ELECTIVE (SSC5c) REPORT (1200 words)

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

I organised my first elective placement in Trincomalee, Sri Lanka – in Trincomalee District General Hospital. The District of Trincomalee is situated in the Eastern Province of Sri Lanka. Trincomalee District General Hospital is the primary tertiary health institution in the Trincomalee District, which has an estimated population of 400,000. It is the central referral institution for the other Government Medical centres within the Trincomalee District. This provided a great opportunity for me to focus on studying common general medical presentations seen in a major referral centre in the Eastern Province of Sri Lanka and be aware of different medical presentations not commonly encountered in the UK. I would also get a chance to gain a deeper understanding of the universal healthcare system in Thailand, and compare and contrast it to the healthcare provided in the UK. Furthermore, spending time in this particular area of Sri Lanka would enable me to embrace a different culture and lifestyle. I chose to self-organise this elective placement in Trincomalee District General Hospital to complement my subsequent 2-week elective placement in Srinigarind Hospital, a leading tertiary hospital in Khon Kaen, Thailand. I elected to spend 4-weeks on the general internal medical ward primarily to develop confidence in responding to acute and common situations as a junior doctor.

I was especially motivated by the opportunity to grasp and learn more about general medicine from a different perspective with the potential of translating and applying the knowledge learnt in a future career of clinical academic medicine for patients on the wards and in the community.

This current elective placement has exceeded my expectations, as I was able to not only gain a deeper understanding of various medical conditions, but also witness diverse medical practice not commonly encountered by medical students and foundation trainees in the U.K.

Whilst working with the team on the internal medical ward of Trincomalee District General Hospital, I encountered many patients with various and diverse medical conditions. However, there were a significant number of patients diagnosed with Dengue fever, which is highly prevalent in this part of the world. I was amazed to witness the how varied the presentation of patients with this condition can be. All patients presented with non-specific symptoms such as headache, fever and joint pain. This made it extremely difficult for doctors to diagnose Dengue fever, but is always a diagnosis that needs to be excluded in every patient due to its high prevalence. It was interesting to learn about the course of the disease and its different stages and see numerous patients in each stage of the disease. This is also proved to be a valuable learning opportunity for eliciting clinical examination signs. For example, patients diagnosed with Dengue fever who are in the 'leakage' phase of the illness typically had relatively vast amounts of fluid in their pleural and abdominal cavity. Consequently, I was able to appreciate and elicit positive clinical signs such as shifting dullness. Even though Dengue fever is not prevalent in the UK, I now understand the importance of rapid and strict supportive management with fluid balance being the cornerstone of treatment. It was important to note that Malaria is now eradicated in Sri Lanka.

I also clerked patients with SLE, which seemed to relatively common. Many of them had advanced disease with full system involvement. Flares of SLE were common and were managed by a general medical team with a short course of immunosuppression and hospital admission. Similar to in the UK, all of the patients with chronic conditions were experts in their condition and played a vital role in the

© Bart's and The London School of Medicine & Dentistry 2014

decision making process as part of their care. Moreover, patients admitted following suicide attempts were uncomfortably common. This had a deep impact on me and I was shocked to see how they were treated. Many young patients were admitted following paracetamol overdose after trivial events such as arguments with friends and family. I also witnessed Digoxin overdose which is ingested in the form of the Yellow Oleander Seed (Thevetia peruviana) which is readily available in the rural areas. Each seed carries nearly 10 times the normal treatment dose of digoxin. On reflection, it is not surprising that patients such as those resort to taking their own life. Sri Lanka has been through tragic and traumatic events in its history and we are now seeing the lasting mental damage it has had on the population. Snake bites were also relatively common. I learnt that many patients actually resort to catching the snake or taking photos of the snake to show the Doctors. Doctors of all grades and nurses are fully competent in identifying types of snakes and administrating the correct anti-venom for the patient. Despite encountering numerous unusual and interesting conditions, I also saw a number of patients with advanced heart failure, urinary tract infections, long-standing diabetes with complications, tuberculosis and alcoholic liver disease. This was especially useful as I was able to apply and reinforce the knowledge I learnt during medical school on the wards to these patients.I was fortunate to clerk and recognize the mid-diastolic murmur of mitral stenosis in a female patient with diabetes and rheumatic heart failure. This was the first time I have had the opportunity to hear such a murmur despite doing numerous cardiology placements within the U.K. Although the majority of cases seen were of patients with common medical presentations, none of the cases were straightforward. Many patients had numerous underlying conditions, which had to be taken into account when providing treatment.

