OBS + GYNAE

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Elective Report

Healthcare in Sri Lanka

I undertook my elective in Galle, Sri Lanka at a maternity hospital named Mahamodara and a general hospital named Karapitiya. My elective began with obstetrics and gynaecology followed with general medicine. I was particularly interested in how the healthcare system in Sri Lanka would compare with the system in place in the UK. I was surprised to learn that the healthcare in Sri Lanka was a free system. This included medicines given within hospital but not regular medicines taken at home. A consultant explained that the money for the healthcare system does not come from taxes. The government has a set amount of money it puts aside for healthcare which is around 3% GDP. However the World Health Organisation recommends that countries spend at least 5%. So we can see that ideally a 2% increase in healthcare spending is needed to meet the requirements set by WHO.

There are obvious differences between the hospitals in England and within Sri Lanka. Within the gynaecology ward there has been a shortage of beds so patients wait on chair until one comes available. Something we are very used to in England is using alcohol gel in between patients however this is not present in the hospitals here. Also a lot of equipment is reusable rather than disposable as is in the UK. This is a reflection of a much smaller budget than what is given to the NHS. However I believe what is done with a small amount of money goes a very long way in Sri Lanka and I have been very impressed with the treatment the patients receive.

Medical Education

I had the pleasure of working with many students of Ruhuna Medical School during this placement. The level of responsibility granted medical students here is much higher than within the UK and the level of work expected of them also appears higher – attendance on a Saturday is normal whereas in UK hospitals it would be very unexpected to find students working on the weekend. I felt the students were much more experienced at performing procedures than in the UK. This will be in part due to increased number of hours in hospital but also due to less restrictions on consent. I was grateful to have the opportunity to practise exams which in the UK can be difficult to gain consent for. Here the women do not refuse student examinations and the students ran a lot of the antenatal clinics themselves seeing numerous patients in one session. An opportunity like this is difficult to find in the UK.

Patient Population

When observing the patients on labour ward I have noticed a few differences in the range of patient problems compared with the UK. The first major difference I noted was more of the females suffered with anaemia during pregnancy and therefore there where an increased number of blood transfusions on the antenatal ward and post natal ward. This is likely due to diet, with many more of the females here being vegetarian, but also a reflection of those who are poor and cannot afford a balanced diet.

I also noticed what seemed like a higher percentage of mothers with either diabetes mellitus type II or gestational diabetes than I observed within antenatal clinics of the UK. This interested me as I suspected that with a poorer population the rates of DM II would be lower, however I observed an increased percentage of those with the disease and an earlier age of onset.

The range of ages of those with child appeared similar to the UK, however its likely there are more teenage pregnancies in the UK.

Within the general medical wards I noticed thyroid disease was a much more significant problem than within the UK and it was interesting to see advanced grave's disease and large goitres. Many patients had been admitted with dengue fever and other infections which are not prevalent in the UK. I also took note of a lack of smoking related diseases, such as lung cancer and COPD.

Care of Patients

The patients within the labour ward received excellent care during birth. Some notable differences were noted between Sri Lanka and UK. Prima gravidas all receive an epistiotomy whereas within the UK this would only be performed if the woman was about to tear, in most cases this is tried to be avoided. Another difference, relating to the earlier point of increased anaemia, is that the cord is clamped after 2 minutes rather than after 1 to help reduce the risk of anaemia in the child.

During the week I met a patient who had sadly had death in utero, within the UK women would be induced to remove products of conception very soon after this was detected however this lady was present on the ward for a few days and then underwent a LSCS.

I have also noted a different technique for dilating a cervix that I had not previously heard of. If the os of the cervix is slightly open and is not dilating a foley catheter can be inserted into the os and the balloon inflated with 50ml of water. This is then left in place for 24 hours by which time the cervix should be a few centimetres dilated.

I have also learnt that isosorbidemononitrate can be inserted into the posterior fornix to help ripen the cervix. This can be used as an alternative to prostaglandins if they are contraindicated due to risk of uterus rupture as it has no effect on uterine contractions.

In the general medical wards

I have enjoyed my time on this placement very much. Everyone within the hospital has been very welcoming to me and encouraged me to get involved on the wards. I was surprised also that all the notes and ward rounds are conducted in English, something I was very grateful for else the experience might not have been so rewarding. I even had the opportunity to assess the cervix during early labour, something that I have not known any student perform in the UK. I would recommend this elective to other students.