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 second elective placement in Khon Kaen, Thailand – in Srinagarind hospital, which is a modern and prestigious hospital. It is regarded as the main teaching hospital for the Faculty of Medicine in Khon Kaen University. This provided a great opportunity for me to focus on studying common general medical presentations seen in a major tertiary referral centre in Northeast Thailand 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 Thailand would enable me to embrace a different culture and lifestyle. I chose to self-organise this elective placement in Srinagarind Hospital to complement my initial 4-week elective placement in a rural district hospital in Trincomalee, Sri Lanka. I elected to spend 2-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 numerous practical procedures not commonly encountered by medical students and foundation trainees in the U.K.

Whilst working with the team on the internal medical ward of Srinagarind Hospital, I encountered many patients with common medical conditions. I saw a number of patients with advanced heart failure, urinary tract infections, prostatitis, long-standing diabetes with complications, tuberculosis and late-stage malignancies. This was especially useful as I was able to apply and re-inforce the knowledge I learnt during medical school on the wards to these patients. Moreover, I gathered the subtle differences of how healthcare is provisioned in Thailand compared to the U.K. In Thailand, medical training comprises of 6 years. Whilst in the final year, students are referred to as 'externs' and ultimately do the jobs of a Foundation Year doctor. What I found amazing was that externs are the first point of call for the nurses and patients in any situation within the hospital. They are also required to work weekends, on-calls, and regular nightshifts. Following training, students progress to work as 'Interns' which lasts 3 years. The 3rd Year intern, who is also referred to, as the chief medical resident is the one responsible for the patients care on his ward on a daily basis. Unlike in the U.K, a consultant does not oversee the care of the patients. I was very lucky to be assigned to two very skilled, dedicated, knowledgeable and passionate chief medical residents and their team during my time. I received vast amounts of invaluable bedside teaching during ward rounds, which occurred twice daily. 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. Doctors in Srinagarind Hospital were also required to attend lectures, seminars and conferences during lunch on a daily basis. During this time, I gathered the doctors in Thailand follow very similar guidelines and protocols to the ones used in te U.K. I had the opportunity to listen to a conference on the updated and revised guidelines for Atrial Fibrillation from NICE. This was useful as it is a major topic that is perceived to be slightly controversial 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 then see these guidelines implemented on three patients on the wards.

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. For example, a patient who presented with exertional dyspnea and orthopnea was diagnosed with heart failure secondary to the underlying idiopathic pulmonary fibrosis. Following this patient enabled me to see the classical textbook 'ground-glass' and 'honeycombing' appearance on HRCT. This patient also had a fever of unknown origin and long-standing diabetes with complications. On this note, I saw a number of patients with below-knee amputations as a result of their poorly controlled diabetes. Furthermore, I was able to appreciate vital classical signs on clinical examination of patients. For example, I had the opportunity to palpate positive Virchow node, significant hepatosplenomagely, witness necrobiosis lipoidica diabeticorum and advanced uremic symptoms. These are all signs that are extremely difficult to appreciate within the U.K on a regular basis.

In addition to seeing patients with common medical conditions, I also saw many patients with conditions I had never seen or studied before. On the first day, I saw a HIV-positive patient with Penicilliosis with prominent facial symptoms. This is a dimorphic fungal infection caused by Penicillium marneffei, whose incidence has increased as an opportunistic infection in endemic areas of Southeast Asia. The patient was treated with Amphotericin B and I was able to witness improvement in his clinical symptoms on a daily basis during my time at the faculty. Furthermore, I saw a case of meliodiosis, which is an infectious disease caused by Burkholderia pseudomallei, a gram-negative bacterium. The patient presented with very non-specific symptoms such as chest and joint pain. The patient was diagnosed with an acute flare-up and treated with intravenous ceftazidime. This settled the symptoms and the patient was subsequently treated with co-trimoxazole and doxycycline for 12 weeks during the eradication phase. I was very fortunate to see a patient who presented with fever of unknown origin and cultured Opisthorchis viverrini in stool samples. This is also known as the Southeast Asian liver fluke and is a common cause of cholangiocarcinoma. Cancer of the gall bladder and ducts is extremely common in Thailand, as the predisposing infection with the hermaphroditic liver fluke can remain asymptomatic till it is too late. I learnt and saw many infectious disease cases. Like in Sri Lanka, Dengue fever was very common. It is an infectious deisease spread by mosqtuisos Patients tended to present with very non-specific symptoms such as fever, joint pains and headaches, which made diagnosis very difficult. However, due to regular outbreaks, Doctors have adapted and been fine-tuned to picking up Dengue fever very easily. All patients were treated with supportive therapy with fluid management being the cornerstone of treatment. I was also very fortunate to see a patient diagnosed with secondary dermatomyositis. The patient had textbook signs, consisting of Gottron's papules, Shawl sign and a Heliotrope rash.

During the time I spent the general medical ward, I was involved in the care of an elderly gentleman with heart failure who was admitted with an infectious exacerbation of his COPD. His multiple co-morbidities, polypharmacy and dependence on carers meant that various healthcare professionals, such as the chief medical resident, respiratory physician, ward nurse and pharmacist and physiotherapists had to work together to ensure it was safe for him to live in the community upon discharge. The interactions between the multi-disciplinary team began immediately after the patient was admitted and was led by a senior nurse who was able to put the patient and his family at the

center of care. This meant that the patient was treated holistically from the outset. This was very similar to practice in the U.K. The varying but overlapping clinical roles of the healthcare professionals also improved the standard and safety of care provided. On reflection, I understand that professionals must be aware of the limitations of their ability and be able to request the aid of others for comprehensive care provision. I will appreciate my role as a foundation doctor within a much larger team of healthcare professionals in every patient I care for and be aware of the support that exists to treat the patient wholly, especially in situations of uncertainty and change.

Moreover, I was very lucky to have observed many practical procedures during my placement. I observed several bone marrow biopsies and aspirations, pleural biopsies and chest drain insertions. All of these procedures were carried out on the ward or near by newly qualified interns with extreme ease and skilfulness. I received invaluable teaching along the way and was allowed to administer local anaesthetic prior to the procedure. I found this very useful as students and foundation doctors hardly get the opportunity to observe such procedures during their placements. Interestingly, a senior doctor or interventionist always carries out these procedures in operating theatres or minor operating rooms in the U.K under radiological guidance.

The facilities within this tertiary hospital were very similar to that of a U.K teaching hospital. However, I gathered from speaking to doctors and students that this is very different to the facilities available in the rural district provincial hospitals, where equipment is scarce and patient care is at a lower standard. When shadowing the chief medical resident, I learnt that he regularly does two 36-hour shifts a week. He works in excess of 70 hours a week which is many more than what is allowed by the European Working Time Directive in the U.K. Doctors are very stretched in Thailand hospitals; however, I found it astonishing that they do not complain at all. Their reasoning is that if they do not turn up to the hospital on a daily basis, there is no-one else to care for their patients. Seeing this was a real eye-opener and it really inspired me to strive further in the ever-changing world of Medicine and patient care within the U.K in a career of clinical and academic medicine.

Lastly, I was able to embrace the Thai culture in Khon Kaen, 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 Thai cuisines and experienced typical Isan 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 attended a culture trip to various Temples and national historic sites in Khon Kaen, which was exceptionally rewarding and useful.

I have been exposed to numerous infectious tropical disease cases during my placement in Srinagarind 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 Srinagarind 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.