

## PERSONAL VIEW

## Sri Lankan health care provision and medical education: a discussion

Z Paskins

**Abstract**

**My elective was spent at a teaching hospital in Galle, in Sri Lanka. My time was spent shadowing final year students in the specialties of general medicine and paediatrics. This period provided me with much food for thought in comparing and contrasting the health service in Sri Lanka with that of the UK and also considering the differences in the style of medical education. In addition, during my stay, I was able to gain some appreciation of the political and organisational problems faced by a country in the midst of a civil war.**

**In this report, I have attempted to integrate an account of my observations with a discussion of the thoughts and emotions that I experienced while working in a developing country. Studying in Sri Lanka facilitated my appreciation of facets of British health care and medical education that I had not previously considered. However, fewer resources do not necessarily mean poorer patient care: could Britain have something to learn from the Sri Lankan Health Service?**

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My elective attachment was spent in Karapitiya Teaching Hospital in Galle, Sri Lanka. I attended the hospital for three weeks in the specialty of general medicine and four weeks in paediatrics. My time was spent shadowing final year medical students for ward rounds, ward classes, clinics, and general ward work.

During my stay at Karapitiya, there was a period of industrial action by the national doctors' union and I was able to gain some insight into the political and organisational problems facing the Sri Lankan Health Service. It was this experience, coupled with the exposure to a different style of medical education, that I found the most thought provoking. In this account, I hope to integrate a account of my observations with a description of some of my experiences, followed by a discussion of some of the issues raised.

**A word about Sri Lanka...**

I was keen to spend my elective in a developing country. I chose Sri Lanka specifically because of a personal connection: my grandparents met there during the second world war and my

grandfather wrote several short stories about his experiences in the jungle. Now, Sri Lanka is in the midst of its own war. For the past 16 years the Liberation Tigers of Tamil Eelam (LTTE) have been fighting in the north and east of the country for "Eelam", a separate state for the Tamils. The Tamils represent 18% of the population, the majority 70% being Sinhalese.

Despite the terrorist activities in the north and east, southern Sri Lanka remains a safe, attractive destination for the discerning traveller. I stayed in Galle, in the southwest (fig 1); the south and west are virtually untouched by the troubles of the war, and life continues largely unhindered.

Sri Lankans are renowned for their hospitality and friendliness, especially to foreign visitors. The family I stayed with were no exception to this rule; they were continually interested in my work and provided every possible assistance with both my studies and the management of my leisure time. There is much to be seen in Sri Lanka; the country itself encompasses a broad range of geographical features and is rich in natural beauty. Stretching sandy beaches, tropical rainforests, the barren hill country, and lush tea plantations can all be seen in one day's travelling on the island.

**Observations****HEALTH CARE PROVISION**

The government in Sri Lanka provides a free health service in the form of Western medicine, practised in hospitals all over the country, and

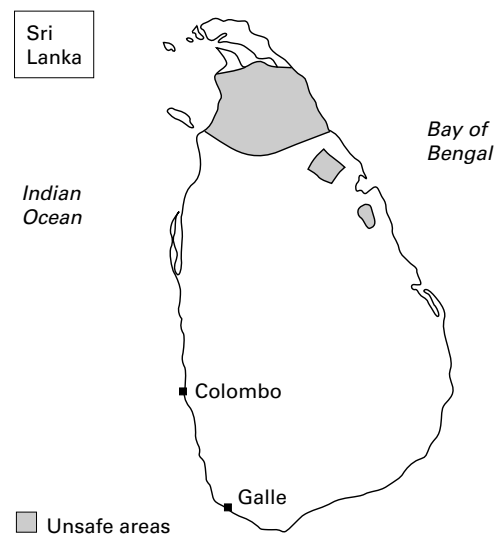


Figure 1 Sri Lanka.

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Ayurvedic medicine (an indigenous, ancient healing philosophy) practised in one hospital in Colombo. The health service (Western medicine) can be divided into preventative and curative sectors.

