ELECTIVE (SSC5c) REPORT (1200 words)

A report that addresses the above four objectives should be written below. Your Elective supervisor will assess this.

1) What are the most prevalent conditions amongst older people in the United Kingdom and how do they differ to those experienced by older people in a developing country such as India?

The conditions prevalent amongt older people in the UK and India are quite similar, the main ones being ischaemic heart disease, hypertension, stroke, COPD, cancer, Alzheimer's and dementia, diabetes and arthritis. In terms of cause of death, ischaemic heart disease, hypertension, stroke, COPD and cancer are the main killers in both countries although tuberculosis features uniquely in the top 10 causes of death in India. Another notable difference is that diarrhoea and air pollution are significant causes of morbidity and mortality in India, particularly amongst older people. [1]

As one might expect, there are significant differences in life expectancy between the two countries, with figures of 83.0 years for women and 79.3 for men in the UK and 69.6 and 67.3 respectively in India. Both countries have enjoyed a rise in life expectancy over the past decade, but the UK rise has been driven by public health promotion and medical advances, whilst the Indian rise is largely due to increased food supply and immunisation. [1]

2) Give an overview of elderly healthcare provision in the UK and describe how it differs from a developing country like India

<u>Funding</u>

In the UK, elderly healthcare provision falls within the remit of the NHS and social services and is, therefore, funded primarily through taxation. Patients have the option to pay for private healthcare to reduce treatment waiting times or to enjoy more luxurious surroundings. They may also be asked to contribute to their residential care, according to their means. In India, this relationship between public and private healthcare is reversed. Public hospitals are less numerous than their private counterparts and the quality of care is generally poorer. In fact, over 70% of hospital care in India is paid for directly by patients and their families. Additionally, residential care is a relatively new phenomenon and is almost exclusively private. [2]

<u>Primary care</u>

In the UK, all patients have access to primary care and this is where most chronic conditions experienced by elderly patients are managed. In India, primary care is underdeveloped and fragmented, with private family physicians outnumbering public family physicians by 8 to 1, although in contrast to public care, private family doctors are often stand-alone doctors with only basic medical qualifications and patient care is often poor. Consequently, most healthcare needs, even basic ones, are currently met in hospitals rather than in primary care. [2]

Inpatient care

In the UK older patients admitted to hospital are placed either in specialty medical wards such as cardiology, respiratory or the stroke unit or on a care of the elderly ward. Patients on a care of the elderly ward are cared for by a range of health and social care professionals who work together to address their multiple morbidities and provide holistic care with the aim of getting patients back to their baseline function and discharging them to a safe place, ensuring they have the necessary support and assistance in place. In India, patients admitted to hospital are usually placed in specialist or general medical or surgical wards. Geriatric wards do exist but are found only in larger urban hospitals. Because healthcare is mainly private, access to specialist geriatric services and occupational and physiotherapists is an additional cost many patients simply cannot afford. [3]

Medical specialty

In the UK, geriatric medicine is a popular, established and large medical specialty, requiring at least 6 years' specialist training after 4 years of general postgraduate medical experience. Geriatricians are to be found in virtually every hospital, along with a dedicated elderly care ward. In India, geriatrics is a fledgling specialty and remains small and low-profile. Indian medical students have minimal exposure to elderly care during their degree and in a country where further postgraduate degrees are required to climb the hospital medicine ladder and pursue a specialty career, MD degrees in geriatrics only came into existence in 2012. As a result, very few geriatric wards are run by doctors with any formal training in elderly care. [2, 3]

Preventative care

The UK Government has a more proactive approach to healthcare, which attempts to improve public health, to identify and manage chronic conditions in the community and to minimise hospital admissions. India has a more reactive approach to healthcare, focussing on acute care rather than preventative medicine. [2]

3) Consider what preventative measures might reduce the number of hospital admissions in older people

Electronic healthcare records accessible by all healthcare professionals directly involved in a patients' care would enable ambulance and hospital staff to know a patient's full medical history (especially chronic conditions and long-term medications) which could enable faster diagnosis and treatment and reduce unnecessary admissions, especially for chronic or palliative conditions.

Similarly, having geriatricians, palliative care doctors and GPs in A&E would enable patients with exacerbations of chronic or palliative conditions to be better identified and managed accordingly.

Better integration of primary and secondary care to provide a more joined-up health service to better support patients with chronic conditions and multiple morbidities.

Better integration of health and social care services, so home carers and residential home staff can get medical advice from doctors and specialist nurses in the community who know the patient. This would also shorten admissions when they do occur, as carers would feel more confident and supported in accepting patients on discharge.

Improved discharge planning to reduce readmissions.

More condition-specialist nurses visiting patients in their own homes or running regular clinics at GP practices.

Strong relationships between patients and their GP to ensure better continuity of care in the community.

Regular medication reviews by GPs to minimise medications, to endure patients are taking their medications regularly as prescribed and to reduce the risk of side-effects and interactions.

More prophylactic prescribing of bisphosphonates to prevent neck of femur and vertabral fractures.

Regular mobility and falls assessments in primary care.

4) Reflect on the knowledge and skills required to work effectively as a doctor in elderly care and consider whether it is a career path I might like to pursue in the future.

Working in elderly medicine requires general medical knowledge of a very broad range of conditions across cardiology, respiratory, renal and gastrointestinal medicine. Conditions seen on the care of the elderly ward also encompass neurology, psychiatry, orthopaedics, rheumatology, endocrinology and haematology.

Strong problem solving skills are also required. Many older patients come into hospital suffering from confusion and with multiple morbidities so taking a history, examining them and making a diagnosis can be particularly difficult.

Excellent communication skills are also necessary to successfully work in elderly care, in order to communicate with patients with poor hearing and cognition, to keep relatives informed and have sensitive conversations with them about residential homes, DNAR orders and palliative care, and to work cohesively with the other members of the multi-disciplinary team.

I have enjoyed working in elderly care could see myself working in the specialty in the future as it offers a wide range of challenges, a team-oriented environment and the opportunity to develop a broad base of general medical knowledge rather than becoming very specialised. I also tend to prefer medical specialties with a focus on holistic care and am also considering palliative care and general practice as future career options.

(1,199 words)

References

[1] Murray CJL. Global, regional, and national age–sex specific all-cause and cause-specific mortality for 240 causes of death, 1990–2013: a systematic analysis for the Global Burden of Disease Study 2013. *The Lancet* 2015; 385: 117–71. http://www.thelancet.com/pdfs/journals/lancet/PIIS0140-6736(14)61682-2.pdf (accessed 09.05.2015)

[2] Evans JM, Kiran PR, Bhattacharyya OK. Activating the knowledge-to-action cycle for geriatric care in India. *Health Research Policy and Systems* 2011, 9:42. http://www.health-policy-systems.com/content/9/1/42 (accessed 09.05.2015)

[3] Wharton Knowledge. *Family physicians make a comeback in India*. http://knowledge.wharton.upenn.edu/article/family-physicians-make-a-comeback-in-india/(accessed 09.05.2015)