ELECTIVE (SSC5c) REPORT (1200 words)

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

I spent my elective at San Ignacio Community Hospital, which is located in the province of Cayo in western Belize. Belize has a healthcare system which I found surprisingly similar to the UK. In particular, the majority of healthcare is provided publicly by the Ministry of Health, with a smaller number of Belizeans using private healthcare. Within the public system, as per the UK, care is free at the point of use, with the exception of surgery which is approximately 150 USD per operation.

Belize is split into four health regions, with San Ignacio Community Hospital falling under the western health region. The western health region provides primary and secondary care services to the local population. Interestingly, only the central health region, which incorporates Belize City, can provide tertiary care and does so for the whole of Belize. This is in contrast to the UK where there are tertiary centres across the country. Outside of Belize City there are seven other hospitals providing secondary care including the Western Regional Hospital in Belmopan, which is the first port of call for patients needing transfer to secondary care from San Ignacio Community Hospital. San Ignacio Community Hospital itself is a level one medical facility, known as a polyclinic. This means the hospital has no operating theatre or anaesthetics department, but has an Emergency Department with a small ward for overnight stays, numerous clinics (including paediatric and general medicine) and a maternity department. Whilst on placement at San Ignacio Community Hospital I spent most of my time in the Emergency Department and the paediatric clinic. I also spent time at the Mopan Clinic, which is a community general health clinic in Benque (to the west of San Ignacio) run by doctors from the hospital.

Learning Objectives

Objective 1 and Objective 3 - What are the prevalent paediatric conditions in Belize, how do they differ from the UK? How does the management of the most common paediatric conditions differ from that undertaken in the UK?

Whilst in the paediatric clinics, general health clinic in Benque and the Emergency Department I was able to understand more about paediatrics in Belize. One of the most common conditions I saw in children was gastroenteritis. It was interesting to see the management of these cases and how this differs from the UK. After taking a history we undertook a full clinical assessment paying particularly attention to signs of dehydration. If the patient was found to be dehydrated they were admitted for intravenous fluids. All patients underwent a stool sample, which is different practice to the UK. This was to ensure the correct causative agent was isolated as there are numerous bugs (including parasites and amoebae) which respond to different treatments. The stool was taken on the first day of presentation, broad spectrum antibiotics given, and the patient returned the next day for the stool sample results and change of antibiotics if necessary.

I generally found the Belizean healthcare system to be very efficient. For example, when I scribed for the paediatrician on the computer system, I was amazed to see a fully central system with all patient records in one place. I have always found it fascinating how the UK has not managed to achieve this yet, and there I was looking at one in a provincial clinic in Western Belize.

Other paediatric conditions I witnessed regularly were injuries, particularly in the Emergency Department. For example, I helped reduce a child's broken wrist which occurred from falling out of a mango tree, and sutured the forehead of a toddler who had fallen off the step she was playing on. I have not spent much time in the paediatric Emergency Department in the UK, but I imagine falls from mango trees are second to none.

A child with a supraclavicular fracture was transferred to Belmopan for surgery. I had to tell the patient and mother that they needed to be transferred there by ambulance. It made me reflect on how lucky we are to have hospitals that can provide most of the care we need under one roof. It also made me think about the complications that could have occurred with the extra time for transfer if the child had signs of vascular injury.

Like the UK, paediatric cases included numerous asthma patients and upper respiratory tract infections. These were both managed in a very similar way to the UK. For example, mild and moderate asthma attacks received 2.5mg of nebulised salbutamol repeated up to three times. There was a designated asthma bay in the Emergency Department with two nebulisers. These were regularly in use by patients, who would come in to use them when they were feeling tight chested. I never saw patients using salbutamol inhalers. This may have been because, as I found out on discussion with one of the doctors, medication compliance is very poor in Belize. Interestingly, in relation to this, drugs are injected and rarely given orally. The doctor stated that this is because of the cultural perception of medication, as patients usually consider injections to work better than oral ones.

One paediatric case that stands out was a lady who was HIV positive and had come in to check the HIV status of her baby from the 18 month ELISA test. The results of the baby in question had not come back. It made me question how babies born to HIV positive mothers are managed in Belize. I looked at protocols set by the Ministry of Health for neonatal HIV management available in the hospital to understand more about case management. I found that the protocols were very comprehensive and similar to UK management. A large amount of antiretroviral therapy was available including Nevirapine, Zidovudine and Lamivudine.