Preventative medicine is concerned with the control of communicable diseases (especially rabies, sexually transmitted diseases, tuberculosis, and leprosy), sanitation, family health, and health education.<sup>1</sup> Preventative health care is delivered by medical officers of health and other public health workers in the community. The preventative sector is considered to be Sri Lanka's best health care achievement. In particular, mother and baby clinics have had a great impact on maternal and infant mortality rates; the maternal mortality rate is currently 2.4/10 000 births, which compares favourably with other South East Asian countries.<sup>1</sup> Similarly, there is also a high percentage uptake for immunisations.

Curative services are provided by the country's hospitals. The large hospitals comprise teaching hospitals, peripheral hospitals, and base hospitals; these have specialist consultants but no specialist wards. The smaller hospitals include peripheral units and rural hospitals; these have fewer beds and facilities and may only have one doctor. Each hospital has an outpatient department, which fulfils a similar role to that of general practitioners (GPs) in the UK. There is no appointment system, patients just arrive and will be seen by a doctor that day, usually a senior house officer. If the patient has a minor complaint they are treated as necessary, if they require a specialist opinion they are referred to a consultant clinic, usually the same day. If admission is required (or demanded) that is also arranged, regardless of bed status. Wards in each specialty take turns to admit patients from the outpatient department for the day (referred to as "casualty day").

Private health care accounts for 50% of outpatient services and 10% of inpatient services.<sup>1</sup> Most patients do not have medical insurance but pay as they go. There are numerous private hospitals in urban areas staffed by doctors of all grades. The set-up is similar to that of a government hospital with an open outpatient department. In addition, there are also a number of GPs; these have no training beyond the preregistration year and operate private surgeries only.

On my first day in Karapitiya Teaching Hospital, I was pleasantly surprised by the facilities, even impressed! The wards were a little dirty, the beds small and close together, but it really wasn't as bad as I had expected (I suspect my preconceived ideas were formed on hearing other students' elective horror stories!). I was most impressed to learn the hospital had a computed tomography scanner, and when I asked if liver function tests were available the consultant laughed and told me "this is the third world, not fourth!"

It wasn't until the following week I realised I had been a little hasty in my judgments. I had judged the hospital by appearances only and was soon to learn more of the real problems. In addition, my first week was during the doctor's

strike, so what appeared to be a full ward, was in fact, half empty. The day after the strike finished there were 204 patients on the two wards to which I was attached—and only 64 beds. The remainder found a space on the floor or a chair if they were lucky. In paediatrics the problem was even worse; the old metal cots were too small for many of the children, while other cots were shared by two babies, and there were still "floor" patients. With so much overcrowding, the main aim of ward rounds was to discharge as many patients as possible.

Facilities were also far more limited than I had first thought. A routine wait for an inpatient ultrasound was three to four weeks and many specialist blood tests we take for granted had to be sent to Colombo. Drugs were also a limited commodity; on one occasion, I was amazed to learn the whole hospital was out of stock of chloroquine. Infection control was virtually non-existent; there were no isolation areas and poor hand washing facilities (a cold tap only). Further evidence of lack of resources was really evident on the paediatric wards due to lack of screening: for example, there is no neonatal testing for congenital hypothyroidism and this condition is commonplace.

Social factors were of paramount importance in the management of every patient, primarily for financial reasons. All drugs given in hospital are free, but outpatient prescriptions issued must be paid for and the price reflects the cost of the drug prescribed. The majority of the patients were from rural areas with very low incomes (average household income is about 4000 rupees a month, less than £40). Many patients could not afford the drugs they had been prescribed and this presented many management problems, especially in maintenance of patients with chronic illness such as diabetes and asthma. The most horrifying example I saw of the influence of the finances on management was in the case of a 9 year old boy who had developed acute-on-chronic renal failure after a snake bite; he was not considered for a renal transplant because his parents could not afford the necessary immunosuppressive therapy. With limited dialysis facilities, his prognosis was poor.

I was absolutely amazed by my first visit to a specialist clinic. Patients stood squashed up like sardines in a narrow corridor, and every time the swing doors to a clinic room opened, a handful of patients would fall in. In each clinic room there were often five or six doctors all seeing patients and usually a queue of patients waiting to pounce on the next available doctor. There was one examination couch and patients were frequently asked to undress in front of everyone else. In one dermatology clinic I attended, the four doctors saw over 200 patients in three hours.

