## ELECTIVE (SSC5b) REPORT (1200 words)

A report that addresses the above four objectives should be written below. Your Elective supervisor will assess this.

**M**y time spent in India has been a wonderful learning experience both personally and professionally . Besides the impact of practising medicine in a high-demand, resource-poor environment, there is a large cultural influence on how healthcare is delivered and obtained. This report will aim to address the objectives set by highlighting some key experiences or observations:

1. Almost every eye I saw during my time at KEM Ophthalmology department had some significant or visible pathology. This best sums up the severity of illness often seen. As part of an student selected component, I spent six weeks at Moorfields eye hospital in the UK. Common pathology frequently seen were mostly age related disease processes. These included glaucoma , cataracts, age related macular degeneration, diabetic eye disease and uveitis. At KEM hospital, I frequently saw diabetic eye disease, eye trauma, corneal grafts, cataracts, some cases of chorioretinitis (both infective and non-infective) and a possible case of ocular TB. Diseases frequently present for the eye department are of differing profiles and usually more severe than would be seen in the UK. For example, I saw an active case of toxoplasma chorioretinitis and a lot of old cases. Although toxoplasma infection is common in the UK (approximately 20% of the population), cases of ocular infection or a previous history are usually only seen in patients with immunocompromise. Another striking difference, was two patients, who presented with fungal infections of the cornea. I have previously read about these in books and was surprised to see a few cases. It is not a top differential diagnoses for corneal infections in the UK and is only investigated when standard treatment fails or in atypical presentation such as farmers. On questioning the patients, both indicated that they were not involved in farming practices or immunocompromised. Intraocular foreign bodies are another common presentation. This is due to poorly enforced work safety practices such as EPP equipment.
2. Healthcare in India is paid for, compared to the UK where it is publicly funded and free at the point of care. However ,in government hospitals, patients often pay a heavily subsidised fee with a significant number under the poverty line receiving free treatment particularly in an emergency. Eligibility for free treatment is determined by a social worker who applies on the patients behalf to the local municipal corporation. With as large population, there is a high demand on the limited resources available at these hospitals. Patients are often seen by numerous private physicians who carry out various tests depending on the patients needs. This means that for a lot of patients, unless eligible for free care, there is no continuity of care where they are seen by the same doctor at the hospital or have all there healthcare needs met at their local hospital. Due to the pattern of healthcare provision and also limited resources, there is no electronic care record system. Patients present to the doctor carrying their medical history in their notes. So on seeing patients, doctors often flick through several pages of results from different care providers and piece together a detailed history of a patient they are unfamiliar with. One striking advantage of the healthcare system in India is that there are no waiting lists.
3. Although the principles underpinning the practice of Ophthalmology in UK and India is the same, as is the knowledge base, the practice and the method of delivery is strikingly different. Ophthalmic practice in India is shaped by a limited-resource high-demand environment: cultural norms and behaviour, the patient attitude to care and the pattern of disease. I spent half my time in the outpatients department (OPD) and the other half at the theatre. Both were very informative as to how care is delivered.



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KEM Hospital is a government hospital which offers healthcare at a subsidised rate compared to private care. As a result, the demand for ophthalmic services is high. Around 150 patients go through the outpatients department per day. This is a considerable number for a department in a hospital in comparison to slightly higher numbers seen at a specialist eye hospital in the UK which is a lot larger with more staff. This places pressure on the doctors to work at quickly as possible whilst delivering safe and effective care. Patients often queue up in large numbers and move in quickly in and out of each section, for example, hopping on and quickly off the couch to have their nasolacrimal duct latency checked. The patients population are also not very educated which means that a lot of the instructions given are often not understood. This increased the time pressures and was a bit challenging for the doctors. Watching the patients in the OCT scanner highlighted this as the machine could not take a reading if the eye was not focused in the right position. Patients often had trouble keeping their eyes steady and the resident spent a considerable amount of time trying to instruct the patients.

The setting of the theatre was markedly different to what I was used to. There were 4 theatre beds in a large theatre as opposed to one per theatre at Moorfields eye hospital. This meant 4 patients could be simultaneously operate upon by the doctors. Also I noticed that there were no blue disposable surgical gowns and the equipments were autoclave and the theatre was washed every week and fumigated. This is understand in a low resource environment. However, all the standard procedures were followed and the equipment were all sterile.

The tools used by the ophthalmologists were not as high tech as commonly used in the UK, but the care delivered was of comparable standard.

Another important learning point for me was after a clinical incident occurred. I observed the resident involved writing a letter in apology for it to the head of department. This was surprising as we have an online reporting form (datix) in the UK in which clinical incidents are reported and then analysed and acted on. On speaking to the head of department (HOD) I was told that such systems weren't available at the hospital and the HOD had taken it upon herself to ensure her residents reflect on and learn from these incidents by requesting a letter. She said the reason for this was because these systems were not available for the patients involved in such incidents and also being poorly educated, most patients visiting a government hospital would mostly be fearful to receive some care. This struck a chord with me especially with the rise of defensive medicine in the UK. It reminded me that doctors are advocates for patients and even in circumstances where there are no checks in place, it is up to the doctor as a professional to uphold themselves to a standard. I hope this is an attitude I apply to my practice in the future regardless of where I find myself.

4. Social determinants of illness in this setting include poverty, poor hygiene and possibly a poor nutritional status. Patients often present with more infectious diseases than the UK. They also present with greater severity as the patients often delay presentation to avoid a medical bill they cannot afford. Other factors include a high pain threshold, ignorance and a lack of education. These impact on what is seen as severe and requiring hospital attendance.



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