Elective Report

St Stephen's Hospital, Tis Hazari, New Delhi

Prior to starting our elective at St Stephen's Hospital in New Delhi, we came up with objectives to focus on, following the placement. In this report I will discuss each objective.

1) ***India gives rise to a wide varied population, spanning from those in extreme poverty conditions to those more well off. During our elective period we are focused on visiting the poorer slums that will give us a broad scope on the disease associated with congested living conditions, infectious and tropical diseases which are a rarity in the UK.***

   Due to the lack of health facilities, we will be tested in our clinical examination skills due to the lack of 1st world health care resources, and therefore experience the problems, that occur when practicing medicine on a very limited budget, with limited resources available to the medical professionals.

I think that during our time in St Stephen's hospital we have witnessed the diversity in patients attending. The biggest difference was seeing those patients in hospital compared to those who were much poorer or lived in slums.

While going to the community outpatients clinics and the outreach programmes mobile clinics we saw conditions that seemed to be much more commonly seen here. Many patients had cough and fever due to the changing temperature. Scabies and ringworm were common due to the poor living conditions and overcrowding leading to easy spread. This programme has some difficulties as the medication given is free but due to limited resources, there is a limit to how much medication they can give out. So only a few tablets are given to each patient and if they don't improve they come back for more.

In hospital, we saw a lot of conditions not commonly seen in the UK. Such as typhoid, enteric fever, Tuberculosis and Dengue fever. There were more infectious diseases seen here especially in paediatrics such as measles. There is an immunisation schedule here where the MMR is included but some patients cannot afford the immunisations so measles is still common here. This financial issue was also seen in other conditions where the best treatment for a condition could not be given as the patient could not afford it, so they had to go for an alternative medication instead. Therefore treatment does rely on whether the patient's family can afford the treatment.

During the outreach programme, we also went to a school to see a government school health programme. Here they did a general check-up for all children at school, including checking their eyesight, blood sugar, haemoglobin and height and weight. We found out that it is very common for children here to have iron deficiency or Vitamin B12 deficiency due to poor nutrition. There were also children with rickets due to Vitamin D deficiency.

2) ***When comparing our proposed trip to Delhi to the UK NHS hospitals, it is clear that standard of care and protocols would be very different, not only because of the differences in disease, but also because of the way health care systems differ in both countries.***

St Stephen's hospital is a semi private and general hospital. There are differences in a financial aspect in terms of the patients that attend, but the hospital caters for everyone. I find that at St Stephen's hospital, the diagnosis is more clinically based as opposed to at home where more investigations are done earlier on. Here they still use investigations but maybe due to fewer resources or the number of patients, t is more so based on clinical judgement. This was especially seen in the outpatient clinics in the community, where it was very busy and patients were seen for around 5 minutes in which time they gave their history and the doctor examined, came to a diagnosis and prescribed treatment. This was also the case in the mobile clinics as they cannot afford to have further investigations, so a diagnosis is made mainly based on the patients history.

3) ***Health education in India with regards to their popular medical issues such as clean water and sanitation, contraceptive care, women's health and safety, and general prevention of infectious disease spread.***

   The safeguarding provided for vulnerable adults and children in 3rd world country compared to the UK, especially with a large incidence of domestic abuse and child poverty.

I found that health education is important here, as many people don't understand the risks of conditions and how to prevent them. So when they come in to outpatients or the hospital it is important for the doctor to educate the patient about the condition and prevention. We were told about new plumbing systems that were set up to provide running water to houses and nurses also educated patients at home about ways of further purify water. A malaria and dengue fever programme is running here where they education families about how stagnant water is a breeding site for mosquitoes and how to prevent this.

In community medicine, they had set up programmes for women to attend to help them get into lines of work where they could provide for themselves, such as cleaning, catering and tailoring. Domestic abuse is still high here and described to us as something quite common and seen as normal here. It is now illegal in India to find out the sex of the baby before it is born to stop feticide.

Infectious disease, being the most common conditions seen here, is difficult to prevent as although doctors and nurses can educate patients on how to prevent it, in poorer areas it is difficult due to overcrowding and poor hygiene.

4) ***Personal goalposts that we would like to achieve are the fine tuning of our learnt clinical skills and increasing education in medicine from a completely different environment to our training.***

   Being put in rural settings, the ability to be able to rely on our own clinical judgements and assessments as oppose to ordering tests and x-rays as well as having the opportunity to

work with much learned colleagues with a different back ground curriculum, giving us the chance to enhance our knowledge and make us more well-rounded and knowledgeable doctors.

The chance to communicate with patients whose first language would not be English, enables us to work on our non verbal communication skills which would be empirical for our medical career as we will be faced with many different patients from different walks of life and backgrounds.

I think we fulfilled our objective in finding out more about other conditions that we wouldn't necessarily see at home but to be aware now of certain clinical signs or symptoms that we should associate them with. I have also seen clinical signs that I haven't seen before at home or haven't seen to this extent. We definitely experienced doctors using clinical judgement as means to treatment. It was definitely interesting to see it happen in the outpatients clinic in the community and mobile clinics.

I found that it was difficult communicating with patients as I didn't speak the language. Although I understood a few common words I would get a translation as I didn't want to misunderstand what they were saying.

Overall I feel we met our objectives and learnt a lot on this placement. We have witnessed more conditions that we do not usually consider in our differential and it has broadened my knowledge of conditions not seen so commonly at home.