Student name: Simerdip Kaur
Email: ha07084@qmul.ac.uk

KAUR, Simerdip
OPHTHALMOLOGY

Appendix 3: SSC 5c (Elective) Assessment (part1)

Elective subject: Ophthalmology
Elective location: Seth G.S. & K.E.M. Hospital, Parel, Mumbai 400 012
Elective dates: 9/4/12 – 27/4/12
Elective supervisor:
DrArjunAhuja, Professor & Head of Department - dr_arjunahuja@yahoo.com

Objectives set by school:

1. **To learn about the common ophthalmic conditions affecting the local population in Mumbai in comparison to London.**

Mumbai and London are in many ways similar. Both are financial, education, healthcare and entertainment capitals in their respective countries. They also attract a large amount of migrants and emigrants who are searching for better opportunities to build a new life. Whilst Mumbai is home to over 20 million people London's population is less than half of that at approximately 8 million.

With regard to diseases affecting the eye however, the two capital cities and countries could not be more different. A recent newspaper article stated that the total number of visually impaired people in India is between 15-18 million. Some of the leading causes of this includecataract and refractive error. In addition to that, nutritional deficiencies affecting children and infections of the eye especially in the poorer communities where good sanitation facilities are not available further contribute toward the problem.

During my elective in KEM - a government hospital and tertiary referral center funded by the Municipal Corporation of Mumbai, the majority of patients I met were from the lower income population. These patients presented to the outpatients department primarily with disease processes affecting the external aspect of the eye as these conditions give rise to irritative symptoms as well as noticeable reduction in vision.For example cataract, infections of the eyelid and conjunctiva, corneal abrasions as well as foreign body and trauma affecting the eye.
These conditions were more prevalent in the outpatients department at KEM against others such as the more "extravagant" retinal detachment – seen to be as a rich man's disease here in Mumbai whereby patients affected by this are often of a higher socioeconomic class and thus tend to present in private practices instead. Nevertheless, there were a fair few patients who presented late with conditions such as corneal ulcers due to their socioeconomic background especially with regard to making travel arrangements into the city for medical advise.

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However, diabetic retinopathy is slowly on the increase as newspapers report over 60% of Mumbai's population are obese raising fears of a diabetic epidemic in the near future.

2. **How is ophthalmic care provided in terms of emergency treatment, surgical interventions and long-term follow up in patients? What is the role of the 'high street optometrist'?**

The government funded medical system in India aims to deliver universal healthcare for its citizens. Essentially medical services such as an outpatient appointment with a doctor are free of charge. Unlike the UK however the patient always bears the cost of the medicines and has to pay for their intraocular lens implantation in cataract surgery.

However when it comes to emergency treatment whether it is Ophthalmic or not, the first port of call is almost always the Accident & Emergency unit at a government funded hospital such as K.E.M. After the initial management of the patient they are then referred on to the appropriate team for further care.

Surgical intervention for ophthalmic conditions in India is provided based on the patients needs and to a minor degree their ability to bear the costs of the necessary equipment e.g. intraocular lens implants in cataract surgery. However, in India medical services that include consultation and prescription of medications are also provided at regular "health camps" conducted on some weekends in locations out of the city center in order to extend these services to the communities who need them the most.

As would be expected it is inevitable that a certain percentage of patients will be lost to long-term follow up. One particular case I observed was a young lady who was prescribed topical steroid eye drops for a certain period of time but she failed to re-attend her appointments and continued using the drops for longer than was recommended and subsequently developed cataract. On discussion with a resident, I was informed that it is relatively common for such incidents to occur and so the Ophthalmologists nowadays are even more cautious and thus rarely prescribe topical or oral steroids for that matter unless it is absolutely imperative.

Unlike the UK, the high street optometrist in India generally only deals with refractive errors and spectacle correction. This is mainly because of the profit driven objective behind these establishments. Nevertheless they are still able to advise patients to see an Ophthalmologist for cases beyond their ability to treat. Their scope remains much smaller as compared to Optometrists generally in the UK whom are involved in manyschemes within Primary Care Trusts (PCTs) whereby Optometrists run screening clinics for diabetic or glaucoma patients and only refer back to the Hospital Eye Service (HES) if any further treatments are needed. UK Optometrists are now also able to prescribe basic antibiotics and other

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basic medications as long as they undergo a short course approved by the PCT.

Objectives set by student:

3. **To strengthen and build on my basic history taking and clinical examination techniques in a different environment to my medical training so far. Also to observe medical and surgical management techniques in Ophthalmology in India.**

The most significant challenge I faced in KEM hospital was communication with patients. Although being reasonably fluent in Hindi and Punjabi the locals spoke to the doctors mainly in Marathi. To overcome this I would request for the junior residents help in translating. Sometimes I would also explain to the patient in Hindi that I did not understand them after which they almost always seemed very happy to start conversing in Hindi with me. Nevertheless, the volume of patients during each outpatient department session was so large that it became apparent I was not going to be able to obtain a full history and perform an examination on the patient in one go. And so I managed to get around this byfollowing the patients case as they went from one test to another to understand the whole picture.

I particularly enjoyed my time doing Retinoscopy and Fundoscopy with one of the residents in the department. I was fairly competent and in my direct ophthalmoscopy skills prior to my elective in Mumbai however I had never tried my hand at retinoscopy and so I jumped at the offer of learning this new test. I found it to be very challenging initially and only after my 3rd day's attempt at the skill did I start to feel more confident in my ability to appreciate the reflective rays of light emerging from the patients retina through their pupil and subsequently manipulate it with a convex or concave lens.

Besides history taking and examinations, I was able to try my hand at suturing in the operating theatre too. This procedure was carried out under direct observation and guidance of fellow resident and I thoroughly enjoyed the opportunity of being able to do so.

I also interacted with the local medical students and taught them how to use a direct ophthalmoscope, which was a fun and rewarding experience. At the same time I attended some of their clinical teaching sessions which were very useful for filling in any gaps in my knowledge on ophthalmic related conditions.

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4. **To explore my interests in the field of Ophthalmology with regard to planning future career pathways. Also to fully engage with the healthcare professionals as well as the patients involved to learn their perspective on the delivery of care as well as to explore patient and doctor satisfaction levels.**

   I spent my Ophthalmology elective in KEM hospital with Unit 2 of the department and their schedule involved alternating days of Outpatient based work interspersed with surgery in the operating theatre.

   During my attachment here, I was able to fully engage with the healthcare professionals and gain perspective on their daily routine. I soon found out that there was an incredible amount of pressure on them in terms of the workload and the high turnover of patients. Still they seemed to be coping very well and working extremely hard at their job. The delivery of care was of a high standard by making the most of the available resources and similarly reciprocal level of doctor satisfaction albeit the long working hours.

   The patients I was able to speak to also reported high satisfaction levels with the care they were receiving. However some do get caught in a vicious cycle of miscommunication leading to the possible worsening of their condition at present or the development of new pathology.

   As for postgraduate Ophthalmic residency training in India interestingly the training program lasts only 3 years after which the trainee obtains a MS (medical surgeon) degree. Whilst in the UK, Ophthalmic specialty is not only one of the most competitive postgraduate fields to get into but the minimum training period is 7 years. This realization coupled with my elective experience at KEM has further deepened my will to pursue a career in this field after my internship years.