ELECTIVE (SSC5c) REPORT (1200 words)

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

During my 6 week elective placement in Sri Lanka, I was fortunate enough to see a myriad of patients and pathologies. I was able to gain invaluable experience by attending ward rounds and clinics in three different hospitals based in the Sri Lankan capital of Colombo. The Central Hospital where I was based for the majority of my time was a private hospital with a well-equipped paediatric department, whereas the Colombo General was a government funded hospital where funds and facilities were quite obviously stretched. I also spent time on the paediatric ward at the Maharagama hospital which was a specialist cancer hospital funded by the government.

There was a stark contrast between the conditions prevalent in Sri Lankan paediatric units when compared with what one may see on a British paediatric ward. The most striking difference was the number of children were diagnosed with infectious diseases such as bacillary dysentery, cholera and vector-borne diseases such as dengue. It was also common to see children admitted who had suffered trauma from road-traffic accidents or animal bites. At the other end of the spectrum there was a very low number of children who suffered from atopic diseases such as allergic rhinitis or eczema. These points contrast with the UK due to a number of reasons. Firstly, the water sanitation in the UK is vastly superior to what one may find in Sri Lanka, leading to a much lower incidence of infectious diseases such as dysentery and cholera. Furthermore mosquitos are fairly rare in the UK, thus Dengue is not a pathology that one will encounter unless the patient has travelled to a country in which it is endemic. The low incidence of children with allergic rhinitis and eczema may be a due to the Th1 vs Th2 theory, whereby children in countries where sanitation is not as good are less likely to develop atopic pathologies when compared with children from more developed countries.

Paediatric services in Sri Lanka are very similar to what one may find in the UK, however there are a number of contrasting elements. The paediatric teams are organised in the same way as the UK, whereby there is a named consultant for every child admitted or referred to a clinic. The major differences come in the responsibilities allocated to the team members. Quite often a child would only be seen by a registrar who would seek advice from their consultant if they felt the need. Furthermore, I noticed that junior doctors were afforded a much greater level of responsibility, carrying out advanced procedures that would normally be reserved for more senior members of a UK team.

Due to the lack of access to General Practitioners in Sri Lanka, many children would present at accident and emergency with ailments that would most probably be seen by a GP first in the UK, such as diarrhoea and chest infections. Due to this, there was quite often a registrar from a paediatric speciality who had the sole task of triaging paediatric patients in A&E. Another major difference between Sri Lankan and UK paediatric teams was the distinct lack of multidisciplinary-team (MDT) management of a child's healthcare. In the UK there is quite often input from nurses, social services and teachers etc, whereas there did not seem to be much of this in any of the hospitals I spent time at in Sri Lanka. I felt that this was an area in which the healthcare service of Sri Lanka could definitely improve as I have seen the great benefits of the UK's MDT approach to healthcare.

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Paediatric pain management is handled very differently in Sri Lanka to what one may find in a UK hospital. I believe that this was due to differences in access to resources, as well as the attitude of the doctors. There were a number of times where I saw children with broken bones and tissue injuries who had their pain controlled with relatively small doses of paracetamol. When I asked the doctors about this I was told that this was due to the price of paracetamol being far lower than other painkillers and that the children did not need stronger medication (e.g. opioids). A lot of the time paediatric units in the government hospitals were extremely short of opioids so they were rationed out sparingly. What I found interesting was that often the children who had presented with broken bones and other painful injuries were unlikely to complain of pain unless they were directly asked about it. Furthermore, parents would often say that the children did not need any more pain killers. When asked why, I found parents stating that 'painkillers are not good for the brain' and 'he is OK he is a strong boy'. Whilst I may have only been able to ask a small cohort, it did seem that in Sri Lanka pain was viewed as a much more mind over matter problem that did not need to be over medicated.

Another difference between the UK and Sri Lanka with regards to paediatric pain management was the lack of painkillers used for procedures in the Sri Lankan hospitals. For example, I did not see an instance where anaesthetic cream was used before the placement of a cannula, nor was Entonox available for procedures such as realigning broken bones. I asked one of the paediatric consultants at the Colombo General Hospital about this, to which he stated that it was partly due to a lack of funds and also partly due to many medical professionals seeing such analgesic treatments as unnecessary.

Sri Lanka itself is a country that bears little resemblance to the UK from an economically developed perspective, however due to its past history of British colonisation it had many similarities in other areas. Firstly, the general population on the whole spoke English extremely well. This was a trait not limited to those from higher echelons of society. The removal of a language barrier helped me an immeasurable amount on my elective as I was able to communicate effectively with the patients. Once I had acclimatised to the climate and social norms of Sri Lankan society I was able to fully immerse myself in the elective placement. I found the way medical teams were set-up was almost exactly the same as in the UK. One aspect that I did have trouble adjusting to was the differences in consultations. In the UK the NHS attempts to take a patient-centred approach, whereby the patients themselves can determine what treatment they want and medical professionals try to accommodate this choice. However, in Sri Lanka I found that patients were often given little choice as to their treatment options. I asked a number of patients about this and every single one of them stated that they did not mind a doctor deciding what to do as they know best. Whilst I do not believe that this is the best way to conduct treatment, I was aware that many of the patients had no issues with this aspect of the Sri Lankan healthcare system.

When one takes into account the limited resources afforded to the Sri Lankan healthcare system, the end result is nothing short of spectacular. From my elective in paediatrics, efficiency and a willingness to adapt and overcome are in my opinion the two greatest attributes of the Sri Lankan healthcare service.

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