GENERAL MEDICINE

ELECTIVE REPORT
by Amira Shamsuddin

**CHRISTIAN MEDICAL COLLEGE, VELLORE, INDIA**

My ideas of India has somewhat been shaped by the years of watching Hindi films with my mother when I was a child. I was aspired to experience the health care system in a country that is so vibrant and colourful, with such strong cultural and religious heritage and so much economic potential. However, before I boarded my flight at London Heathrow Airport, I stashed away my naiveté and focused on the facts. Despite having a large population and such promising economic potential, India has one of the highest rates of poverty in the world. Poverty brings in a lot of issues with health, be it the pattern of disease or the pattern of health provision. From here, my objectives as to what I wanted to achieve from my short elective period at Christian Medical College were set: to learn about the prevalent diseases in India and how health care is provided to and accessed by the citizens, especially the poor.

I had the opportunity to experience a few days of General Medicine in the main CMC Hospital as well as a few days of Community Medicine in the Community Health Department (CHAD). In one of the outpatient clinics, I had an extensive discussion with one of the doctors. He pointed out that India has four main health issues. The first one is the demographics. To provide health care to a population of 1.2 billion is, to put it rather simply, not easy. Doctors at CMC see each day a total of 5,500 patients in the outpatient clinics. That is more than three times the number of patients seen in the outpatient clinics of a UK hospital. I was in awe to see that doctors and other health care professionals here continued their work and saw patients without any hesitations or complaints. Catering to the needs of patients from different communities is also a challenge. Patients speak in different languages, some in Tamil, some in Hindi and some in languages I was not even aware existed. The doctors I have had the opportunity to work with all communicated with me and the other health care professionals in English. However, when they spoke to patients, they would use the language the patients used. One of the doctors did not grow up speaking Tamil or Hindi and so learnt both the languages when he started working in CMC. This is absolutely commendable and shows true effort at providing the best care to patients. After all, how are we as health care professionals going to understand a disease if we do not understand the patient first?

The extremely large number of population also poses a problem with discrepancies in health care provision throughout the country. Health promotion (i.e. family planning, smoking cessation etc.) is better in some parts of the country and scarce in others. In the last 10 years, some Indian states have seen a population growth of 3-4%. This is excellent and rivals that of developed Western countries. However, some states have seen a rise of up to 25% in the population within the last 10 years. There are many factors as to why there is such a huge discrepancy but it all boils down to public education. Where the literacy rate is high, people are more likely

to understand and benefit from health promotion. Conversely, the lower the literacy rate, the less likely it is for any health changes to be implemented by the people. All is not lost, though. During my stint with the Mobile Clinic at CHAD, I was enlightened to learn that families are given incentives to undergo sterilization after the birth of their second child. This provides the motivation and the means for citizens, especially the poor, to be a part of the health promotion benefits.

The second health issue in India is the incidence of non-communicable diseases at a younger age compared to the rest of the world. Health care professionals are beginning to see essential hypertension, type 2 diabetes mellitus and even cancers in patients as young as in their early 30s. Again, I do believe that, whilst the cause is multifactorial, lack of patient education and access to health care remains on the top of the list. Chronic diseases require regular follow-up to optimize care. The Mobile Clinic set up by CHAD is an excellent programme that brings the care of chronic diseases to impoverished areas. The amount that patients pay for medical care depends on their socioeconomic status; some patients pay more, some pay less and some receive free medical care. In an ideal world, health care would be free to all but India is, at the moment, still a way away from ideals. However, I think this system, where citizens are charged for medical care based on their socioeconomic status is a step towards health care equality and deserves applause.

The third health issue is the incidence of communicable diseases such as tuberculosis, leprosy and malaria. To quote the Oxford Handbook of Clinical Medicine, *"Tuberculosis is one reason why the poor stay poor -- and then die"*. Where there is poverty, malnutrition and overcrowding, there will be tuberculosis. However, I learned that, similar to the UK, India is on the right track at handling the disease by incorporating the DOT (directly observed therapy) system for the treatment of tuberculosis. This is desirable and will help achieve the World Health Organization's (WHO) plan to treat 50 million people over 10 years and to reduce therapy duration to 8 weeks. In an outpatient clinic I attended, I had the invaluable opportunity to see a patient with leprosy. Leprosy is one of the diseases that you learn about in books but are unlikely to see first-hand in the UK. Therefore, to be able to learn about the disease in a clinical setting was very rewarding. Although leprosy still affects millions of people worldwide, the introduction of dapsone, along with WHO elimination campaign, have resulted in the decrease of prevalence from 11% to 4/10,000 in parts of India.

