Life as a medical student – a perspective from shores beyond

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When asked to write this article about my experience of medicine in Sri Lanka, it's hard to know where to start. It's not that I don't have pages of memories, but that it feels a long way away from where I'm sitting, in a cold computer room in a small hospital in the suburbs of South East London where the rain is lashing against the windows.

But the weather apart there are many similarities between studying medicine in Sri Lanka and England. In my first week at the De Soysa Hospital for women I went to a tutorial on hypertension in pregnancy. I was transported back to an almost identical lecture I'd had in London just one month before. This epitomises my experience. In the faculty library I found the same textbooks as I have at home. In theatre I was grilled on the same anatomy that I still can't remember. In clinic the medical students still got in trouble for not having clerked a patient, or not being able to identify that elusive cardiac murmur. The tea breaks are always longer than necessary. The medical records are always impossible to find. However, part of the reason I wanted to come to Sri Lanka was to experience a government healthcare system in a completely different culture to the UK. It met my expectations. One of the most poignant differences was the expectations of a medical student. To the disbelief of my Sri Lankan colleagues, in England our attendance is optional. It is recommended that we attend 90% of organised teaching sessions but should we fail, I doubt that anyone would notice. So we are left with our own guilt and fear of exam failure for punishment. In comparison, it was rare that I attended the hospital when the wards were not filled by students on the, apparently 'relatively light' workload, Obstetrics and Gynaecology attachment. Also the level of knowledge expected by a student far exceeds that of the UK. In Sri Lanka I was frequently ashamed by my inadequate knowledge about the pathophysiology of a condition, or the exact dosage of a drug. In the UK, whilst factual knowledge is of course essential, there is an equally strong emphasis on effective communication with patients, and within the multi-disciplinary team.

Another difference in the medical student life is the variety of medical cases seen. In the UK a significant amount of time is spent learning about conditions we are unlikely to see or need to treat. This is because of national screening programmes and efficient primary care. In Sri Lanka, I was fascinated to see many of the 'textbook' clinical signs I have learnt about. Students see vastly diverse clinical scenarios.

This is also a consequence of a very different attitude towards the health care system, by both patients and healthcare professionals. Medicine in England is defined by a requirement for effective communication, respect for patient privacy, confidentiality and autonomy. In theory this is excellent. Patients should have a right to understand the cause of their problems and choose or refuse the treatment options available. In reality it is underlined by a culture of litigation against doctors that fail to meet these requirements. For example, quite frequently a patient will have 'googled' their symptoms, suspect their diagnosis

and believe they need a certain test or treatment. The doctor, if confident, has to traverse the minefield of denying the test or taking the potentially easier option, succumbing to the patient's request merely to reassure.

In Sri Lanka, there appeared to be a more paternalistic approach. Where doctors are held with the highest regard and patients are happy to receive and follow any medical advice given. This difference also affects the medical student exposure. In England, young patients frequently refuse permission for a medical student to observe their consultation. In Sri Lanka, fifteen medical students will crowd into one room holding two outpatient clinics simultaneously. After five years of being taught the alternative, it is not easy to condone this paternalistic approach. However, it is much more complicated when it's dependent on patient education, financial restrictions and time. Indeed, most importantly, in both cases the patients receive excellent care and leave satisfied with their treatment.

Of course financial restrictions make a huge impact on both healthcare systems. Prior to my arrival in De Soysa I thought that 12 patients in a morning clinic was a busy day. After seeing the sheer number of women queuing at the antenatal clinics, I will never think this again. Similarly, without the abundance of tests at the click of a computer mouse, the reliance on clinical skills in Sri Lanka makes a far more efficient doctor. Yet, in some cases financial restriction makes no difference. For example, diabetics in England are provided with home blood glucose monitors, preloaded insulin pens, intensive training courses on managing their condition and in the case of paediatrics, even diabetic holiday camps! In De Soysa the HbA1c must be paid for privately, the blood glucose tested at the GP surgery, Insulin kept in a friend's fridge and drawn up in a syringe. Yet which country has the better compliance to treatment? Money and education can't always buy you the respect required.

Apart from financial concerns, the medical and cultural concerns are also different. For example, having studied sexual health in South East London, and the plethora of problems it entails, I was amazed to discover from the Family Planning Bureau that contraception is only provided for married females, and that this restriction is not expected to cause future problems.

Despite all these differences there are two fundamental similarities in medicine worldwide. The first is the faith that you are doing your best to help another person, irrespective of their social or cultural status. The second is the enthusiasm required by all those involved in teaching and learning the art. Thank you for reigniting mine.