GENERAL MEDICINE

ELECTIVE REPORT

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DAVID WOODS

What medical conditions are common amongst inpatients in the hospital in Mumbai and Jalandhar? How does this differ to my experiences in East London?

During my time in the general medical wards and intensive care, roughly half of the patients I saw had presented with an infectious disease including viral, bacterial, protozoal, parasitic, fungal and worm infections. The commonest diseases I observed were viral haemorrhagic fevers, malaria, tuberculosis and viral hepatitis. As a result of the prevalence of infectious diseases, there was not a day on the intensive care unit in Mumbai when a patient was not admitted with Guillain-Barré Syndrome, many requiring tracheotomy and ventilation.

This largely contrasts dramatically with the UK, where such conditions are rarely seen and then primarily in patients returning from travel abroad. However, I have more experience of tuberculosis than the Indian doctors expected me to have and I attribute this to studying in hospitals in East London, with its highly multicultural communities.

Presentations of tuberculosis and viral hepatitides differed significantly from the cases I have seen previously in the UK. It was explained to me that the vast majority of Indians are exposed to *M. tuberculosis* from a very early age, which causes a self-limiting infection in immune-competent individuals. Therefore, primary tuberculosis is relatively uncommon in India – a more common presentation being reactivation of *M. tuberculosis* during periods of immunocompromise. For example I saw two cases of Pott's disease of the spine, a case of peritoneal tuberculosis, and a number of cases of military tuberculosis. Regarding the viral hepatitides, in much the same way that chicken pox is all but ubiquitous in childhood in the UK, hepatitis A is common amongst Indian children and it is therefore highly unusual to see it in the adult population. Rather, the prevalent infective agent is the hepatitis E virus. Because of the significant risk of hepatitis E to pregnant women and their babies, females of childbearing age presenting with symptoms suspicious of viral hepatitis are monitored very closely and looked after in a high dependency unit, where available.

The World Health Organisation's Directly Observed Therapy (DOT) for treatment of tuberculosis was used in both the hospitals I attended. This affords the patient free quadruple therapy anti-tuberculosis medications provided they attend the outpatient department to take their medications. Publicity for DOT is visible throughout the areas of India in which I travelled, for example on windscreen stickers on taxis and rickshaws, and on advertising hoardings. Interestingly, although I was informed that multi-drug resistant (MDR) tuberculosis is increasingly common in India, all patients I encountered were commenced initially on the standard quadruple therapy we use in the UK. Polio, extremely rare in the West since the development of polio vaccinations in the 1950s, is still seen in India, albeit not as frequently as other

infectious diseases. In both the hospitals I attended, I saw posters requiring physicians to report any cases of acute flaccid paralysis in patients under the age of 16 years to a central authority, in an effort to combat polio.

Aside from infectious diseases, the commonest presentations included diabetes mellitus and its complications, alcoholic liver disease and, on the intensive care unit, hepatic encephalopathy particularly, and respiratory diseases including both COPD and asthma. Interestingly, I noted that at KEM hospital, alcohol related diseases were more prevalent, whereas at PIMS, obesity-related disorders took over. I would propose that this reflects the rather different populations the two hospitals serve.

Discuss the provision of healthcare in India. Does this vary between the government hospital in Mumbai and the private hospital in Jalandhar? How does this compare to the National Health Service as it currently is?

The system of healthcare in India could not be more different to the NHS. At a time when so much change is threatened to the NHS in the UK, observing the healthcare system at work in India served as a fitting reminder of how vital it is that we maintain the NHS as a fully public system providing free, uniformly high and closely regulated healthcare to every person in the UK.

There is no universal system of general practice or family medicine and because of this, there is no single doctor in India who either knows a patient or at least has access to the entirety of a patient's medical notes. I realised that whilst many patients, particularly some of the poorer ones I saw in Mumbai, avoid presenting to a healthcare practitioner until their illness is significantly advances, many patients display quite extreme healthcare-seeking behaviour. Thus it is not uncommon for a patient to consult a large number of doctors, including ayurvedic practitioners, allopathic doctors (as Western medicine is referred to) and village 'doctors' with no qualifications. The hospital doctors assume that the history they can elicit will be far from complete and they are aware that patients will pick and chose which advice to follow and which medications to take. The result is that histories often do not quite add up and compliance with management plans is appalling.

