

Vincentian medicine - Paediatrics to General Practice

During my elective in St Vincent and the Grenadines (SVG) I arrived expecting a paediatric placement and quickly discovered that small-island medicine resists tidy boundaries. Clinics I attended routinely treated children and adults in the same session, and clinicians I shadowed moved seamlessly from managing common paediatric problems such as constipation or phimosis to addressing adult concerns like abnormal liver tests. This was a pragmatic response to the island's realities: a limited workforce, geographic dispersion of patients, and an expectation – among clinicians and the communities they serve – that a trusted doctor will try to address whatever problem a patient brings on the day. In such a setting continuity and personal recommendation carry more weight than a formal referral pathway, and the lines between primary and secondary care blur because the system must prioritise access and immediacy over specialty separation.

The reasons behind that blurring became clearer the longer I stayed. Human resources are simply constrained: a small population and few specialists means many clinicians become, by necessity, generalists. Geography amplifies that constraint – patients travel long distances from outlying parishes or neighbouring islands and commonly prefer to have their problems dealt with in one visit rather than return repeatedly. Financial considerations shape behaviour at every step: patients who pay out of pocket often delay seeking care until an issue becomes urgent, and when they do attend they frequently choose to see a clinician they know or who has been recommended by family and friends. The referral culture reflects that reality; rather than routed through an electronic system, referrals tend to be paper-based and personal, sent to trusted colleagues rather than through a centralised triage mechanism. Those patterns, I learned, create both strengths and vulnerabilities – stronger personal continuity but also the potential for a breakdown in communication, as it is on the patient to transfer important information, e.g blood tests and imaging.

Training and return migration are important pieces of this puzzle. Many Vincentian doctors train abroad – in larger Caribbean centres or in the United States – and bring back clinical habits shaped by those settings. In some cases I noticed a lower threshold for investigation or intervention that would be routine where imaging and specialist beds are plentiful. In SVG, however, those recommendations must be adapted to local supply: diagnostic tests, theatre time and specialist postoperative care are finite, and patients may be unable to afford multiple visits or high-cost investigations. This mismatch can create tension between a clinician's training and what is practicable; it also places a premium on local clinical judgement and on the ability to stabilise and transfer patients when necessary.

One such transfer crystallised those tensions and the importance of good decision-making. I encountered a team who had just stabilised a newborn born with a large anterior abdominal wall defect that had not been identified antenatally. Routine gestational ultrasound is offered in SVG's tertiary centres, but coverage and timing can be variable across the country and in remote settings antenatal imaging is not always available or performed early enough to plan for delivery in a tertiary neonatal surgical unit. The infant presented with exposed bowel and early signs of respiratory compromise; the on-call team protected the viscera, started intravenous fluids and antibiotics, and arranged an urgent air transfer to a paediatric surgical centre off-island. Their prompt recognition, pragmatic resuscitation and coordinated transfer transformed what could have been a catastrophic outcome into a survivable emergency, and it highlighted

how antenatal screening gaps, delayed presentation and financial and structural constraints intersect to shape neonatal risk.

Community health work offered a different window into population need. At a weekend walk-in health fair, nearly every person I spoke named diabetes as their principal worry. Conversations revealed a common misunderstanding: many people think only “pure” sugars — table sugar or sweets — are the problem, while starchy staples go unrecognised as drivers of blood glucose. That perception matters because the Vincentian diet relies heavily on carbohydrate-rich food. At the same time, food imports are a large part of the national economy and food prices are relatively high, so affordable protein and diverse fresh produce can be harder to access. The public health data reflect a rising burden of diabetes in SVG over recent decades, a trend that aligns with the concerns voiced by community members and with regional analyses of non-communicable disease. These patterns — diet shaped by what is affordable and available, widespread concern about diabetes, and limited household budgets — explain why simple, locally relevant dietary advice feels urgent and why health promotion must be realistic about cost and culture.

Mental health conversations were another instructive feature of the clinic. Young people were candid about anxieties rooted in precarious job markets, limited prospects and a pervasive “hustle” culture; older patients more often spoke of health anxieties and loneliness. Specialist mental health services are limited, but community networks — family, church groups, workplace circles and informal peer supports — play a central role in coping and recovery. In a system where formal resources are scarce these grassroots responses matter enormously: they are where social support and psychological first aid are most often found, and they often form the backbone of ongoing care.

Not every learning moment was clinical. On a hike to one of the island’s volcanic viewpoints a friend in our group got a small stone lodged in their eye on the summit. With no ambulance service to hand, a moment of panic ensued. But after short deliberation, an MDT team of medical students formed. And the calm instruction of a keen ophthalmologist-to-be rose up to guide us. We irrigated the eye with bottled water, sanitizing our hands with baby wipes, and encouraged blinking until the particle dislodged. After considering all available options, thankfully the hiker had regained sight and we rewarded ourselves with the view: sulphur eruptions with cascading jungle trees chasing the mountainside.

Taken together, the elective left me with a strong appreciation for what a small-island practice demands: clinical breadth, pragmatic adaptation of external guidelines to locally available resources, and a deep reliance on relationships — between clinician and patient, between clinicians themselves, and within communities. Financial constraints threaded through nearly everything. At the same time, the island’s strengths — visible in the continuity of care offered by trusted clinicians, in resilient community supports, and in clinicians’ readiness to stabilise and transfer complex cases — offer practical foundations for targeted improvements. Better antenatal imaging access where feasible, context-appropriate protocols that assume constrained diagnostics, and community-facing health education about everyday diet and diabetes might each yield disproportionate benefits. If I were to distil the elective to a single lesson it would be this: clinical excellence in resource-limited settings is as much about judgement, adaptability and community engagement as it is about technical skill.



