ANAESTHESIA.

Elective Report

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Objectives:

1. What are the different health conditions that were observed during my anaesthetics attachment?
2. How are health services being provided in Thailand?
3. What is the policy on nosocomial infection control?
4. To enhance my technique on practical procedures, improve basic skills in airway maintenance and attend workshop on advance airway management.

During my 3 weeks attachment in the Anaesthetic Department of Siriraj Hospital, I moved around different subspecialties on a daily basis which gave me a full experience of the specialty in Thailand. In the first week, I spent my time in adult and children cardiothoracic surgery, neurosurgery and emergency theatres shadowing an anaesthetist. Since Siriraj Hospital is a tertiary centre, many rare and complex medical conditions are referred here from different areas in Thailand. Therefore, I had the opportunity to see operative procedures of uncommon cases such as congenital cardiac conditions, primary brain tumours and mediastinal tumours which I had not been able to see in the UK. Seeing these conditions clinically was more meaningful to me than reading from books or a website. One of the more contrasting differences in the practice which I had observed here was that patients were placed under anaesthesia using propofol, fentanyl and midazolam for colonoscopy. Only mild sedation with midazolam is normally used in the UK and therefore I asked the doctor if it was a common practice in Thailand. She told me that it is something which is being promoted in this hospital for greater patient comfort. As a result, greater patient compliance was achieved and many patients choose to come to this hospital to receive treatment and investigation. Although I did think that the sedation was a little excessive at first for such a procedure, I can imagine it to be extremely uncomfortable and therefore prevent many patients from wanting to have this procedure done causing unnecessary delay in their treatment.

After having spoken to some of the residents in training here, I found out that recent graduates are sent to rural areas in Thailand to practise as general practitioners where there is a lack of doctors. Under appropriate supervision, they would help to manage many of the chronic conditions as well as some minor ailments in the rural communities as a preventative measure towards the development of serious health problems much like the general practitioners in UK. In Thailand, patients can get treatment for their illnesses in government hospitals with a minimal fee. This is especially important for patients with low income who are unable to bear the hefty price tags of medical bills. For some companies, they may

provide medical insurance for their employees or have health funds contributed from the wages of all employees which can be claimed when they fall sick. Health insurance and private healthcare can be quite expensive in Thailand and they are mainly affordable only by the upper middle class communities. Sometimes, I feel that we have taken our free healthcare for granted and did not realise how fortunate the situation in which we are in. It is extremely devastating not being able to receive medical treatment due to financial constraints not just for the patient but also for the family.

In 1982, training programs on nosocomial infection control were introduced by the Ministry of Health and the Nosocomial Infection Control Group of Thailand was established 4 years later. The result of such training programs proved great success as nosocomial infection prevalence rate decreased from 11.7 percent in 1988 to 7.3 percent in 1992. Training programs were aimed at improving the aseptic techniques of hospital staff and specific roles were given to infection control nurse to improve nosocomial infection rates. However, the implementation of infection control was not without its difficulties. In one study where hospital staff were interviewed using a set of questionnaires, they found that there is a lack of support from administrators and also that the policy on infection control was not always clear. Infection control nurses felt that there is no career ladder or incentive for them to work full time. My medical training in UK also emphasised the importance of infection control and students were given lectures on the policy of healthcare associated infection before our hospital attachments. We were also taught to perform procedures using aseptic techniques on manikins before practising on real patients. In 2006, the healthcare associated infection rate in UK was 7.6%. Although it is not clear from the literature what the limitations are for our infection control policy, there are particular concerns for certain pathogenic organisms such as methicillin resistant staphylococcus aureus and Clostridium difficile possibly associated with the widespread use of antibiotics.

The doctors were keen for me to practise some of the practical procedures such as venepuncture, arterial blood sampling, intravenous cannulation and endotracheal intubation. I attended the skills lab where I could practise intubations on manikins under the guidance of supervisors. I felt a lot more confident intubating real patients with all the teachings received. It was a brilliant experience since I had not had much chance to do them in the UK. Also, I was very fortunate to be able to participate in a fascinating advanced airway management workshop. The workshop was probably far too advanced for my current level of training but nonetheless was very exciting and the doctors were kind enough to explain how to use the different equipments. I have not seen many of the equipment used during the workshop including the different types of laryngoscopes, video laryngoscopes and laryngeal mask airway designed for intubation. The video laryngoscopes were especially useful for training purposes as I was able to get a very clear view of the airway. In another station, I practised using laryngeal mask airways designed for intubation for the first time. The doctor explained that the necessity for these highly advanced equipments as intubation can be tricky in some patients if they have short necks or small mouths. It was also the first time that I have ever held and used a bronchoscope during the workshop which was quite a tricky instrument. But with guidance and after several attempts, it was a really satisfying experience to be able to manoeuvre the bronchoscope. The excitement of handling so many different types of cutting edge devices during the workshop was truly an exhilarating and unforgettable experience.