GENERAL MEDICINE

YEAR 5 MBBS SSC 5c:

OBGYN FOCUSSED ELECTIVE REPORT IN BOTH GOVERNMENT AND PRIVATE SECTORS IN GUJARAT, AHMEDABAD; INDIA

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BARTS AND THE LONDON

Elective report:

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Objectives:

1) **Describe the pattern of presentations in the city and how does this compare to the UK?**

2) **What basic services are offered in government hospitals and how does this compare to the UK NHS?**

3) **Describe the level of care and services offered to patients and the integrity of the multidisciplinary team compared to that in the UK.**

4) **What is the level of responsibility to junior doctors and are there language and cultural barriers that affect patient care?**

India has a population of estimated 1.21 billion in 2011 where Gujarat has a population of approximately 60 million. The healthcare in Gujarat has private and

partial government funded hospitals. However, unlike the UK NHS services, even the common man earning as little as the equivalent of £5 a week have to pay medical care and doctor bills. However, government hospitals are established to reduce fees and provide safe medical care to all Indian citizens. One such hospital is Shardaben Hospital in Ahmedabad (the largest city in the state of Gujarat). This is one of the oldest hospitals of its kind with a turn over of 100 million rupees and approximately 100 doctors. This is compared to other government hospitals where approximately 80,000 surgeries are carried out and 1,300,000 patients are treated annually.

The range of patients seen in clinics and the city hospitals present with similar obstetric and gynaecology medical issues as UK patients, however, their cases seem to be more advanced. For example, patients seen on their first antenatal visit are often discovered to have preexisting hypertension and diabetes. This is less likely to be as advanced in the UK due to education and primary healthcare services available for all without a fee. Generally, patients presenting to hospitals are in dire circumstances and need of medical care. However, these cases are rarely due to poor diet and lack of exercise due to the lifestyle where people tend to work hard labour hours and eat humble meals low in fat and sugars, which act as a natural protection to cardiovascular diseases. This therefore means that patients presenting with hypertension and diabetes tend to be primary rather than secondary, unlike the UK, thus requiring a higher standard of medical expertise. However, despite a lack of funds and shortage of doctors, the standard of care is constantly improving through education, training courses and a huge assortment of rare and common experiences, even by junior doctors.

The services offered in government hospitals are basic but thorough with clinics and A&E departments although some differences are obvious such as long waiting times and lack of facilities. However, there are good teams established with sisters, nurses and even medical students attending to almost 10-15 minor cases per hour! All medical care has to be paid for and therefore patients are mainly those that require medical treatment that they cannot ignore. For example, a 27 year old lady attended A&E presenting with extreme lower abdominal pain and incontinence. She was found to have a third degree uterine prolapse but refused to attend the hospital as her family could not afford the medical fees. She was treated and her fees were pardoned. Primary services are available to the public and many times, doctors tend to send patients to see GPs instead of waiting in A&E, which is one of the biggest projects undertaken in the UK to prevent wasting resources and effectively using healthcare facilities. This is definitely being implemented in India through advertisement and increasing the availability of primary healthcare services. However, a lot of patients travel from small villages where this information is not reached, thus still posing as a problem. Different specialties have their own departments in the UK, thus making medical care specific with highly specialized doctors. These boundaries are somewhat understandably distorted in government hospitals merely due to the large influx of patients and emergencies however, this increases the level of experience and versatility of junior doctors making them much more equipped to attend to emergencies alone. For example, two junior doctors performed an emergency cesarean section on a young 24 year old lady as the surgeon was performing an emergency evacuation of the placenta elsewhere. Although this situation would never arise in the UK, the expertise and calmness of the juniors during the operation carried out was impressive with a newfound appreciation to learning as much as possible in order to cope with emergency situations. When asked, they revealed that training consisted of learning as much as possible, initially under the supervision of a senior, incase situations such as this arise where two lives can be lost unnecessarily.

A lot of the multidisciplinary teams (MDT) consist primarily of sisters, nurses and a junior doctor where the consultant superintendent of the hospital attends ward rounds twice a day. These ward rounds are very quick and are mainly to identify patients who do not have a plan established as they are complex cases or the junior doctors are worried about. Although the doctors are junior, the level of care and knowledge they display is to a much higher standard than expected. The sisters and nurses role are similar to that in the UK where their knowledge about each patient is in depth and concise. Other members of the MDT are rarely present on ward rounds and are called only if there is uncertainty with treatment or if previous treatment has failed. For example, junior doctors are competent to establish total parental nutrition without consulting dieticians. Physiotherapists are seen more as a luxury in government hospitals but are offered to patients if they absolutely cannot do without them, such as stroke patients. However, the idea of medical bills always bear a large disadvantage to this facility despite the potential to be pardoned of their fee, and thus patients rely on their family for support. Family, I was told was a massive help to discharging patients early as the large family networks always mean that there is someone to care for them at home, and although this is not ideal, it definitely helps to reduce the number of inpatients and hospital complications.

Although the official language of the Indian union is Hindi and English, a census in 2001 confirmed that over 1 million citizens speak one of 29 different languages as their main form of communication. This, together with different background and cultures within India, make it not only difficult to treat patients and communicate with them, but also to educate them against their culture which has been passed down for generations to ensure a healthy lifestyle. For example, a universal cultural belief is to feed pregnant women on a diet of pure butter and sugar sweets to increase the health of the growing fetus. This and contraception are two of the biggest problems faced in women healthcare by medical professionals. Nevertheless, tireless persistence by doctors has shown small but significant changes in antenatal care.

It is an inspiration to see how many patients are treated and consulted per day, with some lasting a few minutes and others taking place in the corridors due to lack of rooms. Despite these modest arrangements, patient care is ensured with attention to their social and economic status, where many patients are forgiven almost two-thirds of their medical bills as they cannot afford treatment. This experience gave a whole different perspective where despite being paid nominal wages and worked hard, doctors were always there to help with a reciprocated gratitude from patients who often became tearful as many of these cases were life and death situations. It quickly became apparent that the experience and gratification doctors receive is incomparable to that in first world countries.