M.119/318
Annex VII

THE UNIVERSITY OF HONG KONG
LI KA SHING FACULTY OF MEDICINE

Report on Local/Overseas Clinical Attachment/Clinical Research for the Final Year Elective Module in April/May 2019

Students are required to upload to the Elective System a TYPED report of **at least 1,000 words** on their local/overseas clinical attachment/clinical research by **May 20, 2019**. In case of a clinical attachment, at least one case study should be included. In case of a research project, a statement of the aims of the project, the methods used and the results obtained should be included.

Name of student: LAU, Edward Chi-Hang

University No.: 2013511278

Period of Attachment: 11th April – 11th May

University/Hospital/Institution: Duncan Hospital (Country: India)

Department/Specialty:

Supervisor: Dr Prabhu L Joseph

Name of Travel Grant Awarded (if any):

Introduction:

Duncan Hospital is a missionary hospital established by Emmanuel Hospital Association (EHA). It is located in the town of Raxaul, right at the India/Nepal border.

Christians doctors from all over the country come over to work here, to help the patients in need, as well as to serve the God that they believe in.

It provides a 24/7 emergency service, as well as inpatient and outpatient services of the departments, including Paediatrics, General Medicine, Surgery, Obstetrics & Gynaecology, Orthopaedics & Traumatology, Psychiatry, and Dentistry. They have also established a community service, with medical professionals going to outpatient clinics in different remote towns and villages on a regular basis.

The aim of this elective is to work among these people in all departments, in order to gain a good understanding of the local practice, culture, and the most prominent healthcare problems that they face. During the stay, it is also a good opportunity to learn about the healthcare and training system of India.

Things that have been learnt:

Due to a shortage of doctors, staff at Duncan always welcomes visiting students and doctors to participate in their daily routines and that was how I started learning from them.

Every morning, I joined the doctors' meeting, where junior doctors reported the cases admitted in the last evening and senior doctors taught. They sometimes had evening classes to prepare the junior doctors for their entrance exams to postgraduate colleges, which I also participated in.

Indian healthcare system was so different from Hong Kong's, while also being so similar.

Their specialties are trained in postgraduate colleges, unlike the on-job training in the British system, which Hong Kong adopts. Indian junior doctors learn knowledge across specialties while working, in order to sit in the nation-wide entrance exam. They then select their preferred field of specialisation, with the high-scorers given the priority to choose. Specialties, to them, are courses taught in a college, after which they graduate as specialists.

This system puts missionary hospitals, such as Duncan, at a disadvantage. These hospitals receive a large quantity of patients every day, which give the doctors a golden opportunity for clinical skills and knowledge. The exam, however, focuses on learn-and-churn knowledge, which you get nowhere but from textbooks. Doctors are, therefore, deterred from working in missionary hospitals if they wish to be perfect scorers in the exam, which is a prerequisite of 'good specialty' and 'good pay'.

All medications and investigations are charged per item. Instead of a panel of investigations, doctors in Duncan have to be very selective of their choice of order, challenging the necessity of each as it may charge a fortune. This practice forces all of us to go back to statistics and fundamental knowledge, e.g. which tests being more sensitive/specific and cost-effective.

Albeit the difference in system, the problems they face are largely similar to ours.

Poor public health education leads to unsatisfactory doctor-patient relationship, health-seeking behaviour, and common misconceptions.

'Northern' people tend not to believe 'southerners', which most doctors are. Southern female doctors are, as one can imagine, not too 'trustworthy' to the locals. Not knowing what 'illnesses' are, locals sometimes cannot even give proper history, confusing everything with a fever, and ask for painkillers even if it has nothing to do with their conditions. They sometimes even neglect symptoms, assuming that is normal, and present to medical professionals at quite late a stage.

Duncan is small and poor - that is true. They run a charity fund that they can offer to the people in need. They do not have an abundance of medications, let alone novel treatments of any kind. However, it is often observed that the healthcare is not limited by resources or manpower, but the public awareness and education. It is in Duncan where I can see the importance of public health.

Drawbacks:

The place is ideal for the training of medical professionals, revisiting the fundamentals every day and challenging one's mind. However, this experience is greatly limited by the language barrier.

Not all Indians know Hindi and some speak local dialects. Being an exchange student knowing only English, one can hardly participate in acute scenarios and case clerking. Staff is most willing to do translation, but only when they are free. With almost 400 patients a day, out-patient clinics are definitely not a place that allows case discussion following each case.

One is encouraged to take up duties in the Emergency Department, where first aids, BLS, and ACLS are often needed. However, when the vitals are stable, secondary survey is, again, limited by language.

Lasting for only a month makes elective period a perfect opportunity to get to know a place, as well as getting familiarised with the local practice, but not enough for one to work at the full of his ability.

Comments/Recommendations:

Being proactive is essential for a foreign student at Duncan.

Actively learn the local practices and participate in the discussions. Asking to help is also most-welcomed as they are more than willing to teach and allow you to carry out

procedures, such as lumbar punctures for paediatric patients. Staying in the emergency room also requires you to perform basic vitals monitoring and clinical procedures, e.g. setting up IV access. Staying in OPD, one can also try and participate in the management planning, prescribing medications and ordering investigations. Everything is possible, as long as you ask.

Case Report/Project:

There are two cases that I remember most vividly.

The first one was my first case in the emergency department, a young child with secondary burn over half of his body. The burn was over a week old and his parents only brought him in because he seemed to 'have lost his 'appetite', not knowing the severity of the burn nor the secondary infection that had already infested might have costed him his life.

All I could do was taking the vitals and clean his wounds.

We could not treat him at Duncan as the skin graft he needed required a higher centre. We made the referral and the parents took him away. However, we doubted greatly if the parents, not understanding the seriousness of the condition, were really going to take the child to the centre. We could not even know if he could take the medications with compliance.

The second case was a pregnant lady I met at the community clinic. Being 30-week pregnant, she has complaint of lower abdominal pain since the first week. She constantly refused any further checkups or even physical examinations and only came to the clinics for painkillers every few months, given by the nurses. When I saw this patient, I insisted on a physical examination and not prescription, as I was worried there might be something worrying.

After long discussion with the patient and her family, they finally agreed to a physical examination, which amazed the nurse, as if miracle just happened. The exam showed discharge from cervix, which required immediate referral to the hospital, to which the family agreed to as well after discussion, amazing the staff once again.

These two instances showed how management of patients is often non-medical, and what good education and discussion can actually help with one's health.