ELECTIVE (SSC5a) REPORT (1200 words)

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

Objective 1:
The pattern of dermatological diseases amongst the Sharjah population has shown to be similar to the general disease pattern in the United Kingdom, despite the anticipated differences. Having observed a dermatology clinic at a local Sharjah Practice during our elective, I was able to see a lot of the common skin diseases including acne, eczema and psoriasis. This is similar to common conditions which I have seen in the United Kingdom, particularly in general practice. It shows that despite being in a different location, there is a consistency in the common diseases worldwide. According to the British Skin Foundation in the United Kindgdom (UK), 20% of all children have eczema, whilst acne and psoriasis are amongst the most common skin conditions encountered 1.

Although, these are common skin conditions, I realise that we are faced with a huge difficulty in treating them as a lot of these conditions have no definitive cure. It is a matter of managing the symptoms and trialling different lifestyle and medical treatments. I have witnessed similar struggles in the UK with these conditions being difficult to tackle, which can cause distress to patients.

Despite this common disease pattern, there were cases of skin complications that we do not commonly see in the UK, such as sun burns, fungal infections and hyperpigmentation. Dr Anwar Al Hammadi, Director of Dermatology, has previously said, “The most common skin problems can be divided into age groups. Among children aged 2 to 12 years it's eczema, viral and fungal infections; in teenagers it's acne and hormone-related problems and in adults the range is wider and includes skin discolouration, viral and fungal infections and hair loss." 2 These are due to the differences in climates and sun exposure in the UAE in comparison to the UK. It is also a large consequence of lack of adequate precautions from the sun. The number of patients with these conditions increased drastically as the weather got warmer and from clinicians experience, they are much more busy in the summer months.

Objective 2:
General practice provision in the UK and UAE has some similarities and some major differences, most of which can be traced back to the overall healthcare systems in the two countries. In the UK, there is the publicly funded National Health Service who guide individual general practice clinics which operate as individual businesses. This is similar to the UAE where, again, individual businesses run private general practice clinics and follow local Ministry of Health guidelines. In both countries, clinics are given the freedom to run their businesses how they see fit and make most decisions by themselves. However, they are both periodically audited and reviewed on their premises and practice by a higher health authority who judge these clinics to an overall standard of care.

Where general practice starts to differ between the two countries is related to secondary care referrals. The UK has general practitioners as the first-line healthcare professionals to see a patient (unless the patient is so unwell they go directly to A&E) and they will assess the patient’s problem. If the GP feels that further assessment by a specialist is required, they will follow an approved referral pathway to the local hospital or tertiary centre as required and the patient receives an appointment from the speciality department.

This differs from the UAE where medical centres or clinics include some specialists as well as general practitioners. These specialist doctors conduct outpatient clinics at the general practice clinics, meaning patients can sometimes bypass the GP if they have a specific problem which can be addressed by a dermatologist or paediatrician, for example. In terms of referrals, there is also a difference as clinicians are not obliged to refer to a certain hospital as there aren't any pre-established links between a private medical centre and private hospital. This means they have the freedom to refer to individual doctors or hospitals where the patient will receive the best care.

Lastly, a huge differentiating factor between general practice in the UK and the UAE is cost. In the UK, attending a NHS general practice appointment is completely free and seen as a basic right to access healthcare. In the UAE, a government general practice appointment is not accessible to non-locals who make up a large proportion of the population. Instead they turn to the private sector who offer their services at a cost. Prices of a single GP consultation can vary greatly in the UAE, ranging from 35 AED (7.67 GBP) all the way up to 300 AED (65.71 GBP).

Objective 3:
Dermatological conditions can have detrimental health consequences particularly its effects on mental health. I have noticed that it is important to tackle the physical and mental health of patients who present with dermatological conditions. A lot of the skin diseases are visible and can cause insecurity for the patient such as acne, psoriasis and hyperpigmentation.
One of the many skin conditions that have stigma surrounding them are hyperpigmentation. There are negative connotations with hyperpigmentation and darker skin tones amongst many of the population leading to them seeking potentially harmful Lightening and bleaching remedies. These views are particularly common amongt the South Asian and African countries. This is due to historical colonization that has lasting effects to this day.

Another stigma that I have encountered is related to acne. There are many misconceptions surrounding the causes of acne including poor hygiene and bad diet. Although these factors can be contributing to acne, they are no necessarily always a direct cause and association with acne. There are many other causes to consider including hormonal imbalances and genetic predisposition.

Lastly, psoriasis is amongst the largely stigmatized conditions. Despite it being one of the most common skin conditions globally, patients still suffer a higher degree of social stigma. This can have detrimental effects on their quality of life and also leads to under presenting of these patients to dermatology clinics. In addition to the effects on mental health, social stigma related to dermatological conditions can affect patient's job prospects, relationships and overall contributing to a higher disease burden

Objective 4:
Attending a dermatology clinic during our elective was extremely beneficial to our medical knowledge as me and my clinical partner Reem have not previously been able to see Dermatology in clinical practice due to the pandemic. It was useful to put our learning from more than a year ago into practice and see the conditons we have read about in practice. As dermatology is a sensory speciality where diagnoses are made through looking and feeling, it was immeasurably valuable to see skin conditions in person and be able to examine patients (with the appropriate PPE).

Furthermore, other aspects of clinical practice were highlighted to me when sitting in a dermatology clinic. For example, prescribing in dermatology involves steroid creams and lots of emollients. Though we have practiced counselling patients on using these medications to treat common conditions like eczema or psoriasis in an OSCE scenario, it is very helpful to see how an experienced dermatologist approaches this and speaks to his patients. It was also useful to see the way dermatological appointments are documented, particularly going forward as junior doctors where documenting will be a big part of our day-to-day jobs.