ELECTIVE (SSC5c) REPORT (1200 words)

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

I managed to organise a unique and quite brilliant 6 week experience at Trincomalee District General Hospital in Sri Lanka. Despite being of Indian origin, I have never before experienced South Asian culture before, and was thus both excited and terrified to have organised a placement at the primary health institution in the entire Trincomalee district. Whilst I had ideas about what a rural hospital on the outskirts of Sri Lanka would be like, nothing could have prepared me for my 6 week period at a central referral institution for over 30 government run medical institutions, spanning an area populated with nearly half a million Sri Lankans.

My ambition was for this was to provide me an opportunity to study common medical conditions seen in Sri Lanka and expand my exposure to medical presentations atypical to the UK. With such diverse culture in London Hospitals, spending my elective communicating with patients who mainly spoke "broken English", I believe this should put me in good stead for giving optimum management to cultural minorities as a Foundation year doctor.

Within the first week, I was both delighted and relieved to learn that the medicine doctors in Sri Lanka learnt was all in English. Even doctors who were less comfortable with English were able to speak fluent "medical English", due to their training being similar to ours. This helped tremendously with my learning experience, as doctors were always happy to inform me on what was happening to patients when I was unclear.

My experience working on the internal medical ward gave me exposure to a huge array of patients with varied medical issues. As I had anticipated, tropical and infectious diseases were a huge problem. Although the doctors were pleased to announce Malaria was no longer a big problem in Sri Lanka, Dengue fever was particular prevalent and is a huge problem in Sri Lanka currently with a lack of vaccination or prophylactic medication. It was incredible to see how varied the presentations could be based on individuals. With far more limited resources and investigations available to the doctors, clinical diagnosis based on history and examination was more important than ever. Tasked with non-specific symptoms such as lethargy, body ache and headaches, doctors were keen to always exclude dengue fever initially due to the high prevalence. Patients of any age and any history could present at any phase of the disease. It was fascinating learning about the febrile phase, critical phase and recovery phase and seeing patient progression over a period of time. This provided me with an excellent learning opportunity to practice my own examinations, such as eliciting shifting dullness in malnourished young individuals with no apparent visual ascites. Whilst I do not expect to see many patients with dengue fever in the UK, such clinical examination practice should help aid me with conditions more pertinent to England. In the extremely rare occasion where I may see a patient, I'm glad I have an appreciation of the supportive management and fluid resuscitation required.

One of the most humbling memories I shall take with me was the sheer number of suicide attempt patients that I saw. Whilst I have seen some in England, I have fortunately yet to see young teenagers admitted having tried to end their life. Within a poor village, my consultant explained to me how often suicide attempts are used by children as cries for attention. With populations being so small and news travelling quickly throughout the village, one suicide attempt can bring more from the same area as other young children are seemingly influenced as a result of the emotion and attention other

attempts generate. As a concept this deeply saddens me. What was even more difficult was how seemingly desensitized the medical staff seemed about such attempts. It was just so common it had subsequently become normalised, and yet was so shocking for me and my elective compatriots. One common method used was via the Yellow Oleander Seed, a readily available plant that carries over 10x the treatment dose of digoxin. Even with this being such a common cause of mortality, the antidote (digibind) is unavailable in Sri Lanka due to it being too costly.

As time went on through my elective, I gained an interesting insight into the history of Sri Lanka and politics. Given the years of political unrest and civil war tragedies, I perhaps gained wider understanding of the impact of politics on mental state and thus future health states.

Other common issues seen were trauma either due to road traffic accidents or animal bites. Dog bites were common in Sri Lanka with a large amount of stray dogs. I was far more concerned with learning about snake bites having seen snakes for the first time in my life just roaming around in the wild! Despite my initial comfort reading in travellers books informing me how snakes tend to avoid humans, I witnessed a bloodied patient enter the hospital having suffered a large snake bite to the neck. Unsurprisingly all doctors, nurses and even most patients seemed very informed regarding snake bites. I was even told stories about patients bringing in snakes to be identified (alive or dead!) having been bitten to ensure they received the correct antidote. Despite it not being directly useful for my foundation training in London, it was fascinating hearing about the neurological conditions caused by Cobras verses different presentations by even more venomous snakes.

