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Elective Report

I have been asked to provide a report of my elective spent in Limehouse at the Harford Health Centre working in primary care. At the time of writing my objectives, I was unsure about where my time would be best used and we had agreed that would carry out an audit. However, it quickly became apparent that it would work well for me to get involved in coordinated care planning with vulnerable patients, particularly those over 75 years of age. Therefore many of my objectives were altered during my elective. I have listed the subtitles for objectives given in the handbook in bold followed by a description of how I achieved each of these objectives.

Describe the pattern of disease/illness of interest in the population with which you will be working and discuss this in the context of global health.

Initially I was aware that the population I would be working in is made up of 90% Bangladeshi patients and so expected to be dealing with language and cultural barriers. Indeed when witnessing patient encounters within the practice, there were a number of patients requiring interpreters and who had cultural aspects to their health complaint. However, in the work I did with vulnerable patients in the community, all the patients were of white British ethnicity. Although communication was often difficult due to poor hearing and dementia, language and culture were not barriers. It may be that this was such a small sample that in fact there are a large number of older Bangladeshi residents who are vulnerable.

Among the elderly women that I visited, they all had very similar health and social concerns. All suffered an element of depression and anxiety due to loneliness and had difficultly sleeping. They all had difficulty hearing which made communication difficult. Most of the women had sight problems as well as mobility problems, either due to osteoarthritis or vascular problems leading to swollen legs. All of these problems as well as poly-pharmacy and poor lighting meant that falls were common in all of the patients I visited and had resulted in multiple hospital visits for all of the patients.

Describe the pattern of health provision in relation to the country in which you will be working and contrast this with other countries, or with the UK

Previously in medical school (on geriatric rotations) I have encompassed similar scenarios with the elderly white British population requiring more from health services due to the lack of provision and care from their own families. Often among Bangladeshi and other Asian cultures, it is common for young people to have their elderly relatives living in the home with them and provide care themselves. All of the ladies I visited had different care provision, including care provided by family members, private and council care services and often neighbours. With all of the patients I visited, there were problems of communication between different carers leading to difficulties for the patients. For example carers not passing on health concerns or worries about hydration or constipation. Continuity of care is a real issue for these patients which is why I can see that having family to care for you alone, whilst putting a large burden on them, probably does provide the best level of care if possible.

Another problem for these patients is that most of them were housebound and unable to get to the GP. I cannot imagine, either, that they would be able to communicate well if they were unwell as they would likely develop some degree of confusion with infection. Therefore, as experienced with one of the patients only a week ago, a minor infection can end up with a few day hospital admissions because there is nobody to monitor the patient and get them to a GP before they end up falling or seriously confused. I do not think it would not be possible with the heavy burden that is already upon London GPs for them to do weekly visits to these patients. However, perhaps better education for the carers as to what signs to look out for and earlier intervention may help?

A Health Related Objective

My health related objectives were to gain clinical experience, which I have. Specifically with the elderly patients I visited. I have certainly had to practice my communication skills! I have

also had to talk about aspects of health I have never had to before in discussing plans for end of life care, organ donation and legal documentation. I believe this was good preparation for work next year. However, I would like to find out more about the legal side of these decisions and plan to look more into the specifics of a DNR order and allowing a natural death and how these differ. This experience has certainly taught me there is a lot that I don't know about the multi-disciplinary team as well; who can commission a care package and how it is decided what is necessary as well as which carers are allowed to provide different services. The carers told me they weren't allowed to cut finger or toe nails and the patients then needed to be referred to podiatry to cut their nails!

My next objective was to carry out an audit. As stated above, I did not carry out an audit, but visited patients in their homes to create care plans instead. I only managed to see four patients so I would have liked to see more. However, I do feel for all of these patients that I managed to understand their full situation and highlight any further care needs they may have. Something that was not part of the care planning process but that I felt was necessary was to write to each patient to summarise our discussion and how we felt any issues that arose would be best resolved. I hope this will be helpful to the patients and to their doctors in the future as a summary of their current situation. I think it would be a great idea if there was someone working doing this full time and who could review the actions set out in the letters to make sure that problems were solved. I do feel that I became more comfortable talking about uncomfortable issues and that I was better able to communicate with these elderly patients with confidence.

Personal/professional development goals. Must also include some reflective assessment of your activities and experiences.

Obviously having not done an audit I do not have an audit report to provide as I said in my original objectives. However, I have attached one of the letters that I wrote to a patient, summarising our discussion and the actions that should and would be taken to improve their quality of life.

In reflection, I am glad that I chose to do my elective in primary care as it worked well for me, being local and flexible. I also feel that I gained greater confidence working independently and preparing for work in the summer. Something I was keen to do was increase my confidence using the computer software which I feel I did so I am pleased the project I chose allowed this. I would have liked to feel I could follow these patients to know that after the work I did, it did result in better and more co-ordinated care for them. I would also like to have seen more patients.

I also sat in on a few clinics at the practice. Whilst it was good to start seeing patients again and build my confidence, I do feel at this stage that I should probably have taken my own session seeing patients on my own. This was offered to me and I declined but in hindsight I think I would feel better going into work if I had done this.

I have enjoyed my time at Harford Health centre. I have been exposed to an area of medicine that I had not really before which I was not expecting and worked independently directing what I did. Whilst I do feel I could have done more, my overall objectives to increase my experience of primary care, work independently and to add to my portfolio were achieved.