Another paediatric case which stands out to me was when a 15 year old Honduran child came into the Emergency Department with a social worker as they had been caught at the Guatemalan border trying to cross illegally. They had been sold by their parents and were on their way to Mexico as part of a child trafficking attempt. Two other children had been involved but had not been rescued. Apparently this is a regular occurrence, and normally occurs on a Friday when the borders are unmanned. The child in question needed a doctor's assessment which included examination of the three main systems. The child was not wearing shoes and had poor hygiene and numerous scrapes and bruises from their journey to Belize. I found this a really challenging situation to witness, not only because the situation upset me, but also because I felt angry that we still live in a world where children are being trafficked. It made me think about how desperate you must be to have to sell your child. The social worker was attempting to re-home the child whilst they worked on finding out their details via the Honduran government. I was impressed by the social system which, although lacking funds and resources such as beds, was doing everything it could to find a safe place for the child.

Objective 2 - How are obstetric services organised and delivered in Belize, and how do they differ to the UK?

San Ignacio Community Hospital has a maternity department which comprises a labour suite, ward and clinical examination room. A ward round is conducted in the morning by the obstetrician, where ladies who have given birth the day before or in the night are examined. The paediatrician also performs a ward round and examines the neonates. On one of these ward rounds I discovered almost a third of babies are malnourished in Belize, which I found a surprisingly high number. As a result, doctors at the hospital were using scoring systems - which included values such as weight, height and girth of limbs - to pick up malnourished infants early.

As with the UK, the maternity ward was a 24 hour service, free at the point of care. It seemed very similar to the UK, as women in labour would call the midwives on duty before arriving at the community hospital for delivery. The department had similar equipment to the UK, such as cardiotocography and ultrasound, although these were not quite as technical.

If the women in labour required a caesarean section, they had to be transferred to the secondary care hospital in Belmopan via ambulance. As above, this made me consider how lucky we are to have medical care under the same roof. During labour, problems requiring urgent surgical assistance for the health of baby and mother can occur at any point. This made me think about the implications on baby and mother during the transfer, which takes around 30-45 minutes. This is a significant amount of time and could be life threatening if, for example, the mother loses too much blood or the baby is foetally distressed.

Antenatal care was provided at the hospital and by the community health clinic in Benque. I felt privileged to be able to see a lady who had tried to get pregnant for eight years find out she was six weeks pregnant. As in the UK, following confirmation of pregnancy, women are referred to the midwife and are given a book for noting important events and key milestones in pregnancy. Also as per the UK, the first ultrasound scan is at 12 weeks.

Objective 4 - Improve my communication skills with children and their parents.

One of the positive aspects of doing my elective in Belize was that English is the predominant language, so I rarely had a language barrier between staff and patients. There are two situations where I believe my communication skills were challenged whilst speaking to paediatric patients and their parents.

Firstly, there was a child who had been playing with his siblings and had fallen over. He presented with a swollen, painful, erythematous elbow (later confirmed as fractured). A gentleman brought him in who was visibly distressed. I had to try and calm him down whilst the doctor performed an assessment of the child. I had assumed the gentleman was his father, but after I spoke to him it emerged that he was trying to adopt the child as the child's mother was a dependent drug user. He was extremely worried for the child being in pain but also concerned that he might not be able to adopt the child if they had been hurt under his care. This raised two issues for me. Firstly, it taught me not to assume who relatives and visitors are, and to always ask that question early on in the consultation. Secondly, it taught me that you need to explore parents/guardians concerns to try and help relieve some of their distress.

The second situation was the child with the supraclavicular fracture mentioned above who needed to be transferred to Belmopan for an operation. On telling the child and mother this, I hadn't really considered an operation to be bad news. On reflection, I did not break the news in a way that we

have been advised in the past. Given the child's response to this news, I should have tried to take them aside (although there were no side rooms in the department) and explain the situation more clearly. This may have made the child less distressed. The mother was calm throughout, but I felt awful that I had treated the event as fairly trivial. This made me reflect on whether injuries and illnesses have become normalised in my mind during my time at medical school. I will endeavour to remember that the patient and their relatives have different ideas, concerns and expectations regarding illness and injury when communicating with them in the future.

Conclusion

I really enjoyed my time at San Ignacio Community Hospital and am very grateful for the support of the staff. I was able to get good hands on experience and excellent teaching. I feel that I now have a better understanding and experience of a healthcare system in a country that is very different to the UK. During my time there I developed my communication and clinical skills and I will take these forward into my future foundation training.