There is no records system in the outpatient department or in the specialist clinics. Patients carry their own exercise books into which doctors write. On discharge from the wards, each patient is given a diagnosis card (the equivalent of a detailed discharge summary) and any *x* rays or other investigation results. The ward notes are kept in the hospital but rarely

retrieved: the onus is on the patient to remember to bring his or her diagnosis card and exercise book when they attend hospital.

#### MEDICAL EDUCATION

Medical education in Sri Lanka is based on the English system, but it is still a very traditional style course. Entry to medical school is awarded on "A" level marks—there are no written applications or interviews. In contrast to the UK, the students spend more time studying paediatrics, obstetrics and gynaecology, and forensic medicine. The students can expect to have to work at a peripheral unit or rural hospital at some stage in their career, where they may be the only doctor; they therefore require a good all round knowledge and must also be able to conduct a postmortem examination.

All the teaching is in English, so I was able to participate fully in the clinical placements to which I was attached. There were between 20 and 30 students attached to each ward; every student had two, three, or four allocated patients. For each patient, the student must take a full history and examination, monitor the patient's progress, and contribute to some aspects of management—for example, draw up diet plans for parents of malnourished children. The students are also responsible for some investigations, for example, urine analysis, which was carried out in a student laboratory attached to the ward.

There was a ward class every day, in which there would be a discussion around a presented case; this event was continually feared by the students, and usually a source of endless frustration for the consultant. Attendance was heavily monitored; one day a student was 20 minutes late because of a bus strike and was punished by losing two weeks' vacation.

Students were allocated to clinics in groups of 10. Each student was required to clerk a patient at 8 am and would then later present the case to the consultant in the clinic. This meant some patients who had travelled miles to the clinic, often overnight, would have to wait from 8 am until early afternoon before they saw the consultant. Each consultation involved a discussion in English and if there were interesting clinical signs to be found, all 10 students would examine the patient.

After graduation, all students are required to complete a preregistration year, during which they can expect to work around 95 hours a week. After this, all doctors are currently guaranteed an appointment as a medical officer in a government hospital. All posts are permanent. Transfers or promotions may be applied for; promotions are awarded on the basis of seniority, with the exception of teaching hospitals. Postgraduate training is available in Colombo (the equivalent of MRCP part I). For further education doctors must train abroad and many do so in the UK.

#### POLITICAL ISSUES: THE DEVOLUTION DEBATE

In 1987, a constitutional act was passed to allow the development of provincial councils and devolution of power from central govern-

ment in Colombo. This change was the result of Indian pressure to resolve the conflict with the Tamils. It was hoped that the Tamil people would accept the notion of more power, in the form of provincial councils, and therefore cease to give their support to the LTTE who specifically campaigned for a separate state.

The constitutional change proved to be unpopular with the Tamils and the Sinhalese, and only partially implemented. Recently, there has been a move to implement the act more fully with respect to the health service.

It is proposed by the government (and a minority of doctors) that devolution or decentralisation would create a far more efficient health service. Currently, all management decisions, including appointment of doctors and disciplinary procedures, must be implemented through Colombo; it is suggested that local control would improve efficiency and effectiveness. Furthermore, Colombo currently has the highest doctor-patient ratio (1:300); some peripheral provinces have as low a ratio as 1:15 000. This maldistribution is unfair for patients and leads to inequality of work; devolution should allow "unpopular" provinces to have the resources to attract more doctors.

The majority of doctors are against devolution. Their basic arguments are as follows:

(1) Provincial councils would be largely composed of members of parliament (MPs) who would have the power to recruit doctors in addition to other management duties. This is heavily opposed because MPs are not trained in medicine or management and there is concern about the level of bribery and corruption in local government.

(2) Other areas where provincial councils have taken control, for example, appointment of teachers and nurses, are not deemed to have been a success.

The strike action was instigated to demonstrate the opposition of Sri Lanka's 4000 doctors to devolution; it was the third or fourth strike this year. Emergency services were preserved, including any treatment of cancers; outpatient departments remained open, although there were no specialist clinics and admissions were greatly reduced. Private services were also affected as many doctors work in both government and private hospitals and ceased work in both sectors for ethical reasons. Officially, there were no deaths as a result of the industrial action but in practical terms it is difficult to estimate the effect on overall mortality, and even more problematic to quantify increased morbidity.

