often frustrated by this. This made me appreciate the highly clinical intuition they often relied on without the basic monitoring, blood tests and scans that we in London take for granted without a second thought. In fact, the only bedside monitoring I saw was in the two "intensive care" beds which only had a blood pressure machine and an oxygen saturation probe. Clinics were also very similar in their style to the UK and I was surprised to see the doctors spending a lot of their time educating patients about their conditions and how it could affect their pregnancies, with prevention rather than cure based strategies. Public health awareness about chronic conditions is in its early days however, and coupled with the lack of medical resources explains the difference in obstetric emergencies seen in Belize.

The doctor-patient relationship I found somewhat different however, with patients leaving all of the decision making to the doctor. It reminded me of what I imagine medicine was like when the NHS first came into existence, with doctor's decisions rarely being questioned and patient care being decided by the doctor without much input or autonomy from patients themselves. The hierarchical system was also very evident. I studied Spanish at school and found it useful on ward rounds and in clinics, because although English is the national language, in reality, the majority of patients were immigrants from neighbouring countries where Spanish is the first language and most doctors and nurses spoke Spanish. I had the opportunity to practice some very basic and probably very

grammatically incorrect Spanish with some patients and at times this reminded me of being in East London in a clinic when an interpreter has not been booked! I thoroughly enjoyed my experience in a healthcare setting very different to the UK, and although the lack of resources available was at times frustrating, it made me appreciate the work done by the doctors at WRH. It also furthered my desire to explore other opportunities to practice medicine abroad once I am fully qualified and have a bit more experience under my belt.