RURAL MEDICINE

Elective Report – Deborah Smith

Objective – to gain international health exposure

This trip was an expedition based elective. It started on arrival in New Delhi. We had pre arranged our internal transfers to Chandigarh in the north of India, in a region called Himachal Pradesh. This region has traditionally had little access to healthcare. More recently, due to changes in government health funding, this has started to improve. Despite this some of the regions inhabitants still have to walk up to 50km to reach their closest hospital. Some pre-medical school students now run clinics in the rural areas as part of their CV building in order to improve their competitiveness to get into medical school. I found this unlicensed medical advice and provision one of the interesting aspects of the elective. The elective consisted of a tour in a convoy of jeeps that moved from location to location, going off road at times, and reaching into the really remote areas in the foothills of the Himalayas. Most of the accommodation was tented as were the clinics. A typical day was a 6am rise, with breakfast at 7am, clinics starting at 8 and close of play by around 6pm. We rotated through 3 adult medicine tents, a gynae tent and a paediatric tent, as well as taking a turn on the initial triage tent or the pharmacy. The pharmacy was not only interesting in terms of prescribing practise, but also looking at ways to overcome language barriers and encourage them to adhere to their medications. Also it was interesting because much of the drugs were donated by US companies or students and hence we had to think of the American equivalents, such as acetaminophen instead of paracetamol! We saw a wide variety of patients. On some days the whole village would turn out to watch us and send along their sick ,and on other days we would visit the local Buddhist monasteries and run paediatric clinics for the young monks. We were able to learn much about their culture by living alongside them in our tents as we would often get visitors of an evening round the campfire and we would be as interested in their lives as they were in ours. We saw a great deal of chronic disease. The most shocking thing I found was the frequency of hearing loss in the teenagers due to untreated chronic eardrum perforations in their younger years. I got to use an Otoscope and opthalmoscope every day which increased my familiarity with those examinations. Other common ailments were musculo-skeletal complaints secondary to the manual labour in the fields, so my musculoskeletal examinations also became much more slick over the 5 weeks! One of the good things around the organisers of the trip was that they run other camps that provide surgical interventions so if we saw a bad cataract case they could keep a track of that patient and invite them to have treatment on the next eye surgery camp.

Objective – to learn, develop and apply practical skills

We were in tented clinics, and this provided some interesting challenges to our burgeoning practical skills! When it rained or hailed the patients queueing to be seen would all try to come into the tent with us and therefore maintaining dignity and confidentiality became quite difficult. I had to perform a hernia examination on an elderly man in a school room with only his (non English speaking) daughter present (we had translators but none with the right dialect for this Tibetan refugee). I had to demonstrate what I was going to do using sign language , which his daughters found very funny, so I had to maintain a professional attitude whilst trying to also be friendly and non threatening. As it turned out he had a significant indirect hernia with a history that indicated he might be occasionally strangulating and therefore he was referred to the local hospital (via his GP who was working with us) immediately. My examination skills were tested daily as we often had patients with abdominal pain (GORD being very common due to the smoking and spicy food) and we also saw some congenital heart disease. We were lucky to have an American cardiologist along on the trip and he had brought with him 10 artificial heart valves, donated by drug companies, so we were able to donate these to the local cardiac centre and ensure the children seen were likely to benefit from them. I also had two opportunities to treat finger injuries. In the first the patient had cut the top of his finger off in an agricultural machine. Under senior supervision I cleaned and irrigated the wound, debrided it and dressed it before he was sent off to a hospital some 50km away in order to have the bone removed and plastic surgery . In the second case an unfortunate young man (he had already been diagnosed with polio at the age of 27) had been in a pressure cooker accident and he had suffered steam injuries to his face and eyes and had blown the top of his finger off. I had to check his vision (which was fortunately ok) and then avulse the fingernail which was hanging off. I had to clean the very dirty wound and debride it. Again he had to be given prophylactic antiobiotics and be referred to hospital for further treatment once I had dressed the wound. It was also interesting that in this part of India most patients carried their own health records and many of them brought in x-rays and investigation results for us to interpret and comment on.

Objective – to develop sensitivity to different health care systems and experience different cultures and lifestyles
This was one of the most interesting aspects to the elective. The use of non qualified students to provide healthcare was fascinating. The ratio of patients to doctors was exceptionally high. I saw a more autocratic system of medicine. Many patients described their previous medical consultations as much more dictatorial by the doctor, and many of them had not been told what kind of medication they were on, just that it would help them. They found our communication skills quite odd sometimes as they had often never been asked by a doctor how they felt about the proposed management plan! One of the challenges for me was not to show how frustrating it is to see the permanent deafness in children who could have had simple treatment earlier. Another aspect was the difference in acceptability of some questions. It was very difficult to ask about sexual history and some of the translators amended their questioning so you couldn't get a proper answer. There was also such a stigma about TB that it was not acceptable to write this as a differential on their patient note, instead you had to put the obvious TB symptoms so that another doctor would recognise it as such. The local doctors report suspected cases to the government before they tell the patient and then the government send health teams to their home to test their family and close contacts. This was very different to the UK and felt uncomfortable.
The environment is very tough in the foothills of the Himalayas. This gave rise to particular pathologies, musculo-skeletal complaints secondary to the sheer weights they are carrying on their backs and the position they adopt. Pterygium and irritant conjunctivitis was common due to the sunshine and dust. The environment for us was very different to the UK. The electricity comes on for an hour or so in the morning and then again for an hour or so in the evening. Access to clean water is difficult and contamination by faeces is common place. It was great to be able to live amongst the villagers and we had a few evenings where they put on music and celebrated (possibly for us being there but it seemed just the excuse for a social gathering) and we got to exchange views of different societies. There were vast differences in diet and a mainly vegetarian menu was available. The advent of freely available cheap alcohol is giving some issues in the region and we are now seeing some areas invoking a complete alcohol ban for any public gathering. It certainly was something to be kept in mind when taking an abdominal pain history as alcoholism was commonplace. In terms of customs and cultures we had strict rules about what we wore. We had our feet covered and were clothed to ensure that ankles to shoulders were covered and that we didn't offend. We had chaperones for the majority of examinations. We had clinics at the schools on some days and we would wait for them to sing their national anthem and songs before they would be allowed to come and see us. They have recently started to provide free dental care and we hoped to add to this campaign by performing own our play (hastily devised) with characters playing nasty bacteria and heroic toothbrushes, followed by demonstrations about effective toothbrushing. Having about 100 children laughing delightedly at our antics was a real high moment of the trip.

Objective - my personal objective was to attempt to develop my medical and practical skills in a challenging environment. In the tents we experienced torrential rain, some of the worst hailstorms I have ever seen and even snow on a couple of days at the higher altitudes. Despite the weather conditions and long hours I thoroughly enjoyed it, and enjoyed sharing and exchanging knowledge with the American graduates. One of my biggest challenges was enduring the living conditions when I contracted (what we think was) Giardia. I didn't manage to take on fluids or eat for 5 days , stopped passing urine and then went into hypovolaemic shock. I had to be cannulated under less than sterile conditions, go onto a drip, and because we were due to move to another clinic site I had to tie my fluids to the roof of the jeep in order to keep them running whilst we drove for 3 hours over a mountain to the next site. This was perhaps a good test of my sense of humour and general resilience! Fortunately I improved within 24 hours of getting fluids on board and was back in the clinic the next day. We were also required by the supervising doctors to give a presentation on a medical topic relevant to the pathologies seen in the region. My colleague and I were asked to speak on Peptic ulcer disease, which we did to an audience of about 30.

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