

## **ELECTIVE (SSC5c) REPORT (1200 words)**

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

**Apollo hospitals are world renowned for being of a high quality of care, but also offering affordable Indian people (as well as those around the world) immediate quality care. There is a health service in India (India Health Service (IHS)) that offers services free at the point of use, much like the NHS. This allows free care for all, including those who cannot afford to pay for themselves. However, there is a lack of funding and resources available to the IHS meaning the quality can vary greatly. There is also medical council, however it is rare for a patient to be able to take their case to them, given a cultural difference in expectations of the health service.**

**Apollo hospitals (a well accomplished private healthcare provider), offer a very high standard of care, very fast. There is a price for this, however it is surprisingly affordable as compared to costs incurred by the NHS. This doesn't necessarily mean its affordable for the average Indian, however it is surprisingly affordable for a relatively large proportion of the population. This reflects also how well the Indian private healthcare sector has managed to efficiently and affordably offer high quality care, at the point of need – for example, elective surgeries can be offered within days to weeks as opposed to months.**

**During my time in Apollo, I shadowed Dr. Magesh, a consultant geriatric doctor – notably, the only one within the hospital. Unfortunately, geriatric medicine hasn't taken off in India, even within the private healthcare setting. There is a difference in healthcare problems as compared to more developed countries, such as the UK. The Indian population is ageing, nevertheless there is still very high mortality rates for diseases of the young. For example, India has the highest child mortality rate in the world, and particularly high death rates for road traffic accidents and tuberculosis – two preventable causes of death. There is health promotion for drink driving and recognising tuberculosis, but these causes of death remain high for the time being.**

**Health education in India has lagged behind much of the world (as has many parts of Asia) – there is a strong appreciation for heart attacks and heart disease now in India, but stroke is poorly understood, and someone suffering an acute stroke won't be rushed to hospital by family as they would with chest pain. For these reasons, it seems geriatric medicine may take a while to properly become a growing specialty in India – Hopefully mortality for communicable and preventable disease will fall in the coming years and geriatric medicine will become more prominent, improving the standard of care for older adults, and increasing the efficiency and cost effectiveness of healthcare. Most of my time was spent in clinic with the consultant geriatrician. The vast majority of patients presented after a health check (a £90 charge for a battery of tests including general bloods, mammography/PSA, ENT, dental and cardiac consultation etc). Most of these patients purchased a health check when presenting for a symptom.**

**I learnt that cultural and social factors account for vast differences as compared to the UK in terms of the whole process of patients presenting, as well as the patient-doctor interaction and compliance of the patient with the doctors prescription and/or recommendations. To start with, help seeking behaviors (more notably for men) in India are poor relative to the UK (excluding mental health to some extent). Acknowledging there is a health problem is something that many men find difficult, and many of them must be prompted and/or forced to make the presentation to the doctor by their loved**

ones. This is mainly due to the stereotypical male role- not wanting to show any weakness or admitting the need for help. Once the patient presents, accepting appropriate treatment can be another difficult step in the help seeking process, for the aforementioned reasons.

Another difference I noted was how prevalent anxiety during consultations were. This is also due to cultural reasons – people fear that being labeled with a disease will make them look weak to their social counterparts, and stigma is another reason – for example, being labeled with a mental health problem. Another reason for the anxiety is financially related – many of these patients use their savings for health checks in hope of reassurance, however worrying about the possibility of being giving a bad diagnosis that could either be costly or unaffordable – this is a growing problem, it is not uncommon for people to borrow money from loan sharks and ultimately be unable to pay the interest, and commit suicide. Because of this, doctors sometimes refer them for treatment in government hospitals to avoid this problems, but this is another source of anxiety for an uneducated person who may be unsure how to progress through the complex system of triage and referral as found in Indian government hospitals.

It is beyond the scope of this reflection to talk about all the diseases and consultations I encountered, however I will give mention to some interesting things I learnt about geriatric care in India. Vitamin D deficiency is a common problem in the UK, especially within the South-Asian population. Paradoxically, in the sunny state of Tamil Nadu, vitamin D deficiency was also extremely common – over 75% of healthy Indians. This is important given the high rates of osteoporosis. Osteoporotic fractures carry a high burden of disease in terms of morbidity and mortality, but also costs on the healthcare system – many thousands of pounds are spent on hip replacements for example, whilst vitamin D, calcium supplements and bisphosphonates are relatively cheap. Reducing osteoporosis in older adults is a major public health issue for which there is still a lack of appreciation amongst healthcare professionals (besides geriatricians) and older adults alike.

Dementia is another big issue in India, and highlights some of the social issues that encompass the cultural and economic problems in caring in India. Dementia is a poorly understood disease, which results in families being divided and sufferers becoming social outcasts, more so than that of western countries. Given India's conservative culture, disinhibition (such as sexual) and behavioural and psychiatric symptoms of dementia are not only distressing for family, but also causes stigma within communities against sufferers. Families also sometimes struggle to care for their loved ones with dementia – typically the adults of the family must go to work to feed and provide for their family, making long term caring very difficult. Fortunately, many families are extended and there are family members at the disposal for this purpose. However, as India modernizes and families move to more urban areas, the extended family breaks down and nucleated families are becoming increasingly common worsening the carer burden in India.

My time during the elective has been fruitful, as I have reinforced much of my knowledge on the subject, but have also been given opportunity to practice seeing patients, and taking brief histories and examinations to screen for red flags for sinister disease. I appreciate some more of the socio and psychological underpinnings of consultations and presentations of patients that are important to appreciate when negotiating a label and management of a disease that may be diagnosed. My time in India will be remembered throughout my career, and I'd like to give special thanks to Dr. Magesh for teaching me much about geriatric care and the Indian healthcare system, and the differences in healthcare.