Coronary heart disease is the leading cause of hospital deaths in Sri Lanka [1]. The objective for patients with coronary heart disease is to reduce the risk of further coronary events. There is clear evidence that risk factor modification will help to achieve this objective [2], but studies in the United Kingdom [3] and Europe [2] have shown that the control of risk factors after a coronary event is often inadequate. Little data is available on the control and prevalence of risk factors in Sri Lankan patients. The purpose of our study was to assess the control of risk factors, use of appropriate medications in secondary prevention, advice given on secondary prevention and screening of first degree relatives for risk factors among patients after acute coronary events.

Patients with a history of myocardial infarction or unstable angina within the past 3 to 12 months attending medical wards and clinics at Sri Jayewardenepura General Hospital from August to December 2002 were included in this study. Data was collected using an interviewer-administered questionnaire. Results of biochemical tests were obtained from the patients’ medical records. We examined whether the patients had achieved the goals recommended by guidelines for secondary prevention of coronary events drawn up by the Joint European Societies [4,5]. They were, to stop smoking, make healthy food choices, and become physically active; to achieve a body mass index (BMI) less than 25 kg/m², achieve a blood pressure below 140/90 mmHg, a total serum cholesterol level below 5 mmol/L, and LDL cholesterol concentration below 3 mmol/L. We studied a total of 143 patients (men 83). The sample consisted of patients aged from 34 to 80 years. A past history of myocardial infarction was present in 63%, and the rest had unstable angina. Blood pressure control had not achieved the target in 25.9% of the patients. Glycaemic control was poor in 27.3%. The total cholesterol was more than 5 mmol/L in 61.6%, and LDL cholesterol was raised above 3 mmol/L, in 77.6%. The body mass index was above 25 kg/m² in 30.1%. The 75.5% of patients were not exercising at all. The recommended target of brisk walking 3 km three times weekly was achieved only in 11.4%. Consumption of a high fat diet was noted in 22.8% and 5.2% of patients continued to smoke. The reported use of beta blockers was 53.8%, ACE inhibitors 86%, aspirin 90.9% and lipid lowering drugs 56.6%.

Advice regarding the need to reduce the intake of fatty foods had not been given in 24.5% of patients. None of the patients had been told the importance of a regular exercise schedule. Only 45.5% had been advised to exercise. A 55.2% had not been told the importance of controlling hypertension and diabetes. Only 1.4% of patients had screened their first degree relatives for risk factors. The level of advice given to the patients on life style modification by the health care team was clearly inadequate. The use of drugs in secondary prevention is satisfactory, especially of aspirin and beta-blockers. In general, our study showed that patients’ compliance with regard to drug therapy is more satisfactory than compliance to non-therapeutic measures. Introduction of cardiac rehabilitation clinics would enable better and focused attention, to be given for secondary prevention in patients after acute coronary events.

References

Usha C Samarasinghe, Consultant Radiologist, Nawaloka Hospital, Colombo 2; Neville D Perera, Urological Surgeon, National Hospital of Sri Lanka, Colombo 8; Dilani Lokuhetty, Senior Lecturer, Department of Pathology, Faculty of Medicine, Colombo 8.

Correspondence: UCS, e-mail: <nevi603@sltnet.lk> (Competing interests: none declared). Received 1 October 2003 and accepted 8 March 2004.
To the Editors:

Unacceptable teacher behaviour or medical student abuse?

Anxiety and its provoking factors during undergraduate courses have been a concern of many researchers. Issues such as examinations, dislocation from home environment, personal relationship problems and problems related to finances and accommodation have all been identified as factors responsible for anxiety [1].

We present data on certain aspects of teaching that provoke anxiety and adversely influence self-esteem of students. We conducted two surveys using anonymous self-administered questionnaires developed to describe the learning environment of students in the Faculty and teaching hospitals.

This preliminary survey was conducted in 2001 on a random sample of 41 final year students (from a batch of 174) immediately after completing their course in the Faculty of Medicine, Colombo (Group A1). The response rate was 70.7%. The second survey was done in 2002 on final year students (Group A2), and among intern medical officers working in the Colombo group of hospitals (Group B). The latter consisted of 20 graduates from the Colombo Faculty (Group B1) and 42 from other Faculties of Medicine (Group B2). Responses were received from 124 from A2 and 62 from B (response rates were 70.8% and 69.7%, respectively). The relevant results are tabulated (Table 1).

Table 1. Results of surveys

<table>
<thead>
<tr>
<th></th>
<th>Medical students</th>
<th>Interns</th>
<th>Interns</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>(A1)</td>
<td>(B1) Colombo</td>
<td>(other than Colombo)</td>
</tr>
<tr>
<td>N=29</td>
<td>N=124</td>
<td>N=20</td>
<td>N=42</td>
</tr>
<tr>
<td>Rarely or never praised by a teacher</td>
<td>10 (34%)</td>
<td>75 (58%)</td>
<td>4 (25%)</td>
</tr>
<tr>
<td>Scolded in front of other students</td>
<td>11 (34%)</td>
<td>60 (48%)</td>
<td>10 (50%)</td>
</tr>
<tr>
<td>Collective punishment meted out to whole group</td>
<td>12 (41%)</td>
<td>46 (37%)</td>
<td>Not available</td>
</tr>
<tr>
<td>Felt humiliated for comments made by teachers for mistakes in English</td>
<td>7 (24%)</td>
<td>17 (13%)</td>
<td>5 (20%)</td>
</tr>
</tbody>
</table>

We were surprised by the manner in which medical teachers use punitive measures on adult learners. Such an authoritarian learning environment does not promote independent learning [2]. Punishment of a group of students for the fault of a few is unfair and against the principles of natural justice. Humiliation of students for making mistakes in English, which is not their mother tongue, is clearly unacceptable. The above behaviour of teachers could be defined as student abuse or bullying [3, 4].

Medical schools have a duty and obligation to curtail such teachers’ behaviour. A mechanism has to be in place to entertain complaints by students. If we do not take such an action, the solution may come from agencies outside the university system, for example, the Human Rights Commission or Sri Lanka Medical Council.

References


Saroj Jayasinghe, Associate Professor, Department of Clinical Medicine, Pubudu de Silva, Research Assistant, Damani de Silva, Senior Lecturer, Department of Psychological Medicine, Faculty of Medicine, University of Colombo. Correspondence: SJ, Tel:+94 1 2695300, e-mail: <sarojoffice@yahoo.com> (Competing interests: SJ and D de S are medical teachers where the study was done). Received 8 August 2003 and revised version accepted 16 March 2004.