ELECTIVE (SSC5c) REPORT (1200 words)

A report that addresses the above four objectives should be written below. Your Elective supervisor will assess this.

Describe the pattern of disease/illness of interest in the population with which you have worked and discuss this in the context of global health?

Sri Lanka is a small island in South East Asia. it has a population of 21,273,000 and a life expectancy of 75 years at birth. The disease that interests me within this population is ischaemic heart disease. Ischaemic heart disease is the number one cause of death in Sri Lanka, comprising 23.6% of deaths, roughly 32,600 in 2012. Cardiovascular disease is also responsible for the largest amount of years of healthy life lost due to premature mortality in Sri Lanka. In a global context, cardiovascular disease accounts for over 17 million deaths each year. 80% of these occurring in low and middle income countries. it is estimated that by 2030 more than 23 million people will die a year from cardiovascular disease. Therefore reducing the levels of cardiovascular disease should be a global priority.

Describe the pattern of health provision in relation to the country in which you have worked and contrast this with other countries, or with the UK?

Health provision in Sri Lanka is split between public and private sectors. Similar to that of the UK. There are 555 government hospitals in Sri Lanka, and as well as providing traditional healthcare, some of these hospitals also have Ayurvedic services, which involve ancient healing practices entrenched within buddhist tradition.

Similar to at home there are preventative practices, which involved limiting the spread of infectious disease, and educating patients about lifestyle and health. There are practitioners within the community who strive to impact this area and have been fundamental in the attainment of the millenium development goals.

As well as these community based services, there are also hospital based ones. Each hospital has an outpatients department which works similar to a GP practice. Patients are assessed there by a doctor and depending on the severity of their presenting complaint they will either be sent home, seen by a specialist in their clinic, or admitted to the hospital. During my time in Sri Lanka I went to quite a few cardiology clinics at the National Hospital in Colombo. Sri Lanka has only 4 electrocardiologists for 22 million people, and the clinic I frequented housed 3 of them. The amount of patients being referred to this clinic was overwhelming. Some patients had travelled for hours to try and see one of these 3 physicians, with many being turned away. This for me highlighted the biggest difference between our public health services. In the UK we have healthcare for all, with easy access to local facilities, be it a hosptial, a GP, pre hospital care, or a specialist. However in Sri Lanka, there are not enough doctors to go around, thus there is a limit to how much of the public can actually access public services.

During my time here I have been fortunate enough to experience both public and private sectors, which allows me to contrast them. There are a large number of private hospitals due to the rising income of some individuals. These account for around 50% of outpatient services and 10% of inpatient services. Patients tend to use the private sector on a 'pay as you go' basis, as medical insurance is not very abundant. I was based at Central Hospital, which is part of the Asiri group. The significant difference I noted for the 'pay as you go' approach between Sri Lanka and UK was the price

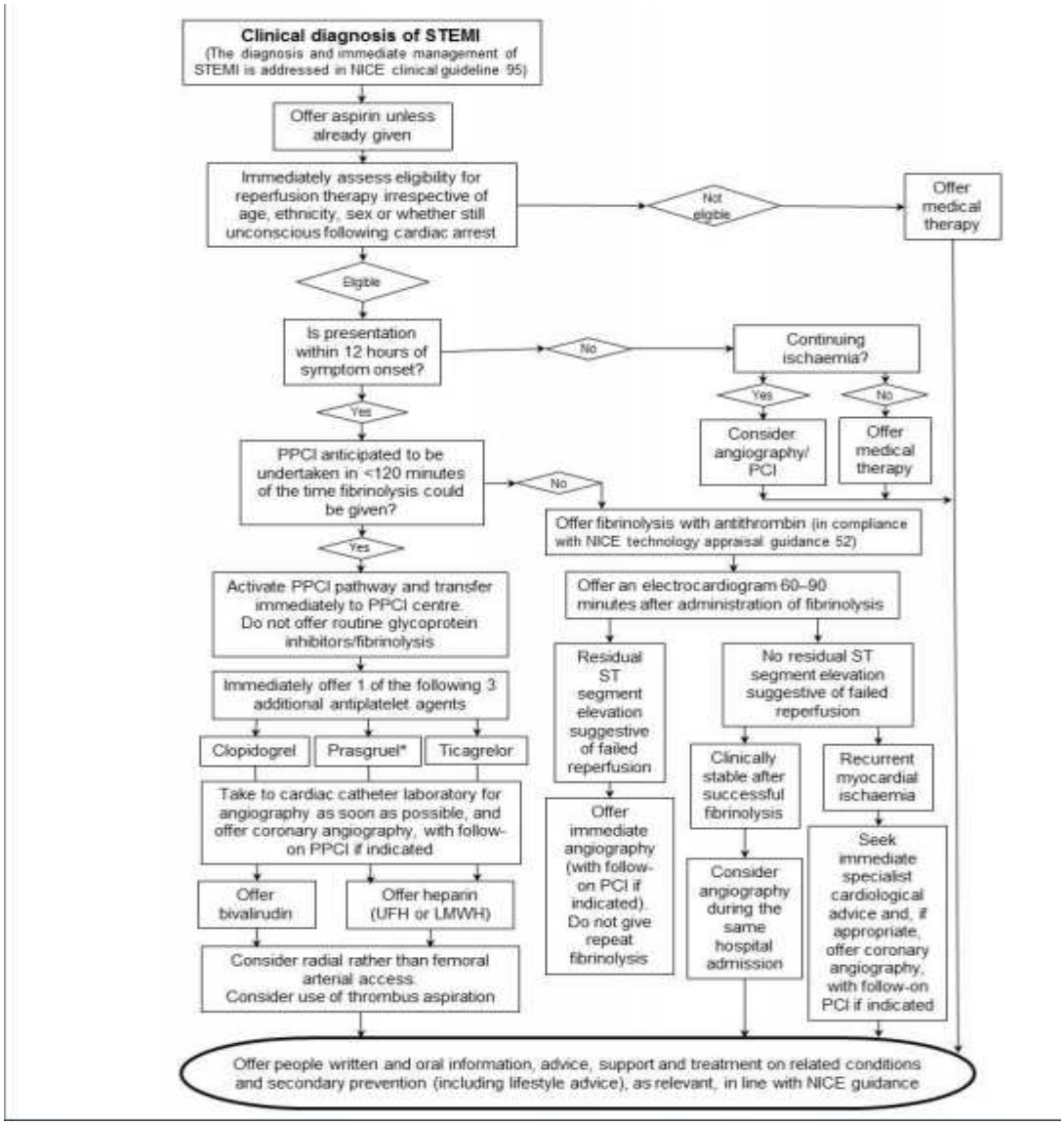
of the procedures. For example an echocardiogram at Central Hospital was about £20, whereas if you go to Harley Street it would cost £360.

