ELECTIVE (SSC5c) REPORT (1200 words)

A report that addresses the above four objectives should be written below. Your Elective supervisor will assess this.

1: Describe the pattern of disease/ illness of interest in the population that you will be working in and discuss this in the context of global health: What are the prevalent conditions found within the intensive care unit in Sri Lanka and how do they differ from the UK and other LEDC's.

Sri Lanka is a relatively small island with a dense population and has a wide distribution between areas of wealth and those that contain many individuals living in poverty. As a result, different areas of Sri Lanka have various different prevalent diseases depending on location within the country. One of the most striking differences is the prevalence of tropical diseases specific to the Asian continent that are less likely to be found in both the UK and other LEDCs, for example the prevalence of Denge fever (a mosquito born infection)- especially in areas such as Negombo (Just north of Colombo)- which are unlikely to be found within intensive care units within the UK.

Despite some of these tropical diseases being prevalent, there are also other diseases and conditions commonly found within the intensive care unit that can also be found in the UK, such as patients suffering after trauma, respiratory conditions (usually atypical pneumonia) and coronary diseases. This is especially evident in the capital Colombo's National Hospital. These patients however, have poor access to primary healthcare and as a result end up largely with end stage diseases due to their late presentations. However, this is not always the case, as in some hospitals with some private funding- such as in the Central hospital, patients are often treated quickly and more often then not, recover.

2: Describe the pattern of health provision in relation to the country that you will be working in and contrast this with other countries, or with the UK: How do the Intensive Care service and Anaesthetic service differ in Sri Lanka, compared to within the UK?

In Sri Lanka, the Anaesthetic service given to many patients is very similar to that found within the UK, due to well-regarded international guidelines on anaesthetic practice, but there are also still many differences to that which I have experienced within the UK. Firstly the number of operations that go ahead in Sri Lanka tends to be less due to funding issues and skills on the ground, but of those that do go ahead, they are less likely to be cancelled thus, operative lists are often quite efficient. In terms of the skills available, in the UK, it is very rare to have any less than 2 anaesthetic doctors (often 1 consultant and 1 specialist registrar) and 1 anaesthetic practitioner for each operation, however in some of the government controlled national hospitals this is not the case, and often it is one doctor, who is not always consultant level. Furthermore, many of the drugs used are different to those found in the UK, for example, propofol is used in almost every operation in the UK, however is only used sparingly in Sri Lanka due to cost and availability issues. I have also found that in the UK, there is a current trend towards offering nerve blocks and local anaesthetics for certain operations as they

seemingly have a good outcome when it comes to pain control post op however, in Sri Lanka this happens at very few hospitals in the capital.

The Intensive Care service also has a combination of some similarities to that within the UK and some key differences. Perhaps one of the biggest differences is that some hospitals do not offer an intensive care service and if they do, very skeleton in its operation. Maharagama hospital, despite being a specialist cancer hospital and containing some of the sickest patients I saw during my time in Sri Lanka, did not offer an Intensive care service, instead cared for all its patients on specialist medical wards, which were heavily overpopulated. This was due to the lack of available doctors to give the 1-1 or 1-4 care we are used to in the UK. In some of the most built up hospitals, the Intensive Care service was very much akin to that found within the UK with some of the same equipment and specialist care.

3: Health Related objective: Respiratory failure is a common condition found within the Intensive Care Unit in UK hospitals, how is this managed within a Sri Lankan Hospital and what are the differences between Sri Lanka and the UK?

Respiratory Failure is commonly found within the Intensive Care units of Sri Lankan hospitals, however slightly less so than the UK- but as a whole, it is managed very similarly. There are Sri Lankan national guidelines on the management of respiratory failure akin to that found in Britain (BTS guidelines). In central hospital in Colombo, equipment available is very similar to that found in the UK, including BiPAP and CPAP machines, and their use is very similar. In less well-developed and funded hospital such as the National Hospital these facilities are often not available and if they are, are being used intermittently by a number of patients rather than for the extended periods of time they would be used for within a British hospital. One thing that is ubiquitous in both Sri Lankan and British hospitals is the use of oxygen therapy in the management of respiratory diseases. This is most likely due to the fact that it is cheap to obtain and very easy to deliver. I was surprised at the use of venturi masks in some of the less well-funded hospitals, but they were still present and well used. Lastly, the use of antibiotics differs significantly in Sri Lankan hospitals in comparison to British hospitals in the treatment of respiratory failure due to infective causes. This is due to the fact that away from well-funded hospitals, some antibiotics are difficult to obtain. Penicillin based antibiotics have a tendency to be used over others, which I assume is based on their cheapness and easiness to use and purchase. Due to the limited nature of antibiotic use, quite often there are no specific hospital guidelines on antibiotic use.

An important part of the treatment of respiratory failure in Britain is the availability of an on call anaesthetist if the patient is no longer able to breathe on their own and needs some support, however in some public Sri Lankan hospitals, this again is not always the case and as a result, there are many more doctors who are trained to intubate and maintain airways if necessary, which is incredibly useful as it means there is no delay in getting certain skills to the ward when necessary.

4: Personal/ professional development goals: To reflect on how the contrasting attitudes towards medical professionals in the UK and Sri Lanka affects my treatment of patients in both clinical

situations as well as improving my communication skills with both patients and other health care professionals who do not necessarily share the same language as myself.

Attitudes towards healthcare professionals in the UK and in Sri Lanka differ significantly. In the UK as a whole, patient care is very much seen as a two-way contract between the care-giver and the patient, however in Sri Lanka, there is implicit trust between the patient and the Doctor to provide the best and correct treatment. Both methods of care have their advantages and disadvantages, with the British system having much more of a communication element to it, meaning that patients often go away well informed and able to make an informed decision about how they want to progress with their own care, however the Sri Lankan system is much more based on a quick and safe turn around of patients. It is unlikely that the British system will ever return to this system, however seeing how quickly decisions can be made effectively by clinicians in hospitals in Sri Lanka has given me an insight into just how much can be achieved without complex tests and using 'the medical brain.'

Communicating in some hospitals in Sri Lanka is more difficult than others depending on the Local population. Communicating in Colombo is much easier than in other areas such as Negumbo or Mahagara where the population is less effluent and have less ability to speak English. Communicating with these patients using non verbal cues and gestures was difficult but rewarding at the same time and should help in the future when speaking to patients in Britain who have less ability to speak English, especially as we become more diverse and multicultural. This will be relevant when I progress towards my F2 year where I move into a central London hospital in an area with a high proportion of migrants from Europe and Africa. This can also be used when I work with other professionals who may not speak English as a first or even second language to convey more complex points.