ELECTIVE (SSC5b) REPORT (1200 words)

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

Introduction

I attended a General Practice in Sandwell in the West Midlands. A place once best known for its role in industrial revolution, and nicknamed 'The Black Country' as a result, Sandwell has remained in the top 20% of the country's most deprived areas. The life expectancy of men and women in Sandwell falls below the national average, living 7.5 and 6.3 fewer years respectively. There resides an ethnically diverse population, primarily Indian, Pakistani, and Polish people, giving rise to a specific pattern of disease; one that I have become familiar with during my time in East London.

Describe the pattern of disease/illness in the West Midlands and explore this in a global context.

During my elective placement I found that the pattern of disease in Sandwell, West Midlands, largely resembled that of East London. In particular, cardiovascular disease (such as hypertension, hypercholesterolaemia, angina), diabetes, and respiratory disease (such as COPD and TB) were predominant. I found that the local rates of recorded diabetes and tuberculosis exceeded the country's average, with a tuberculosis value of 33.5 locally and 13.5 across England. Since GPs are, by and large, the first port of call for patients, the UK's primary care services have a central role in the multidisciplinary approach to diabetes and TB management. With regards to the former, GPs have a role in educating patients of risk factors for diabetes (such as a dietary factors) and consequences of poorly controlled blood glucose levels. They empower patients to make changes to their lifestyle, provide treatments to improve glucose control, and ensure regular follow-ups that enable early identification of complications. For the latter, they work closely to ensure at-risk patients are vaccinated and/or tested for TB, contacts are traced, risk of transmission is reduced, and adequate treatment is received.

There are many countries across the globe in which diabetes and TB are amongst the leading causes of morbidity. Broadly speaking, these countries tend to lie within Sub-Saharan Africa and the Indian sub-continent (the same ethnic backgrounds as many of our UK patients). For these countries, managing these conditions effectively in the wider context of society can prove much more difficult than in the UK. For example, although India strives to treat those diagnosed with TB and trace their contacts, in practicality, this can be much more difficult to achieve due to high population densities and difficult-to-reach groups of people.

Describe the provision of diabetes services in UK primary care compared with that in India.

Diabetes services in the UK are multifaceted. Primary care services, which include doctors, nurses, and healthcare assistants work not only to treat patients with diabetes, but also to prevent the development of diabetes. They increase awareness of risky behaviours, emphasise the benefits of lifestyle change, and inform patients of the many health consequences that an uncontrolled blood glucose level can have. They offer regular check-ups and screening for such consequences, in the hope of catching them and intervening early, should they arise.

India has the largest number of people living with diabetes of any other country in the world. It has been estimated a whopping 66.8 million people living in India suffer with the condition, and thus we might expect its diabetic services to reflect this. However, despite such gargantuan numbers of people living with diabetes, it has been reported that awareness and diagnosis of the condition is actually very low, suggesting that a distinct paucity of diabetic services exist. Further, the economic impact of diabetes in India is one of the highest in the world, mostly resulting from micro- and macrovascular complications that develop as a result of poor glycaemic control. This strengthens the belief that diabetic services in India still have a long way to go, particularly with regards to implementing screening programs and promoting early management. It seems that for a nation with such a high rate of diabetes, its population only seem to meet with health professionals once it is too late.

Describe public health initiatives set out that are aimed at improving the health of specific ethnic groups.

In any GP practice across England there are usually numerous patient information leaflets pertaining to a number of different health conditions, including and not limited to diabetes, TB and hypertension. In Sandwell these leaflets were also available in different languages in order to educate and empower ethnic populations. They also ran pre-diabetic clinics which aimed to educate patients and optimise glycaemic control, hoping to eliminate the need for medical management in the future. Further, the Sandwell and West Midlands group launched a campaign, which hoped to identify people at risk of TB and reassure those who are not. It was named 'TB or not TB, that is the question' and consisted of a short video and screening survey. It aimed also to provide education to ethnic groups with regards to tuberculosis risk factors, method of transmission, signs and symptoms, and what testing entails.

Through working in a different environment and being exposed to different styles of teaching, I hope to build upon the clinical and communication skills that I have learnt at Barts.

Working in Sandwell, I was exposed to people from multiple ethnic backgrounds. As mentioned above, the majority of patients attending the practice were of Asian (usually Indian or Pakistani) descent, living locally in tight-knit communities and having little exposure to the English language as a result. For me this was comparable to many of my experiences at Barts, being placed at GP practices, which primarily served a Bangladeshi populous who also speak little English. My time at Barts equipped me with the skills required to recognise (and have a low threshold for) the limitations of a consultation where there is a language barrier. In the UK it is widely recognised that non-English speaking patients often receive inferior care, and have poorer outcomes than their English-speaking counterparts. This reinforces the idea that high quality care and optimal patient outcomes rely heavily upon effective communication between doctor and patient. Overall, my time in the West Midlands afforded me the opportunity to build upon my communication and clinical skills through repeated practice and feedback from my supervisor.