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I undertook my medical elective at Hinduja Hospital in Mumbai, India where I was able to experience and observe renal medicine in several different ways. A lot of this exposure was in renal outpatient clinics where I was able to contrast the doctor-patient interactions to that which I was used to in the UK and examine patients with interesting and different conditions to what I had seen before, ranging from Takayasu's arteritis to lupus erythematosus. The different cultural considerations in India were a particularly interesting learning point when considering patients with chronic renal failure. For example, one family were having problems with the fact that it would be unsafe for the patient to conceive with her poor renal function which was causing tension between her family and the one she had been promised to marry in to. The patients were also much younger in general to any renal patients I had seen before and this was shocking at first, especially when discussing the prospect of lifelong dialysis with a young 7-year-old boy. As well as this, the cause of many patient's renal failure seemed to be cryptogenic and run in families and there seemed to be no intensive hunt for underlying genetic causes or otherwise which contrasted to the sort of investigative medicine I had seen in the UK and appeared to be an opportunity for furthering knowledge and research.

I was lucky enough to be able to observe a renal transplantation during my placement and see the complex aftercare of numerous transplantation patients both on the ward and in clinics. In surgery I observed the renal physicians prepare the kidney after removal from the donor and watched as the surgeons transplanted it in to the recipient. Although the hospital was private its charitable commitments means that poorer patients had their treatments including transplants part or fully funded, and I feel I was able to interact with patients from a wide range of backgrounds.

On the intensive care unit, I saw the more acute side of renal medicine where hemofiltration was used for patients in renal failure or with severe fluid overload. Renal consultants were able to make decision about suitability of patients for treatment but interestingly having seen palliation and de-escalation of treatment as a viable and appropriate option for many patients in the UK this was never discussed with patients on my placement and the threshold for renal replacement was much lower, with it seen as a standard treatment for many patients on the ICU. In addition, doctors told me that DNACPRs were not used and thus even the most frail and unwell patients seemed to be for full escalation and resuscitation. This was a particular topic of reflection for me and I thought that this may be due to a complex mix of cultural norms, legality and a large private healthcare system where money may often trump pragmatism.

I was shown around the renal dialysis unit, known as the AKD or artificial kidney department which ran at full capacity every day with military precision. As soon as one patient left the bay, another was waiting with their personal filter where the technicians cleaned and exposed their fistula for cannulation. I found the experience interesting, but it also made me reflect on the true cost of dialysis which seems on the face of it to a miracle treatment. Seeing so many people having to make the often long journey into a centre that will offer them dialysis took up a huge proportion of many patient's time and the unit itself was small and crowded with patients simply sat on a bed watching television for hours a week during treatment.

My interest in non-communicable disease was developed on this placement as I was able to observe the huge burden of disease in India, especially that caused by type 2 diabetes as many patients on the AKD were diabetic nephropathy patients. There is an obvious role for primary prevention in renal disease and public health interventions have an important role in India in reducing the seemingly vast number of chronic renal failure patients, especially if renal replacement capacity may struggle or be too expensive for many to afford. Diet would be an obvious first target- with surveys estimating as much as 70% of the Mumbai population being overweight or obese, and readily available high calorie foods on every street corner.

My elective was a fantastic insight into renal medicine in a developing country and I also was able to gain a wider exposure to the speciality. All of the doctors at Hinduja Hospital were friendly and welcoming and I am very grateful to them for their hospitality and learning opportunities.