Whilst at Central hospital I also spent time on the Coronary Care Unit and in the Emergency department. The difference between these wards and the wards in the National Hospital were huge. There were much fewer patients, much more staff, a cleaner environment and more equipment. Staggering when you consider that the two hospitals are 300 meters apart. The wards at Central hospital were very similar to that at home, and a lot of the equipment was from the same manufacturer. I was also fortunate enough to go into theatre and watch a mitral valve replacement and CABG. Again it was a very similar set up to that in the NHS, combining a very safe environment with clinical excellence.

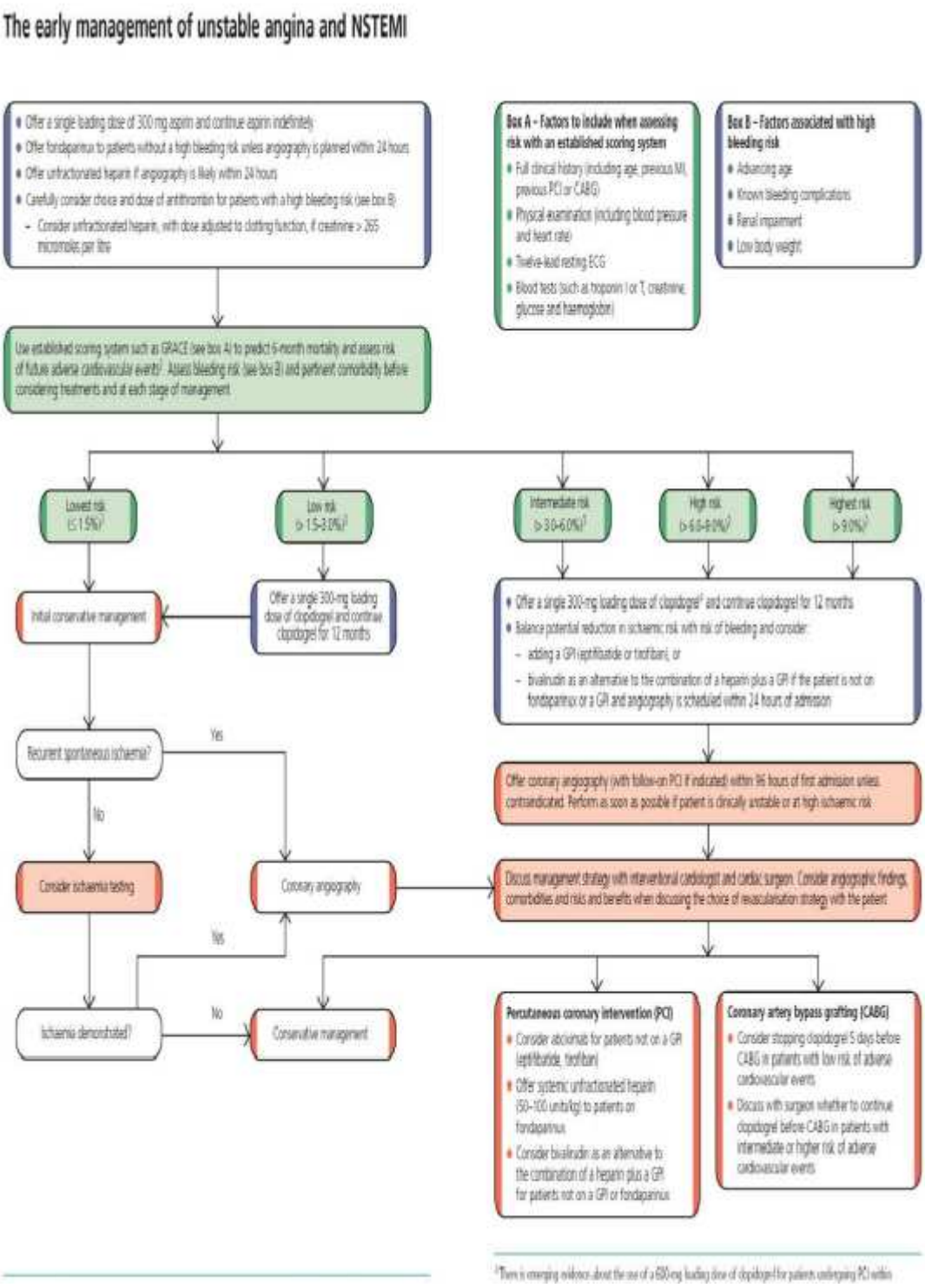
To be able to compare and reflect on how myocardial infarctions are managed in Sri Lanka and contrast this with the UK?