The family I stayed with were not inconvenienced by the strike at all; one family member developed a cough during the strike and promptly visited his local pharmacist (a friend of his) who supplied him with his regular antibiotic without prescription.

During the strike, the President of Sri Lanka publicly instructed MPs to form ballot lines outside hospitals, calling for an end to the strike. She specifically instructed them not to enter any hospital grounds. However, many opponents to the strike did enter hospital grounds during these ballots and some doctors'

cars were vandalised. Government vehicles were also seen outside doctors' houses, from which stones were thrown at the doctor's windows.

The strike was resolved after 18 days, when the government agreed to appoint a committee to investigate the devolution problem.

### Discussion

#### HEALTH CARE PROVISION

If life expectancy can be used as a crude measure of health, then Sri Lanka has improved considerably over recent years; life expectancy for a man is now 69.5 years.<sup>1</sup> The health service has excelled in recent years in preventative medicine, and provides a good standard in curative medicine, with access for everyone.

Many problems arise from overcrowding; too many patients for far too few resources. One doctor told me he actually thought there was less overall mortality during the doctors' strike as the reduced number of inpatients resulted in a better standard of care. Although the standard of treatment given by the doctors is very good, they are greatly limited by the facilities. I found the doctors really quite inspirational, especially the house officers, and their attitudes to the amount of hours they work; they consider 95 hours a week is essential to gain sufficient experience and clinical exposure to increase their clinical expertise.

The lack of primary care and an effective records system makes continuity of care difficult; one confused inpatient was started on eight cardiac drugs on admission, as indicated by her diagnosis card—a few days later she admitted to not have taken any medication for years. The use of both private and public sector by many patients can also be problematic. Patients who use GPs may be at a disadvantage as the GPs do not have adequate training. They also have no incentive to refer a patient who may require a specialist opinion as they will lose income.

I don't think I appreciated or even considered the value of the welfare state in prescription services before my elective. The number of inpatients with diabetic and asthmatic complications was phenomenal, purely because the patients couldn't afford the maintenance therapy. The diabetic problem is further compounded by the culture; most elderly patients refused point blank to inject themselves.

Although patient finances were an essential consideration in every patient, other social and psychological aspects of management left much to be desired. Privacy was not available for most patients in the clinic or on the ward. Explanation was reduced to a bare minimum due to pressures of time and numbers. I was able to really appreciate this by talking to the family I stayed with and their friends and relatives; they all complained of insufficient explanation by doctors. I offered some simple dietary and exercise advice to one family member who had been told to lose weight and he was quite grateful for some direction! A further social problem was the use of English by the doctors as most patients are not familiar with

the language. I've often cringed in clinics or ward rounds in England when an anxious patient has had to endure meaningless jargon used by doctors discussing the patient's condition among themselves. In Sri Lanka the problem seemed to be worse; on many occasions I saw the doctor explain something in detail to the students or doctors in English before uttering a word to the patient.

To compare the health service in Sri Lanka with the UK is not appropriate because of the huge differences in culture, expectations, and attitudes of patients and most importantly, of finite resources. However, some aspects of the Sri Lankan system could be seen as actually being better than the UK, in particular, the fact that patients can expect instant access to a specialist consultant. There is no doubt that patient expectations are totally different in Sri Lanka and the UK; it could be argued that most patients in the UK would not tolerate waiting in a cramped waiting room for four hours, sitting in a clinic room with half a dozen other patients, and then only having a five minute consultation. The Sri Lankan outpatient services are undeniably overcrowded, but none the less extremely efficient; I couldn't help feeling it made somewhat of a farce of our ridiculously long outpatient waiting lists!

#### MEDICAL EDUCATION

My personal medical education over the elective period was greatly enriched. The abundance and diversity of the clinical material on each medical ward was quite amazing—so much so that competing with 30 other medical students to examine patients was no problem; it was actually beneficial to have so many students so you could have a discussion around an interesting case and compare examination findings. The patients were all extremely cooperative and didn't complain at being examined by several consecutive medical students. I was able to examine up to 10 patients a day, which allowed much needed improvement in my examination skills. The plentiful teaching also contributed greatly to my learning, both in clinical skills and in knowledge of specific conditions. However, although I found the seven weeks extremely advantageous, I was not sure that I would benefit from this style of education for the entirety of my course.

