Medicine in Brazil

“Brazil is not a country for beginners” – Tom Jobim

“O melhor do Brasil é o Brasileiro” (The best of Brazil is the Brazilian)

Just hours after landing in the country, on the way to meet my host in the city of Pouso Alegre, I found myself stranded on the side of the road in backcountry Brazil. This was my first time travelling abroad alone, I was without a functioning mobile phone and was acutely aware that I could hardly have been more conspicuous as a ‘gringo’ (foreigner) what with my blue eyes, blond hair, and huge red suitcase.

The bus had broken down and I was standing with the other passengers in a field, wondering how on earth I was going to get to my destination. All this in the context of a media coverage in the run-up to the Olympics which had portrayed Brazil as plagued by administrational incompetence, poverty and violent crime. Needless to say, I was feeling quite on edge.

Fortunately, realising I was a foreigner, the other passengers allowed me to borrow their phones and a group of us chatted away for an hour or two, eating traditional biscuits that one of them had brought, waiting for the next bus. The locals wanted me to feel welcome and to tell me about the best side of their country. I had been in Brazil for a matter of hours, but had already made my first friends. Such goodwill set the tone for the next month, in which I was touched by the warmth and generosity of Brazilian people.

I was here to do a placement in neurosurgery in a hospital in the state of Minas Gerais. Minas Gerais, famous for its cheese and coffee, is stereotyped by Brazilians as being very ‘caipira’ or countrified – think cowboys with plaid shirts and straw hats, horses and carts and dusty country lanes. My hospital, called Hospital das Clínicas Samuel Libânio, was located in the small city of Pouso Alegre (population: 140,000; or about the same size as Oxford), located inland and close (at least in Brazilian terms) to both Sao Paulo and Rio de Janeiro (a 3 or a 5 hour drive respectively). Relatively rural, yes, but the proximity to Sao Paulo and Rio meant the experience was quite different to what I might have got in more remote and deprived areas of the country. I was, after all, in the south east, which is the most economically developed of Brazil’s four regions. However, this did not prevent from seeing tropical neuro-infectious diseases, stabbings, road traffic accidents and a whole approach to medicine which was somewhat different to that of the NHS.

A photograph of Pouso Alegre and a map of Brazil showing its location in the South-East of the country.
A traditional Brazilian ‘caipira’ smallholding just outside the city.

The hospital receives both private and public patients, although the private and public areas of the hospital are separate from one another – almost as if they were two separate hospitals – and medical students generally only work in the public areas of the hospital. I was assigned to work with the neurosurgical team and spent the majority of my time shadowing their residents (trainee neurosurgeons), who were between 1 and 4 years out of medical school. Though these residents had not long finished medical school and were relatively young, I was impressed by their competence. I also spent time in the emergency department with other teams (the general medics and general surgeons) and some time with the hospital’s (only) clinical neurologist.

### Medical training in Brazil

Doctors (often) enter speciality training straight out of medical school in Brazil, although medical school takes 6 years, and the final year is somewhat like being a not-quite-fully-qualified and unpaid ‘F1’ doctor in the UK. In addition, speciality training programmes are generally a few years shorter than their equivalents in the UK.

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A typical day for me consisted of the following:

- 7 am: Arrive and read up on the patient’s notes while the resident updates the notes
- Attend small group teaching sessions
- See ‘ambulatory’ patients on the ward (this is a walk-in clinic that is held on the neurology ward)
- Assess patients in the emergency department
- See referrals from general medical wards, orthopaedics, paediatrics and assess our patients in the ITU
- 7 pm: Finish for the day, usually leaving the on-call resident to work for a few more hours!
The patients I saw

Over my 3 weeks I saw patients with the following conditions/complaints:

- **Neurosurgical patients: (intracranial problems):**
  - Sub-arachnoid haemorrhage x5
  - Intra-cerebral haemorrhage
  - Acute subdural haemorrhage x2
  - Chronic subdural haematoma
  - Head trauma (no bleed) x2
  - Posterior fossa tumour x2
  - Posterior fossa subarachnoid cyst
  - Posterior fossa abscess
  - Pituitary adenoma
  - Ventriculitis
  - Infant with varicella and hydrocephalus
  - Cerebral aneurysm (un-ruptured) x2
  - Arterio-venous malformation
  - Venous sinus thrombosis
  - Sudden onset headache (other)

- **Neurosurgical patients (spinal problems):**
  - Cervical trauma x6
  - Cervical spondylothesis
  - Musculoskeletal low back pain x4
  - Spinal stenosis (degenerative) x2
  - Spinal disc herniation x2
  - Infant with spina bifida
  - Spinal abscess

- **Neurological patients**
  - Headaches
    - Migraine x4
    - Occipital neuralgia
    - Trigeminal autonomic neuralgia
    - Headache: tension or other x2
  - TIA x3
  - Stroke x6
  - Carpal tunnel syndrome x4
  - Bell's palsy
  - Multiple sclerosis
  - Epilepsy x3
  - Transient global amnesia
  - Paraesthesias
  - Confusion, normal pressure hydrocephalus x2
  - Generalised anxiety disorder

