COMMUNITY MEDICINE

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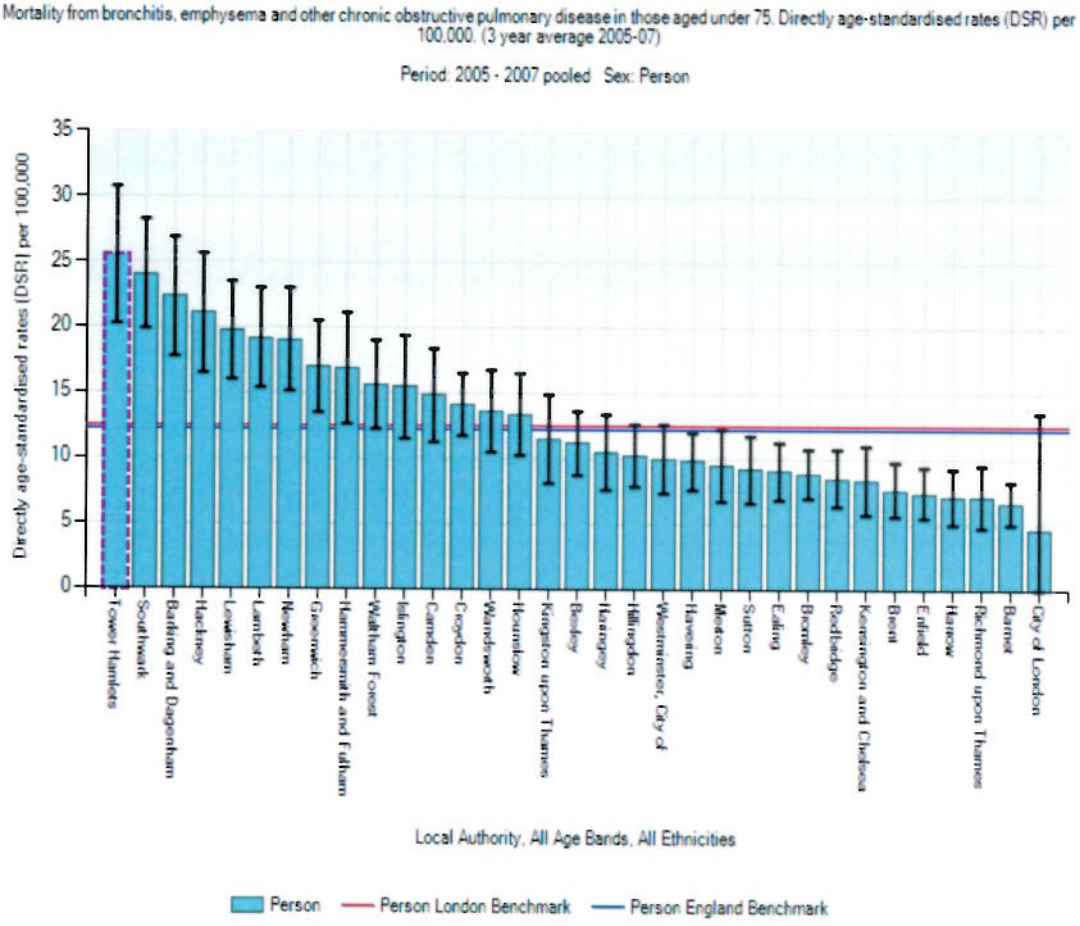
Elective Report - Stroudley Walk, Bow, London, Summer 2011.

1) Describe the main causes of morbidity and mortality in Tower Hamlets, and their significance.

Tower Hamlets have one of the most economically and ethnically diverse make ups of all of the London Boroughs, being home to one of the largest Bangladeshi populations outside of Bangladesh. Life expectancy is 75.3 years in the borough, while national figure lies 2 whole years higher at 77.7 years. The rates of mortality have been shown to be improving, but at the same rate as the national picture, with little reduction in the gap between the two. While this indicates that healthcare strategies are having an effect in Tower Hamlets, it suggests that an even more intensive approach is required to bring the borough in line with the national picture.

A comprehensive review of morbidity and mortality in the area is beyond the scope of this essay. A good example of a condition that affects a large proportion of the population and that has a heavy cost on the healthcare services is Chronic Obstructive Pulmonary Disease. One of the primary causes of COPD is smoking, a highly addictive practice with a higher prevalence in lower socio-economic groups, and one which is popular in the Bangladeshi community. In tower hamlets, the rate of mortality due to COPD is approximately twice that of the rest of the country! The reasons for this are multi-factorial and include language, culture, socio-economic classes, health education and engagement of the population with this



education. Basically, different people smoke for different reasons. This illustrates how in order to tackle COPD related mortality in Tower Hamlets a multi-faceted approach is needed, taking into account medical, cultural, social and economic differences in order to redress the health inequalities in the borough compared to the rest of the country.

