PALLIATIVE CARE

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ELECTIVE AT THE INSTITUTE OF PAIN AND PALLIATIVE MEDICINE, KOZHIKODE / CARITAS HOSPITAL, THELLAKOM, KOTTAYAM. KERALA, INDIA

REFLECTION

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I chose the location of Kerala, South India, for my elective so that I could learn about the provision of healthcare in the developing world while being able to visit my family during my spare time. I was especially interested in having this experience in Kerala not only because it is where my family originate from, but also because the state is unique in being a region of the developing world with a set of high quality-of-life indicators. In terms of healthcare, Kerala boasts the highest life expectancy in India (75 years for males, 78 years for females) and a low infant mortality rate (12-14 per 1000 live births, compared to 60 per 1000 for India as a whole). This is all despite the fact that there is actually a relatively low per-capita income.

Conversely it has the highest morbidity rate, 111 per 1000 in rural areas and 88 per 1000 in urban areas. Thus even before setting off I knew I would have an interesting experience- seeing how good healthcare can be delivered in the developing world, to a population with relatively poor health.

There are several breeds of traditional medicine practiced in Kerala, among which Ayurveda is the most common. Unfortunately I was unable to observe any traditional medicine. Nevertheless, I was lucky enough to have both parts of my elective arranged with ease.

I spent the first portion of my elective in the Institute of Palliative Medicine, Kozhikode. The Institue of Palliative Care is fairly unique in that it has been a pioneering healthcare centre in India, I shall write more about this below.

The second portion of my elective was spent in Caritas Hospital, a large private hospital in Thellakom, Kottayam. Apart from its size,

Caritas Hospital is fairly typical of Private Hospitals in Kerala. All the major specialties are present. Almost all of the facilities required to deliver essential medical/surgical care are present, with patients with complex cases requiring special care being referred to larger superspecialty hospitals in big cities like Ernakulum. However resources are not as abundant as in the West and some conveniences for both doctors and patients are lacking. For example, it is not straightforward to deliver supplemental oxygen to a large proportion of the beds; doctors must look at CT and MRI images on films, as opposed to being able to view the images on a monitor. The hospital often struggles to cope with the sheer amount of patients and there is often a lack of beds – this is mostly due to the fact that Kerala is one of the most densely populated states in India.

The main factor of concern to both doctors and patients in delivering healthcare is the cost. Despite its high levels of social development relative to the rest of India, the average level of wealth is not much higher among Keralites. Only 2% of Keralites have Health Insurance, thus most healthcare is paid for out of pocket. The cost of a week-long hospital stay may commonly be equal to a month's salary. Here compromises may have to be made in providing decent healthcare. The only alternative for patients who are particularly poor is to go to a government hospital in one of the big cities, but these are much more crowded and it is said to be particularly hard for doctors in these environments to deliver adequate care to patients.

In Caritas Hospital I spent the first part of the morning with consultant physician Dr John Joseph and went on his ward round. Later on I would go to Radiology. I had recently developed an interest in radiology as a potential career path, and I am happy to say that doing this elective has convinced me that Radiology is indeed the specialty I would like to do in future.

The Institute of Pain and Palliative Medicine (IPM) was founded in 1993. Its aim was to provide palliative care on a non-profit basis to terminally ill patients in the area of Kozhikode, a city in the north of the South Indian state of Kerala. It is a community-based service receiving funding exclusively from charitable donations and community fundraising efforts, operating outside of the authority of Kerala's healthcare system. The IPM was so effective in providing quality care to terminally ill patients that it was soon able to incorporate provision of care to chronically ill patients who could not access mainstream healthcare providers (for financial reasons or otherwise).

Numerous centres linked with IPM soon sprang up around the region, taking after IPM's success. Similarly, these were non-governmental organisations. However, the efficacy of these community-run and community-based services was quickly recognised by the state government. Government officials introduced a policy that all councils should have their own local palliative care service, to provide care for all patients requiring palliation regardless of whether or not they are in reach of one of the already-existing NGO's. There are over 400 such centres across North Kerala funded by the NRHM, the government body set up after introduction of the policy.

The reputation of the IPM spread not only throughout the state of Kerala but also internationally. The World Health Organisation designated the IPM as one of five 'collaboration centres' throughout the world, as it is seen to be a model of how a palliative care service can be run in 'developing world' nations.

The IPM is comprised of the main institute building, where terminally ill patients are provided with 24-hour care. Also, chronically ill patients with acute episodes and those being initiated on antiretroviral therapy can be seen to here. There is also an outpatient clinic located on the Calicut Medical College campus, where patients undergo consultations or they may be attending prior to being admitted to the main IPM building. The nurses at IPM do daily 'home care' visits, during which they see chornic patients for routine follow-up, attending to any changes required ie. Wound care, bed sores, catheter care, dietary advice, etc. Doctors accompany the nurses on the home care visits once/twice a week, monitoring their condition, attending to any new signs/symptoms and altering medications as required. Patients are seen by doctors on average once a month, may be more or less depending on their needs.

