FOR MR FISI

GENERAL MEDICINE

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Medical Elective: India

Objectives:-

1) Describe the healthcare system and services provided in the hospital observed and describe how it differs from the UK
2) Describe one particular condition and its prevalence. Compare it to what you have seen in the UK
3) Describe some clinical observations that you have seen in the departments
4) Write your own reflections and experience and focus on your personal developmental goals

My experience in India was based in Ahmedabad in India. Ahmedabad is situated in Gujarat, one of the few states in Gujarat where alcohol is prohibited. Unless you have a non-Indian passport, then you can apply for a one month license. It is the 6th largest city in India and a commercial hub that is quickly developing. I stayed with my uncles, one who lives 45 minutes away by rickshaw and the other 15minutes.

I cannot really compare the healthcare system I have observed in India with what I have observed in the UK. Medical students in the UK have experience only in the NHS, and in India I was placed in a private hospital. Government run hospitals do exist in India and they attract a large population of citizens, as their consultation and treatment costs are low. Private hospitals are more likely to attract the upper middle class and higher, as although it is more expensive they are cleaner and well run with well recognized accreditations. Sterling hospital, where I was placed also attracted a large number of patients from abroad for procedures and preventive health-check packages on offer. This highlights the increasing demand in medical tourism. For example there was a young girl from Nigeria who had been living in India with her parents for 9 months, she was under going three dialysis treatments a week and was due for a renal transplant. In the UK, a much lower percentage of people opt for private treatment, as the NHS is used by people of all social classes. In the UK, people are more likely to choose private healthcare for procedures that the NHS do not give, such as procedures for cosmetic purposes or if they do not fall within the NHS guidelines for certain procedures such as a gastric bypass.

An acute case in India will first be seen by the family doctor who will then recommend that they see a specialist. In the UK, the citizens are likely to go to a walk-in clinic or A&E straight away without consulting their GP. The specialist in India decides which investigations to do and designs a treatment plan. Consultations, investigations and treatments all have to be paid for. However, if someone who cannot afford any treatment comes into a private hospital then primary treatment is free of charge. With a range of treatment, investigations and procedures with different costs at different hospitals, patients in India have a vast range to choose from and easy access to health care by obtaining different opinions if they wish.

In OPD there were some patients who were sent from the ward who needed specific investigations, but most of the patients were those that had chosen to do a preventative health-check up. Sterling hospital has a good system where consultations and investigations are done on the same day and a full report is handed back to the patient by evening. In OPD I observed echocardiography and pulmonary function tests. I met a 16 year old boy in OPD, who was admitted in hospital after he had gone to the dentists for a teeth clean. His gums were bleeding and the dentist had some difficulty controlling it. After relevant tests he was diagnosed with Acute Myeloid Leukaemia. His echo showed a posterior wall pericardial effusion. The doctor showed me echo images of other interesting cases. A clot in the left ventricle was visible on echo of a female patient with rheumatoid arthritis, and I saw pre and post-op images of a patient who had an umbrella closure of an ASD in the ostium secundum. The umbrella had

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dislodged into the right ventricle and so the patient had to undergo emergency surgery, with an increased risk of a pulmonary embolism. I learnt how useful echocardiography is in the diagnosis of heart diseases.

The Medical Intensive care unit (MICU) was busy. Most of their patients come straight after having angioplasty and so they stay there was 48 hours which in included in the package. There was a 63 year old male patient admitted into hospital because of palpitations. He has a history of atrial fibrillation and atrial flutter 6 years ago that was treated medically. Echo showed global hypokinesia and tachycardiomyopathy, and was indicated for coronary angiography to increase coronary blood flow. Another patient, 80 year old female patient who had an automated implantable cardioverter defibrillator (AICD) put in February 2012, had come in with dyspnoea. She had, had recurrent ventricular tachycardias and multiple shocks, it was decided she be treated best medically.

Heart disease is much greater in high-income groups in India than the low-income groups[i]. This is why private hospitals have more cardiovascular procedures in demand. The differences lie in a longer life expectation in the upper class, with a richer diet. Serum cholesterol is also higher in the upper class population than in the lower class; however is diet is not the only factor that plays a role in cardiovascular disease. As people of low economic backgrounds make up almost 90% of the population, over all, heart disease is much lower in India than the UK. Even so, non-migrant Indians when compared to their migrant siblings had significantly lower serum cholesterol, blood pressure, smoking rates and body mass index[ii].

Ahmedabad is well known for its textile industries with large cotton mills set up here. Here there is a small prevalence of biosynosis. This is a chronic disease of the lung brought on by inhalation of cotton dust or vegetable fibres. Although it is less prevalent in Ahmedabad now, its prevalence is overall increasing in the developing world due to rapid industrialisation. Nonetheless, the prevalence of biosynosis is decreasing worldwide.

My aim for this placement was to further my history taking and clinical skills. However I could not practice these much. Patients at Sterling pay for the best care, and so it is the hospital's responsibility to provide just that. So although I could not focus much on my personal developmental goals, I understood that even though I had passed my MBBS exams, I had minimum experience. More so, I learnt how important observation was, and the extent one can learn by merely watching. If I was to talk anyone going to India for a medical elective I would advise that that split the time between a private hospital and a government run hospital, as opportunities to practice clinical skill are more available in government run hospitals and also make a better comparison of the healthcare system with the NHS can be made.

Word count: 1133

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[i] Padmavati, S., Epidemiology of Cardiovascular Disease in India: II. Ischemic Heart Disease, Circulation Journal of the American Heart Association, Ciculation 1962, 25:711-717

[ii] Kooner, J., Coronary heart diease in the UK Indian Asians: the potential for reducing mortality, Available URL: http://heart.bmj.com/content/78/6/530.full, Heart 1997; 78:530-532