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GENERAL MEDICINE

Elective Report

What are the common health conditions presenting to rural clinics in Belize? How is this different to the common health conditions seen at GP clinics in the UK? What are the common health conditions presenting to a city hospital in Colombia & how does this contrast to the UK?

Gastroenteritis and other intestinal diseases are significant health issues for Belizeans, particularly for poor rural populations. Respiratory conditions, particularly the common cold and pneumonia were frequent conditions presenting to the community clinic as were dermatological conditions such as ringworm and eczema, and dermatological conditions not so common in the UK like scabies. Vitamin A deficiency is common due to poverty and malnutrition and children are given vitamin A supplements when seen in clinic.HIV is prevalent and is often routinely included when the patient needs a blood test without informing the patient that it is being tested for. Dengue fever is a problem during the rainy season. As in the UK, hypertension and diabetes are chronic health conditions seen and treated by community doctors in Belize. Many of the pregnant patients attending the maternity services at the polyclinic had to see the doctor due to testing positive for a urinary tract infection on urine dipstick or they presented to the doctor directly with lower urinary tract symptoms. At the clinic there was a separate clinic just for wound care which treated wounds attributed to diabetes or trauma such as stab wounds, for example. In general the health conditions seen at the community clinics in Belize are similar to the health conditions seen at GPs in the UK such as ailments concerning the respiratory, gastrointestinal and dermatological systems and chronic health conditions like hypertension and diabetes.

In the trauma department I mostly saw patients involved in motorcycle accidents, which is a major problem in Colombia and accounts for most trauma cases that are seen in the hospital which is not as a significant problem in UK. I also saw a number of landmine victims who were flown in from the jungle who had to have limbs amputated. In the ICU there were patients with severe exacerbations of COPD, heart failure, patients with polytrauma affecting the head, thoracic and abdominal cavities mostly due to motorcycle accidents and injuries due to violence –gun shot and stab wounds.

How are medical services and care provided in Belize? How does this contrast with Colombia and the UK?

There is a national healthcare system in Belize that is funded by the government through taxes and global aid (particularly from UNICEF and grants from countries such as the USA and UK) and accounts for 9% of the total of the Belizean government budget. This system covers the cost of a visit to the doctor in the community setting but not including any invasive procedures or diagnostic imaging. Standard prescriptions, antenatal and all childhood vaccinations (the childhood vaccination programme is the same as in the UK) are free. If a patient needs to be referred from the community to a hospital they will need to pay for any treatment received there. The national healthcare system does not include financial cover of diagnostic tests such as CT scans, surgical procedures and abortions which is illegal whereas in the UK everything is free for patients. Doctors can also work in the private healthcare system, but because the government pays their wages during the day it is against the law for the doctor to work in the private sector during normal working hours. This differs to the UK where there is no restriction to when a doctor can work in the national health service or private sector.

Belize has an electronic health record system which lets patient data and medical notes to be accessed by any healthcare professional in any medical facility across the country once it has been entered electronically; therefore a hospital can access any notes that were made at community clinics which is a much more efficient system than in the UK.

The hospital I worked at in the south of Colombia, Neiva University Hospital, has 450 beds and two Intensive Care Units (General and Women). Once Colombia had a strong national healthcare system but now the healthcare system in Colombia is mostly private for financial gain. Even though there is a national healthcare system, both the national and private systems are corrupt as patients are denied treatment if it is deemed that the treatment is too expensive. Healthcare in Colombia has become a commercial system for profit with a number of private insurance businesses that offer health insurance paid for in advance mainly for profit. This is unlike the UK where healthcare is an establishment that is socially orientated and not for financial return.

Describe a patient case seen in both Belize and Colombia, explaining how the patient was investigated and managed. What are the similarities and differences in how a patient presenting with these conditions would be investigated & managed in the UK?

In Belize a 54 year- old gentleman presented with a one week history of a productive cough and coarse crackles on auscultation. He had a past medical history of TB. The doctor suspected that he had pneumonia. He was treated with intravenous Gentamycin for which he had to attend the community clinic to receive these antibiotic injections everyday and at the same time he could be checked to see if he is improving. The doctor said ideally he should have a chest X-ray but it is costly and the patient would have to pay for it at the hospital. In the UK a mild pneumonia would be treated at home with antibiotics. If a patient's symptoms are severe they may require hospitalisation or referral to a hospital for a chest X-ray to confirm the diagnosis of pneumonia which can then be treated at home.

In Colombia a 32 year-old gentleman involved in a motorcycle accident was found to have cerebral oedema and a basal skull fracture on CT scan. His GCS at presentation was 9 and he deteriorated to 7 in a few hours. He needed to be transferred to the ICU but there were no beds available. The team gave him mannitol and decided to watch and wait. He died two days later. He should have had a decompressive craniotomy but our consultant who is the only neurosurgeon who does this procedure was not on call that week so the patient did not have any surgical intervention. In the UK this trauma patient would have been investigated and managed medically in the same way but they would have had a craniotomy and would not have been managed with 'watchful waiting'.

What have I learnt (clinical or non-clinical) from my experience at placements in Belize and Colombia? How will these experiences influence me as a junior doctor?

In Belize I enjoyed the challenge that community clinic presented of being the first healthcare professional that the patient would see and having to be able to diagnose what was wrong with the patient based on their clinical presentation and with no investigations or basic ones such as bloods and urinalysis and to then organise a treatment and management plan. This will help me as a junior doctor when clerking patients to take a focussed history and examination. This focus applies when ordering investigations too.

In Colombia relatives had to ventilate the patient with oxygen while the team were busy doing other things for the patient which really shocked me and affected me emotionally, and relatives were present at the bedside when the patient was being treated in the trauma department so any bad news was broken in a rather rushed and inappropriate setting. As a junior doctor I will ensure breaking bad news is done sensitively and in an appropriate setting and I will also think of how the patient's situation impacts not only them but their relatives too.