PAEDIATRICS

Elective 2012

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1.) What are the prevalent paediatric conditions in Ahmadebad? How do they differ from the UK?

With a high proportion of the children being malnourished, many of the illnesses and diseases arise as a result of this. Malnutrition is considered to be a leading cause of child mortality in India. Protein energy malnutrition and micronutrient deficiencies are major contributors to higher mortality rates from pneumonia, malaria, diarrhoea and measles. It was upsetting to see that the high volume of children who came from poor backgrounds would have their parents spend a huge proportion of their income on getting good treatment for their illness. The lack of facilities had also been highlighted on several occasions. A 5 year old child had been admitted after falling from a second floor of a building. The boy had suffered several head injuries but we were unable to make a diagnosis of what side of the head the bleeding had been occurring as there was no CT scanner. The nearest facility for this was 3 hours away and by this time the child would have haemorrhaged to death. A burr hole had been drilled into the wrong side of the head and by the time this had been realised, we attempted to amend this by closing up the right side and drilling the left. The blood had been drained after a long operation, however the patient passed away the following day. It was extremely upsetting to see such deaths as in the UK adequate facilities and investigations would prevent such a thing happening. Hence I realised that patients often could not be saved due to the poor resources.

In outpatients I had the opportunity to see many cases of TB. Weight and pulse were taken for clinical indicators of wellbeing and if available at the time a chest x ray would also be done. The patients often presented with the classical onset of cough, weight-loss, night sweats and chest pain or haemoptysis. Contract tracing was rarely attempted

due to the high prevalence and patients often defaulted on treatment when they felt better.

2.) How are the paediatric services organised and delivered? How does this differ from the UK?

I was surprised to see children frequently sharing beds and the ward rounds consisted of large teams and a huge number of patients to see. There were many interesting cases including a 2 month year old boy diagnosed with osteogenesis imperfect who had blue sclera and bowing of the femur. I also had the opportunity to undertake a paediatric life support course with fellow students which was extremely enjoyable and is usually taught as a post qualification course in England and hence I felt fortunate to have this opportunity to learn as a student and be one step ahead for when I am a junior doctor. Again, there were numerous situations when there was a lack of funding for the appropriate medications required for treatment. An example was a 7 year old boy with terminal B thalassaemia major, I knew had he been treated in England his outlook would be better.

The doctor-patient relationship was in India less centred on the patients than it is in the UK. Doctors adopt a superior status and are looked up to more. Consent, privacy and dignity of the patient have also not risen to the degree of importance that they have in Western healthcare in recent years. However with the number of patients seen everyday and the lack of financial support this is hardly surprising. The relationship between healthcare professionals and patients influences how students are taught and there is not much emphasis on the patient's ideas, concerns and expectations. Despite this some students still applied these approaches and all were highly inquisitive and eager to learn about Western methods.

3.) To identify the health concerns of homeless youth and the impact of a homeless lifestyle on general health

Numerous aspects of healthcare in India differs to that of Britain. A few of these being the lack of resources, the sheer number of patients seen and the fact that healthcare is only partially subsided by the government. One of the doctors mentioned that in order for a country to provide an average health care service, not excellent, simply average, they must spend a minimum of 6% of their GDP. In India the figure for 2012 was 1.3% and healthcare is fairly low on the priority list as far as the government are concerned. Hence the squeeze on their resources is inevitable and it doesn't seem that there will be any changes in governmental hospitals any time soon. The poverty in India is striking and the sheer number of children living in poverty is upsetting to see. The consequences being an increased risk to infection due to a poor immune system.

4.) To gain confidence in understanding and managing a variety of cases

The main effect of my exposure to the India healthcare system was to increase my appreciation of the resources and the living conditions we have in the UK, which we take for granted and one of inspiration having seen how hard the Indian Doctors work. I knew in advance that I was not permitted to undertake practical clinical skills such as taking blood. I went to Ahmedabad seeking to improve my clerking, examination skills and clinical knowledge. The emphasis of the teaching was on clinical skills and method. The lack of resources in India means that doctors cannot rely on a barrage of investigations to diagnose patients. Instead investigations are ordered sparingly and physicians depend on their clinical skills, clerking and examination technique. I was delighted to have the opportunity to improve my clinical method. The knowledge,

enthusiasm and work ethic of Indian doctors and medical students has left a lasting impression on me.

However at the same time, the elective has enabled me to realise the importance of giving back to society, to those who really do need help, to those who are less privileged, to those who only want happiness through good health and family life. For me it is now a personal challenge, a mission and a duty to remove these inequalities and provide access to healthcare to as many souls as possible. It is their right and we cannot deny such a right.