Sri Lankan education seemed to be centred around learning a large amount of facts. To achieve this, the students had a highly structured timetable, a large amount of teaching input, and constant monitoring of their achievements. The teaching, although extremely useful, tended to use intimidation tactics and students were frequently disciplined for not meeting expected standards. The students, although undoubtedly very knowledgeable, perhaps lacked the confidence of their British counterparts.

The experience of witnessing a different system allowed me to re-evaluate my own education; I was really able to appreciate the value of the British reforms to medical education. The flexibility of the timetable in our clinical years and the lesser emphasis on fact learning facili-

tates development of self directed learning, personal management skills, and problem solving skills. I also now appreciate the relative lack of monitoring and disciplinary action; surely clinical medical students should possess sufficient self discipline and maturity to take responsibility for their own learning?

Sri Lankan medical education is slowly undergoing change; medical schools in Colombo are now introducing a modular system based preclinical course. Further reforms to clinical teaching may not be desirable or particularly easy to implement for many reasons. Firstly the sheer numbers of medical students on the wards necessitates a highly structured timetable. Secondly cultural differences are important in choice of style of education. In Britain, we are fortunate enough to be able to move away from home to university; I believe this lifestyle change results in considerable development of personal independence, which is essential if one is to take control of one's own learning. In addition, the importance of learning the skill of self directed learning is unfortunately not as relevant in Sri Lanka; as most jobs are for life and promotions are awarded purely on seniority basis there is no incentive to further one's education after graduation.

#### POLITICAL ISSUES

It was interesting to see a strike "in action", especially in the light of threatened industrial action by the UK's junior doctors. However the situation in Sri Lanka is unlikely to happen in the UK; in Sri Lanka, a strike must cause far more morbidity as all curative services are rendered inaccessible.

However, the people do find alternatives, as the family I stayed with demonstrated—unfortunately this type of dealing is commonplace—as pharmacists will not only except old prescriptions but also dispense drugs without prescriptions at all. The consequences of this could be massive, from increasing antibiotic resistance to, at worst, fatalities.

The political results of the strike are not yet clear as the appointed committee has not yet completed its investigations. The general consensus among doctors is that devolution is, in theory, the best option for better organisation of the health care service at a local level; however, in Sri Lanka it is not deemed a feasible option due to the alleged level of corruption among MPs. The inappropriate conduct of MPs and their supporters was exemplified throughout the strike by violent attacks on doctors' property.

The whole issue of devolution is undoubtedly very complex and I have only scratched the surface. It is clear, however, that Sri Lanka

is a country in political chaos. I cannot possibly estimate the consequences of the implementation of devolution, but the fact remains that the patients are already suffering, as a result of repeated strike action.

#### Conclusion

My elective has been an invaluable experience and I am sure that this experience contributed considerably to my undergraduate medical education and my professional development. At the most basic level, my medical knowledge has been greatly enriched and my clinical skills have undoubtedly benefited from this placement.

As I have already stated, a direct comparison of the Sri Lankan Health Service with Britain is not appropriate; however, some degree of comparison is inevitable and this has enabled me to consider aspects of British health care and medical education in a new light. In general, I feel I have gained a greater appreciation of many facets of the British system that I have previously taken for granted. Direct exposure to the consequences of political problems in Sri Lanka has resulted in my developing a greater interest in political issues affecting the health service in the UK; I think this has been a particularly important part of my professional development.

The very act of living in a third world country for two months has facilitated development of further personal skills. I found living with a Sri Lankan family really enhanced my overall experience. It allowed me gain a better understanding of Sri Lankan society so I felt more able to relate to patients' social circumstances.

To conclude, I would strongly recommend Sri Lanka as an elective destination. It is an ideal location to see Western medicine practised in a third world setting (especially if you are a relatively inexperienced traveller) and there is unlimited scope for enhancing your medical knowledge and clinical skills; it is also an opportunity to enjoy great hospitality and a beautiful country.

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1 Ministry of Health, Sri Lanka. *Annual health bulletin*. 1997: 12–31.