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GENERAL MEDICINE

Elective report

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Consider the main reasons for acute admissions in a relatively resource poor country

The wider societal patterns of behaviour influence those admissions seen in the emergency department, and the vast majority come under the category of trauma. The vast amount of vehicles such as tuk-tuk's, which offer very little protection to it's occupants, share road space with cars, busses and lorries makes it unsurprising that road traffic accidents account for a large proportion traumatic injury. It is a problem increasing in scale, putting more pressure on the local health care provisions. Also under the heading of trauma, injuries at home are another common cause of orthopaedic injury. Most home construction and renovations seems to be done by the home owner themselves, rather than a hired builder, and safety standards are not robust.
Without the established general practice network of the UK, inoculations are missed by some children, and as such there are a number of admissions for infectious disease including measles and typhoid. Adult infections commonly presenting include pneumonias and meningitis.

Consider patterns of illness in a country with no universal healthcare system and compare to the UK

Stating there is 'no universal healthcare system' in Sri Lanka is an poorly made assumption made prior to experiencing the health care system in country. There is fundamentally free health care at the point of delivery. However, unsurprisingly this is not as well resourced as the UK. Free healthcare is based at the hospital, where patients present and wait to be seen, assessed and admitted as necessary. This is not just an emergency route to care, but for cases that in the UK would be seen as more GP based. General Practice does exist in Sri Lanka, but in a private format, offing those able to pay a way of seeking medical knowledge without the long queues of hospital. Rather than a specialist role as is in the UK, it is seen as a good earning opportunity for newly qualified doctors who have completed their one year post graduate training to perform some 'simple medicine'. They work for the state funded system during the morning, and practice independently as a GP in the afternoons. It was a surprise to the Sri Lankan final year students I was with that we could not do the same, and that GP is seen as a specialty. There is not a complete absence of community medicine, but it is not a coherent service. Medical students are assigned a family to oversee for a number of months, and 'tested' by consultants based at the hospital as health issues arise. However this is more of a learning exercise for the students.

Consider methods of treatment of common local pathology

Sri Lankan medical practice, and indeed it's teaching, is based on a UK model. It was explained to me simply that medicine is taught in english because all of the available texts

are in english, with no resources based in the local Singhalese language. The choice to use a UK model, over other developed states, is no doubt linked to Sri Lanka's colonial ownership by the British, which in historical terms only ended relatively recently. Patient notes are written in english, using the same abbreviations we would recognise (Hx, O/E and so on).
Therefore, methods of treatment follow the same aims as those in the UK, though the comparative poverty of resources in Sri Lanka make achieving those aims challenging. The hospital we were based in had all the equipment one would expect of a western hospital such as CT, bronchoscopy, endoscopy and fully furnished operating theatres, though their use is stretched much more thinly.

Experiences of surgical and aesthetic techniques in an alternative care setting

My first experience of theatres revealed a number of differences the Sri Lankan system uses, all due to needing to provide as much care as is economically possible. Theatre gowns are not disposable, but laundered and reused, though they are still applied using the same sterile technique. this applies to the drapes and covers laid over the patient also, with only small amounts of gauge used to soak up blood near the site of incision. The coast savings in not having to destroy large quantities of disposable items, and reusing others, are simple measure that I was told allow for a lot more to be done. Similar savings were made with the anaesthetic equipment, with face masks being wiped with alcohol wipes between patients.
The working of theatres too showed most aptly the difference in attitudes to health care patients have in Sri Lanka, which very much remains paternalistic. Patients are brought into the theatre, laid on the operating table and undressed as appropriate, with some concession for their modesty. They are then put under GA in a room usually full of the anaesthetic & surgical team, and a horde of medical students. There is none of the patient centred concern such as in the UK, where the anaesthetist normally makes the anaesthetic room a very calm environment.
Other examples of this functional approach in Sri Lanka was in surgical outpatients, where the consultant, registrar and house officer all sit round a table, and each see a patient concurrently. There is no concern over confidentiality. The room had one examination couch used in turn by each doctor as they needed, and by us as patient were put forward for us to examine.