ACCIDENT + EMERGENCY

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From the Emergency Department in Singapore to the Operating Theatres in Sri Lanka. This is my Elective Report.

How are Emergency Department services organised and delivered in Singapore and how does this differ to the NHS.

For such a small country, Singapore has many district general and university taeching hospitals. Most of these have their own emergency department (ED) which receive patients based on the proximity to the hospital. Patients are then transferred on if needed to tertiary care hospitals.

This system is very similar to that of the NHS. However while care is free in the NHS, patients have to pay for their care through their insurance policies. This includes the ambulance to the hospital! With regards to National Univeristy Hospital where I did my elective, it usually has its busiest days on Monday and after midday rather than weekends and nights because this is when the cost of the ambulance is the cheapest. On arrival patients are triaged by nursing staff who take obs and perform bedside tests before referring patients onto minors which are staffed by middle grade doctors or onto major. In majors there are three tiers of care, P1 equivalent to resus, P2 which is high to medium priority and then P3 which is low. If the cases are classed as P1 or P2 cases the ambulance crew radio to ED to inform them of what to expect and an ETA. Care in majors is delivered by senior and associate consultants and middle grade doctors. The nursing staff are also highly skilled and can sometimes lead the care for patients. Investigation are ordered on the intranet and usually performed almost immediately as there is a resident radiographer dedicated to the ED. Results for the investigations are reported within the hour. Once stabilised patients are either admitted or discharged.

There was a stark difference in the level of efficiency and speed at which cases were dealt with. The higher number of staff and more modern facilities meant that patients were seen swiftly and because of early consultant input management was started quickly. During my 2 weeks I became envious of this and wished the NHS could adopt these points. However I came to realise there is always a cost in having such a modern service in the fact that someone has to pay for it and as a result of this patients usually present late during their course of illness. Therefore despite how efficient and modern the services is, there is only so much you can do for a patient who has now presented with an intractable disease.

Describe the healthcare systems in Singapore and Sri Lanka and compare and contrast these with the NHS.

The Sri Lankan healthcare system in some respects is similar to that in the UK. There is primary, secondary and tertiary care provided by either by the government or private sector. The private sector tends to have better facilities though the patient has

to pay a greater amount to access these. Government hospitals however do require patients to pay a small amount towards the medications.

In terms of how care is delivered, Sri Lanka has adopted very similar hierarchical systems to that of the UK. There are Junior House Officers, then seniors, Specialist Trainees, Registrars and finally a Consultant. Patient admitted to a University Hospital also have a medical student attached to them as well as nursing and portering staff attached to the ward. Because of the lack of consultants and consultant surgeons, teams can have a larger number of patients with a great breadth and variety of presenting complaints.

The presenting complaints are usually late in presentation due to a number of reasons. Firstly cost implications for the patient's means the patients refrain from seeking medical care. Lack of patient medical knowledge coupled to little or no screening programmes means conditions are not put on radar. Coupled to the sheer strain on the health systems there is also no time or money in practising preventative medicine.

This surprisingly was the case in Singapore as well because the insurance system inevitably meant there was little or no government funding for screening programmes and patients presented late.

Singapore's healthcare was also delivered through a similar system to that of the UK but many of the hospitals were now starting to adopt a US style.

Was there a communication barrier between myself and patient and colleagues? Did this affect my care for the patient and what strategies were employed to overcome this challenge.

Many of the patients did not speak English and were only fluent in Sinhalese or Tamil in Sri Lanka. These languages are very different to Hindi or Gujurati which I can understand so there was obvious communication barrier between myself and the patient. With regards to the team, I was able to communicate effectively with doctors and medical students because they had learnt English as part of their studies.
In order to overcome the challenge of speaking to patients, I learnt a few simple Sinhalese phrases as well ask fellow medical students to act as interpreters. This seems to work well and I was usually able to come to a diagnosis from the history and convey information on management back to the patient and their family.

The majority of Singaporeans were bilingual in English and Mandarin Chinese. The small population that was only fluent in Chinese were the elderly. In order to overcome the communication barrier I usually asked question either through a nurse or doctor who were fluent in the language.

What are the most common general surgical conditions encountered in Galle and how do the differ to the common conditions encountered in the UK.

In Galle general really does meant general! It is difficult to typify the common cases because of the variety of presenting complaints that walked or was wheeled through the door. Trauma orthopaedic cases were common usually as a result of road traffic

crashes. Abcesses of different body parts and other infective pathologies such as fasciitis and epidymo-orchitis were also common. Thyroid surgery as well as lumpectomies and urological problems were they other common conditions. Then there were cases which were similar to that found in the UK such as acute appendicitis and peripheral vascular disease secondary to diabetes or artherscleros is.

The reason for why it is so difficult to draw parallels between UK and Sri Lankan general surgery because in both countries general entails different conditions treated. In the UK general usually covers upper/lower GI surgery and the acute abdomen, breast or endocrine as well as simple day surgery such as lumpectomies or haemarrhoidectomies.

The Sri Lankan systems does all of the above plus anything else the surgeon has an expertise for. Because of the lack of surgeons, it is a requirement for surgeons to be skilled in other areas as well in order to treat their patients. The result of this is highly skilled multi-talented individuals who can confidently and competently deal with an array of surgical cases.