Maria Mirza
08030775 4

Name:- Maria Arooj Mirza Date:- 29-04-14

ELECTIVE REPORT

I write this report after completing my elective at The Karmakshi Memorial Hospital in Tamil Nadu, India where I was privileged to shadow the many doctors and nurses in various departments of the hospital; casualty, surgery, ICU and radiology.

Objective 1:- Health related objective; compare and contrast public health in India to the United kingdom

In the UK, there is great emphasis on the prevention of illness superseding cure and this manifests in the various immunisations, neonatal checks, screening for breast, colon and cervical cancer as well as smoking cessation campaigns. In India, there too is emphasis on certain public health strategies; anti-tuberculosis campaigns, promotion of women's health, newborn care, breast feeding & programmes. These government iniatives have revolutionised healthcare in India, although there remains a need to move towards preventative medicine. In India, the vaccinations are free and health care professionals can visit patient's homes to vaccinate them thus facilitating accessibility.

Smoking habits have changed dramatically in the

UK with enhanced knowledge and research into the detrimental effects smoking has on health, thus leading to a decline in smoking, particularly amongst men. This anti-smoking campaign manifests throughout the media; smoking advertisements being banned, banned smoking indoors and education of the public starting in the schools. However, there is no widespread anti-smoking campaign as such in India, however I learnt that smoking is prohibited in public places. In contrast to the UK, there are no specific routine screening programmes that involve inviting patients for a breast cancer check-up for free. There is however a 'Master Health' programme in Kamakshi Hospital, which at the expense of a certain fee, one may undergo a full health check-up, however one must need the initative, finance and education to realise the importance of such a health screen. There has indeed been a move towards the direction of preventative medicine, however, after conversing with many doctors, finance remains a fundamental limiting factor impeding the progress of healthcare in India.

<u>Objective 2:- Describe the pattern of health provision in relation to the country in which you will be working and contrast this with the United Kingdom</u>

Healthcare in India share many similarities as well as differences when compared to the UK

Maria Mirza
080307754

The similarities include the various clinical procedures observed during casualty; cannulas, ABGs and venepuncture e.t.c. The equipment utilised in the practical procedures were very similar. The emphasis on hand washing is clear in both the UK and India, however as in England, the hospitals display abundant posters and provide accessibility to hand sanitising gel on every bed; wards, casualty. In India, in ICU, there was meticulous hand hygiene practices with hand sanitiser gel at each patient's bedside.

Another similarity conspicuous in both the hospitals in the UK and in India, is the importance of team work. This was evident throughout the casualty, ICU and surgery placements, where doctors and nurses were working together to provide the best management for each patient. After witnessing a cardiac arrest during casualty, it was clear that CPR also shared some similarities as well as differences to that in the UK. For instance, in the UK, CPR protocols have been ammended to include uninterrupted chest compressions, not the same in India. Furthermore, some of the equipment utilised during CPR varied to what I had seen in the UK, for instance the defibrillator machine which resembled the older ones used in the UK.

Whereas in the UK, the majority of healthcare

is government funded via the NHS, and hence healthcare is free for all. In India, the healthcare system is very different as the private sector forms up to 85% of the healthcare system. There are indeed government funded hospitals, but these cannot boast the same quality of healthcare, cleanliness and resources offered by the private hospitals.

During the casualty placement, it was made clear that the private hospitals in India do not share the same familiar problems experienced in the UK; bed shortages, long waiting times. Instead, there is extreme flexibility and availability of resources. For instance, in India, if a patient needs an MRI, there is no delay. A patient requiring a new pacemaker after the batteries had run out after 10 years, had it replaced on the same day. After conversing with many doctors and nurses, it was clear that they enjoyed the freedom offered by the Indian healthcare system, however they felt that resources could be utilised more efficiently and more cost-effectively. Whilst in the UK, every procedure is chosen after meticulous deduction, in India, there may be over use of certain investigations that may not provide any additional benefit to the patient. The fast pace and flexibility of the Indian healthcare system make it appear an attractive option.

Maria Mirza

Maria Mirza
080307754

The quality of healthcare and standardisation of care across the country is fundamental in the United Kingdom with the introduction of NICE guidelines and GMC rules and regulations. In India, although there are overall hospital regulations, there are no set guidelines for doctors to adhere to for instance NICE guidelines in terms of medical management. Nevertheless, some doctors still choose to follow certain guidelines, like NICE, with the final decision being based on their own clinical knowledge and experience. Thus, they may provide the best quality of healthcare that they feel fitting for each individual which has the advantage of greater flexibility. However, despite this flexibility, there is the limitation of not having standardise quality of healthcare and so in some hospitals far away from the city centre, the same quality of healthcare can not be guaranteed.