Additionally, I gathered the subtle differences of how healthcare is provisioned in Trincomalee compared to the U.K. I was allocated to the internal medical department which was split into the male and female ward. The day would commence in the early hours of the morning with a consultant led ward round very similar to practice in the U.K. House and senior-grade doctors will arrive early to make sure all patient notes were updated and all was in place for the ward-rounds. Each ward comprised of approximately 10 patients. Interestingly, new outpatients who required consultant review would be seen briefly at the end of each round on a single examination bed. The speed at which each patient was seen can be related to a medical conveyor belt and was eye-opening. In the afternoon, I took the opportunity to visit several outpatient clinics. The department was overflowing with patients that healthcare professionals hardly had any space to move around let alone work. On inquiry, patients arrive at 4am in the morning in order to obtain a ticket for an outpatient appointment on the day and this still does not guarantee them a consultation. In the U.K, a Doctor consults up to 12 patients in one session. In Trincomalee, each doctor will see up to 100 patients in one sitting. This was hard to believe until I experienced it. All investigation results such as BP measurements etc were recorded by hand and transferred between departments by patients and porters. However, X-rays had recently been transferred to electronic systems.

The wards at Trincomalee District General Hospital were structured differently to those in the U.K. The patient beds in the internal medical wards were a lot closer together and more cramped. Moreover, the lack of hand cleaning devices and sanitation equipment within the hospital was shocking. Healthcare professionals managed with a small sink in the corner of each ward which was hardly used as it was not practical for the Doctor to wash hands between each patient. Facilities at this hospital were limited. For example, healthcare professionals did not have access to a CT Scanner. When patients were admitted following a query stroke, they have to be transported by car to the

© Bart's and The London School of Medicine & Dentistry 2014

nearest CT Scanner in Kandy 4 hours away. This voids the guideline recommendation of administering thrombolysis therapy within the 4-hour window. Furthermore, there was no Lactate on Arterial Blood Gas analyses. These are investigations that we take for granted in the U.K. Witnessing how doctors overcome these limitations by relying solely on their clinical history and examination skills was truly inspirational.

I was very lucky to be assigned to a very skilled, dedicated, knowledgeable and passionate general medical consultant and his team during my stay. I received vast amounts of invaluable bedside teaching during ward rounds. I found this especially useful as I am now in a position to apply this knowledge when caring for patients from abroad in the future. The patients in the hospital spoke either Sinhalese or Tamil. It was motivational to see Doctors speak to each patient in their first language so fluently and subsequently explain the condition and management plan to me in English. Doctors in Trincomalee District General Hospital were also required to attend lectures, seminars and conferences during lunch on a daily basis. I had the opportunity to attend a pharmaceutical sponsored seminar on sepsis on one evening. This was very interesting as it allowed me to realise how the Doctors in Sri Lanka follow very similar guidelines and protocols to the ones used in the U.K. I was amazed at the depth of knowledge that doctors and students in all stages of training encompassed during the guideline discussion. During the following days, I was able to witness these guidelines implemented on several patients on the wards.

Lastly, I was able to embrace the local culture in Trincomalee, Sri Lanka, which was very rewarding in many ways. Most importantly, the hospitality I received from the hospital Doctors, administrative staff and friends I made along the way was second-to-none. I tasted different Sri Lankan cuisines and experienced typical Tamil and Sinhalese food whilst simultaneously absorbing a great deal of knowledge about the history of the country and its traditions. I was exposed to the vibrant local nightlife and visited various Temples and national historic sites in Trincomalee, which was exceptionally rewarding and useful.

I have been exposed to numerous infectious tropical disease cases during my placement in Trincomalee District General hospital. I feel this has improved my understanding and will aid me in developing differential diagnoses when treating patients from abroad. It will also allow me to think laterally when encountering complicated cases. My elective placement in Trincomalee District General hospital has been a remarkable and eye-opening experience. I feel it has provided me with a boost of confidence that will be useful when commencing to work as a Foundation Year 1 Doctor in August as well as motivating me to strive further in a career of clinical and academic medicine.

© Bart's and The London School of Medicine & Dentistry 2014