ELECTIVE (SSC5c) REPORT (1200 words)

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

Student Number: 110028273

Medical Elective Report

I completed my medical elective at Columbia Asia Hospital in the city of Bangalore in Southern India. This is a private, multispecialty hospital with 90 beds where I had the opportunity to spend 2 weeks sha dowing a consultant rheumatologist (Dr. Sharath Kumar), 2 weeks in accident and emergency (under Dr. Lakshmi Gangadharan) and 2 weeks in the department of internal medicine (under Dr. Narendra Prasad).

1. What are the most common medical conditions treated in Bangalore ? How does this compare with the UK?

4. Gain a flavour of tropical medicine and explore how it is practiced in India.

Healthcare in India has a number of fundamental differences compared to that of the UK. For example, issues such as infant and maternal mortality, malnutrition, poor sanitation and poor drinking water are quite commonly encountered. In addition to these poverty-related problems, India also faces a multitude of tropical infectious diseases mainly attributed to its climate. Notably, I was able to appreciate the increased prevalence of gastro-intestinal infections due to poor sanitation and difficulties in food storage due to the hot and humid climate. During my time at Columbia Asia, I was able to develop a good understanding of how routine management of malaria, dengue fever and TB are conducted – an aspect that is predominantly textbook-based in the UK. I learnt to appreciate the different types of fever, the common associated symptoms and how to thoroughly investigate a fever of unknown origin. I was especially surprised at the frequency with which doctors identified non-pulmonary cases of tuberculosis and I learnt a lot about these varied manifestations. Similarly, during my time in the emergency department, I

witnessed a significantly greater number of road traffic accidents (RTAs) compared to that seen in UK hospitals. This is probably due to the bad condition of the roads, vehicles and the high number of two-wheeler traffic. This made me reflect on the importance of strict and effective traffic rules and the great benefit they bring to public health. Indeed a common theme I identified throughout my placement was the emphasis on acute or curative medicine rather than preventative medicine. Although prevention campaigns have been undertaken in India with much success, still more importance must be put on primary prevention strategies.

As I was based at a private hospital catering for a relatively wealthy population, I equally encountered more familiar problems to the UK doctor such as obesity, cardiovascular disease and cancer. Overall, much time in outpatient clinics was spent educating patients with hypertension or diabetes on the need to modify their lifestyle and adhere to drug treatment. The main difficulty was in tailoring this advice according to local health beliefs, dietary habits and exercise tendencies.

2. How is healthcare organized and delivered in private hospitals in India?

Good healthcare in India is only really found in private hospitals and several networks of such hospitals exist throughout the county. Unlike the UK, the public sector is very limited in resources causing high waiting times, inconvenient operating hours and can also be more difficult to access. On the whole, the quality of care is relatively poor in these government institutions. Hence, people are forced to pay directly from their pocket in order to receive the best care. It was interesting to see that patients pay for their outpatient consultation before arrival. Each test, investigation or drug that is prescribed must be paid for individually by the patient and in many ways, hospitals seemed like places of business. Therefore, very anxious patients would keep returning to the lab to get unnecessary blood tests and scans repeated. Nevertheless, clinical medicine is practiced in a very similar way in both countries: there is a considerable emphasis on good history taking and examination. The most recent studies and

research is considered and implemented in treatment strategies. In some cases, precise management protocols from NICE or American equivalents are followed closely. Furthermore, most of the instruments and medical appliances used were the same as those I have used in the UK, making practical procedures quite familiar territory.

Nevertheless, I did note a few important differences in consultation style. It was very apparent to me that patients have a very high regard for their doctor's opinions and create a doctor-centred medical interview setting. This redirects the focus of the consultation from what the patient has to say, making them say less about their history and ask fewer questions. The overall result from a medical perspective is a need for a different range of communication skills. This seemed to increase the importance of investigations as well as clinical judgement in the process of decision making and giving patient advice. Although certain skills mentioned above may have to be tailored to the Indian setting, attributes such as good team working with the multidisciplinary team of nurses, physiotherapists, dieticians, customer care staff and other doctors is, as in the UK, crucial to effective healthcare provision.

An aspect I found particularly interesting was the use of combination tablets, brand names and the influence of pharmaceutical representatives. Naturally, in the privatised nature of Columbia Asia, the doctor prescribes a specific brand name for a particular drug that the patient will buy. There is therefore considerable competition between drug companies producing the same drug (under different names) and this causes a number of positive and negative consequences. From my experience, this allows for more innovation in drug composition and the use of combination pills, hence reducing the number of tablets consumed daily. On the other hand, it creates a grey area between the pharmaceutical companies and the doctors where the doctors may be influenced by reasons beyond the scientific evidence. With the NHS moving towards a partially privatised structure, I found this experience highly valuable in understanding the other side of the coin.

3. Develop a better understanding of rheumatological disorders and explore how they are managed in India compared to the UK.

I am very pleased with my time with the rheumatology consultant. I gained a significant amount of knowledge and experience in identifying clinical signs; had the opportunity to watch joint ultrasound scans, aspirations and injections; and also did some research into the current diagnostic criteria of common rheumatological diseases. I saw a significant number of rheumatoid arthritis, gout, psoriatic arthritis, paediatric arthritis and ankylosing spondylitis patients as well as performing specific case studies on two patients – one with systemic lupus erythematosus and the second with mixed connective tissue disorder. I was able to analyse the various journeys these two patients had gone through, having met various specialist and performed a range of tests before finally being admitted and seen by a rheumatologist. I will never forget the drastic improvements they experienced once they were started on appropriate therapy. The main disease modifying agents used in India are methotrexate, hydroxychloroquine, sulfasalazine and leflunomide. The use of monoclonal antibodies is still very new and expensive for this setting (where patients will directly fund their own drugs).