The other factor that is significantly different is funding. Whilst it was fantastic to see that the vast majority of medications at KEM, a government hospital, were prescribed free of charge to the patient – meaning both that the patient only paid hospital charges and that the doctors had significantly more freedom over their prescriptions than we do in the UK – this is far from the norm, even in other government hospitals. In the UK I have never seen a patient denied vital healthcare because of their financial situation, but I saw this far too frequently in India. One young child with a patent ductus arteriosus and failure to thrive required admission to allow adequate parenteral nutrition to prepare her for a simple operation to repair the duct. However, upon finding out the cost of admission the parents refused and the doctor was forced to simply give the

parents nutritional advice and tell them to return if the child deteriorated. A second patient, a 16 year old boy, was admitted with a pneumothorax secondary to pulmonary tuberculosis. The lung failed to inflate with a chest drain due to the underlying disease. He required a thoracotomy with pleurodesis and or resection of the diseased lung tissue, but his family was unable to afford the operation. Therefore he remained as an inpatient from my first week at the hospital to when I left for the UK, with a chest tube in situ and a lung less than 50% inflated.

How do consultations in India compare to those in the UK? We have been taught a patient-centred model, specifically the Calgary-Cambridge Model. Is a similar system followed in India? Are there any particular difficulties faced by the clinicians?

Outpatient consultations in the private hospital in Jalandhar broadly followed the same format as a consultation in the UK, with a brief history followed by an examination. However, I noted that due to the frequently very large number of patients needing to be seen in each session, the time available for each consultation was very short. As a result, the physicians often relied on spot diagnoses, forming an impression within a few lines of the history and confirming it a brief examination. The medical students at KEM were taught to elicit extremely thorough histories and the clinical teaching for students and junior doctors was excellent at both hospitals, with great focus on clinical signs. Thus it is apparent that the ability to so rapidly form a diagnosis is a skill the physicians are able to –and indeed must – acquire because of the large volume of patients they care for in a short period of time.

Many unique difficulties are faced by the physicians during their consultations. For example in one clinic I attended, three physicians saw patients simultaneously, in the same room. A continuous stream of patients came in through the open door, and none of the patients were afforded any privacy. There was also continuous pressure from the waiting patients to wrap up the consultation and move on to the next.

It was highly interesting to observe the dynamic of consultations, in which a patient's relatives were also present – in particular when a female patient was accompanied by her husband. I have seen this frequently in our hospitals with South East Asian patients. The perceived difficulties this can sometimes cause in the UK are often attributed to a language barrier, with the husband being assumed to speak more English. However in India, during consultations conducted in the local language, the same dynamic could be observed, with the husband providing the history and asking the questions, rather than the patient. Additionally, in the many of the consultations I observed, it was the patient who directed the consultation, rather than the physician. When these two observations are considered together, it is very easy to understand the difficulties which can sometimes be faced when consulting South East Asian patients in the UK.

Further explore paediatrics as a potential career in a setting outside the UK. What experiences in India have encouraged me to pursue a career in paediatrics?

I was able to gain experience of paediatrics both in the emergency department and in the paediatric department at PIMS. However, although I encountered paediatric patients on the intensive care unit at KEM, I did not spend any time with the paediatric team. I was also fortunate enough to be able to spend some time in the neonatal intensive care unit – a subspecialty which has particularly interested me, and in which I did my SSC5a. Thus I feel I was able to attain a reasonable insight into paediatrics in India.

The medical conditions I saw were different to those I have seen on paediatric wards in the UK and therefore some of the diseases that have sparked my interest in paediatrics were not part of my experiences in India. However, the same general aspects I have enjoyed about paediatrics in the UK were again apparent at PIMS: primarily that I find I get on very well with paediatricians and I greatly enjoy the challenges working with children and young people and derive a lot of pleasure from doing so.

Having spent time doing paediatrics whilst in India, I am still feel I would be very happy pursuing a career in the specialty. However, I still am not ready to rule out some of the other specialties that appeal to me. Therefore, I think it is very important that I discuss careers early on during my FY1 year with my Academic Supervisor and utilise the resources available to me, particularly taster days, to enable me to decide which core training I want to apply for during my FY2 year.