

Lessons learnt in Sri Lanka as elective students

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Abstract

Annually, a number of final year medical students from Lund University in Sweden travel to various healthcare facilities globally. We chose to go to the island of Sri Lanka, spending our elective at the department of Obstetrics and Gynaecology in Colombo. The dissimilarity between healthcare in Sweden and in Sri Lanka was evident throughout our stay. The design of healthcare facilities in Sri Lanka focused less on patient privacy and more on efficiency. The workload for doctors in Colombo was heavier than their Swedish counterparts. In general, outcome for Swedish patients is favourable when compared to Sri Lankan. We believe the difference in outcome is due to the unequal financial situations of the countries. Teaching approach in Sri Lanka diverted from Swedish practice by being more authoritarian but also exceedingly efficient. The large number of patients in wards and outpatient clinics allowed for us to experience a wide range of patient cases, offering important insights in medicine. It has been questioned whether the tradition of international electives is ethically justifiable. We therefore believe it important to stress that throughout our stay we were participating as observing students, not practicing doctors. We regard our elective a valuable experience, providing us with knowledge we will use in our future profession. Time spent observing Sri Lankan healthcare will also serve as a reminder to remain humble towards different cultures. We are now aware of the privileges we have, practicing medicine in a socioeconomically strong country.

Practice Highlights

- It is likely advantageous to include an international elective in medical training.
- Teaching methods and approach to teaching varies greatly between countries.
- It is important to respect and acknowledge cultural as well as financial differences between regions.

I. INTRODUCTION

Annually, a number of final year medical students from Lund University in Sweden travel to various healthcare facilities globally. We selected the Faculty of Medicine, University of Colombo, Sri Lanka for our elective. Sri Lanka has lately become a popular destination for outgoing elective students from Lund University. The overseas electives unit at the Faculty of Medicine at the University of Colombo was officially established in 2012, but the first students started coming in 1994. The unit now caters to over 100 students per year (125 students in 2016).

The main reason for our choice of Sri Lanka as our elective destination was the good reputation of the elective program, with the welcoming and friendly

ambience known to be accompanied by an ambitious and demanding learning environment. The country remains an attractive elective destination for many doctors-to-be. The appeal of this island state seems to lie on the unique combination of advanced healthcare in a resource-limited setting spiced up with rare medical conditions and the aspects of tropical medicine. In addition, the island has much to offer in terms of the rich cultural heritage.

Obstetrics and Gynaecology was a natural choice of specialty for us since we all developed a growing interest in the field during our clinical rotation in Sweden. Also, we saw the elective as a precious opportunity to deepen our knowledge of Obstetrics and Gynaecology further, since our medical training in Sweden, including the 21-

month post-graduate internship, only incorporates five weeks in the Obstetrics and Gynaecology department.

II. GLOBAL PERSPECTIVE

A. Healthcare Settings in Sri Lanka and Sweden

Although a fairly small island, Sri Lanka has a population of 21.2 million people as compared to 9.9 million people in our homeland Sweden. Sri Lanka has a gross domestic product (GDP) of around 81 billion USD and spends 3.0 % of this on healthcare. By comparison, Sweden has a GDP of 498 billion USD and a health expenditure of 11.0 % of GDP (The World Bank, 2015a, 2015b).

Within the field of Obstetrics and Gynaecology, Sri Lanka displays relatively low numbers of maternal and neonatal mortality. In 2015, the maternal mortality ratio in Sri Lanka was 30 in 100 000 live births, which was amongst the lowest in the region according to the World Health Organization (World Health Organization, 2015). The corresponding number in Sweden is 4 in 100 000 live births. The neonatal mortality rate was 6.3 in 1000 live births in Sri Lanka in 2015, as compared to 1.6 in 1000 live births in Sweden (The World Bank, 2015c).

Even though there are still obvious differences in mortality related to pregnancy and infancy when you compare Sweden and Sri Lanka, a lot of changes have been made in the latter country over the last decade. The focus on improving healthcare has resulted in a decrease in the risk of fatal outcomes in both mothers and children. For example, in 2007, 98.6 % of all deliveries are now supervised by a qualified attendant (The World Bank, 2015c). Also, considering the fact that the number of doctors in Sri Lanka was 0.7 physicians per 1000 people in 2010 while the corresponding number was 3.9 physicians per 1000 people in Sweden, the performance of Sri Lankan health care is evidently impressive (The World Bank, 2010).

We spent our four weeks' elective programme at the De Soysa Women's hospital in Colombo. The hospital, initially called the De Soysa Lying-In-Home, was founded in 1879 by a businessman named Sir Charles Henry de Soysa and is the second oldest maternal care centre in Asia. It was established with the purpose to provide maternal care for women with poor socioeconomic status, who by the time of foundation did not have access to proper maternal health care. Furthermore, the first Caesarean section in Sri Lanka was performed in the De Soysa Lying-in-Home in 1905. Since then, the hospital has played an important part in the development of improved maternal health care and in the education of obstetricians, gynaecologists, nurses, midwives and medical students (Seneviratne, 2004).

Colombo and its hospitals have been exposed to violence and disasters, as it suffered from the civil war that lasted between 1983 and 2009, as well as the tsunami in 2004 that destroyed parts of the city and killed thousands of people. When considering the preconditions and circumstances, it is impressive to notice that the quality of Sri Lanka's healthcare still matches those of the wealthier countries (BBC, 2018).

B. Field Observations

Coming from a country where a delivery room holds one mother and her partner at a time, the number of patients held per square meter in the wards and in the labour rooms was sufficient to amaze us. For example, a ward held about 30 beds in the same room and there could be up to six women in the labour room simultaneously. Another surprise was delivered when we entered the outpatient clinics of De Soysa Hospital for Women. The doctors in those clinics could see 15 to 20 patients in two hours, which would roughly be equivalent to a day's work in a Swedish outpatient clinic.

