ORTHOPAEDIC TRAUMA

MBBS: SSC 5C

Elective Objectives

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Elective objectives

The tropical island of Sri Lanka is most famous for the production of tea, coffee, rubber and coconuts and as a famous tourist destination. Sinhala and Tamil are the two mainstay languages; however, English is widely understood and spoken. The private hospitals in Sri Lanka include many internationally recognised quality standards. These hospitals also consist of highly qualified staff with recognised qualifications from the UK, USA and Australia; hence many of the medical staff spoke English. However, I found that this was also the case at The National Hospital of Sri Lanka, situated in Colombo 8, the capital of Sri Lanka. This hospital is a government hospital, meaning that anyone, the rich or the poor, could be treated here, as opposed to privatised hospitals in which mainly the rich would attend. This hospital is well-known for being the largest hospital in South-East Asia, with 3000 beds and this number can be doubled if one includes the space underneath a bed, as I unusually witnessed the hospital utilizing. This hospital is also a well recognised tertiary referral centre in Sri Lanka.

I was very privileged to be accepted by this hospital which I had heard about in the past, and being allocated to the trauma and orthopedics department was also quite exciting. My placement had a mixed role of observing as well helping the junior doctors carry out their daily tasks. The elective objectives which had been put together before the elective were fulfilled, and further information and knowledge were also acquired.

Objective one

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: What are the most prevalent types of trauma, specifically orthopedic found in Sri Lanka?

During my placement at The National Hospital I was able to witness different types of orthopedic trauma. This varied from simple fractures which simply required fixing using splints to major breaks to nearly all the long bones of the body being affected. It became quite obvious from the start that the main orthopedic emergencies arose from road traffic accidents. As the placement went on I saw many displaced tibial plateau fractures and saw the consequent fixations of these using screws and plates. Some of these fractures I saw had actually developed

from undisplaced fractures where conservative measurements were advised but instructions were not adhered to, such as not placing pressure on the leg and walking great distances with such injuries. However, looking in greater depth into the individuals' situation it was greatly apparent that it was a necessity for the patient to carry on with everyday activities to earn a living and so such patients felt they never had any choice but to become non-compliant to the instructions which were given to them. I did however find that in the outpatients department that the orthopedic traumas caused by the 2004 tsunami which hit countries within the Indian Ocean were still being seen as follow-up, ongoing cases. This demonstrated how orthopedic injuries can affect the global health of the patient. Patients were seen where limbs were lost in the disaster as the damage was too much for the limb to be salvaged, many limbs were also lost due to necrosis of the bone. I witnessed many patients with prosthetic limbs. I was told by the registrar of how during this period there was an increase in the use of external fixators, wound debridement and techniques of soft tissue cover and a shortage of equipment arose during this period.

Objective two

Describe the pattern of health provision in relation to the country in which you will be working and contrast this with other countries, or with the UK: How are the orthopedic services organised and delivered? How does this differ from the UK?

Again, referring to the time of the tsunami I was told of how The National Hospital had the situation of a massive increase in trauma victims very much under control due to its 3000 bed capacity enabling these patients to be managed appropriately. Patients whom suffered from falling debris on their limbs resulting in crush fractures had expertise of only one orthopedic surgeon and two general surgeons. However, the number of surgeons increased one to two days later and have since now have a good team of orthopedic surgeons. Initially, there was also a shortage in Kirschner wires and Steinmann pins desperately required for surgery, there was also a shortage in external fixators. This came about due to the obvious increase in trauma patients. The problem was solved by donation of equipment by aid agencies, orthopedic companies and officials. There is no longer such a problem in this hospital as I was advised of how

communications were stronger between the hospital and suppliers of trauma equipment, including, external fixators, intramedullary nails and plates etc. Further training for specialists in this field were also identified and now medical staff had regular training on e.g. new equipment etc. Although the UK has thankfully not suffered from such disaster as a tsunami, medical equipment, good quality facilities and highly trained orthopedics are more readily available than that seen in Sri Lanka. In the UK malfunctioning of e.g. air conditioners, imaging equipment and risks involved in such surgery are also a lot lower.

Objective three

Health related objective: What is the mortality and morbidity rate of those suffering from orthopedic trauma in Sri Lanka.

Facts taken from the statistics database found in the hospitals database suggested that the overall mortality figure for accidental deaths in Sri Lanka was around 6,850 deaths for the year 2010 (total estimated population in Sri Lanaka of 20,000). A quarter of these deaths were found to be directly due to orthopedic trauma of some type. This is quite a poor statistic as in large these accidents were deemed preventable. For example, the largest numbers of orthopedic traumas were caused by road traffic accidents, which of course in essence could be preventable. It could be suggested that with better quality road maintenance, care whilst driving a vehicle and greater road traffic awareness these statistics could be greatly reduced. It could also be suggested that morbidity related to orthopedic trauma from e.g. osteoporosis of the bones could be decreased. Early monitoring and prescribing calcium and multivitamin supplements to the frail and vulnerable may help. Taken together, and along with other suggestions to reduce mortality and morbidity it is quite apparent that financial restrictions and lack of finances play a great role in these grave results.

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Objective four

Personal/professional development goals: To compare and contrast the orthopedic services offered in Sri Lanka compared to the UK?

There was a very obvious difference in my opinion between the healthcare services offered in the UK and Sri Lanka. This difference was diminished if the patient was prepared to pay for their healthcare. If this was the case I saw that the patient's treatment was just under par compared to the patients in the UK, whereby healthcare is provided free-of-charge by the National Health Service. The divide was made increasingly more obvious at the initial registration for each patient. There were two queues that had to be formed, those that were paying for their healthcare and those that were non-paying. The queue for those that were non-paying was very lengthy indeed and although this was the case patients that were paying and had come after the other patient set was noted to be seen a lot quicker. Those that also paid would also have much comfortable beds whereas those that were non-paying were also seen to have to share their space with another patient underneath their bed. These experiences were very new to me with the knowledge of the standards in the UK. The equipment that the orthopedic surgeons used was imported from abroad such as India, Australia, US and UK. However, working conditions were quite hard for the medical staff. I witnessed on several occasions that the air conditioning systems were not working during lengthy operations, creating a difficult environment for the team to work in. I have observed lengthy operations in both the UK and now Sri Lanka but found the latter experience quite hard to deal with for the entire length of the operation due to the climate.

Overall, my time and experiences in Sri Lanka, at the National hospital, cannot be summed up in this essay. The experiences that I had were indeed incredible. Having witnessed how the medical teams had to experience hard conditions yet still deliver good medicine and how patients have to suffer the consequences of poverty, I give my utmost respect to them all, yet feel very privileged that I will be joining such a service as the NHS back home in the UK.