Before I came to Sri Lanka I was interested in the management of myocardial infarction. I had spent a lot of time at the London Chest hospital, which specialises in Percutaneous Coronary Intervention. The guidelines for the management of myocardial infarction in the UK are very clear:

STEMI management NICE guidelines CG167:



NSTEMI management, NICE guidelines CG94:



However in Sri Lanka there are no definitive guidelines for the management of myocardial infarction, and the choice of how to proceed is down to the cardiologist in charge of that care. With regards to managing these patients, the cardiologists in Sri Lanka use the European guidelines to structure the care provided. However due to difficulties with ambulances and the time delay in getting patients into an appropriate facilitity, and also due to the limited number of centres that provide this service, the rules with regards to time to stenting are relaxed. Otherwise hardly anyone would be eligible for this service. However the service provided is very efficient and the same equipment is used as in the UK. The only difference being that in the National hospital, a lot of the equipment is reused in order to cut down on costs, and washed at high temperatures in order to resterilise them. The other striking difference is the patients themselves. Those as young as 28 were having myocardial infarctions, and

many of these were of normal BMI. When I enquired further it seemed that there was a strong family history within these patients, with some also having diabetes. As well as this the amount of stenosis seen in patients was much more widespread than that in the UK. Most of the physicians I spoke to attributed genetics to these differences, something that I will be keen to evaluate further when I get home.

Currently it seems that separate guidelines for the management of myocardial infarction in Sri Lanka are in the process of being created, and once these are published it will be interesting to compare them to those in Europe.

Develop my leadership abilities in an alien environment, and reflect on the difficulties I had approaching issues of patient safety as I would in the UK?

During my time at medical school I learned a lot about Leadership and Management. I co-founded a student society with 3 other students, and helped develop an SSC in this area. One of the main aspects that interested me was patient safety and human factors, especially in the light of Mid Staffs and the subsequent Francis Report. Coming out to Sri Lanka I was keen to see how this would translate into a different medical system.

In the public hospital the first thing I noticed was the signs for hand washing, and the alcohol gel around the beds, so basic infection control measures were available. The next thing was the different uniforms the staff wore in order to help distinguish roles, again essential in order to aid communication. The level of respect for senior members of staff was very high, with consultants all being referred to as 'sir'. However I wonder how much this constrains juniors from speaking up if they see a consultant do something they don't agree with. Furthermore, everything was paper based, so accessing a patients medical history could be rather challenging, and reminders of things like allergies were not as abundant as at home. There was an obvious lack of staff for the amount of patients that needed to be seen, with many patients waiting in coridoors. The most striking difference for me was the lack of communication between different disciplinary teams. In the UK one of the main approaches to ensure holistic care for patients is a multidisciplinary approach, and we are very fortunate to be able to easily communicate with other healthcare professionals. Most of the time these individuals are within the same building, whereas in the National Hospital the services are split between different buildings, making it even more difficult to facilitate effective collaboration.

In the private hospital, again the first thing I noticed was the signs for hand washing, and the alcohol gel around the beds. As well as this the staffing levels were very good, and with many wards being only half full there was roughly a 1:1/1:2 ratio of staff to patients. Again the uniforms were very clear and it was easy to identify the roles of different medical professionals. There was a lot more bedspace, which meant that equipment was more organised, and there was a lot more disposable equipment in order to improve infection control. With many services being housed within the same building it facilitated better communication between teams, however my experience with this was limited.