ELECTIVE (SSC5c) REPORT (1200 words)

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

I divided my time between Cho Ray hospital in Vietnam, one of the busiest hospitals in South-East Asia, and a non-governmental organisation (NGO) in Timor-Leste, Bairo Pite Clinic (BPC), that is one of the busiest health clinics in the country.

From my experience at Cho Ray hospital, the commonest surgical condition is trauma in Vietnam, especially neurosurgical and orthopaedic trauma. It forms a large proportion of the operations that occur day to day. Trauma also comprises 80% of A&E attendances. These are not uncommon in the UK, however they only form a minority of the surgical lists. There is limited trauma seen at BPC, this is mainly due to the lack of an ambulance service run in Timor-Leste. Therefore any people who experience serious trauma often die before any medical or surgical help can be received.

In Vietnam, the neurosurgical trauma operations were grossly similar to how they were performed in the UK, the only differences were: that instead of a saw to perform the craniotomy, they used a gigli wire; and instead of using plates and screws to hold the skull together, they created small holes and sutured them together. One of the great differences between Vietnam and the UK was in the running of the operating theatres. In Vietnam there are two operations going on in the same operating theatre at the same time, this results in the theatre not being cleaned thoroughly in between the operations. The equipment that the theatres can use is also more basic than that which we have in the UK.

The common surgical conditions in the clinic at Timor-Leste are lumps and bumps. Their management is purely through excision under local anaesthetic, there is no other anaesthetic available or surgical instrumentation. The surgical instruments that they do have are older than what we have in the UK. Episiotomies are also frequently performed, however these are without any anaesthetic. This is different to the UK in that there are a variety of anaesthetics available for all operations, and different techniques for minor procedures such as curettage and diathermy along with local excision.

The healthcare system in Vietnam was similar in some respects to that of the NHS: the hierarchical structure; the rotation of shifts; and the organisation of A&E. However outpatients looking for a consultation with a doctor, had to be reviewed by a nurse to determine what speciality clinic they needed to go to, there are no GP equivalents. There were also a lot fewer nursing staff, this left relatives to care for the patients. Another shortage was beds, often there were multiple patients to a bed or trolley, and trolleys were parked anywhere where there was space, including the corridors outside. The major difference in being that the healthcare is not free; you either pay for it upfront or have healthcare insurance. Both of the systems in Timor-Leste and Vietnam are paper based, and all imaging is still on films; this is a sharp contrast to the predominantly computer based NHS. The healthcare system at BPC operates through the founding doctor seeing patients on an outpatient basis, admitting only those who warrant inpatient treatment. These patients have their observations taken by a nurse, and are clerked by a doctor or a medical student (who reviews the case with a doctor). The doctor in charge of the ward reviews all patients in the afternoon; there are normally two doctors, more if there are volunteers. Every morning the founding doctor leads a ward round, which generates the jobs that need to be done. The doctors and medical students work Monday to Friday 0800-1800/1900, and Saturday 0800-1300, whilst the founding doctor remains on-call for the rest of

the hours as well. There are great similarities and differences to the NHS. Similarities include: the outpatient review being alike a GP surgery; the admission of patients is akin to the process in A&E; and the running of the wards. However the healthcare staff to patient ratio is a lot lower, this is seen as there is no rota of weekends and on-calls, apart from the rare weekend off; and there are no junior doctors, this role is fulfilled by the medical students.

Unfortunately I was not permitted to spend much time in the operating theatres with the anaesthetists, as I was not a Vietnamese medical student. So the majority of the airway management that I saw was in A&E, mostly in resus. The equipment that they have is a lot older than what we have in the UK. There is also less equipment available for airway management; in the UK there are LMAs as an intermediary option in between intubation and oropharyngeal airways. However, in Vietnam these do not exist, and a lot of the doctors had not even heard of them. Another difference is that the doctors are extremely skilled; they manage many different airways through blind intubation without the advantage of video laryngoscopy. In the UK there are always a few video laryngoscopes in the anaesthetic department so that anaesthetists are able to effectively manage difficult airways without causing too much harm to the patient. In A&E in Vietnam there were no machines that could provide a continuous ECG trace, the only monitors available for the sick patients (mainly those in resus), showed the heart rate, oxygen saturations and the blood pressure.

The greatest issue facing the Vietnamese population in accessing healthcare was the lack of money that they had. This meant that many do not invest in healthcare insurance, therefore they leave coming to hospital until they are very unwell or in pain that is too much to bear. Unfortunately this means that often their hospital bills are much more than they would have been had they come in earlier to receive investigations and management, and definitely more than if they had invested in healthcare insurance in the first place. For a few, they may be lucky enough to have their bills paid for by a small charitable fund that the hospital has access to, however this is very rare and none of the doctors I worked with had seen a patient receive this.

I was able to develop my non-verbal communication skills, unfortunately I was not able to further improve my communication skills with interpreters, as there were not any available for me to use in A&E. Also as the department was so busy, the two doctors that spoke English as well as Vietnamese were unable to interpret for me, they did explain what was going on all the time so I was not left in the dark. They also were very good at getting me to devise management plans for the patients that they were looking after by explaining to me what the patients was complaining of, and to also assess the patients.

My placement was very useful in getting me to develop and practice my interpretation skills of ECGs, x-rays, CT scans and MRI scans. This was not something that I had expected, but that I greatly benefited from.