General practioners are common to both the UK and in India. One major difference however is that there is no need to make an appointment to see one in India, whereas in the UK, it may take several days to be seen by a GP. In that respect the patients' complaints can be dealt with much more quickly and efficiently in India. During the casualty placement, it was evident that a triage system screening each individual patient presenting in terms of severity would be a useful option to adopt.

Accessibility to doctors, GPs and thus investigation and management is much faster here in India compared to the UK as patients can directly approach doctors without waiting for a referral from a GP which is a much more efficient system in some regards.

Objective 3:- Personal and professional developmental goals. Must also include some reflective assessment of your objectives and experienc- e

Before embarking upon this elective in India, I set out numerous objectives for myself to achieve including learning about the health conditions prevalent in India, gaining confidence in clinical skills and learning as much as possible. In casualty, I was able to practice clinical skills; performing an ABG, placing a nasogastric tube in a patient suffering from carcinoma of the tongue. I found it quite challenging, particularly when communicating as Tamil is not my first language, however my friend who speaks fluent Tamil helped me tremendously. However, I do feel more confident in these procedures and on the third day of casualty placement, a young man, around forty years old came in collapsed secondary to myocardial infarction and CPR was commenced immediately. I had taken part prior to this in London, offering chest compressions so did not feel too inexperienced. I felt it was extremely useful

Maria Mirza
08030775

to see how the arrest was managed by the team and took part in providing chest compressions and even delivered the shock via the defibrillator. I feel that being competent in good CPR is invaluable and will be most beneficial for future training posts as a foundation doctor.

Objective 4:- Describe the pattern of disease illness of interest in the population with which you will be working and discuss this in the context of global health:-

The pattern of illness in India shares many similarities as well as differences when compared to the UK. Whereas in the UK, cases of Tuberculosis, Malaria, Dengue fever are rare overall, in India, there is a high rate of tuberculosis. One patient was observed to have a granulomatous TB lesion of the cerebral cortex. Similarly, Malaria and Dengue fever are conditions that are much more commonly witnessed in India than in the UK. The few similarities in illness pattern include vitamin D deficiency and increasingly type II Diabetes, obesity and heart disease similar to that observed in the UK. This may reflect the more western lifestyle adopted by the people in India with the introduction of shops like McDonalds as the country is developing rapidly. On a visit to Northern India, two years ago, I visited the developing

city, Delhi and also travelled to Rajasthan and I observed that people in the more developed areas like Delhi had adopted a more western lifestyle including their diet and were overweight in comparison to rural Rajasthan citizens.

It was conspicuous that infections are a common cause of illness in India, more so than in the UK. This perhaps reflects the lack of sanitation and awareness as well as education on the importance of hand hygiene. In the UK, there is strict bare below elbows policy for all members of staff. However, in India, there is no such policy in action. During the surgical rotation, it was clear that every precaution was taken to minimise infections with meticulous hand washing and scrubbing-in which was similar to that in the UK

Discrepancy in health beliefs amongst the general public was also an aspect that became clear on my placement after speaking with patients, I soon realised that there is a lot more focus on alternative medicine; reflexology, accupuncture, and Ayurvedic medicine, compared to the UK.

During the ICU placement, I came across a female patient who attempted suicide by hanging. In the UK, suicide amongst females usually takes the form of less brutal methods,

Maria Mirza
080307754

for instance paracetamol overdose, however, suicide by hanging is more common in India and I have observed two cases over the last three days. Indeed, just like on ICU in the UK, I came across patients attempting suicide via ingestions of poisons with two ladies taking organophosphate pesticides. In the UK, ICU beds are hard to come by and per each bed, there will always be a nurse, constantly monitoring the patient, recording observations every 15 minutes. In India, although there are nurses attending to all patients, there was no one nurse to each patient.

It is clear that cost is a major factor determining health care both in the UK and in India. As in the UK, a large percentage of the government funding is spent on health care, there is less inequality. The same cannot be said for India and cast remains a limiting factor which perhaps limits such practices as having one nurse per ICU bed amongst other resources and medical treatment. Furthermore, due to the poverty rife amongst India, many people can not afford health insurance, and this only serves to widen the gap in healthcare provided to the wealthy and those of lower socio-economic status.

After completing my placement in India, I feel I have acquired knowledge, hands-on clinical experience, seen interesting and unique patient case scenarios and have met some lovely and memorable people.