

## Parag Bakshi Fellowship essay

I took part in an international health experience which was sponsored by the Delaware Chapter of the ACP in Dr. Bakshi's honor during the month of April, 2005.

I traveled with my wife, who is a physician, to New Delhi, India. After a brief, one day visit, with my wife's grandparents, we boarded a train bound for Jalandhar City, in the Northern state of Punjab. The Shatabdi express, the name of this train, took about 5 and a half hours to reach Jalandhar. The scenery along the way was beautiful: colorfully dressed farmers, red tractors and small villages dotting here and there among golden fields of grain, against a blue cloud laden sky.

Arriving in Jalandhar, we noticed a major contrast to New Delhi beyond the obvious, such as size. The complexity and pace of the city is different. The culture is Punjabi, unique in both of language and customs. Although English and Hindi are the two national languages of India, there are so many different cultural and ethnic flavors spread among the states of India. My wife's knowledge of the Punjabi language and script was helpful in navigating throughout Jalandhar.

My elective took place at the Guru Nanak Mission Trust hospital in Jalandhar City. It is a not for profit hospital supported by a trust in the United Kingdom. It is affiliated with the Sikh religion. It is named after Guru Nanak Dev Ji, who founded Sikhism in the late 15<sup>th</sup> sikhism. Sikhism is a monotheistic religion that developed within a cultural mix of Hindus and Muslims. There are many Sikhs around the world, although the majority are in Northern India.

The hospital is not as modern as are the private facilities in the U.S. and New Delhi. It has six floors and approximately 200 patient beds. In house specialties include pediatrics, otolaryngology, general surgery, orthopedics, internal medicine, ophthalmology, and pathology. Many of these beds are in common wards. For those patients who can afford the additional rupees, there are some private rooms. In the open wards, it is common to see a male in one bed and a female not too far away. Oftentimes, a family member will stay with the patient, helping with the daily care. The light in the wards is fluorescent, but windows abound and are open, ushering in the sounds of the many different and sundry forms of transportation on the streets, from three wheeled auto rickshaws, to larger goods carrying trucks – all honking their horns in a cacophony of mechanical birdsong.

The medical ward consists of around 60 or so beds, with 2 –3 three nurses, called sisters, and a team of house physicians, most of whom are fresh out of medical school with their MBBS degrees. Many of them are studying to sit for a specialty exam so that they may earn their M.D. In India, the competition to gain entrance into medical school is keen. Applicants compete against thousands, in which success is measured by the scores on entrance exams. The competition begins well into the equivalent of high school.

We rounded daily with the house physician team and attending physicians. I also spent 4 hours daily in clinic with the chief of medicine, Dr. Kulbir Sharma. In his outpatient

clinic, better known as “the OPD” (outpatient department), he may see well over 80 patients per day during the peak preharvest season.

The OPD essentially functions like an internal medicine clinic, combined with the added urgent care patients and occasional emergencies. Patient presentations varied but the common things were indeed common such as diabetes and hypertension. Interesting patient vignettes were common from a 50 year woman with childhood poliomyelitis and flaccid paralysis of the lower extremities coming in for a routine check up, to a 40 year old female with fever, weight loss and a chest x-ray consistent with military TB. I saw several adult patients who had had poliomyelitis as a child. The aforementioned patient had such severe atrophy of her lower extremities with flaccid paralysis, that she ambulated in a squatting position, with her buttock about 3 inches off of the ground, moving her legs by grasping and lifting them with her arms. She did not have a wheelchair, couldn't afford one, yet had a smile and look of determination on her face that could move mountains. A Sardar (male Sikh) farmer came in one day for a routine check up for his hypertension. Interestingly, he had classic pitting scars on his face along with an atrophic and blind left eye, residual effects of a childhood smallpox infection. Iron deficiency anemia is common, although the cause is often helminthic, from hookworm infestations from farmers working outdoors barefoot.

The order of business in clinic was treat the patient, as is the credo of medicine, yet to be mindful of his or her resources. Tests were ordered based on what the patient could afford. This hospital has a pathology lab (laboratory), x ray department, and most major specialties (except OB/GYN). Yet, if a patient needs an upper endoscopy or a CT scan, they have to go to another facility, such as a private physician's own specialty hospital. They have to be able to pay up front for their services and tests. Dr. Sharma performed very focused histories and physicals, reflective of his strong clinical acumen and years of experience. Oftentimes the only clue on physical exam that confirmed our suspicion from the patients history was a palpable spleen in a patient with enteric fever, or a prolonged expiratory phase in a patient with asthma. The joy and curiosity I had with medicine during my third year of medical school, was reignited while rotating through this clinic.

Patients of varying social backgrounds carry their medical records on their person, and although some were noncompliant, the responsibility they took for themselves was impressive. In the hospital, it is the patient's family's responsibility to go downstairs to the pharmacy and buy a bottle of sterile saline, a vial of cefotaxime, or an IV start kit and tubing. I did not once see any complaining from patients over this; they were so grateful to receive medical care, and were respectful of the physician. Even during our efforts to try and resuscitate a woman in cardiac arrest, her husband walked down three levels to purchase more glass ampules of adrenaline and atropine; only to witness us pronouncing her dead minutes later. It is certainly a different concept in India. Although the access to care has many barriers, financial being one, patients seem to be very empowered in their healthcare.

The house physicians were very friendly. My wife and I befriended one in particular, Dr. Divya Grover, who invited us out on excursions with her family in and around the city. We stayed at a hotel about 2 miles from the hospital. Oftentimes we would walk in the morning to the hospital or take a rickshaw (three wheeled bicycle – person powered). Walking was more convenient if we wanted to purchase a mango or two from a seller.

The experience was very rewarding. It was more than a medical rotation, but a cultural immersion. The medicine was just one facet of the experience. A rotation such as this has helped me to reevaluate my perceptions and to experience the immeasurable curiosity I have for the art and science of medicine.

I would like to add that Dr. Bakshi had an immense fund of knowledge and drive within Internal Medicine. His presence in the residency program is greatly missed.

His contributions to Christiana Care's Internal medicine morning report will always be appreciated. His ability to teach medicine from the nuances of managing hypothyroidism to generating stellar differential diagnoses has greatly added to my residency training, and is certainly inspiring. I would like to thank his wife and family for supporting my elective. I would also like to thank Dr. Saberi, Dr. Diane Coniglio and her subcommittee, and the Delaware Section of the ACP.

Sincerely,

John C. Vandover, M.D.  
PGY-5, Emergency Medicine/Internal Medicine