ELECTIVE (SSC5c) REPORT (1200 words)

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

During April and May 2015, I was fortunate enough to gain an opportunity to attend the Paediatric Department of Sappasithiprasong Hospital, Ubon Ratchathani in North-eastern Thailand. The health system in Thailand is very much like the United Kingdom (U.K.) in that it is a universal public health system free for all at the point of care. Sappasithiprasong Hospital has many similarities with that of the Royal London as both hospitals are very large tertiary care centres. However, the hospital did not only look after local patients or those from neighbouring areas. It also accepted patients from many parts of the Isaan province (North-eastern province) and neighbouring countries such as Laos, often without cost incurred upon the patient's family.

The department was quite extensive consisting of 3 paediatric intensive care units, 3 neonatal intensive care units, 5 general paediatric wards (including a specialist haematology and oncology unit), neonatal and post-partum facilities and an outpatient unit. This in most respects is similar to that of the Royal London. One difference was that there is only one main emergency department, within which paediatric patients are usually seen by any physician. This is unlike the Royal London which has it's own separate children's accident and emergency department.

Another difference between the paediatric services in the United Kingdom and in Ubon Ratchathani was the patient pathway in secondary care. Patients can attend the emergency department just as in England. However, patients attending the outpatient department in Sappasithiprasong may either be new presentations with or without prior referral, or they may be follow up appointments from a previous hospital admission or longstanding chronic condition. This contrasts with the pathway in England which inevitably follows one of two main routes, the emergency department or through referral (usually from a general practitioner).

From my initial observations upon arriving in Ubon Ratchathani, the atmosphere was a huge contrast to that of England. I found it a much more chaotic with many members of families waiting and sleeping in the corridors and around the hospital. I also began to realise the large workload the doctors and nurses of the paediatric department dealt with. As time went along, I really began to see the huge differences between Thailand and the U.K. This was apparent through the resources available, and most surprisingly the level of competency amongst the Thai equivalents to U.K. medical students and foundation doctors.

In respect to the resources available in the U.K. compared with that of Sappasithiprasong Hospital, we are very fortunate to have many luxuries that are available such as disposable sterile equipment. In Sappasithiprasong Hospital I found that a lot of items such as sterile drapes and other equipment were re-sterilised after use. There were also a number of pieces of equipment that just would not be found anymore in England, for example glass syringes. Despite these superficial differences, it was apparent why Sappasithiprasong Hospital is well renowned as they are still able to provide excellent patient care. Whilst carrying out supervised

procedures I was conscious of unnecessary wastage, which I hope will benefit my practice on return to the U.K. in becoming a mindful doctor.

The most eye-opening revelation for myself was the number of skills a final year medical student (known as an extern) or a foundation year 1 equivalent (known as an intern) were able to perform competently without supervision. This included procedures such as intubation, lumbar puncture, thoracocentesis and even bone marrow aspiration. Venepuncture was a skill almost exclusively delegated to nursing staff and rarely carried out by doctors. As a final year medical student almost at the interface of becoming a foundation doctor, my practical skills are that of a 3rd or 4th year Thai medical student. Admittedly it left me feeling demoralised but I hope this experience will be a stimulus to undertake every opportunity to advance my practical skills training that I will encounter as a foundation doctor in the U.K.

As a tertiary care centre, the numerous cases I encountered whilst at Sappasithiprasong Hospital were wide ranging from the very common to some rarer presentations or conditions I may not see all together in the U.K. During my time on one of the general paediatric wards, I observed the management of conditions I was more familiar with such as exacerbation of asthma, bowel obstruction and renal diseases such as glomerulonephritis and nephrotic syndrome. My intitial two weeks of elective were spent in the paediatric intensive care unit which had an abundance of respiratory conditions such as laryngomalacia and aspiration pneumonia secondary to various underlying problems including cerebral palsy and cleft palate with cleft lip. Not many patients with cerebral palsy and swallowing difficulty receive enteral feeding. This is due to parents perceiving such feeding would increase the burden of care. Therefore, the risk of aspiration is higher in this patient group. With the specialist haematology and oncology unit I was able to examine many patients with childhood malignancy and observe their management.

The much rarer conditions I encountered included Kawasaki's disease with complication of coronary aneurysms, suspected Takayasu's arteritis, recurrent cryptococcal meningitis in a patient with suspected immunodeficiency, Steven Johnson syndrome and a King Cobra snake-bite that fortunately did not result in envenomation but only cellulitis. Some of these conditions I have only encountered in textbooks and never thought I would see as a real-life case. Dengue fever, a relatively common differential diagnosis amongst febrile children, was an interesting condition to learn about. Although it is not something I am likely to see as I work in the U.K., when the principles of dengue fever and dengue shock syndrome management were explained it helped reinforce my existing knowledge about basic management principles such as fluid therapy and fluid balance.

A particularly difficult case was that of a 2 year old Thai girl whom I encountered on two separate occasions. Her underlying disease was a glioma of the brainstem for which she was receiving chemotherapy. However, her condition was considered incurable and she was receiving chemotherapy as palliative treatment at the parents' wishes. I first met her during a round in the specialist haematology and oncology unit for patients who were to have diagnostic testing (lumbar puncture or bone marrow aspiration) or intrathecal chemotherapy. She had

dysfunction of her extraocular muscles resulting in convergent strabismus and the side effects of her chemotherapy were clearly visible as she had marked hair loss.

The second time I met her was the following week whilst attending the intensive care unit. She had been admitted after presenting with dyspnoea and pyrexia. She was diagnosed with febrile neutropenia and developed pneumonia. The patient then needed antibiotic therapy as per hospital guidelines for patients with the complication of neutropenia secondary to chemotherapy. It was a difficult case to observe but interesting as it demonstrated the challenges faced by healthcare

professionals in regards to balancing the benefits and risks of treatment (which were severe in this case of chemotherapy) whilst addressing the wishes and concerns of the patient and their family.

Whilst I rotated around the various parts of the Paediatric department I was given the opportunity to observe and then attempt various practical skills under direct supervision. This included venepuncture in children, intubation and lumbar puncture. Although I would say I am not completely competent in the latter two skills, I most definitely valued these opportunities as it has given me confidence in approaching them in the future as I go on to develop my practical skills. I was also able to examine blood films, bone marrow aspirates and understand how to perform cell counting of cerebrospinal fluid samples using a microscope. Blood films were always found attached to the results inside the clinical notes folder. These skills are now mostly redundant in the U.K. as it will be reported from the laboratory and we are used to learning simply from images in textbooks. However it is still performed by doctors in Thailand who may want a rapid result, for example of CSF, instead of waiting for the laboratory. The blood films and bone marrow aspirates were always examined by one of the haematology consultants.

Lastly, I was fascinated to see the dynamic of the patient-doctor relationship in Thailand. In Thai culture, this relationship is quite a paternalistic one as the patient and their family hold great respect for doctors. They are usually willing to accept instruction and treatment from the doctor, as they are perceived to be holding the patient's life in their hands. There was much less of an emphasis around the concept of consent. This contrasts the U.K. where the focus of this relationship is more of a partnership and in any of our actions, from simply taking a history to the most invasive procedures, we must seek consent from the patient.

I am very grateful to have benefitted from the vast differences I experienced at Sappasithiprasong Hospital and learn from the greatly skilled and determined doctors, nurses and other healthcare professionals. I am glad to have chosen Sappasithiprasong Hospital over other locations and I would highly recommend this hospital to any medical student as I was met with great kindness, friendliness, hospitality, help that was much needed whilst travelling alone, and enormous generosity from all whom I encountered along the way during my time in Ubon Ratchathani.