GENERAL MEDICINE

Elective Report

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What are the significant health issues in Belize? How do the state and hospital address these concerns?

There was a very public and open awareness towards HIV/AIDS. Belize currently has the highest incidence of HIV/AIDS of all the Central American countries, especially among the teen and young adult demographic. To tackle this at a national level, the United Nations Development Programme (UNDP) has provided the country with a grant in order to subsidise the cost of HIV/AIDS education, free testing (as well as screening for other sexually transmitted infections), barrier contraception and psychosocial support to adults and young children affected by the syndrome. Having only been implemented in 2011, it is too early to assess the significance of the programme. In our first week at the hospital we clerked a patient who had recently learnt of his HIV status and consequently attempted suicide. During the history taking process it was evident that there is significant stigma attached to the condition. Despite being started on a course of anti retroviral medication, the patient was not given any further instruction, follow-up or receive the psychosocial support he was evidently in need of. In the UK, we incorporate a more holistic approach towards patients with chronic, life-limiting conditions.

Additionally, the local governments also try to educate and increase awareness of HIV/AIDS to the general public. For example, one of the major places of interest in the Cayo District was the large football stadium, which was in constant use. The walls of the stadium were adorned with large painted murals, slogans and anecdotes educating the key public health statements aiming to target those at risk of HIV/AIDS infection, such as "save your life…wear a condom", HIV: don't be afraid to ask" and "free AIDS test in the hospital". Drives such as this would be very effective at targeting high-risk individuals who do not go to school or those with very basic literacy skill.

However, despite being defined as an emerging and developing nation, it was quite refreshing to see mental health awareness in the town and hospital. San Ignacio Community Hospital also has its own mental health unit with a team of three nurses led by the hospital physician. In my previous experience of emerging nations, mental health is still a taboo topic that is often brushed under the carpet due to conflicts with cultural and spiritual beliefs.

What is the nature of healthcare provision in Belize? How does this differ to the NHS in the UK?

Having been under the British Empire for over one hundred and twenty years, the former British Honduras adopted the legislature and constitution of Britain as trade, industry and government became established in the country. As a result, Belize currently has a similar system of a mixed healthcare service as is provided in the United Kingdom. That is to say, eleven public hospitals provides free basic healthcare (at the point of delivery), which is

funded for by the state. The majority of healthcare demand is for antenatal services and emergency medicine. There is greater variation in the social demographics of the Belizean populace when compared to the UK. For instance, as well as having defined upper, middle and working class groups there are also indigenous tribes such as the Mayans. Such tribes still have no fixed abode yet frequently attend the ER (emergency room) and are lost to follow-up. This is in stark contrast to the UK where the vast majority of residents are registered to a general practitioner and are of a fixed abode.

For those who can afford it, doctors also see patients at their private clinics (costing anywhere from US$10-60) for basic treatments, and for life threatening conditions or major procedures, many middle class patients elect to leave the country to seek treatment in Cuba or the United States of America.In the UK we benefit from evidence based research, which ultimately means that the treatment and standard of care is similar, if not identical whether you choose free (NHS) or private healthcare.

The supply of healthcare, especially in rural areas such as San Ignacio, greatly outstrips the demand for it. As a result there is a shortfall of physicians. During our time, the emergency room and medical wards were understaffed so I elected to spend the majority of my time in these areas in order to help ease the workload on colleagues. All of the doctors in the hospital had trained abroad in neighbouring countries, and had chosen to take up residency at the hospital in exchange for a favourable financial incentive. This of course is very different to the training structure and allocation of doctors across hospitals in the UK where posts are created in order to meet the demand for healthcare, which is a consequence of healthcare economics and resource allocation.

What are the main obstetric concerns in Belize and how does this differ to the UK? How do the assessment, diagnoses and management differ?

I have found there to be similar obstetric concerns in Belize as with the UK. The majority of obstetric attendees were considered high-risk pregnancies due to the mother having undiagnosed diabetes (polyhydramnios), hypertension and pre-eclampsia. These are also conditions of concern in the UK. As a result, the expectant mothers were admitted to the ward at thirty-six weeks and closely monitored by the midwifery team. Despite the lack of investigative equipment, blood pressure measurement, sonic ultrasound and urine dipstick were adequate enough to monitor these women.

I was unable to witness any form of AROM or assisted delivery due to lack of appropriate equipment. It was later explained that the equipment could be easily procured but the obstetricians preferred caesarean section deliveries, as it is associated with a lower incidence of neonatal mortality than instrumental delivery. Despite the risk of wound infection or dehiscence, additional post partum complications such as post partum haemorrhage, uterine rupture and placenta accreta could be more readily managed during a caesarean section. In the UK, the incidence of postoperative infection is much lower, and complications during delivery can be readily managed due to the availability of suitable equipment and trained practitioners.

As mentioned, due to lack of a laboratory, many routine blood investigations and tests were unable to be performed. Therefore, as relatively inexperienced healthcare workers, we found it difficult to arrive at a primary differential.

Reflect on the necessary skills required to be an effective leader in a resource scare environment. What learning points could be implemented into my practice as a junior doctor?

As a prospective junior doctor trying to formulate a differential diagnosis in a resource-scarce environment, the learning curve was incredibly steep. Unlike medical training in the UK, it is simply not good enough to state that I would like to request "a full blood count, BUN (U&E), amylase, haematinics, tox screen etc", when there are no facilities to instigate these baseline investigations. There is a lot of emphasis on clinical acumen and obtaining as much detail in the history as possible. It is crucial to note that this is entirely dependent on clinical experience. Therefore when I start my Junior Doctor post (residency) I would not hesitate to consult a fellow colleague or a senior for advice, considering my relative lack of experience, as I would not want to make the wrong decision and ultimately endanger patient safety.

Equally, I feel that I should think carefully, premeditate and be able to justify the important baseline investigations that I suggest. Not only does this enable the conservation of scarce resources within the NHS, it also prevents the patient from being the recipient of unnecessary investigation, whether it is a simple serum amylase or head-CT.