COMMUNITY MEDICINE

Elective Report

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Belize and Columbia

1. *What are the main conditions seen in a rural polyclinic in Belize and a city hospital in Columbia? How does this differ with the common conditions seen in GP surgeries in the UK?*

   The main conditions I saw in Belize were pregnant women coming for antenatal check ups and newborn babies being brought for their first baby check ups. This differed from the UK because it was midwives who ran the clinics and did the check ups in polyclinics as opposed to obstetricians in the UK. When any problems were encountered, the women/ babies were referred to the general practitioner at the clinic. The nurses also routinely give all babies BCGs which is not common in the UK. Other common conditions included traveller's diarrhoea(as it is a touristy area)and also contact dermatitis from people who had been swimming in the sea. Dog bites were also common. There were also many 'worried well' patients who came for general check ups. The health care professionals put this down to the service being free of charge. There were also patients who came for sick certificates to claim benefits just like in the UK.
   In Columbia, I mostly saw trauma patients. Road traffic accidents are extremely common as people drive motorcycles without wearing helmets. I therefore saw a lot of traumatic brain injuries. There were also people who had lost limbs in landmines. Dengue fever is also common here. HIV and tuberculosis are also prevalent. These conditions are not as common in the UK. There were also some patients who had injuries resulting from drug related crimes. In the intensive care unit, there were patients with pneumonia, sepsis and pancreatitis.

2. *How are health care services delivered in Belize? How does this differ from Columbia?*

   In San Pedro, Belize, there is a population of 20,000 and there are a few clinics on the island. At this particular polyclinic there were three general practitioners and four nurses. They offer GP clinics, maternity and child health care services led by nurses, wound care services, and they also have an observation ward which has three beds which is used for acute emergency medical care. They also have an onsite pharmacy and have facilities to do blood tests. All of this is free for patients including prescription charges (and so this is how it differs from the UK). Treatment is also free for all foreigners and so many patients come from neighbouring countries such as El Salvador and Mexico for treatment. However, if a patient requires an xray or ultrasound scan they must go

elsewhere where there will be a charge for this service as this polyclinic does not have the facilities to provide this. Also, if mothers wish to have a copy of their baby's ultrasound scan they must pay for it.

In Columbia, all patients must have health insurance. They can either pay for a public insurance or opt for private insurance. However, the system is highly corrupt. The insurance companies (both public and private) usually keep the money for themselves and refuse to pay for expensive treatment and often let patients die.

3. *Describe a condition seen in Belize and a condition seen in Columbia and explain the similarities and differences in how the patient was investigated and managed compared to the UK?*

   I saw a child with bronchiolitis in Belize. In the UK, this child would either have gone straight to the emergency department or have gone to their GP surgery where the GP would have referred them to the emergency department. However, at this polyclinic, the child was seen straight away by the doctor who was in the middle of clinic and had to stop what he was doing to see the child. The child was taken to the observation ward and was immediately given a salbutamol nebuliserwhich helped the wheezing straight away. The oxygen mask did not have a strap to keep it attached to the child's face so it was repeatedly removed and the child's oxygen saturations kept dropping to less than 90%. In the UK, the child would have been given continuous oxygen titrated according to their needs. Next, a cannula was inserted by the nurse (although she had difficulty doing this as it would not stay stuck down). In the UK, the doctor would have done this as the nurses usually are not skilled to do this. She was then given normal saline. This is not routinely started in the UK until the child's breathing problem is treated. She was then written up for methylprednisolone (in the UK she would have had IV hydrocortisone) followed by aminophylline. In the UK, ipratropium bromide is the next step following IV hydrocortisone, followed by magnesium sulphate and only after this is aminophylline started. The patient was then left to be observed by the nurses on the ward. In the UK, she may have then had a chest x-ray however this polyclinic does not have the facilities for this.

   In Columbia, I saw a patient who had just been in a road traffic accident. He had suffered a traumatic brain injury as he was not wearing a helmet whilst driving his motorbike. He had very little monitoring equipment on him. Although a team of neurosurgeons were looking after him, they did not have the resources or the skills to perform an emergency decompressive craniotomy and so he patient was left to die in the emergency department. South Columbia only has one neurotrauma surgeon who is trained to carry out this operation which could potentially save many lives. When this consultant is not on call, patients are under the care of surgeons who do not have the skills to treat such patients and so they are left to die. They do not have the money or resources to teach

these surgeons these skills but they are working hard to change the system and get these surgeons trained.

4. *How has working in a rural polyclinic and a busy trauma centre with limited resources improved my knowledge and how I care for patients? What have I learnt from the experience?*

   Before coming to Belize I assumed the polyclinic would be in a rural area with limited resources. However, it seems to be in a touristy area with adequate resources. When patients need scans they are referred elsewhere and so this is how the clinic lacks resources but this is similar to GP surgeries in the UK. I therefore do not think this aspect of my clinical experience here has improved my knowledge or changed the way I work. However, being able to be hands on in clinic and examine patients in antenatal care and do baby check ups was enjoyable and allowed me to practise these skills which will be useful for my FY2 placements in paediatrics and obstetrics.

   Seeing so many traumatic injuries in Columbia was extremely upsetting, particularly as the hospitals did not have the skills or resources to treat them. Watching patients suffer or even die made me see the patients' and their families' perspectives on their conditions. It also made me feel extremely helpless and I really hope that our consultant can change the way the system is run there to get more surgeons trained to deal with these traumatic brain injuries, which he is desperately trying to do. I also had the opportunity to learn how to do a FAST scan which I hope will come in handy when I start working soon.