

ELECTIVE (SSC5c) REPORT (1200 words)

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

For my 6-week long medical elective, I decided to go to Sri Lanka and base myself around the capital city of Colombo. I gained invaluable experience by interacting with surgical patients on the wards, in theatres and during clinics. I was mainly based at the Central Hospital, which is a privately run facility and part of the Asiri Group of healthcare services. I was also lucky enough to spend some time at two state-funded facilities (Colombo General Hospital and Maharagama Cancer Hospital). This allowed me to gain greater perspective of how surgical conditions are managed in Sri Lanka and thus make a more informed comparison with such services in the UK.

There is a marked similarity between the organisation and management of health systems (including surgical services) in Sri Lanka and the UK. Both countries have a hierarchical approach to healthcare in terms of secondary and tertiary care, where doctors refer between the various levels based on official criteria and clinical judgement. There is also the scope for sharing of information amongst the various teams, so as to maximise multi-disciplinary input when making decisions and helping patients try to recover their quality of life. The design of the hospitals are also very alike in that they have attempted to efficiently allocate resources, by constructing relatively modern multi-storey buildings and housing as many services as possible in one place. However, there are some stark differences between the two countries when it comes to healthcare systems. The major difference is that Sri Lanka effectively does not have a community-based care system akin to that in the UK. Instead, they train their A&E doctors to have general practitioner skills and rotate them around as outpatient doctors who offer primary care in hospitals. This lack of community care results in uncertainty and unreliability because the hospital's resources become stretched, staff invariably feel the extra pressure, and there is no means to offload the added workload. Furthermore, it means that some patients have to travel long distances and wait long hours to consult a doctor; when the equivalent service could be provided more locally and even dealt with by other members of the healthcare team.

Another way in which Sri Lanka and the UK are similar is their prevalence of surgical conditions. Both countries have significant rates of trauma and plastics cases, where an extensive proportion are down to work-related injuries or road traffic accidents. Despite this, the similarity itself seems to be quite superficial because the ideas behind their commonality differ between the two countries. Two reasons why trauma cases are thought to be prevalent in Sri Lanka are the relative poverty of the population, and their underlying behaviours. The former has various knock-on effects when it comes to sustaining a living such as: taking on multiple jobs, doing jobs fraught with risk, having to work during childhood, etc. The latter relates to aspects like driving behaviours, where people seem to be less safe on the road compared to UK standards. For example, some drivers take it on themselves to form extra lanes whereas others overtake in spite of oncoming traffic. All of these increase the chance of trauma, but the demographic still take the risk out of necessity or disregard. Meanwhile, plastics cases are said to be common in Sri Lanka because of the multi-disciplinary approach to trauma care and the negative effect of infectious diseases on wound healing. These diseases are widespread due to various factors

(e.g. overcrowding, poor sanitation, climate, etc) so wounds regularly get infected and reinfected. This inevitably leads to greater morbidity and sometimes results in death.

In addition to trauma and plastics, cancer is a relatively prevalent surgical condition between the two respective countries. According to recently collected data, the most common cancer of women in Sri Lanka and the UK is Breast cancer. The management of Breast cancer is very similar between the two where women from both countries are consulted and examined, before being offered the same set of investigation and therapy modalities. The only difference is that the former carries out the procedures over several meetings and the latter does it as a one-stop clinic. In contrast, the most common cancer of men in Sri Lanka is Head & Neck cancer whereas it is Prostate cancer in the UK. This high incidence of Head & Neck cancer has been attributed to chewing 'betel nut', which is a combination of areca nut wrapped in betel leaves. Chewing of areca nut is carcinogenic to humans but it is an age-old tradition, custom and ritual in many parts of South Asia. Men are known to chew it more than women, where it is taken to be an important symbol of love and marriage. As a result, preventing this surgical condition by reducing consumption of 'betel nut' has proved very difficult and only one scheme has made any progress. The scheme in question focused on the cultural side, by persuading the head Buddhist monk in Sri Lanka to substitute out his areca nut and hoping others would follow suit.

Lastly, the interaction between surgeons and patients in Sri Lanka bears some similarities with that of the UK. In general, there are the same high levels of professionalism, conduct and ethics between the interacting parties which I believe are crucial to forming effective working relationships. On the whole though, there are many noticeable differences when the two systems are compared. For instance, the healthcare system in Sri Lanka appears to be a doctor-centred approach where doctors determine the treatment and patients are given very little choice. The patients themselves have no objection to this approach because they feel doctors are more knowledgeable about medicine and therefore know best. Although I understand this is a cultural difference, I still feel a patient-centred approach is better as it empowers the patients and gets them involved in their own care. Aside from the above, clinics in Sri Lanka have a much higher turnover than the UK, with doctors seeing up to 50 patients per session. The seemingly infinite patient numbers and need to keep waiting times to a minimum means that the consultations become extremely focused and some aspects of the case are not probed. Even though this is necessary to manage the vast patient load, I still think doctors should be given more time in the consultations in order to deal with the holistic parts of each patients care.

In conclusion, there are marked similarities and differences between the surgical services in Sri Lanka and the UK. There are many factors which contribute to these such as population dynamics, economic status, and cultural differences. Sri Lanka and the UK are seen as developing and developed countries respectively, but I believe both could learn much from each other. This medical elective has given me the opportunity to do just that and it has been one of the best experiences of my life.