During the final year of medical school, I was given the opportunity to undertake an elective period abroad to discover how medical practice differs from the UK. I chose to spend my elective in India throughout August and September of 2007.

I had planned to spend August on the *Himalayan Health Exchange* (HHE); a challenging 4-week medical/dental trekking expedition through several Tibetan settlements located in a remote high altitude region of the Trans Himalayas in North India. This provides free healthcare and medicines to people in need, on a trail that is high in altitude, rough, challenging and lies above the Himalayan tree line, with clinics and campsites located between 12,000 and 13,500 ft.

After meeting in Delhi, the team took the short flight to Leh, in the Ladakh region of Jammu & Kashmir. On stepping out of the aeroplane I immediately felt palpitations, light-headedness and disorientation: the effects of going from sea level to 3,000m in a matter of hours, even though we had begun acetazolamide treatment to prevent symptoms of acute mountain sickness (AMS). Shortly after this, I developed a persistent cramping pain in my right calf. Due to the recent air travel and possible dehydration and lack of investigations available, the possibility of a deep vein thrombosis could not be excluded and I began taking aspirin. After 2 days rest and acclimatization, we set off on a 2-day bus journey to Pedom. Unfortunately, I developed severe breathlessness and as there was every possibility of it being caused by a pulmonary embolus, I was evacuated.

The emergency evacuation was protracted over a week: the field physician needed to contact the travel insurance company to inform them of my condition and arrange an emergency helicopter. Given the restricted area of Jammu & Kashmir in which we were traveling, it took a day to arrange an Indian Air Force helicopter evacuation back to the military hospital in Leh, where I began taking enoxaparin and spent a sleepless night. A medical evacuation team from UK-based *International SOS* flew me to a *Max Super Specialty Hospital* in Delhi, where I was subject to gambit of tests and investigations; all of which came back clear and negative.

With no identifiable cause and my symptoms resolved, I was discharged and flew home to England 5 days later, with the tentative diagnosis of atypical AMS. I later presented this information to the field physician via E-mail; he thought it possible that I suffered high altitude pulmonary edema (HAPE) although this can only ever be a speculative diagnosis. This demonstrates the medical challenges one can face in the remote developing world; lacking access to imaging and investigations we consider routine and mandatory in the UK, as well as high altitude medicine: both of which I was able to experience first-hand. Interestingly, *International SOS* invited me to their London office to give an interview of the whole experience and feedback on how they handled my evacuation. I was so inspired by their operation, that I may even join their staff as an evacuation doctor in the future.

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With my expedition curtailed, but my health restored, I set about working in King's College Accident & Emergency Department, in South London. I spent three weeks there, mostly attending nightly trauma calls, suturing and assisting in resuscitation. Although not part of my original elective plans, I feel my time in A&E allowed me to gain greater confidence in my ability to perform clinical procedures in the acute setting whilst thoroughly enjoying it.

The second of my planned elective placements was organised by the *Charities Advisory Trust*, a UK registered charity, in conjunction with the *Association for Health Welfare in the Nilgris* (ASHWINI) an Indian charity, to offer medical students a unique opportunity to see an integrated health programme in a poor rural community. The medical student elective aims to provide an interesting, engaging and most importantly genuine elective placement for medical students and professionals, whilst at the same time generate a stable source of funding for the ASHWINI health project.

This 5-week programme involved one week of observing various community projects in the eco-friendly *Green Hotel* of Mysore, Karnataka (which happens to be painted green), and another 4 weeks of hospital apprenticeship in Gudalur Adivasi Hospital, Tamil Nadu.

In Mysore, one of the more inspiring projects we visited was the *Association for the Welfare of the Mentally Disabled* (AWMD). The AWMD was set up in 1987 to provide shelter and safety for mentally (and physically) disabled children and their mothers, from the stigma they receive in the slums of Mysore, in addition to appropriate education and life skills. Some of the older members, not able to earn a living independently, can go on work placements that are appropriate to their level of capability or make arts and crafts that, when sold, contribute to their own welfare. This provides them with the opportunity to be part of a working society as well as take some responsibility for their own wellbeing. The overwhelming success of the AWMD has led to oversubscription of their service and the birth of their home early intervention programme: parents spend Saturdays, learning skills that they can impart to their children and provide social support by meeting with other parents of mentally disabled children. This gave me an insight into how stigmatised psychiatric illness is in India, with reports that even fathers/husbands of these people ridicule and disown them. One can sponsor a child or contribute to other aspects of AWMD via their website www.awmd.org.