The IPM focuses on providing 'wholesome' care to its patients. Doctors and nurses not only provide treatment for patients' medical or surgical diseases but also monitor their psychological state, referring to the resident psychiatrist if needed. They are responsible for co-ordinating joint care with alternative medicine providers- patients may receiving ayurvedic or homeopathic treatments, and many benefit from yoga and unani.

Almost all medical care and medications are provided for free, with the exception of those receiving experimental treatments. Those requiring surgical procedures do not have to pay. The IPM has a fund to provide food rations for the family and educational subsidies for the children of

those deemed 'poor' or 'very poor', as well as matresses for those whose standard of living is so low that they are forced to sleep on the floor.

In IPM the pattern of terminal illness was largely the same as that in the UK. Cancer of the lungs, breast, prostate, and colorectal cancers were the predominant cancer diagnoses. Similarly there were many patients with heart failure and end-stage renal disease. However, in the chronic patients, I saw a much higher rate of HIV, with many patients of all ages being started on antiretroviral therapy. Additionally I witnessed a much higher rate of paraplegia. I saw patients as young as 32 rendered quadriplegic as a result of falls. This can be attributed to a more relaxed attitude towards/difficulty enforcing health and safety regulations. Many fell after climbing coconut/mango trees, a problem never encountered in the UK.

At Caritas Hospital, I was shocked by the staggering rate of Type 2 Diabetes Mellitus; much higher than that in the UK. I had seen many diabetic patients in IPM, but I could not appreciate the extent of the epidemic as I was observing mostly terminal patients. In Caritas a massive proportion of the patients were diabetic, and it was disheartening to see that the general level of diabetic control was poor. Many of the type 2 patients were controlled with insulin, and the consultant regularly had to adjust the insulin dose beyond the recommended guidelines as the blood sugar was so high. Diabetic foot and other skin lesions were a common sight, and many were suffering from neuropathy/nephropathy. Otherwise, the most significant difference in pattern of disease was the different range of infectious disease encountered in Kerala. I saw a number of cases of dengue fever and a few cases of leptospirosis. I saw two patients admitted after being bitten by snakes. Another important difference I saw was in patients with COPD. During my studies in London, I had come to see COPD as primarily a disease affecting smokers. However, in Caritas I saw many patients who had never smoked with COPD. This is in part due to a blurring of the lines between diagnosis of asthma vs COPD, but also because of increased pollution and burning of woodfires in kitchens.

The following is a list of patients I saw during one of the 'home visits' in IPM:

- An 80 year old man with hypertension, benign prostatic hypertrophy and coronary artery disease, currently experiencing a urinary tract infection due to the catheter being unchanged for

3 weeks. He had a difficult catheterisation so he required referral to urology. A recent blood glucose was abnormal so he required further testing for diabetes.

- An 80 year old lady with hypertension, diabetes, and a large left ovarian cyst. Mild fatty liver and pleural calcifications were noted on radiology. She was still experiencing abdominal pain due to the cyst. Also, pyuria was noticed on inspection of the catheter. The catheter was changed two days later during the nurses' visit and a sample taken for culture and microscopy. Her glycaemic control was noted to be poor as her blood sugar exceeded 2x the normal limit
- A 70 year old man bed-ridden due to a fractured humerus and femur after a fall 5 months previously. Stage I bed sores were noted on his back, and the plan was to perform a saline wash and compression. He was exhibiting symptoms of dementia.
- A 94-year old lady with a left trochantic fracture as well as a past history of hypertension, currently experiencing problems due to diminished mobility.
- A 36-year old man left paraplegic after a fall 4 years previously. He was undergoing an experimental stem cell therapy for which he had to travel to Kottayam (8 hour drive south), which could not be funded by IPM as the therapy is still in clinical trials.
- A 65-year old lady with a cancer affecting the roof of her mouth and a left sided hemiplegia post-stroke, with a past history of diabetes and hypertension. Pyuria was seen in the catheter and it was noted that catheter care was poor, thus the carers required further education on good catheter care.
- A 80 year old lady bed-ridden due to fractures in both legs, currently experiencing
- A 56 year old lady who had undergone resection of an ampullary carcinoma now having liver metastases. She had also received triple bypass surgery for coronary artery disease. Past history of diabetes and an anal fistula. She was still experiencing abdominal pain with tramadol.
- A 75 year old lady who had undergone excision of a cancer in the tongue five months previously as well as 18x courses of radiotherapy, still requiring another 12 courses, now on step II analgesia
- A 56 year old man with cholangiocarcinoma now invading local lymph nodes, deemed as incurable by urology and admitted to IPM for respite care.
- A 60 year old man with recurrent colon cancer despite hemicolectomy performed in 2009 and numerous courses of chemotherapy, now with liver and bone metastases,

commencing radiotherapy that day. Step down to analgesia with tramadol.

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