ELECTIVE (SSC5c) REPORT (1200 words)

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

Compare and contrast the common presentations to primary care in the Philippines with those in the UK

There are many similarities to primary care presentations in the UK, and a number of differences.

Common problems include diabetes mellitus and hypertension, which I had previously thought to be diseases of the developed world. Such patients typically differ in build from British patients, with obesity relatively rare, suggesting that the aetiology may differ slightly. Genetic factors are likely to play a part, compounded by a diet relatively high in salt and fat, and low in fresh fruit and vegetables.

In addition to diet, there are a number of other pressing public health concerns. Smoking is common, with regulations on advertising of tobacco far more lax than in the UK. Alcohol is cheap and readily available. Use of shabu, a type of methamphetamine, is widespread and causes many health problems.

Sanitation is also an area in need of improvement, and diarrhoea is therefore a common presenting complaint. Simply giving antibiotics cannot deal with the root cause of the problem. In Compostela, I observed how Dr Ichin, the lead doctor and co-ordinator for health services throughout the municipality, had an enormously complex role, encompassing environmental health and improving sanitation.

Other common presenting complaints that would be rare in the UK include puncture wounds and dog bites. Tetanus and rabies cover is required in each case respectively.

Learn how healthcare is funded and organised in the Philippines, and compare the level of provision with that in the UK.

Publicly-funded free healthcare is very limited in the Philippines. Where facilities exist, such as the Vicente Sotto Memorial Medical Centre in Cebu City, they are stretched to a degree that is unheard of in the UK. As I walked through the door on my first visit, I was met with a room packed with patients who might have been considered appropriate for ITU in an NHS hospital, with their families helping provide care. One elderly man wearily rested his head on his palm as he squeezed the bag to ventilate his younger, intubated relative. Elsewhere in the hospital it was usual to see two or more patients sharing a bed. Medication must be paid for and stocks are limited. I witnessed patients dying of treatable causes such as sepsis without adequate resuscitation or antibiotic administration, ostensibly for financial reasons.

In a country where poverty is common, government hospitals are the only option for treatment for a large number of patients. Even in subsidised facilities such as CIM-CMSS, the small charges that are levied for equipment, medication and procedures prove prohibitive for some patients. For example, a patient might opt to delay treatment until a firm diagnosis is reached. In addition, lab and imaging facilities are often very limited. Providing optimum care is therefore a great challenge, and in stark

contrast to the UK, where large panels of bloods and imaging tests are often ordered almost without thought.

For those who can afford it, a standard of care approximating that found in more developed nations is available. This applies only to a small proportion of the population. A form of social health insurance also exists, called PhilHealth. It was created in 1995 and now claims 100% coverage of the population. It is not comprehensive, however, with some claims being turned down, and the benefit frequently not covering the full cost of care. This means that, paradoxically, the richest in society tend to utilise PhilHealth the most. As such, health inequality remains extreme, and the largest source of health expenditure in the Philippines remains out-of-pocket expenses.

Explore the common causes and treatment protocol for diarrhoeal disease in this environment.

Causes of diarrhoeal illness include pathogens also common in the UK, such as Escherichia Coli and viral gastroenteritides, plus many others that would be rare. Often these are associated with poor sanitation, such as open sewers, an impure water supply and a lack of washing facilities. In Paknaan, the barangay of Mandaue City in which we spent the bulk of the placement, these problems are present in many households. Some families live in overcrowded conditions, sharing a single room, which exacerbates the difficulty in maintaining good hygiene.

In this area, Entamoeba Histiolytica is a common differential diagnosis, and the stools of patients are routinely examined by microscopy. I myself contracted dysentery during my first week of placement, highlighting its commonness, and experienced the treatment protocol for bloody diarrhoea both as a patient and doctor. Where facilities exist, stools are examined prior to prescription of an appropriate antimicrobial. Where they do not, or if there is some diagnostic doubt, a common treatment protocol would be oral Ciprofloxacin and Metronidazole for seven days, to cover bacteria and amoebae.

Discover what it is like to practise medicine in a resource poor environment, with differing patient profiles to those found in the UK

The first thing that struck me on beginning the placement was the amount of responsibility given to students and junior doctors compared to the UK. During their first clinical year, unpaid interns assume many of the responsibilities that foundation year doctors would perform in the UK. As you ascend the hierarchy, from postgraduate interns to residents and consultants, numbers noticeably thin out as a consequence of flight to better paid roles in the private sector or abroad. There is much less supervision available for students and therefore patients are often seen by very junior staff.

The absence of facilities that we take for granted is just as noticeable than the lack of senior support. A good example is that of defibrillators. Velez Hospital has two, CIM-CMSS has none, but in the UK you can find them on every ward, and even in many supermarkets and coffee shops. In smaller hospitals, labs may offer only a handful of tests, and imaging is conducted off-site by private enterprises. Even where facilities are available, patients usually have to pay for each investigation, and the cost is prohibitive for some. There is often a great deal of diagnostic doubt around such cases, with great emphasis placed on the results of physical examinations.

Patients typically present later in the Philippines, with more advanced disease. In the main, patients need to pay for their treatment, excepting some rare circumstances. Given that poverty is widespread, adherence to treatment protocol is simply unaffordable for many. Asthma is a good example of a disease that is often allowed to progress. While patients are advised to take preventer inhalers, for many the cost is prohibitive. A common strategy is therefore to take only a salbutamol inhaler with a course of oral steroids during acute exacerbations. This is risky, and tragically, can have fatal consequences.

These factors, taken in combination, result in poorer outcomes for patients. It is my impression that the health workforce are generally very skilled and have a good knowledge base, but they often have to deal with insurmountable odds.

ELECTIVE (SSC5c) REFLECTION

This information will be used to monitor placements for safety and to provide useful information that we can pass on to students for the future. (Please complete the sections below).

Was it what you expected?
The placement was different from what I expected. Most of our time was spent experiencing life as students in a Filipino medical school, rather than seeing patients. While this was rewarding, at times it didn't seem particularly relevant. That said, the students have vastly more responsibility than UK students, and are the first point of contact for most patients. They are subject to strict rules, and although we had more freedom, we felt a little restricted. The healthcare was much worse than I had expected. This truly is third-world medicine.
Clinical experience?
Patient contact was variable. For the bulk of the placement, in Paknaan, the only opportunity to see lots of patients was on the one half-day per week at Mandaue City Hospital. Apart from that, there was lots of pointless waiting around. We spent one week in Compostela while mass circumcisions of young boys were being performed: "Operation Tuli". Boys lie next to each other on trestles (usually erected on the local basketball court), are draped in newspaper and operated on in sequence. This happens every summer. It was interesting but concerning to watch and I would advise any future students to decline the opportunity to perform circumcisions on ethical grounds as we all did. The week in the emergency department of Vicente Sotto Hospital was an intense and often disturbing experience. We spent a day in ob/gyn, paediatrics, internal medicine, trauma and surgery. The hospital is busy, poorly resourced and there are hardly any qualified doctors. As a consequence the care is extremely poor. We saw many patients die and found the fatalistic attitudes and bizarre clinical decision making of some staff frustrating. There were lots of opportunities to perform clinical skills, but one often had to question whether the requested interventions were appropriate. There wasn't much to do in the private clinic in Bohol, but that was welcome having completed a week in Sotto.