ELECTIVE (SSC5c) REPORT (1200 words)

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

Objective 1: Describe the pattern of disease/illness of interest in the population with which you will be working and discuss this in the context of global health

Objective 2: Describe the pattern of health provision in relation to the country which you will be working and contrast this with other countries, or with the UK: A direct comparison of local ILS, MI and acute heart failure protocol to current NICE guidelines.

One of the major medical epidemics in Sri Lanka is diabetes. A lack of knowledge of the disease, in addition to other risk factors such as obesity and smoking being rife, contribute to heart disease and strokes being a major cause of mortality in the country. There is a distinct difference in the way such acute emergencies are dealt with based on whether the patient can afford private healthcare or is confined to national healthcare. The difference between the two health systems was quite startling. Private healthcare is comparable to the best the NHS has to offer. In fact I found that private hospitals were much more efficient in planning procedures such as angioplasties (of which 16 were conducted in one day, in one theatre). Protocol followed in such hospitals is based on accepted international protocol, again comparable to treatment received in the UK. On the other hand, national health care, with respect to acute medical emergencies is very slow. Patients may have to wait hours for emergency procedures. I feel that this plays a part in the mortality rates of such emergencies in the country. Protocol followed for such emergencies is loosely based on international protocol. However expensive drugs such as fondaparinux are not available. Procedures such as coronary artery bypass grafts are commonly conducted, rather patients are given lifestyle advice and medically managed. With respect to NICE guidelines, in comparison to guidelines used in Sri Lanka, locally written in depth guidelines are published for disease endemic to the country. Examples of these include Dengue fever, Malaria (although now much less on a concern), rabies and various parasitic infections. Such guidelines are used in both national and private hospitals. With respect to heart disease and Myocardial Infarcts, treatment is loosely based on guidelines published by western research groups, however I found that in practice, treatment is largely based on the recommendation of the Consultant in charge.

Objective 3: Health related objective: How can knowledge of different disease protocol be used to have a positive impact in the NHS?

One of the biggest differences I found when comparing private hospitals to the NHS was the level of efficiency. The attitude seemed to be 'time is money'. Surgical theatres were always in use. The right staff was always in the right place, if there was a delay, this was usually due to a patient factor. I feel the NHS could learn from the systems in place to achieve this. Furthermore accountability for rescources was rather cumbersome. Every item used in surgery was counted and signed for. In retrospect this was probably possible due to the low cost of labour in the country. Allowing staff to be hired specifically for this purpose.

On direct comparison of state funded hospitals and NHS hospitals, the lack of funding is quite apparent in Sri Lanka. Casualty is overcrowded, in one particular hospital I visited, Xrays were being conducted with a mobile xray machine in a corridor. However I found that again doctors were well trained e.g. a 1st

year junior doctor (the equivalent of a UK F1 doctor) with whom I spent some time going over ECG's probably was as good as a UK specialist doctor when deciphering ECG's. The essence of this seems to be that doctors are well trained to cope with the lack of recources and availabilty of only basic tests. I felt that due to this, they have much better knowledge of basic medicine when compared to Doctor in the UK in a similar position.

Another quite striking difference I noticed in Sri Lankan Heathcare was the cultural difference in the was doctors are percieved in the country. I found that the vast majority of the population (albiet a large proportion of this were the middle to lower class) spoke and treated doctors with very high regard, a direct comparison that comes to mind is the was a junior doctor would approach a strict consultant. The doctors on the other hand, had very different approches to patients. Varying from comletely patient centred to completely abrupt and dismissive. I sat through quite a few outpatient consultations that began with 'Whats wrong' and ended with 'OK'.

Although the social and cultural aspects of the elective were very different to my expectiations, the language barriers were quite workable. The main languages spoken in the country are Sinhalese, Tamil and english. Throughout my six weeks, I found that I was able to communicate with the local population in english, and at least get the message across, if not have a good conversation. With respect to healthcare, there were some instances with elderly patients when I was not able to communicate at all. However, generally I managed to understand the gist of the problem, and ask at least a few basic questions.

One of the particular challenges I found on this elective was the Hierachy of doctors and communication with different specialities. I had the opoortunity to spend a few days in different hospitals within the Central group (Asiri) and two national hospitals. During these visits I was allocated time with different specialities. I found that referral between specialities is cumbersome, with no set system in place. Getting 'lost in the system' was a major problem, with patients turning up on wards and clinics with no one sure why they were there and whom to see. This is probably due to a lack of infrastucture, in addition to the use of paper patient records (similar to the NHS system) which are not stored properly nor efficiently delivered when requested. Indeed numerous patients took their notes home with them and brought them in themselves to outpatient appointments. In one particular case, a patient had been referred to a cardiac surgeon from his Gp (the patient lived about 300km away). Having had his outpatient appointment, he was asked to have basic tests such as an ECG and ECHO, which the patient was to have done in what can only be described as diagnostic 'shops' outside the hospital. He returned in the afternoon with the results. However he had left his notes with the doctor in the morning. The receptionist would not let the patient see the doctor without his notes and the patient ended up waiting to 6pm for the doctor to leave clinic before speaking to him. As the doctor did not recall keeping his file, the patient was scolded for not keeping his file safe and asked to return when he had found his notes. The patient was quite emotional at this point and I found the episode quite disturbing.

In conclusion, this elective was pretty much what I expected, the people and culture of Sri Lanka are amazing. I hope to return to the country some time in the future as a fully qualified doctor.