The fourth health issue is maternal mortality and childhood vaccinations. Poorer citizens are at a higher risk of maternal mortality from lack of access to antenatal care and consequently failure to identify high-risk groups. They are also less likely to complete the vaccinations for their children. I was very happy to learn that this is being managed by the CMC through the aforementioned Mobile Clinic and CHAD. Pregnant women are seen in the Mobile Clinic at their local villages whilst high risk ones are referred to CHAD. The women are also encouraged to give birth in hospital institutions to ensure safe labour as well as offered incentives to complete the vaccinations for their children. Overall, my experience at CMC has been rewarding. I am well impressed at the computer systems used in the hospital, which is comparable

to those used in the UK. However, I am aware that CMC is an exception and that most of the hospitals throughout India remain deprived of the basic necessities to provide quality medical care to patients. I believe the health care system in the country has some problems, however, I also believe that the system has unquestionable potential and can be improved.

## HOSPITAL KUALA LUMPUR, MALAYSIA

I spent another three weeks at the Accidents & Emergency Department in Hospital Kuala Lumpur (HKL) for my medical electives. My main objective for the short medical stint is to explore the health care system in Malaysia as preparation for practice as I have decided to continue my medical training here. Although I am Malaysian I have never experienced the health care system from a medical professional perspective. My second objective is to compare the pattern of health care provision in Malaysia to that in the UK. I have trained as a medical student in the UK for five years and so am familiar with the system there. I was excited to see and learn from the similarities and also the differences between the two health care systems.

I learned that the A&E department in HKL is divided into green zone for minor cases, yellow zone for major cases and red zone for cases requiring resuscitation. There is also a designated 'asthma zone' within the area. I witnessed efficient division of care that catered to patients' needs. The health care professionals worked hand in hand to deliver the best care to patients. HKL has a team of medical assistants who are well trained in triaging trauma patients and who are always on the ready to receive incoming patients at the A&E. The patients here go through multiple steps of triage, via phone from when they first contacted the emergency helpline, in the ambulance and at the A&E via the medical assistants. Communication is key and I was pleased to see that the medical assistants were very well trained to triage patients and to hand over important information. In London, the London Ambulance Service (LAS) has similar responsibilities to those of the medical assistants in HKL. The paramedics of LAS will triage patients whilst on the ambulance and relay the information to A&E doctors. I was pleased to have witnessed such efficient division and provision of care in both cities.

I had the opportunity to be a part of the National Trauma Pre-Conference held at HKL. I volunteered for the 'Major Incidence Rapid Exercise Response' (MIREX) and gained valuable knowledge from the experience. I witnessed excellent teamwork from the participants and learned new things about managing patients in a disaster setting. To be a part of such a prestigious event was very rewarding and was unlike any other. I was able to consolidate my knowledge on emergency care as well as learn a great deal about disaster medicine.

The patients I saw in A&E were varied, from road traffic accidents to neurological emergencies. One that was particularly interesting (and I am quite biased as I have an inclination towards neurology) was a 32-year-old gentleman who presented with a right-sided weakness on a known background of an arterio-venous

malformation in the basal ganglia. I had the chance to train in the Acute Stroke Unit at the Royal London Hospital (RLH) last year. The A&E there was well-equipped with facilities and CT scanners nearby. We received multiple stroke patients daily and each of them were rapidly assessed by a stroke senior house officer and wheeled in to the CT scanner immediately following the assessment. A consultant neurologist or neurosurgeon would then be called in to review the patient accordingly. This was standard practice there and I find that I often take the accessibility of facilities and resources for granted. The provision of care for the AVM patient in HKL was similar to that for neurological patients in London; however, the time frame involved was not. The CT scanners were not located near the A&E and therefore the time to reach a diagnosis and formulate a plan for the patient took longer than it would have in London. Whilst this is not a major issue (the patient was eventually wheeled in to theatre and had life-saving surgery, hooray), it is something that I find I have never really thought about before. In this day and age, the facilities are as important as the physicians in the process of diagnosing and treating patients. For cases like stroke, or in this gentleman's case, a cerebral haemorrhage, time is of the essence and the accessibility of resources is imperative. This is something that I have learned to appreciate from my period of medical electives here. All in all, it has been a rewarding experience and I hope that I will be able to apply the knowledge that I have gained from HKL in my medical training in the future.