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Elective Report

Describe the prevalence of Diabetes Mellitus in Belize and discuss this in the context of global health.

In Belize, Diabetes Mellitus is the leading cause of death whereas in the UK the disease ranks 16th in the top causes of death. The death rate by diabetes in Belize is 74.28 and this ranks 13th in the world for the disease in comparison to the UK which is 5.04 and 185th in the world. The reason for this difference is due to increased awareness, screening, diagnosis and active management of patients in the UK in comparison to Belize. An epidemiological study conducted in 2008 showed a significant number (13.1%) of people in the population to have Diabetes and of that population only 60% knew that they had the disease. The study also showed the prevalence of the disease increases with age with most diagnoses made between the ages of 40-64 and in this age category women were more likely to have diabetes than men. This pattern of prevalence is different to that of the UK as diabetes largely affects males but have the same age group. A possible explanation for the difference could be due to diet, lifestyle and a lack of screening and awareness of the disease. Ultimately, the healthcare service in Belize lacks resources and is severely understaffed to manage Diabetes in the same way as westernised countries such as the UK.

How does the Accident and Emergency department in Belize differ from the UK?

The accident and emergency department in the Western Regional Hospital in Belmopan, Belize, was very different to the A&E departments that I have had placements at in the UK. The actual department itself was very small with patients waiting in a small open room next to the car park, which was always overcrowded. In the department there were only a few cubicles for patients to be seen and these were small, stuffy and had only the most basic equipment available such as dressings. The hospital had no computed tomography (CT) facilities in the hospital so patients who required CT scans had to be sent to Belize city or were either diagnosed using basic imaging techniques such as X ray and ultrasound which inevitably lead to a delay in management. Patients were triaged but not nearly as effectively as the emergency departments in the UK and there was no monitoring of time patients have been waiting with no concept of breaching. Patients that required surgery often had to wait longer than they would in the UK due to severe understaffing as there was only one surgeon on site for the whole hospital. The department was also understaffed contributing to the long waiting times for patients and the majority of doctors in the department and hospital were volunteers.

Improve practical skills

During the attachment we spent most of our time in the emergency department but we also helped out in the other departments of the hospital due to understaffing our help was greatly appreciated. In most of the wards there would only be one doctor, the majority of doctors being volunteers, and two nurses so they found it difficult to cope with the demands of maintaining a ward of 25 patients. Therefore, we had many opportunities to perform basic practical procedures on patients that we will be expected to do during our foundation years such as venepuncture, cannulation, catheterisation, wound dressing, setting up and administering IV transfusions.

Improve confidence and ability when seeing patients

I feel my confidence in diagnosing and managing patients has greatly improved, as the exposure I had received during my placement was very different to that I have experienced from shadowing in my six years at medical school. There was more responsibility and a feeling of importance and being an essential part of the team as I was asked to perform many tasks and see a vast number of patients. Through performing multiple practical procedures daily during my attachment I feel I am thoroughly prepared to handle these tasks when I start my first rotation in August.