Anaesthetics and ICU in Mauritius

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I chose to go to Mauritius as it has a public health system comparable to the UK in that it is state-funded and free at the point of care, however it is a middle income country with a high burden of non-communicable disease (23% of the population have diabetes compared to 5% in the UK, and 1/1000 of the population are on dialysis), with poorer funding of public healthcare, especially primary care. In addition to seeing how anaesthetics and ICU worked with these different challenges and in a different healthcare system, French is widely spoken in Mauritius and I hoped to practise some French in the clinical setting.

I spent my elective in Sir Seewoosagur Ramgoolam hospital, the biggest hospital in the country, spending time in both anaesthetics and ICU. While I had originally planned to carry out an audit of implementation of the Surviving Sepsis Campaign guidelines, this proved to be unfeasible to quantify due to variability of documentation. However, I was involved in the treatment of a number of patients with sepsis in ICU, and observed that while the SSC guidelines were available on the unit, some points could not be followed in the hospital due to the resources available: for example, hydroxyethyl starch was used instead of albumin for fluid resuscitation of septic shock (against the recommendations of the SSC). Furthermore, I noted a low threshold for treating ICU patients (for example, with head injury or stroke) with broad-spectrum antibiotics in the absence of a full septic screen.

I shadowed anaesthetists on general surgery lists, which I found interesting due to the variability of cases and thus types of anaesthesia used. The number of patients per list was substantially higher than I had seen in the UK, which was in part due to much more rapid turnaround between patients, with no team brief or WHO checklist used. I was told they were bringing in the checklist during my placement but after its implementation there was still no formal ticking-off of items, the checklist was simply available to read in theatre. The relative lack of resources compared to the UK was evident in terms of re-use of equipment which would be disposable in the UK: sterile fabric drapes and gowns are washed and re-used. However, the practice of anaesthesia was very standardized, and many of the challenges I observed-for example, spinal anaesthesia in very obese patients-were reminiscent of problems faced by anaesthetists in the UK. My knowledge of anaesthetics was much improved by the experience and teaching I received in theatre on pharmacology and managing the anaesthetized patient.

My time on ICU was very interesting from both a medical and an ethical perspective. I saw a variety of pathology: mainly trauma, sepsis and stroke, but also rarer cases such as peripartum cardiomyopathy and tuberous sclerosis, and was able to follow patients' progress during my time on the unit. I was interested to hear the doctors couldn't refuse to escalate a patient to ICU if they had a bed free, even if they felt curative treatment to be unlikely-for example, I saw several elderly patients with massive brainstem strokes intubated and ventilated. This frustrated them as it could lead to other patients in need being denied a bed, but it seemed to be part of the medical culture. While ceiling of care decisions do not seem to be part of routine care, the ICU doctors decide themselves on which patients are not for attempted resuscitation, but this is not documented or discussed with families. Anecdotally it seemed resuscitation is documented even when not attempted, although I did not observe such an arrest during my time on the unit. Hearing this

prompted me to reflect on the reasons behind this paternalism (trying to spare families distress) and made me appreciate UFTO forms and attempts to normalise conversation about DNR in UK hospitals. I was given good bedside teaching on physiology and pathophysiological concepts and was able to observe central lines, chest drains and treatment of refractory sepsis. However, there was not much scope for carrying out procedures as the unit was well-staffed with nurses competent in performing procedures. Similar to my observations in theatre, while medical care was of a high standard, there were infrastructural challenges, such as the CT being broken and having to transfer often ill patients to another hospital for scans, and very low blood stock meaning a patient with massive haematemesis having to wait for more blood to be transported to the hospital.

My experience in Mauritius was very beneficial for me going into final year. Although I was mainly observing, the doctors were very friendly and knowledgeable, giving me excellent ad hoc teaching and getting me involved in the team. It was interesting to see a different health system dealing with the needs of an overall poorer population with a different demographic make-up. As well as this, seeing the different culture of medical paternalism and worse patient education prompted me to think about what I thought of as professionalism and how much I value communication and shared decision making. My only real disappointment was that I didn't get to speak as much French as I had hoped, but I got at least some experience in that too. Unfortunately, the sad postscript to this report is that during my placement the Ministry sent out a letter stating that after 1st August 2016 policy would change (for unspecified reasons) and they would no longer accept any elective students in the country! The doctors we met weren't sure why this had been decided; it is a shame as my elective was such a rewarding experience. I am very grateful to the AAGBI for making it possible.