ELECTIVE (SSC5b) REPORT (1200 words)

A report that addresses the above four objectives should be written below. Your Elective supervisor will assess this.

Introduction

My medical elective was based at Services Hospital Lahore, a busy inner-city government-run teaching hospital in Pakistan. Compared to the UK, Pakistan is relatively resource-poor and has poor health literacy. Lahore itself is a well-developed metropolitan city in the heart of the Punjab province, and has a population diverse in age, social class and background. Due to the hospital's reputation and specialist services, people also travel dozens of miles from nearby towns to be seen here. Consequently, there was significant variety in the presentations, which led to unique opportunities to observe and elicit signs I would be very unlikely to see in the UK.

Healthcare Provision

Being a government hospital, it provides care largely free of charge to patients. There are small fees for admission, and in A&E some equipment for the patient may need to be bought from medical stores. Consequently, attendees are for the most part poorer members of the community - people who are typically less educated than the average patient in the UK, and with varying perceptions of health, disease and the role of doctors. The middle and upper classes more often choose to attend the huge selection of private hospitals in the city. According to online lists, there are 48 private hospitals and only 16 public hospitals in the city of Lahore. Many of the private hospitals are smaller than their public counterparts, but they are reportedly used by 70-80% of the population (Ministry of Finance, 2011). During my stay, the interior minister of the country was shot in his home village and brought to Services Hospital by helicopter. Security was extremely high, and it seemed extremely odd to me that such an important and wealthy individual would choose to be an inpatient here rather than a private hospital. Asides from being an attempt to strengthen public trust, I was told that the quality of complex care in large public hospitals in big cities is better than in many private hospitals, because of the presence of many top-level surgeons and physicians that specialise in specific fields.

Presenting Problems

The majority of my time was spent on one of the four medical units, which covered gastroenterology and endocrinology. Here, many of the presenting problems were similar to those observed in the UK – upper GI bleeds, vomiting & diarrhoea, jaundice. However, there were a number of underlying differences. Severity of the symptoms and underlying diagnoses were in general more severe. For example, those with meningitis would often have persistent reduced consciousness and dependence, and more often than not the cause was tuberculosis. Infectious diseases predominated, and among them, tuberculosis, hepatitis B & C, and typhoid were some of the most common. In fact, tuberculosis is listed as the 7th leading cause of death in the country (WHO, 2015). Underlying co-morbidities were also different. While diabetes and hypertension are also very common in the UK, they were often more poorly controlled here. Other relatively common co-morbid conditions included chronic viral hepatitis, HIV and tuberculosis – all of which complicated management significantly. IV drug users made up a sizeable portion of the patients I saw, both on the ward and in A&E presenting with overdoses. Some cases I would be extremely unlikely to see in the UK, for example a case of a young adult with stunted

growth due to untreated congenital hypothyroidism who presented with megaloblastic anaemia and protein energy malnutrition and was subsequently diagnosed with coeliac disease.

Health Literacy

The relatively poor health literacy of the patient population presented some unique problems. Much more often that in the UK, they would present in the very late stages of a disease, at the point that they could barely function at home. A typical example is a middle-aged patient presenting in a critical state to A&E and is found to have end-stage renal failure. Upon exploring their history, it is noted that they are diabetic and hypertensive, but stopped taking medication several years ago. Their non-compliance could be due to a lack of knowledge of the long-term complications and the importance of consistent management, thinking they had been effectively treated due to their lack of symptoms or just not being able to afford the drugs long-term. Patient's health literacy seemed to mostly come from what they had heard from friends and family, but also what they remember being told by doctors in the past and from limited public health campaigns.

One striking absence from the health system that I had not considered in the past was the that of public health screening programmes. Asides from the lack of infrastructure in many areas, a lack of awareness of several conditions (e.g. colorectal cancer) is a major barrier to this. This is changing however, with more and more awareness campaigns and small-scale screening programmes run by NGOs. It does appear that health literacy is slowly improving, presumably due to access to the internet and outreach work. I spent a day in a rural health centre in a nearby village, where I met a team that regularly goes out informing locals of the dangers of dengue fever and how to prevent mosquitos breeding in their area. Since then, dengue rates had dropped significantly.

Doctor-Patient Relationships

Poor health literacy meant that doctors were only able to impart limited medical knowledge. This affected the doctor-patient relationship as it meant that patients either had to blindly accept the doctor's advice or blindly reject it. Due to the large patient burden, particularly in the outpatient setting, doctors simply wouldn't have time to explain disease processes to patients. Another effect of this limited time is that history-taking would very often be composed primarily of closed questioning, and patients understood this, so they conveyed the relevant information clearly and quickly. While I was there, no patient complained about not receiving enough time with a doctor, even though it was very little time compared to what is seen in the UK. All of this was conducive to a relatively paternalistic role for doctors. As it is, I don't think the system in public hospitals would be able to work any other way.

Every patient has an 'attendant' - a family member or friend who would be by their side at all times and act as their assistant. They would advocate for the patient, collect equipment from the medical store with doctor-written orders, take blood samples up to labs, take the patient to imaging departments, manoeuvre the patient in bed etc. The attention a patient got from the medical team for their ongoing problems often depended on how much their attendant spoke up for them – one who was better educated or had a background in the medical field would be able to recognise and articulate more issues with the patient, and get more information in return. They formed an important part of the doctor-patient relationship.

Conclusion

My experience during my elective exceeded by expectations. It put my time in the NHS, both as a trainee doctor and as a patient, into perspective, and made me appreciate many of the features I had previously taken for granted. I was able to learn a huge amount about various aspects of healthcare, as well as the culture of health and disease in Pakistan. It is an experience I wouldn't hesitate to recommend to any other students.

[1] Ministry of Finance. (2011). Pakistan Economic Survey 2010-11 (pp. 141-149). Islamabad: Government of Pakistan.

[2] World Health Organization. (2015). Pakistan: WHO Statistical Profile. Retrieved from http://www.who.int/countries/pak/en/