21YAAD
SULTAN
OPHTHALMOLOGY

Post-elective Assessment

Hard copies of appendices 2, 3 (short written report; 1200 words; address 4 pre-elective objectives; give to placement supervisor for their assessment to grade + copy to School) and 4 (short reflection; series of structured questions; copy only to School).

Print page 33 (letter from Dr Carrier), 34 (Placement registration); 35-39.

Objective: What are the prevalent ophthalmic conditions and how do they differ from the UK/World?

It is estimated that by the end of the 20th Century, there would be 38 million blind and 110 million people suffering from low vision, in the world. In the developing countries cataract, nutritional and infectious eye diseases would still be the leading causes of blindness. In industrialised countries ocular complications of metabolic diseases like diabetes and ARMD would be the leading causes of blindness.

The Sultanate: In 1996, a nationwide community based health survey estimated bilateral blindness at 1.1% of the population, more than the rate of developed countries (between 0.3% and 0.5%); 78% of these were above the age of 60 years. The following are the causes and percentage proportion percentage of blindness: cataract (30%; 3% of total pop.), corneal opacities (31.6%; 2.9% of total pop.), trachomatous (23.7%; 1.1% of total pop.), non-trachomatous (23.7%), glaucoma (11.5%; 0.13% of total pop.), phthisical eyes (9.5%). Hence, 80% of the causes of blindness detected in the survey were either curable or preventable. Following this survey, intensive strategies towards targeting the above six disease began. Diabetes was estimated to affect 10% of Omanis over 20 years old, with an additional 10% with impaired glucose tolerance; other work found that 20% of diabetics had diabetic retinopathy.

The UK: It is estimated that 50% of sight loss is preventable or treatable. In the UK, AMRD was responsible for 57% and 56%, of blindness and partial sight respectively. Glaucoma was responsible for c.10% of both blindness and partial sight. Whilst diabetic retinopathy caused 6% and 7.4% of blindness and partial sight respectively.

Objective 2: How are the services organised and delivered – does it differ from the UK?

In brief, both in the UK and Oman, the public sector provides most healthcare needs, the former through direct and indirect taxes and the latter through reallocation of predominant oil-wealth, for which the Omani economy is still heavy reliant on, 40% of 2008 GDP originated from non-oil sectors. The Sultanate is a young country that underwent massive modernization just over 30 years ago, which included the foundation of the Ministry of Health. The Sultanate's health system cares for a population of 2.5 million (27% are expatriates), significantly it has large young population, the median age being 19 years, with only 3.5% of the population aged over 60 years, though life expectancy is 74 years.

In the 2009, 9.3% of UK GDP ($2.45 trillion; population 61.7million) was allocated to healthcare, which is less than its European neighbours, such as France (11.7%) and Germany (11.3%), however, in Oman, 3% of a GDP of $46.8bn (population 1.7 million Omani) was spent on healthcare – still,

relatively Oman still spends less than the UK and much of Europe - different healthcare needs will account for much of this, though as Oman's grows and ages as will its health-related expenditures.

The MoH is responsible for policy, planning and implementation in coordination with the health sector; the public sector runs 90% of hospitals, which is probably comparable with the UK, though exact figures were unavailable. In Britain, The Department of Health (DoH), has a complex hierarchy in which Trusts exists that manage many hospitals on behalf of the DoH, there are also independent 'foundation' hospitals that are paid directly and hence have greater autonomy. Along side this, a body called the National Institute for Health and Clinical Excellence (NICE) decides which new treatments and drugs the NHS should pay for; a similar body works within the Omani MoH.

Objective 3: Obesity in Oman and the Middle-East

Overweight and particularly obesity is a major risk factor for several important diseases, especially hypertension, coronary heart diseases and diabetes mellitus. Obesity is a WHO recognised world epidemic, and as of 2008, 1.5 billion adults were overweight (BMI > 25), of these 500 million were obese (BMI > 30).

For comparison, the following are countries with their respective percentage of obese population: Saudi Arabia (35.6%), UAE (33.7%), Bahrain (28.9%), USA (32.2%), and the UK (24.2%).With the number of overweight, typically the same percentage throughout. In all Gulf countries, obesity rates are highest amongst women, as high as 70%.

A cross-sectional study of Omani adults in 2003 reported that 47.9% were either overweight or obese, with lesser prevalence in young adults and those (more) educated.

Develop language skills – at least basic level consultation and communication.

At the start of this elective, my command of the Arabic language was intermediate at best, superseded by English at work/school and at home. However, on occasion I have been summoned or out of desperation offered to translate for a couple of patients whilst in hospital or general practice.

My aim during this elective was to carefully observe the way in which doctors greeted patients, and take with me some good examples. Furthermore, I had wanted to improve my vocabulary related to medicine.

Whilst in eye clinic, I observed a non-native Arabic speaking specialist registrar that communicated well simple instructions during examination, was able to decipher questions no matter the dialect, and responded reasonably. Throughout, I was also conveniently joined by an orthopaedic surgeon taking his own 'elective/taster' in ophthalmology – he was invaluable. Daily, I scribed a list of words that I either didn't understand, or presumed would be useful. I was able to ask the obliging surgeon to check my spelling, and explain meanings of words. He was encouraging, and time allowing insisted I consented and examined patients.

Outside of hospital, I chose to be hosted in student accommodation instead of living with relatives, I felt there would be better exposure to different dialects and push me away from what I feel comfortable in.