Foreign traders have long used the lush Nilgiri Hills in Tamil Nadu for tea production, and with the local tribal people, the Adivasi, unwise to the practices of competitive, capitalist markets, they have become poor. In the last 20 years, the Adivasi have reclaimed this land, set up the Association for Health & Welfare in the Nilgiris (ASHWINI) in order to address the lack of government assistance in the area, and aimed at the tribal needs.

ASHWINI bought a building in Gudalur, from which to manage doctor-led rural and public health education programmes. In time, this attracted patients, whereby the sickest were "admitted" and hence Gudalur Adivasi Hospital was born.

Today, two doctors, a surgeon-come-physician and an obstetrician, two dentists and a core nursing team staff Gudalur Adivasi Hospital (GAH). During my visit in September, I was also fortunate enough to welcome an eminent visiting Professor of Paediatrics.

A routine day at GAH begins with 8:30 teaching[1] followed by a ward round of all in-patients and new admissions. Tea is served before the morning walk-in clinic, where the doctors will see all who turn up on the day: non-tribal patients are welcome on Mondays and Thursdays and on these days it is not uncommon to see more than one hundred patients. After lunch, there is more teaching and tea, before clinic is continued. The on-call student(s) is then required to admit and work-up all new patients for the next day's ward round. GAH also has a labour and newborn room for deliveries, as well as an operating theatre, where the obstetrician performs caesarian section deliveries under spinal anaesthesia.

The teaching I received, formally, on ward rounds or in clinic, was of the highest calibre and it was interesting to learn about, see and manage patients with conditions that are less common or not at all seen in the UK. Of the routine days, I most enjoyed the on-calls, as this was when I was responsible for managing patients and delivering babies: I delivered two healthy babies, a boy and a girl.

Unfortunately, given the lack of resources that we in the UK would consider routine, it was sometimes all we could do to watch someone deteriorate. A case that will remain with me is one of a middle-aged man that had suffered a myocardial infarction and subsequent complete heart block. If he had been in the UK, he would have received a pacemaker, but in this case, it was just a matter of making him comfortable whilst he slowly died.

At least once a week, students were encouraged to go on field visits with health animators (HAs). HAs are local people that are employed and trained in promoting good hygiene, dispensing simple analgesia and six-monthly de-worming tablets for children. They also carried out the monitoring of malnutrition that plagues these parts, by weighing the babies. It was also another good opportunity to practice clinical skills in the field, with a view to deciding whether patients should make the trek to GAH (sometimes days long without transport). Training health animators in such a way has allowed GAH to reach a much wider population than those willing and able to visit the hospital: dispensing much appreciated medication to patients that would have otherwise gone without and providing education that enhances the health of the local population, especially when delivered by someone they know and trust.

[1] Teaching ranged from management of common paediatric/obstetric conditions to surgical techniques and case scenarios.

I did however, experience some frustration here, with belief and culture overriding the autonomy of sick people, preventing them from seeking a doctor's opinion from which I'm sure that would have benefited and choosing to go home to ride it out or even just to die.

In some towns that were far away from any medical care, students would go with one of the doctors to conduct an outreach clinic in a requisitioned room, often in a school or back of a shop. Here the doctor and students were able to clinically assess patients and prescribe antibiotics for infections, but mostly reassure parents that their children were okay. The biggest complaint was that of scabies and it was our job to educate them on throwing out or boiling their clothing and bedding to eradicate the problem. I was amazed at one 11 year-old boy who had developed a full-body infection as a result of scabies and didn't appear to be the least bit bothered by it: just one example of the level of illness these people are willing to tolerate and why these outreach clinics are so important.

For me, India was a great opportunity to experience the limitations of developing world medicine, both as a visitor to high altitude and as an observer of a wholly different culture. I know that my confidence in clinical medicine has improved, sometimes through necessity rather than choice, and I hope to carry this with me throughout my future training.

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Thank you for your time in reading this and please feel free to contact me with any queries.

With best wishes

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