ELECTIVE (SSC5c) REPORT (1200 words)

A report that addresses the above four objectives should be written below. Your Elective supervisor will assess this.

Objective 1: What are the prevalent health conditions of the population served by the hospital, and how do these differ from those in the UK and other more economically developed countries.

In St. Vincent, there are several prevalent health conditions. Diabetes and hypertension are usually some of the first things asked about in the medical history, and are the only two conditions to be featured as specific yes/ no answers on the emergency department proforma. This in essence is probably due to the population majority being Afro-Caribbean; along with the local diet. This consists maninly of white rice and sweet white bread, and soft drinks which do not have diet alternatives, or whose sugar-free alternatives are much more expensive. There is also a cultural trend towards energy supplementation for children; ensure build-up drinks are available in most supermarkets, and flavoured milk drinks are advertised for the number of calories they contain. This is a worrying trend which is only likely to exacerbate the trend towards diabetes which is being seen increasingly in the community.

According to WHO data from 2011, hypertension is a big killer in Saint Vincent; in terms of deaths/ 100,000 population SVG has 32.0 and UK 3.7. I found this to be an unusual cause of death to document- I do not believe I have ever seen a patient in the UK die of malignant hypertension without other cause e.g. stroke or heart disease. This can be seen as also more common in Afro-Caribbean communities such as in the local population, and is also intrinsically linked to the higher incidence of diabetes.

Asthma is also surprisingly common. Asthma deaths/ 100,000 population stands at 2.7 in SVG vs 1.1 in the UK. Previously I imagined that diseases of hypersensitivity would be less common in less developed nations following the hygiene hypothesis; however asthma is extremely common; here they have a bay in A&E which caters solely for nebulisers and oxygen for patients who regularly come in with wheeze. There is also a separate triage system in A&E for asthma sufferers.

HIV rates are relatively high here, and is a relatively taboo subject, identified by a code on the front of patient cards (the proforma used) to signify infection. Steps are, however, being taken to advocate safer sexual practices, such as the provision of condoms at the desk of the emergency department.

Objective 2: How do the emergency service and internal medicine facilities differ in St. Vincent in comparison to the UK?

There are many differences between the UK and St. Vincent systems. On internal medicine the most striking difference is the lack of diagnostic tests/ imaging. It is relatively rare to request a CT scan for instance, and there are no MRI scanners on the island. There is also a distinctly different focus; towards accurate diagnosis based on thorough examination with an emphasis on in-depth knowledge of pathogenesis and away from a focus on patient experience or holistic care.

There is also less of a social care or benefits system; although run on an NHS-based model of health systems if for example a patient is crippled and cannot work again they will rely on the kindness of their families and receive little or no financial government support.

Another change is use of drug brand names instead of generic names. There is also an issue of financial instability in the hospital. Consequently suppliers are not being paid on time and therefore the

hospital ends up with a paucity of available drugs. For example for one week of my placement local anaesthetic and heparin were two drugs not available in the hospital, amongst many others.

Additionally, if a patient cannot be treated in the hospital, say for example for common sights in Britain such as joint replacement in OA or HER positive breast cancer, they must also fund their treatment in another health centre, such as the US or Cuba, or pay for drugs not available on the island to be shipped over. This can be extremely expensive and devastating financially for normal families, and some people go without because they cannot afford their treatment. This is in striking contrast to the UK whereby the vast majority of conditions can be treated on the NHS.

In A&E, aside from the differences previously mentioned, there is no time objective. Everything tends to happen at a slower pace, and patients may be in cubicles for many hours until beds become available. This is obviously a massive difference in focus to the UK, and in my opinion is much better.

Objective 3: Diabetes is a common condition in both the UK and St. Vincent; how does the treatment of type 2 diabetes differ in the two countries?

The treatment of diabetes in St. Vincent is in the main strikingly similar to that in the UK in the most basic terms. Metformin is widely used and sulphonylureas are also available, as well as insulin as a last resort. Other drugs such as the GLP1 analogues are not usually available for those whose control is inadequate. Blood sugar is measured by a system called GMR.

According to figures produced by the World Bank, World Development Indicators - Last updated April 23, 2013, the rate of diabetes in the UK is around 6% of the population and in SVG around 12%; so roughly double the proportion of patients have problems with blood sugar control. This can be attributed to the factors indicated above, as well as the consumption of alcohol which contains a lot of sugar, such as rum and beer.

Complications of diabetes are relatively common, such as ulcers. Patients are offered yearly foot and eye checks as in the UK, however my feeling is that they are less encouraged to attend and compliance can be very poor.

Objective 4: To reflect on how the contrasting attitudes towards medical professionals in the UK and St. Vincent affects my treatment of patients in both clinical situations as well as improving my communication skills with patients and other healthcare professionals who do not necessarily speak the same language as myself.

There is a difference in attitude towards medical staff in the UK and St. Vincent. In St. Vincent it is normal to examine patients with much less preamble than at home; doctors will regularly pull down patient's eyelids without letting them know what they intend to do, or examine and talk to patients without curtains drawn or in corridors. I feel like there is greater emphasis on the fact that patients are ill here and have presented themselves for treatment, whatever that may involve, with less avid attention towards how a patient feels about situations they are placed into.

I feel as though my communication skills have improved; when I first arrived I found it very difficult to understand some of the patients because of the sometimes thick accent in the area, however I am getting used to this now. Language barrier has consequently been less of a problem that I foresaw previous to the placement. I feel, having come to the end of my primary medical education, that practice in taking histories and examining are always appreciated, however I do not think I have learnt any new skills specifically, rather further honed skills I already possessed.

I have come to respect the religious aspect of healthcare as important in different communities; whereas this is a subject which is overlooked at home, spiritual care here is at the heart of nursing staff priorities. I feel that paying attention to the religious needs of patients at home, if they require such care, can only be a good thing and will help to improve care.

Word count: 1, 148