GENERAL MEDICINE

Joshua Rubenstein: Elective Report

Compare and contrast the patient demographic and the care that patients receive at the Tibetan Delek Hospital vs. Tanda medical college

My main placement was at the Tibetan Delek Hospital. This hospital is a small, charity hospital run by an Italian non-government organisation. The hospital was founded in the 1970s in order to provide care for the Tibetan population of Dharamsala, who had fled to the region when the Chinese Army invaded Tibet in 1959. Various Tibetan 'colonies' were established in India, and thus patients come from nearby Tibetan communities in the state of Himachal Pradesh, as well as neighbouring Jammu and Kashmir. Roughly 80% of patients are Tibetan; the remaining patients are Indian locals and foreigners. The hospital is currently run by three Tibetan medical officers, who rotate on-call shifts every three days. They practice as generalists, and mainly see general medical cases and some obstetrics and paediatrics. Additionally, an Italian doctor who represents the non-governmental organization that funds the Delek, and another Tibetan doctor, collect data on the hospital's tuberculosis patients, as well as contributing to ward rounds and case discussions. The Chief Medical Officer, who also happens to be the chief physician of His Holiness the Dalai Lama, is often absent. However, when he is in Dharamsala he runs general medicine clinics and performs upper gastro-intestinal endoscopy lists.

The Dr. Rajainda Prasad Medical College at Tanda (RPMC) was established in 1999, and is about 20 km from the Delek Hospital. With 500 beds it is considered to be a large hospital. I was fortunate to be introduced to one of RPMC's professors of medical education, and so I was given the opporuntity to spend the day at the hospital. At this hospital, I saw only Indian patients on the male medical wards, although there must have been other, non-Indian patients at the hospital – the Delek refers many patients to Tanda. The team of doctors at RPMC were all Indian, and they had a structure to their team very similar to that of a UK general medical team - with doctors in roles equivalent to the British house officer, senior house officer, registrar and consultant levels.

Both hospitals had an organised system of monitoring patients through ward rounds; documenting patient progress by writing in patient notes; referral to other teams (in the case of Tanda) and other hospitals (in the case of the Delek hospital) by letter.

The resources at Tanda were better than Delek. Delek lacked particular equipment that we in the UK would regard as essential – e.g. ABG machine, ventilator, ITU – Tanda had these. Additionally, the Delek had no specialist teams, being a small, general hospital. Therefore patients had to go elsewhere for surgery, high risk obstetrics, and some diagnostic servies.

However, Tanda's superior resources were offset by the fact that Tanda was extremely busy: Tanda is a government hospital and therefore care is free, for the most part. Given that the population of India is financially poor, patients flock to it, and therefore its resources and staff are hugely overstretched (for example, patients had to literally share beds). Therefore, despite their better equipment, the doctors

and nurses at Tanda didn't have time to fully attend to patients' needs. This wasn't the case at Delek: fewer patient numbers means that although the doctors were busy, they were able to spend an adequate amounts of time attending to pts' care needs.

Finally, I noted that there was better hygiene at the Delek, with alcohol gel around the hospital; this was conspicuously absent at Tanda, as was hand-washing between pts.

Describe the pattern of disease in the Tibetan population seen at the Delek hospital, and discuss this within the context of global health

Diseases seen at the Delek can be considered to be a mixture of 'Western' diseases and infective disease commonly associated with less economically developed countries.

The former are caused by unhealthy lifestyles with people living longer than previously – such as cardiac failure, hypertension and COPD –as well as polluted urban environments – such as asthma, and again, COPD. The WHO estimated in 2004 that 235 million people had asthma and 60 million people had COPD. The WHO's Chronic Respiratory Diseases Programme aims for 'better surveillance' of chronic respiratory diseases, primary prevention and improving care for those diagnosed with the disease.

More minor infective diseases seen at the Delek included everyday coughs, colds and sore throats – which in the UK would have been dealt with by general practitioners; as well as infective diarrhea due to poor water sanitation. According to the WHO, diarrhea is responsible for 4% of deaths world-world each year – however, children make up the bulk of mortality from diarrhea, and I did not see many children with diarrhea at the Delek[1]

However, two more serious infective diseases – which are the two most pressing diseases to affect the Tibetan refugee community in India – are tuberculosis (TB) and hepatitis B. The ways in which these diseases have spread amongst the Tibetan community are complicated, and I cannot hope to do these subjects full justice in a short word count; therefore, below is a short and simplified summary from a lecture by Dr. Kuncho, who works at the Delek.[2]

TB spreads via droplet transmission. It infects people, but may lie dormant for many years until the host is immunosuppressed. The Tibetan refugee community in India has been exposed to factors that both increase the likelihood of droplet transmission – such as scarcity of shelter results in people sharing rooms; an infected person can therefore infect those who he is living with – and those that reduce the strength of the immune system – such as malnutrition in the early years of Tibet's occupation by China in 1959. Additional psychosocial factors – a need to develop a 'mental and physical resilience' in order to survive the adverse circumstances that refugees find themselves – and a need to prioritise other things in life as a refugee than one's health (food, shelter, work, etc.) – can lead to late presentation. In turn, late presentation increases the likelihood of transmission, as well as the severity of the disease.

