

## **ELECTIVE (SSC5c) REPORT (1200 words)**

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

I undertook my elective in the small city of Moga, in the state of Punjab, India. I worked in Kaura hospital, a multi-specialty centre and specifically concentrated on the surgical aspects of the hospital. The hospital spanned over two floors. The first floor contained a walk in clinic, six side rooms, a laboratory, a treatment room and a pharmacy. The second floor contained 2 theatre areas. There was also a third floor, however this contained a small hostel for the nurses who worked within the hospital to live in, free of charge, so that are able to attend emergencies if need be.

The hospital specialised in laparoscopic surgeries and surprisingly the commonest condition requiring this surgery was cholecystectomy. I was astonished by this due to the fact that a laparoscopic cholecystectomy is equally one of the most commonly performed procedures in the UK as well. My initial thought was that hysterectomies would be the most common reason, due to the cultural acceptance of surgery as permanent contraception. Equally Moga is a rarely rural area that mainly consisted of fieldwork and farmers, however it would seem that the city has industrialised and therefore more and more of its populations has taken on sedentary jobs and therefore lifestyles. Consequently the amount of gallbladder removals due to inflammation has risen.

With regards to post-operative care, the hospital has dedicated beds in side rooms for surgical patients. In the UK, due to the NHS, post-operative care is provided free of charge to all patients, regardless of the income they earn. Furthermore follow up care can also be provided either through GP visits or referrals to a specialist consultant if need be. However in India, only government funded hospitals offer free care, which in itself is limited to the immediate stay of the patient in the hospital. However I worked in a private hospital and therefore all care had to be paid for. From what I could see most families would pay for the immediate care of their relatives after surgery, which consisted of saline drips, antibiotics and wound care. However after the first mandatory two or three days in hospital, the family would then ask to switch to oral medication as quickly as possible as this was cheaper than the intravenous drips which were being used to deliver the antibiotics. Furthermore the patients' family would then only pay for bandages and change the dressings themselves. I found it admirable that families would take on a lot of the patients hygiene care themselves. In additions to the families were very keen to ask both the nurses and doctors and sometimes even me on what caused the illness and how to prevent it in the future. This was something that I had only seen a finite amount of this in the UK, where patients families would only visit their relative for one to two hours per day and the conversation between the doctor and families would mainly consist of asking the current condition of the patient and when they would be discharged.

The highlighted differences could exist for a number of reasons. Firstly the UK population is far more educated than the population of India, with better access to online resources. Therefore families in the UK could already know a copious amount of the disease that has affected their relatives and therefore are more concerned with the immediate wellbeing rather than prevention, as this information they can access online. The second reason could be related to finances, since the population of India are more deprived, prevention for them carries more importance.

As mentioned before post-operative care consisted of drips, antibiotics and changing the surgical site. On many occasion the doctors were presented with the conundrum of patients not being able to

afford any post-operative care. In situations like these the doctors decided that infection was the biggest risk that the surgical patients faced and therefore encouraged antibiotics wherever possible. For patients who couldn't even afford this care, nutrition was made of the utmost importance. The doctors sat down with the relatives and tried to work out what they could afford in terms of food and tried to formulate a plan to ensure that the risk to the patients' health was minimized.

With regards the patients care once they had left, this was wholly dependent on the relatives of the patients and how they balanced the needs of the patients to what they could afford. The doctor recommended affordable follow up visits wherever they could. I asked the doctors about how they keep records of how the patients are doing after surgery and the doctors highlighted that a major obstacle was the facilities available at the hospital. Ultrasound scans were not offered at the hospital and therefore patients' had to go to third parties for scans. This posed the problem of patients opting for different scan specialists who prepared reports or offered different opinions. Sometimes patients would be satisfied with the report that the scan physician would give and would therefore opt not to come back to the doctor who treated them. There was very little the doctors at Kaura hospital could do to overcome this.

The nurses also played a very important part in trying to offer the best care possible despite the financial troubles of the patients. Wherever they could nurses would offer medical advice on nutrition, wound care, exercise. They effectively tried to improve public health.

My last objective centred on difficult conversations encountered by the doctors associated with financial difficulty. Having the privilege to sit in with the doctors I was able to see first hand the techniques used to handle situations like these. In the UK, most difficult conversations centred around breaking bad news with regards to a terminal illness or the loss of a loved one, this was the first time I experienced breaking bad news with regards to finances. The doctors offered the families tea and other beverages while explaining the illness that the patients had. They then went on to explain the treatment options. The doctors then sat in silence and waited for the families to absorb all the information that was given to them. The families would then, in a roundabout way, ask for the prices for each of the treatment options. Once this was discussed, the families tried to negotiate the prices for the surgical treatment options as this was deemed the best treatment however it was also the most expensive. The doctors however had their hands tied as prices were completely non-negotiable, however the doctors did have a list at hand of different charities that help subsidise medical costs. They also had a list of hospitals that offer the same treatment at lower costs if patients meet certain criteria. I was very pleased with the ways that the doctors handled situations like these and hope that I can follow suit should I ever have to face a challenge like this.