Apart from the tropical infectious diseases, horrendous psychological distress and ferocious looking animal bites, I also saw a lot of "normal medicine", or rather what I consider normal in England. Advanced cardiac pathology, liver disease on a background of alcohol abuse and chronic diabetes were also common in Sri Lanka. This allowed me to reinforce knowledge I had learned over medical school and practice my clinical examinations. It was also interesting to hear about different causes of common conditions in the UK, for example lung cancer. One would expect smoking to be the obvious cause of lung cancer worldwide, yet in Sri Lanka, many women suffer due to traditional cooking methods used in the villages.

With a personal interest in Management, I was very interested in seeing how such a Hospital would be run and compare it to the UK. The overall healthcare system in Sri Lanka did not appear to be too dissimilar to that of the UK, despite the difference in quality of service provided due to a lack of resources. The Ministry of Health has overall leadership and control with primary care, district general hospitals and tertiary care centres in major cities. Similarly to England, patients have access to both the government run hospitals and private healthcare for t hose who can afford it.

My internal medicine wards were split according to gender; with consultant lead morning ward rounds taking place similar to the UK. Their equivalent FY1s arrived early to ensure all notes, investigations and administration was ready for the consultant. The wards seemed chaotic and unorganised with such variety of patients seen on one ward, with new patients just sitting on the floor outside the ward waiting for a bed. At the end of each ward round, the consultant would quickly see the patients waiting outside the ward and make a rapid decision on whether they need a bed or should be sent home. These patients were all examined one by one on a single bed. With such little resources and such huge population demands being placed on the hospital, less priority was given to

issues such as bed cleanliness or even hand washing between patients. The skill level of the consultant was phenomenal, with the ability to speak 3+ languages fluently (English, Tamil, Singhalese) and make such rapid decisions on patients without full investigations. I was amazed to see how the consultant was absolutely familiar with UK guidelines on investigation and management, before wryly smiling and stating that this hospital did not have the facilities for such investigations, and thus clinical diagnosis and immediate management were commenced.

I have mentioned lack of investigations readily used in England, but no example resonates with me more so than the following. In England, guidelines are stringent on the timely investigation and management of stroke. In Sri Lanka, doctors do not have access to a CT scanner unless their patient is driven over 5 hours away to Kandy. I found this incredible to hear with such emphasis on the 4h30 window placed in England for thrombolysis. Another similar example can be described with ischaemic heart disease, with the nearest cath lab for angioplasty similarly being over 4 hours away.

Given that I see my future as a GP in England, I was very interested in seeing how the clinics were in Sri Lanka. In Trincomalee, patients lack access to primary care services. As a result, patients come to open hospital clinics to receive medical attention. The crowd of patients waiting to see by doctors is simply indescribable. Seemingly hundreds of people would stand in the waiting area in such humidity/heat with no fans, all desperate to see the doctor. The doctors operated in such small areas with little room to move. I have experienced the "pressures" in England of running my own clinics in final year, being afforded 30 minutes per patient before presenting my diagnosis and management plan. In Sri Lanka, each doctor would see over 100 patients per sitting. This is something that simply cannot be described in such intense heat. Whilst this is not something I am keen to experience again, this humbling experience will certainly remain with me when I find myself overrunning a clinic in the UK.

Overall I feel very humbled by my experience of medicine in Sri Lanka. The doctors were truly inspiring with their knowledge of not only their local medicine (within resource limitation), but seemingly the entire UK guidelines. It was perhaps naïve of me to expect otherwise, but it was amazing to see how most doctors here frequently read literature such as the Lancet and BMJ. It gave an awe inspiring feeling of medicine transcending culture, race and religion. The hours they worked and conditions that they worked in were truly challenging. The lack of specialization forcing a need for incredible general doctors was amazing. I feel more motivated than ever to commence my Foundation Training in August, and feel mentally tougher due to my experiences.