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[1] http://www.who.int/water_sanitation_health/diseases/diarrhoea/en/

[2] Source: Dr. Kuncho, one of the TB/public helth doctors at the Delek

Factors that perpetuate TB transmission include:

- the migratory nature of the Tibetan community in India: for example, some members of the Tibetan population of Dharamsala move in the winter in order to find work elsewhere. This leads to the increased spread TB; makes DOTS (directly observed treatment, short-course) more difficult; and leads to poor adherence to treatment. The latter two sequelae of the Tibetan migratory lifestyle have contributed to the development and spread of multidrug resistant and extremely drug resistant TB in the Tibetan population.

- Newly-arrived refugees, as well as orphaned children or children from poor families – are educated in boarding schools. Additionally, a significant proportion of the Tibetan population live in monasteries. Such communal living arrangements, with shared dormitories, leads to increased likelihood of droplet transmission.

On the world stage, TB is mainly a problem where HIV/AIDS is prevalent – i.e. Subsaharan Africa. However, HIV/AIDS is not a problem in the Tibetan refugee population of India, and it is hoped that this remains the case. A rising number of cases of TB is being reported in South East Asia. [3]

Hepatitis B is the other main threat to the Tibetan population in India. Hepatitis B has been endemic amongst the populations of the Far East and South East Asia for years, according to Dr. Kuncho. Transmission occurs vertically, from mother to foetus, or horizontally. Horizontal transmission can be sexual. However, the hepatitis B virus is resilient outside the human body, able to survive for up to 7 days. Therefore transmission easily occurs e.g. between people living in the same house, for example, through the sharing of towels and between school children during play.

The problem of hepatitis B infection has been addressed in China and Taiwan with vaccination programmes. However, the displacement of the Tibetan population made it difficult to establish a vaccination programme amongst Tibetans. Only recently has the Tibetan government-in-exile established one for newborns.

Describe the pattern of health provision in India and contrast it with the UK.

Indian medical care is a combination of public and private provision. There are large public government hospitals. Here, basic healthcare is free, although some of the more advanced facilities and surgeries are not (e.g. ITU at Tanda). Private provision can be 'for profit' – run, for instance, by chains or brands of hospitals – for non-profit, which can be run by non-government organizations. [4] The Delek hospital, where I did my placement, is an example of the latter. This is to be contrasted with the UK, where the contribution of non-profit healthcare providers towards total healthcare is much, much less than in India, due to the quality of the National Health Service. I found it interesting that, despite the increased role of the private sphere in Indian healthcare, health insurance is extremely uncommon. Of course, I

[3] http://www.who.int/mediacentre/factsheets/fs104/en/
[4] http://www.cehat.org/publications/pb10a53.htm

was expecting this to be the case amongst the poorer parts of the Indian population; however, from discussion with one of my colleagues who has completed his elective placement at a private, for-profit hospital in neighbouring Punjab, health insurance seems to be uncommon even amongst richer people in Indian society.

At the Delek hospital, there was an interface between non-profit and for-profit private healthcare providers – patients here would be referred to the diagnostic services in for-profit healthcare centres when such facilities were lacking at the Delek. In the UK, this doesn't arise –charitable healthcare groups tend to be involved in nursing care provision – such as Macmillan palliative care nurses – rather than diagnosis.

Finally, another large contrast between the Indian and the UK system is that Indian hospital outpatient departments can act as first point of contact between the patient and the healthcare system. This is not the case in the UK, where a referral by a general practitioner to the hospital is required.

In the UK, Asians are the most numerous ethnic group. Most members of this group understand Hindi/Urdu, the lingua franca of the Indian subcontinent. I have frequently witnessed scenarios in UK hospitals where being able to speak this language would be useful. Moreover, from a personal point of view, my mother and her family are Indian, and thus the language is part of my cultural heritage. I therefore view this elective as an incentive to learn, and an opportunity to practice, Hindi. I shall reflect on how knowledge of the language has affected my experiences on my elective.

The Delek Hospital is a hospital for the Tibetan community, and therefore most consultations were carried out in the Tibetan language. However, there were a few Indian patients, and these consultations were carried out in Hindi. Having learnt some basic Hindi, which included some medical phrases, I was able to get the gist of these consultations.

I derived most benefit from speaking Hindi outside the hospital. I stayed with Indian families for four of the three weeks I was in India. Although these families were fluent in English, their domestic staff - a common luxury amongst middle-class Indians - were not. I was therefore better able to speak with domestic staff. Dharamsala - in particular, McLeod Ganj (the part of the area where I was staying) - is a popular tourist destination for foreigners. Therefore the locals had, on average, better English than the Indians that I met in Delhi and Mumbai. However, I feel that I was able to build rapport with the locals by communicating with them in their local language. Finally, some locals couldn't speak English - such as a few taxi drivers or some of the staff at the hotel I stayed in - and therefore speaking Hindi with them was an important survival tool!