That there were several doctors working separately with different patients around the same table was also dissimilar to Swedish practice. In Sweden, integrity is highly valued and the strict confidentiality of each patient is legally established. Therefore, it was surprising to see how relaxed and natural the Sri Lankan women were among each other. The tranquil approach of the patients regarding gynaecological and obstetrical topics seemed to facilitate practice for the heavily burdened Sri Lankan doctors and was something that we were highly impressed by during our elective.

As proclaimed by our previous elective colleagues, the Sri Lankan doctors proved to have great depth of knowledge regarding physiology and clinical assessment. Luckily, throughout our stay at the De Soysa Hospital, doctors in general were very generous in sharing their knowledge with us, and teaching was regarded importantly by all staff members. The teaching approach in Sri Lanka is different from the one that is practiced in our country of residence. In Sweden students are encouraged to discuss, theorise and not to act too confident, whereas in Sri Lanka we were rebuked for using the word "maybe" when answering a question.

C. Learning Environment in the De Soysa Women's Hospital

The learning environment in the outpatient clinic was quite different compared to what we are used to in Sweden. In Sri Lanka, the number of patients seen per doctor was substantially higher than in Sweden. This created a somewhat hectic learning environment but also provided an opportunity to discuss a large number of interesting cases in an efficient manner. We strongly feel

that it was advantageous for us to partake in the outpatient clinics and it has been shown to be beneficial for students as it provides insight in various clinical topics and increased case exposure (Almoallim et al., 2015).

A common teaching method in Sweden is the discussion of prewritten patient cases in a classroom setting, whereas in Sri Lanka every patient is available for bedside case discussion. Applying theoretical knowledge on real patient cases seems to facilitate and rationalise learning as this allows for a holistic approach to learning (Salam, Siraj, Mohamad, Das & Rabeya, 2011). Unfortunately, because of a different perspective on patient integrity and high demands on patient-doctor communication, this kind of teaching is not applicable in Sweden.

We experienced a more pronounced hierarchy in Sri Lanka than in Sweden. This also affected the method of teaching, resulting in a more authoritarian approach. Not only were we unused to calling elder colleagues Sir and Madam, but also to the way hierarchy allowed for more experienced doctors to dictate the terms of the department. Questions were posed in a manner expecting straight and correct answers, not leaving any room for hesitation or speculation. Even though we were unfamiliar with this authoritarian climate, we still felt included and expected to partake in everyday work in a more natural manner than in Sweden.

D. Ethical Dilemmas Encountered as an Elective

Despite providing valuable experiences and practical training for students, it has been questioned whether the tradition of international electives is ethically justifiable (Gilbert, Miller, Corrick & Watson, 2013). Prior to departure, the importance of maintaining ethical standards during the elective was emphasised by our university. Hearing from students having gone to developing countries, this is not always an easy task, them being required to take responsibility beyond their level of training from the receiving institution. Luckily, we never faced such dilemmas in Sri Lanka. Throughout our stay, it was evident that we were participating as foreign students, not practicing doctors.

Something that did bother us throughout our elective was the fact that we could not properly communicate with the patients. The women were all very generous in letting us examine them, reading their medical charts, and observing them during a wide range of interventions and assessments. However, not being able to introduce ourselves and explain the purpose of our presence did feel wrong. The fact that Sri Lankan doctors often spoke English with us and when discussing patients amongst themselves facilitated our stay, but at the same time it

disabled the patients to partake in discussions regarding their own health. While the Sri Lankan women might find this plausible, it could also be intimidating for patients to know they are the topic of discussion while being unable to comprehend what is being said.

Participating in an elective program in the Obstetrical and Gynaecological departments of Colombo was a rewarding experience for us. We were however curious how the hospital staff viewed such endeavours from foreign universities. Both doctors and nurses seemed to operate under a lot of pressure and our presence might have disturbed the hospital staff when performing their tasks. As elective students, we might unintentionally have gotten in the way, or delayed a nurse in performing her tasks. A doctor working fast to cope with workload might also have wasted precious time explaining a patient case to us. Regardless, it is important to note that we were very well received by everyone during our elective in Sri Lanka.

E. Potential Improvements

In the running of international electives, it is clear that the teaching habits, as well as the learning environment of sending and receiving institutes differ from one another. An exchange is beneficial not only for the foreign student, but also for the receiving institution, as it provides an opportunity to gain novel insights.

Coming from a culture where adhering to appointed times and locations is expected, we believe that an appointed supervisor and a more structured approach overall would be favourable. Also, giving students assignments such as case presentations during the course could support learning and improve contact with local doctors. As stated by Onishi in the Kaohsiung Journal of Medical Sciences, case presentation is an acknowledged learning method and can facilitate students' clinical development (Onishi, 2008). Not surprisingly, it was in fact an integrated part of the training of junior doctors at the hospital.

Lastly, it would have been interesting to talk to Sri Lankan medical students to learn how their education is structured and what is expected of them. Unfortunately, this was not possible as they were on strike during our stay.

III. CONCLUSION

We regard our elective a valuable experience, providing us with important insights. Time spent observing Sri Lankan healthcare will in the future serve as a reminder to remain humble towards different cultures. Sweden being a country that has not waged war for centuries is at a financially advantageous point relative to Sri Lanka.

We should remain mindful of how privileged we are, working as doctors in a socioeconomically strong country. Nevertheless, it is clear that there is much for us to learn and be inspired by from our colleagues in Sri Lanka.

Note on Contributors

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Declaration of Interest

The authors declare no conflicts of interest.

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