

A reflective report comparing the management of end-stage renal disease in St. Lucia with the West Midlands, UK.

Amy Orme, The University of Birmingham

I undertook my four week elective placement at Victoria Hospital in St. Lucia, one of the Eastern Caribbean islands, focussing on renal disease and its' management. The hospital is located in the capital, Castries, and is the main public hospital and trauma unit for the island. With 150 beds, including six acute care beds and one resuscitation room, it hosts the major medicine and surgical specialties. Although the Government partly funds patient care, the patients' themselves typically incur substantial costs. Often patient can't afford consultations, investigations and treatment, resulting in them not presenting until a late stage.

Renal medicine was evident across the whole hospital and during my placement I was fortunate enough to divide my time between the renal department, the medical wards, A&E and paediatrics. The renal department which is composed of the renal dialysis unit and outpatients clinic is run by one consultant and his team. They are largely of Cuban origin with Spanish being their first language, which differs from the local language of Creole, a mixture of English and French. Consultations were always in English, although they were somewhat fragmented or difficult for one party at times due to varied accents.

The dialysis unit is staffed by nurses and technicians, nine in total. Patients arrive for their session and the unit has 11 beds. Another smaller unit of seven beds also operates at a near-by site. Dialysis sessions run on a rolling basis, each session approximately four hours in duration and three of these take place each day, over six days. Therefore patients are allocated into groups whereby they all receive their treatment on the same days each week, allowing for familiarity and the chance to bond with one another. Patients either receive treatment on Monday, Wednesday and Friday, or Tuesday, Thursday and Saturday. The unit is also always on standby to deal with any emergencies. I remember feeling at the time that the set-up almost mirrored the UK and this way of organising the dialysis seemed to work well. However, it could be argued that still the dialysis unit is not at full capacity as it is not used on a Sunday or overnight routinely, due to religious reasons and also patient and staff inconvenience, respectively.

Currently on the list are 66 patients, however more than 100 patients are now on the waiting list having entered end stage disease (CKD stage 5). Therefore, it is inevitable that unfortunately not everyone will receive dialysis. Unlike in the UK where patients are counselled from an early stage about their deteriorating renal function, this doesn't always happen in St. Lucia. One reason for this is that patients typically present late. Community medicine and primary care is often inadequately sourced so patients aren't detected at early stages of disease. Secondly, referral from primary care to secondary care is often delayed. Thirdly, access to primary care has its' own obstacles and a shortage of doctors so patients often have difficulty obtaining appointments. Fourthly, education is lacking and there are cultural differences regarding health, such that many believe in home remedies. Fifthly, the healthcare is often costly for a patient as it is only partly funded by the government.

In contrast to the UK, once patients are placed on the waiting list and dialysis is imminent, they often are not prepared for dialysis by having a fistula formed. Staff expressed that this is partly due to the

cost of producing fistula's which may never be used and secondly as this procedure would raise the hopes of the patient that they will receive dialysis when often a bed may not come available. Therefore, patients usually undergo this procedure once receiving dialysis so there can be problems gaining access initially until the fistula has been created and matured.

Statistics for the islands' renal disease and demographics of patients were unobtainable from the Ministry of Health, although purely from observation dialysis patients were typically young. I was shocked to discover the average age of dialysis patients was between 35 and 40 years with hypertension being the main causative factor. This could be attributed to poor diet with a high salt intake, urbanisation and introduction of fast food chains to the country, lack of funds for patients to afford a well balanced diet and partly due to genetics. However once hypertension has been diagnosed, lifestyle advice has been offered and medications prescribed, often patients do not have the money to pay for the medication so they continue to have poorly controlled hypertension despite the efforts to control it. Likewise, diabetes is a huge problem in the Caribbean and this is another preventable and controllable risk factor for renal disease.

Another difference which I witnessed was that haemodialysis is the only type of dialysis offered on the island, whereas a large proportion of patients in the UK use peritoneal dialysis. Many choose this option as it offers more flexibility for them to continue with their lives. However, it is not available in St. Lucia for a couple of reasons; lack of funding to provide this service and the difficulties and complications associated with peritoneal dialysis such as the associated infection risks. An additional treatment offered in the UK at specialist units is transplantation. On the island it is not offered, but can be performed at Barbados. Although, the patient would have to solely fund their own care, so is rarely seen.

I would also like to comment on one particular case that highlighted many differences between the delivery of care out in St. Lucia to that I have witnessed whilst on placement in the West Midlands, UK. This patient was a young male prison inmate who had been seen previously regarding poor renal function. He presented to the clinic this time with increasing tiredness. Blood tests were taken at the prison and the results showed anaemia and a GFR of 14. The doctor requested for the bloods to be re-taken as they arrived at the lab later than they should have. The patient was concerned that the diet he was given at the prison was inadequate to meet his health needs, yet the doctor could not write a recommendation or address these concerns as it was at the prison managers' discretion. This seemed to differ from the approach that is taken in the UK, whereby everyone regardless of their circumstances is treated in their best interests and authorities will take note of health issues. Secondly, the communication between the doctor and patient was minimal in comparison to what we may expect to happen in the UK, with such serious news being broken to the patient. The doctor commented how he was putting the patient on the dialysis list and that there is a fairly substantial wait. However, I did feel as though the patient left the consultation not quite grasping what this information meant. I was surprised that the patient, nor the prison staff, asked any questions as the information given to them was very brief. This was a common theme which I witnessed across many specialities at the hospital. Patients hold a great deal of respect for the doctors and the hierarchy system in place means that enquiring or questioning their decisions are more or less unheard of.

This placement was a fantastic opportunity to experience healthcare in another country. This eye-opening experience has highlighted how fortunate we are in the UK to have free, unlimited

healthcare at our fingertips. It may be concluded that St. Lucia is still far behind in terms of the services and provisions we have in the UK, however it is making the correct steps to tackling such large public health issues.