- **General medical patients:**
  - Delirium x3
  - Lymphoma
  - Alcoholic liver disease x2
  - Heart failure x2
  - Mitral regurgitation
  - Peri-orbital cellulitis
  - Pneumonia x2
  - Pleural effusion
  - Hepatocellular carcinoma
  - Oesophagitis
  - Angina
  - Acute asthma attack
  - Anorexia bulimia

- **Surgical patients**
  - Acute abdomen x2
  - Umbilical hernia
  - Eye trauma x2
  - Ear trauma
  - Hand trauma
  - Severe trauma: stabbing x2
  - Inhalation injuries

Although formally this was a neurosurgical placement, with the neurosurgeons at this hospital I saw a lot of patients that in the UK would be seen by other specialities. There is very rarely a neurologist on call so the neurosurgeons saw all the patients with anything remotely neurological, including headaches, strokes, TIAs, seizures and even patients with acute confusion/delirium. They also see a lot of paediatric patients with seizures and headaches etc. who would probably normally get seen by the paediatricians in the UK. There are also no neuro-radiologists in the hospital, so the on call neurosurgical resident has the responsibility of reporting all the brain and spinal imaging.
Observations and things I learned

1. The mix of private and public healthcare in Brazil seems to result in inefficiencies

Brazil’s health system mixes public and private sector provision. Three-quarters of the country’s 200 million population depend on free care from the ‘Sistema Único de Saúde’ (Unified Health System) which is the largest public health system in the world. The remaining 25% of the population receive care in the private sector, although many use the public system as well. While it would be difficult to measure, I got the impression that the influence of the private sector results in over-investigation, over-diagnosis and over-treatment.

For example, from what I observed, patients in Brazil seem to have just as many, if not more, MRI scans than patients in the UK; this being despite the fact that Brazil has a lot less money to spend on healthcare than the UK and MRI scans are relatively expensive. Patients arrive in the public emergency department holding print-outs of brain scans they obtained from private clinics – which they may not have needed in the first place – and the neurosurgeons then have to spend time reviewing the images and explaining everything to the patient. This seems fairly inefficient but I suspect it occurs because someone, somewhere along the line, stands to make money from every scan performed.

2. Primary care (general practice) in Brazil is not what it is in the NHS

Though they exist, primary care services vary considerably in quality and generally there is a reluctance among patients to use primary care. Patients prefer to come straight to emergency department or see a specialist directly through the private system, rather than see doctors in the community ‘Basic Health Units’. As a result, some patients appeared to lack good co-ordination of their care and I suspected that many more had sub-optimal control of chronic conditions like diabetes and blood-pressure. This really reminded what an asset our GPs are to the NHS.

3. Guidelines, protocols, algorithms and evidence-based medicine matter less in Brazil

Here in the UK we are used to seeing patient notes and bedside folders full of sheets of things which have to be done, checked-off or filled in and signed: thromboprophylaxis risk assessments, DNACPR discussion, MUST scores, Warterlow scores, NEWS scores etc. Even the medical clerking (the history taken by doctors when patients first come into hospitals) is completed using a template that helps to remind the doctor of all the key areas of the history and examination. We seem to have a form for everything. By contrast, the patient notes in Brazil consisted of just a few sheets of essential clinical information which were updated every day. It was a relief not to see a single tick-box exercise during my time in hospital.

Targets in Brazil are also conspicuous by their absence. There is no target for emergency department waiting times, surgery waiting lists or ‘door to needle time’ for stroke treatment. Clinicians operate free from the fear of performing poorly in the next round of audit. Staff are simply focused on providing the best quality of care they can and getting patients through the busy emergency department as efficiently and safely as possible.

In general, far less emphasis is placed on guidelines, protocols and ‘evidence-based medicine’. Instead, doctors have greater freedom to exercise professional judgement and tailor treatment to the patient in front of them. Doctors also seem to rely more on personal clinical experience (or that passed down through teaching) – I didn’t once see a doctor referring to the latest guidelines for management of a particular condition. However, anecdotally, it’s difficult to say whether this reduced emphasis on guidelines and protocols actually affects the quality of care that patients receive because I wasn’t collecting any data on patient outcomes.
Final thoughts

Brazilians might just be some of the friendliest people I have ever met; I was received with open arms everywhere I went. Staff and other students were approachable and keen to teach and exchange perspectives on medicine with a foreigner. The atmosphere in hospital was a lot more informal than it is in the UK; staff were constantly having fun and joking around but it seems this workplace banter is crucial in maintaining morale and a strong close-knit team.

I return to the UK with a heightened appreciation for our country’s free healthcare system, an appreciation for the fantastic work of NHS GPs in particular and a realisation that good, patient-focused medicine can be practiced without recourse to guidelines and protocols. However, perhaps most importantly, I feel a renewed enthusiasm for my profession and a desire to emulate the positive aspects of the Brazilian way in my working life.

The hospital: Hospital das Clínicas Samuel Libânio, Minas Gerais.
One of the student year groups at a gathering hosted by one of their professors

Me and some of the staff in the emergency department
Parties with patients in the haemodialysis department – only in Brazil!

A training session with a simulated patient and the air ambulance crew