ELECTIVE (SSC5c) REPORT (1200 words)

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

When deciding where to go on my medical elective I wanted to go to a place which had a healthcare system and healthcare problems which were not only diverse but also a stark contrast to the NHS. I chose Colombo, the capital and busiest city in Sri Lanka, as the ideal place to gain this once in a lifetime opportunity; to spend six weeks in a foreign hospital and experience a lower economically developed country's healthcare environment.

I spent all six weeks of my elective in Sri Lanka which allowed me to understand the healthcare problems that were more prevalent amongst the general population attending hospital. Due to Sri Lanka being an island in the Indian Ocean one may expect diseases of a tropical nature to be prevalent. In comparison to the United Kingdom this is certainly the case, however when observing general medical wards throughout my six weeks, chronic disease patients of middle and elderly age suffering from cardiovascular disease were the most prevalent.

This disease pattern shows close similarities with the United Kingdom; with the majority of patients I saw suffering from ischaemic heart disease or stroke. I noticed a high prevalence of diabetes patients during my hospital experience in Sri Lanka. This fact falls in line with a risk factor well known for diabetics in the United Kingdom; that is patients of South Asian origin. Interestingly, there was a higher proportion of patients I observed in Sri Lanka, who had much poorer controlled, severe, further progressed diabetes than patients typically seen in England. In fact in Sri Lanka the effect that diabetes has on mortality is far greater than in the United Kingdom.

Another interesting observation I noted was that there were less patients presenting with malignancy in Sri Lanka than in the United Kingdom.

However I also saw many medical conditions which I have not encountered in the United Kingdom, particularly those of a tropical nature. There was a high amount of patients with query dengue fever symptoms, in particular, amongst younger populations. The acute and severe nature of this fever is seldom seen in the NHS, however was relatively common in Colombo.

The distribution of disease and complaints was also wealth related, with less wealthy patients presenting later in state funded hospitals such as the National Hospital of Sri Lanka. This was as opposed to private hospitals such as Central Hospital; the healthcare access wealthier patients had, meant that they would present as and when they had a problem.

The services offered varied between Sri Lanka and the United Kingdom, as expected, however there were many similarities. The doctors themselves are all extremely competent, well trained, and offer as good a service as hospital provision allows them too, perhaps with a slightly more paternalist attitude than seen in modern day doctor patient relationships in the NHS. However due to the virtually non-existent primary care service (a huge difference from the United Kingdom), sometimes Accident and Emergency facilities are overrun and fail to cope with the high number of patients. This was not as much of a problem that I noticed at privately run hospitals in the country who are a lot better equipped to deal with the huge numbers that state funded hospitals sometimes have to deal with, including a fully functioning Accident and Emergency department, not often seen in the United Kingdom.

Another difference was that in certain state run healthcare facilities, beds often had two to three occupants, and over-crowded general wards sometimes had patients being treated on the floor. It was also not uncommon to see dogs and cats roaming the hospital and ward. This was extremely different to anything I have experienced in the United Kingdom or indeed private facilities in Sri Lanka.

IT services within hospitals and in particular on the general medical ward are also generally to a lower standard than the UK. Electronic patient databases have not been introduced to the healthcare system yet and doctors are therefore fully reliant on hand written patient notes as the only way of delivering information and communicating information about patients.

I also saw patients on the general medical ward who had started medication such as co-amoxiclav prior to hospital admission. These patients had obtained the drug as an over the counter preparation from the pharmacy for what is usually a prescription medication in the UK. This shows a clear difference between drug dispensing in the UK and Sri Lanka and may also lead to increased microbial resistance, which due to the already limited access to medication and funds allocated for drugs would cause a further burden to the healthcare system in Sri Lanka.

In the United Kingdom there is huge emphasis placed upon the multidisciplinary approach and MDT, however from my experience in Sri Lanka this is non-existent. The doctor is the first and last port of call. However within the team of doctors on the general medical ward I did notice huge amounts of trust placed in junior doctors (equivalent to FY1 and FY2 levels), who would be afforded responsibilities which in the UK would be given to more experienced doctors.

Further to my observations on general medical wards in Sri Lanka already noted, the diseases and patients who differed to those in UK, were of greatest interest to me. In particular, the high number of dengue fever patients, in comparison to the UK, but also in comparison to malaria patients. Malaria was once rampant in Sri Lanka, causing a high number of hospital admissions and a high relative mortality, but now prophylaxis is deemed not necessary and the disease has being eradicated. This is due to the management of the vector, i.e. the mosquito, and transmissions of malaria. The same approach has been suggested for dengue fever however due to the modality of transmission control is extremely difficult. For example when travelling around Colombo and Sri Lanka in general I noticed many wet paddy fields, pools of still water, still water lakes and huge areas of water. The increased rainwater (due to monsoon season) is helpful for the agricultural economy but this in combination with deficient irrigation is a huge contributor to dengue fever. It is very difficult to manage and so as it stands will continuously be responsible for patients on the general medical ward.

Shadowing and essentially become part of the team as a student doctor was an invaluable experience. Honing practical skills that I have worked hard at becoming effective and efficient at during my clinical years at medical school was extremely helpful, especially on the horizon of becoming an FY1.

Attitudes towards doctors from patients was very respectful, but very different from the UK. Whilst the UK healthcare system has evolved its approach to communication with patients to that of a patient centred approach, the majority of my experiences in Sri Lanka revolved around a paternalist approach from the doctor with the patient wholly accepting everything the doctor would say, without particularly having a strong opinion. Many patients I spoke to had a 'doctor knows best' attitude and were happy to comply with any advice they were given.

The two most common languages in Sri Lanka are Sinhala and English. Communicating with patients in private hospitals was generally less difficult due to the English speaking demographic at these hospitals. However there were many non-English speaking patients at the National Hospital and Maharagama Hospital (both state-funded). This posed a problem when communicating information and taking histories, however with the practice I had during this elective placement I feel I have become more effective at this skill, especially as it is a skill needed for certain patient populations in the UK and specifically east London where I will be spending my FY2 year.

This elective placement has been a significant contributor to my continuous progress towards becoming an effective and efficient clinical practitioner. Taking an interest in general medicine for six weeks allowed me to see and talk to a diverse range of patients in a foreign healthcare environment, developing my clinical, practical and communication skills in ways I have not been able to before. The experience of a placement abroad was incredibly enthralling and wholly fulfilling as a transitioning medical student to a junior doctor.