ELECTIVE (SSC5c) REPORT (1200 words)

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

1 - Compare and contrast the common presentations to primary care in the Philippines with those in the UK

The access to care differs widely between the UK and the Philippines, and there is a different disease profile due to differences in lifestyle and social circumstances by the majority of the populations of both countries. These are important factors which impact hugely on the common diseases with which patients present to primary care; these also impact the stage of disease that triggers patients to seek health care.

The top 5 pathologies responsible for presentations at the Pakna-an community medicine facility (where we were based for the majority of the placement) are TB, diarrhoea, malnourishment, diabetes mellitus and hypertension. The last two of these diseases would be seen very commonly in UK primary care, where many of the consultations involve the management of chronic disease, DM and HTN featuring prominently in the UK also.

TB, malnourishment and diarrhoea are seen in the UK, but without the same prevalence or advanced level of disease. For example, TB is relatively common in some populations in localised areas of the UK - for example the immigrant Bangladeshi population in east London - but this would largely be death with in specialist tertiary care centres. There are many local TB DOTS centres in the Philippines where non-specialist clinicians are familiar with treatment protocols and regularly manage such patients, due to the high prevalence of the disease in the local populations.

Diarrhoea is another common presentation, with infective causes high up on the differential diagnosis; amoebic dysentery is something that I have have not encountered in the UK, but which is of concern here, with services set-up to investigate and manage the condition (e.g. immediate availability of stool microscopy in local health centres).

2 - Learn how healthcare is funded and organised in the Philippines, and compare the level of provision with that in the UK.

The level of medical provision varies widely within the Philippines, and is determined by several variables, such as location (e.g. rural vs urban) and financial as there are private and publicly funded hospitals and different forms of insurance cover. These factors mean that to wealthy Filipinos have access to care comparable to that found in UK hospitals, in the internationally accredited institutions found in major cities such as Cebu and Manila; the large number of poor Filipinos with no insurance cover have access to publicly funded healthcare, which has local health centres serving barangys and municipalities as well as regional hospitals and tertiary centres such as Vincente Sotto in Cebu.

Where in the UK we are fortunate to have medical services which as free to access at the point of care, this is not the case in the Philippines. In the public hospitals there is no charge for consultations and many of the common and basic medications needed for the common presentations seen are supplied by the governement. However, availability of these supplies is limited, and if there is no supply available when the patient needs it then they (or a relative) are given a prescription to

purchase the supplies from a local pharmacy. This is the same for consumables such as IV cannulas, fluids, urinary catheters, etc. Procedures are carried out free of charge, though there is a charge for the consumables as above.

This can act as a barrier to care, and treatment is withheld while the medications or consumables are acquired for use. This can impact blood for transfusions, though again there is a blood service, but demand outstrips supply and so there is a shortage and delays on administration of blood product where they would be required in a more urgent manner.

There is a middle tier of health care, which is private, but delivered by medical interns (students) and Post Graduate Interns (first year doctors) under the supervision of consultants and residents, and the finances for this are more complicated, but less expensive than full private care, which would be fully consultant led.

It is also interesting to note that the care delivered in the public hospitals is directed by the residents (the stage below consultant - as in the USA), with very little or no supervision by the consultants.

The result is a public health service with scarce resources and which lacks input from the most experienced clinicians, which makes the most appropriate use of these resources difficult to manage at times. There is an abundance of students/medical interns on the wards and in the ER, but there large number of patients being admitted thinly spreads the attention offered to them by the more senior staff available (I.e. the residents).

3 - Explore the common causes and treatment protocol for diarrhoeal disease in this environment.

Diarrheal disease is a common presentation to primary and secondary care centers in the Philippines. This is contributed to by the living conditions of the local population and the availability of sanitary drinking water. There is a scarcity of water supply, especially to the more deprived areas in both the urban and rural setting. Many families do not have water plumbed into their homes, and instead use a combination of communal water pumps for washing and cooking, and bottled water which is bought for drinking water. Additionally, many families live in densely packed structures in very close proximity to other families and households. This lack of space means that there may be difficulty maintaining sanitary conditions and that communicable diseases (such as some of the diarrheal diseases) can be transmitted easily.

Common invective causes of diarrhea in the Philippines include amoeba and amoebic dysentery (e.g. Entamoeba histolytica), bacterial causes (such as Campylobacter jejuni, Salmonella spp., Escherichia coli, Shigella spp) and viral causes.

Common investigations of the patient presenting with diarrhea would include stool microscopy to determine the cause of an infective episode. Treatment would include supportive measures, importantly hydration: if oral intake is still possible this would be supplemented with 'Oral Rehydration Therapy' mixtures containing the needed electrolytes and the glucose needed to facilitate absorption in the gut, if oral intake is not possible then IV fluids are used to replace water, energy and electrolytes. Additionally antibiotics are used: for example ciprofloxacin and metronidazole, depending on the clinical picture.

People at risk of more severe disease would be children, the elderly or other adults with co-morbidities which would induce lower physiological reserve. These patients would require closer monitoring and lower thresholds for intervention.

4 - Discover what it is like to practise medicine in a resource poor environment, with differing levels of access to care and different attitudes to health.

The most striking contrast between the rescources available in a UK hospital and those in the Philippines was at Sotto (a public hospital funded by the governement). There is huge deman for treatment there, as it is the only referral hospital serving the whole of Cebu island (population approaching 3 million), and even takes referrals from the rest of the Visayas and Mindanao island. The scarcity of resources at Sotto is both in terms of materials and senior manpower. In theory the care delivered at Sotto is largely free of charge, but due to the scarcity of supplies (e.g. Drugs, fluids, blood products, consumables) patients often have to purchase there own from local pharmacies before they receive treatment. This makes it difficult for some to afford the treatments, and when they can there are delays to urgent treatments which would ideally happen in a much more timely fashion.

Two examples that struck me were a pre-term baby with Respiratory Distress Syndrome, who needed ventilatory support as surfactant. There were no ventilators in the ER and so she was intubated and the family we're responsible for 'bagging' their child; there was no surfactant available and he family could not afford any so this was not administered. As a result the child died shortly afterwards.

The other example was of a lady presenting with an incomplete misscarriage who was hypovolaemic, anaemic and going into sepsis, presumably from the retained products of conception. As part of her treatment she needed a transfusion. She was clinically anaemic and in shock, but we had to wait for a FBC to be processed by the lab which took a few hours due to the large number of tests to be processed. Then a further delay was in getting a blood type. This was further confounded by a shortage in blood. The result was that the patient presented at 5am, and still had not been given any blood by 5pm when I left the ward that evening.

The patients and the relatives were amazing in their resilience and patience. There were no complaints or attempts to push forward their case above another patient, and they had an extra-ordinary pain threshold. Procedures that would have had people crying out in pain the the UK barely raised a grimace from them, and the delivery suite holding 8 mothers was surprisingly quiet.

There were some clever ways round needing some of the equipment that we take for granted but are scarce in the public health system here: ECG monitors use suctn cups for the lead connections so there are no consumables needed, paracentesis drained into coke bottles, among other examples.

The placement at Sotto was an education, and has made me reflect on how fortunate we are in our NHS that we take for granted.