This not only applies to COPD, but for a range of other conditions that are a major problem in the borough including Coronary Heart Disease and Diabetes Mellitus.

2) Compare the primary healthcare system to that of another country.

As my elective was in the United Kingdom in Bow, I will focus on a general overview of the primary care system in the UK and a reflection on my experiences in it in the 3rd objective.

Primary Health Care is a concept developed by the World Health Organization in the 1970's and enshrined in the WHOs Director General Halfdan Mahler (1973-1983) definition of "Health For All": "The health services must be accessible to all through primary health care, in which basic medical help is available in every village, backed up by referral services to more specialized care." Thus primary healthcare are the services with which the public have first contact about their presenting complaint.

In the United Kingdom these services include GP practices, dental practices, community pharmacies and optometrists. There are some 800,00 GP appointments per day, 250,000 dental appointments, 1.2 million health related pharmacy visits and some 31,000 sights tests performed each day (DoH.gov.uk).

GP practices function as 'gateways' to secondary healthcare. Patients are referred by their GP to the specialist most appropriate to their needs. GP's therefore must be able to identify and categorize the broadest possible range of conditions, and then know which specialist is best able to deal with them. Not only this but GPs must also be able to recognize when someone is effectively healthy, or 'worried well'. Therefore, as GPs are responsible for referrals and many initial diagnoses, GPs are also responsible for a large portion of spending within the NHS budget. This is an essential aspect of our primary healthcare system, and one which the current government has been taking steps to increase in importance.

3) Describe an interesting case

See attached referral letter.

Reflection on the case and on working in a primary healthcare setting:

This case was the first patient I met in the primary healthcare setting who could be classified as 'worried well'. He was a caucasian, middle class gentleman who presented with a range of non-specific symptoms and who was a highly anxious individual. He was keen to obtain a private referral to an ENT specialist, as he felt that the route of his problems lay within his sinuses and throat.

I performed a thorough history and examination on him, covering all of the major organ systems and possible associated symptoms, but was unable to identify anything that would give me cause for concern, other than a high level of stress at home and at work. On discussing the case with my supervisor, he agreed that the patient was most likely simply anxious and that the symptoms were stress related, and that I should write the referral letter and document my lack of findings in the notes.

I chose to reflect on this case as this was the first time that I had properly felt responsible for identifying a patients symptoms as having no organic cause. I found this case difficult to forget about over the following days, and was worrying that I may have either missed something, or that there may have been things present in the history and examination that I did not realize were significant! I discussed my worries with Dr.Amuludun. He explained that one of the features of primary care is that you can always call the patient back if you are worried about something, and that patients will always return if things don't improve or get worse.

In hindsight this was a valuable experience for me as it highlighted the importance of being thorough, confident in your abilities, but also knowing your limits and when to ask for help. It helped me develop confidence in my clinical skills and to make me more aware of where my limits lie, and consequentially how to improve and expand on them.

4) Assess the importance of good communication skills in the setting of a GP practice.

Being a student in a GP practice and seeing patients independently enabled me to practice my communications skills on a daily basis. I feel that this kind of intensive experience has enabled me to be more aware of patients moods, attitudes and personalities. For example, I would call each patient into the room from the waiting room. This allowed me to firstly, observe their behavior, gait, dress and mood, and secondly to observe their reaction to be being seen by a student. I have learnt that this brief moment reveal a large amount of information about a patient. Do they move quickly, or are they slow and lethargic? How are they dressed and how is their personal hygiene? Are they organized, or do they have belongings and papers everywhere? Are they here with someone else, does that person come through? How much eye contact do they make? Do they seem at ease in a room full of other people or are they visibly uncomfortable surrounded

by strangers? These are all questions which can often be answered before the patient has even been greeted. This placement has helped me to sharpen my powers of observation and perception. I have learnt that these observations are 'snapshots' that can be used to form a larger image of the patient and their well being.

I feel that this placement has taught me the importance of being observant, not only for physical signs, but also for behavior, language, tone and mood as a part of the medical history and examination, and as a means to aid the development of rapport with patients. While at medical school we received comprehensive teaching about core communication skills. This placement let me practice these skills, but also allowed me to learn about the more subtle aspects of communication that cannot be taught as easily in a classroom. These are skills that I feel I will find invaluable, and take with me into my professional practice.

References:

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