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Letter to the Editor

Implications of the current economic crisis on anaesthesia and critical care services in Sri Lanka: observations of a junior anaesthetist

B M Munasinghe

District General Hospital, Mannar, Sri Lanka.

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Corresponding Author: B M Munasinghe, E-mail:< malakafmp@gmail.com > https://orcid.org/0000-0001-8373-4752

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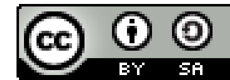

Introduction

Sri Lanka has seen one of the worst economic crises of its history. This has had significant detrimental effects on several aspects of the health system including patient care and the well-being of healthcare workers. If the current status quo persists, it might lead to a long-term collapse of the system. While this affects all the specialties, the effects on anaesthesia and critical care services are noteworthy.

Effects on patient care

The financial crisis in the country resulted in significantly reduced imports of essential and lifesaving drugs [1]. Severe shortages of drugs included intravenous induction agents, muscle relaxants, reversal agents, vasopressors, inotropes, antiarrhythmics, intravenous electrolyte solutions (mainly potassium) and spinal anaesthetic agents. This led to curtailing of routine surgeries with prioritization of elective oncological and paediatric surgeries in our centre, a remote District General Hospital in Sri Lanka. Subarachnoid blocks and peripheral nerve blocks were adopted in place of general anaesthesia whenever permitted. Use of drug vials for multiple patients, whenever possible, mainly the spinal anaesthetics (such as heavy bupivacaine) were similarly practiced while maintaining sterility and preventing cross-contamination. The shortage of vasopressors, especially in critical care, was managed with peripheral vasoconstrictors such as phenylephrine. The unavailability of antiarrhythmics and intravenous electrolyte solutions was critical. Short-acting muscle relaxants had to be used

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in cases where muscle relaxation and general anaesthesia were warranted, followed by spontaneous breathing. This, at times, did not provide ideal surgical conditions.
Unavailability of equipment was also prevalent, locally. These mainly included airway adjuncts such as endotracheal tubes, heat and moist exchange filters and syringes etc. Reuse of endotracheal tubes after proper disinfection, use of a single heat moist exchange filter at the exhalation port of the breathing systems and cautious use of syringes had to be adopted. The low stocks of disinfectant solutions had a deleterious effect on such practices. The reduction in central venous and invasive arterial pressure monitoring and the simultaneous lack of blood gas monitoring had a considerably negative effect on critical care. The remaining few blood gas samples had to be rationed and reserved for paediatric and emergency treatment units. Gas analysis and invasive pressure monitoring had, at times, to be substituted with non-invasive clinical monitoring. Local protocols had to be implemented, especially when decisions had to be taken regarding the weaning or escalation of mechanical ventilation. Critical care admissions had to be tightly screened to ensure the most efficient use of scarce drugs, equipment, and healthcare personnel.

The fuel crisis had a definite negative effect on healthcare in terms of reduced transportation of drugs and equipment. The transfer of patients from our centre had to be restricted. This meant that both urgent and elective advanced investigations such as computed tomograms, immunological studies and specialized inputs saw delays. Transfers needed prioritization in cases of critically ill, obstetric and paediatric patients. Admissions of patients for elective surgeries were also reduced due to a near-complete halt of public and private transport.

Effects on healthcare workers

Markedly limited fuel reserves in the country led to days-long queues and limited transportation facilities, affecting the continuation of daily anaesthetic and critical care services. Work schedules using extended rosters had to be implemented. Despite reductions in workload in anaesthetic services due to limited surgical cases, the physical exhaustion and plummeting economy led to anxiety and uncertainty among healthcare workers. The outcome and net effects of these on the acute and long-term psychology of healthcare workers and, in turn, the healthcare services have not yet been evaluated. Island-wide, as a specialty, the rapidly rising inflation with effects on acquiring and sustaining even basic needs prompted a considerable number of specialists (predominantly anaesthetists and intensivists) and intermediate-grade doctors to migrate to other countries for job opportunities. The doctors who have been completing postgraduate training in the UK have resorted to permanent or short-term stays without returning to Sri Lanka. This void of anaesthetists and intensivists will negatively affect the sustenance of such services, especially in the country's remote centres.

These are a mere fraction of the detrimental effects on the country’s healthcare as a whole. The College of Anaesthesiologists of Sri Lanka, with numerous local and foreign donors, fought valiantly to restore the anaesthetic and critical care services and were, for the most

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part, successful with regard to the acquisition of drugs and equipment, which is highly admirable. This being said, preparedness for such economic calamities and their effects on healthcare should be in place in countries with fragile economies. National policies to make sure the continuity of essential anaesthetic and critical care services and the safeguarding of involved healthcare workers are a priority. The lessons learnt should be fundamental for rebuilding. I am sure that, as anaesthetists and intensivists, we will be able to revive our country's healthcare system with vision, courage, and dedication.

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