ELECTIVE (SSC5b) REPORT (1200 words)

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

I chose to carry out my elective at Mahamodora Maternity Hospital located in Galle, Sri Lanka. I wanted to be able to experience Obstetrics and Gynaecology in a developing country but also travel to a country that I have never been to. Mahamodora Hospital is a tertiary centre that has about 400 beds and delivers specialist maternity care to the whole of the southern province of Sri Lanka.

The healthcare service in Sri Lanka is similar to that in the UK in that they provide free healthcare to all citizens. Sri Lanka's expenditure on healthcare is about 3.5% GDP compared with 9.1% GDP in the UK. Despite Sri Lanka's low expenditure on healthcare, health indicators are similar to those in more developed countries in the region.

Antenatal care is arranged very similarly to the UK, with it being mostly community based care. Nearly all pregnant women receive antenatal care, with routine appointments being once every 4 weeks until 28 weeks' gestation, then once every 2 weeks until 36 weeks' gestation, once a week until 39 weeks' gestation and then twice a week until 40 weeks' gestation. Those with high risk pregnancies are referred to Mahamodora hospital from community based doctors.

During my time, I was fortunate enough to see patients with a diverse range of clinical presentations. For example, on the antenatal ward I met women with pregnancy induced hypertension, premature rupture of membranes, gestational and type 2 diabetes, bipolar disorder during pregnancy to name a few. One particular case which stood out to me was that of multigravida with mitral valvuloplasty for mitral stenosis secondary to rheumatic fever and mild mitral regurgitation. After being assessed she was first taken to labour ward for an artificial rupture of membranes and then very quickly transferred to the intensive care unit for closer monitoring as she was at risk of going into heart failure. I was very surprised to learn that women delivering in the intensive care unit was not uncommon, something that I have never seen occur in the UK. Perhaps cases like hers and others delivering in intensive care unit may have been offered an elective caesarean section if in the UK in order to minimise such intrapartum complications, whereas in Mahamodora caesarean sections are reserved for emergency cases.

One of the most common obstetric complications in Sri Lanka is postpartum haemorrhage, although the prevalence of postpartum haemorrhage has dropped in the last few years. Use of oxytocin is commonly seen in the labour ward and is used for active management in the third stage of labour to reduce the rates of postpartum haemorrhage.

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A noticeable difference I observed during my time here is the management of pain during labour. In the UK epidurals are very common form of pain relief for women advancing through labour and every women receives Entonox (nitrous oxide and oxygen). During my placement I observed many women give birth without any pain relief. Pain management for those in significant distress included either pentidine IM injections or Entonox.

Moreover, other differences I observed was that women held a different birthing position and a higher proportion of primigravidae received episiotomies to prevent larger perineal tears, probably due to the women tending to have smaller pelvis. I also observed that there is a delay in clamping the cord allowing the neonate to receive more oxygenated blood and nutrients. Women spend one to two nights in the postnatal ward after uncomplicated vaginal delivery, where they are given advice on breast feeding, contraception and monitored for complications. This is a bit longer than in the UK where most women go home after a few hours, the same day.

Furthermore, commonly seen gynaecological conditions includes fibroids, subfertility, PCOS, early miscarriage, gynaecological malignancies. During my time here I assisted in theatres, one of which was ligation of fallopian tubes and found that a number of women chose this route of contraception after completing the family.

The healthcare culture is visibly different to that in the UK, in which certain aspects such as patient centeredness and patient privacy were far less pronounced. Many beds are in close proximity. On the labour ward, beds are only separated by ward curtains and I noticed there was laxity in closing curtains around beds when patients were exposed in front of other patients and staff. Nonetheless, the patients seem used to this and do not seem to mind.

Unfortunately during this placement due to language barriers my communication with patients was limited and so I unable to take histories myself. However I did have plenty of opportunity to developed my clinical skills and get hands on experience. With the help of the doctors and midwives I was able to examine many patients. I also received a lot of teaching from the doctors and was taught how to use the Pinard horn which I had not seen being in use in the UK.

Overall, I have very much enjoyed this placement, and have found the experience to be truly eye opening. In the future I aspire to practice medicine in the developing world and this has been a fantastic first experience of that. All the staff have been extremely helpful and friendly. I would highly recommend this placement to future students.

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