Paediatric Oncology, Tata Medical Centre, Kolkata, India

I spent my elective working on a paediatric oncology ward at Tata Medical Centre (TMC), a specialist cancer hospital on the outskirts of Kolkata, India. TMC is a charity hospital where the cost of treatment is subsidised with donations from philanthropists. India's public healthcare system has many financial restrictions and when state hospitals cannot provide patients will often turn to the private sector. However, this alternative is beyond the means of many in India and charity hospitals provide high quality medical care to those who would otherwise not be able to afford it. This is important in oncology, as cancer treatment is expensive, but even more so in paediatric oncology, as the parents of young children are typically young themselves without the savings to support medical treatment.

Working at TMC was an eye-opening experience. Children's cancer is one of the most difficult areas of medicine to work in, but it is also one of the most rewarding. Many cancers in paediatric oncology do respond well to therapy but even in these cases the treatment programmes are prolonged and arduous, and demand great courage from the patients and their parents. Many children are too young to understand importance of treatment, which makes the process even harder. However, despite all of this I found that the children continued to confound my expectations, from their powers of recovery to their positive outlook on life. There is also a lot of support that patients can give each other. Accommodation was provided nearby for families to stay during treatment, and meeting others going through similar ordeals was helpful for both the children and their parents.

Medical care at Tata Medical Centre is not fully subsidised and patients contribute to the costs of treatment, especially at the start of therapy while paperwork is being processed. Because of this, even with financial aid families with low incomes still face limitations on what treatments they can afford. It is a frustrating experience as a medic to know what treatment a child needs but be unable to give it. Additionally, the intersection between illness and poverty can lead to painful decisions for the parents. Cancer treatment can bankrupt a family, and they must take into account factors such as how many other children are at home to support, or how likely the cancer is to be cured. Sometimes cost dictates the ceiling of care that can be offered. Certain cancers can only be cured with a bone marrow transplant, but their cost is beyond the reach of most patients at the centre. It is difficult to see children with cancers that might have been treated successfully if they had been born in the UK, or if their families were more prosperous. In other cases cheaper drugs have to be used despite the increased risk to the patient's health. Cheaper antifungal drugs can inhibit the breakdown of chemotherapy and increase the risk of side effects, such as permanent liver or nerve damage. The antifungals that do not interact with chemotherapy are unaffordable for many, and so patients are forced to use cheaper antifungal cover that carries a greater risk for their health.

There are aspects of the Indian healthcare system that the UK could learn from. Patients were asked to buy certain medical supplies themselves, such as lumbar puncture needles. The result was a relatively small financial burden on each patient but a significant saving on the part of the hospital. In the context of an underfunded NHS, minor or nominal payments from each patient could lead to greater savings overall while minimising the impact on the population. Similarly, the centre chose not to fully subsidise their medical treatment. This was primarily to make their funds go further, but some also argued that financial contributions lead to patients taking more responsibility over their own health. These approaches to medical care are not commonly discussed in the UK. However, the use of financial contributions to influence personal behaviour, as has been seen in the recent charges for plastic bags, is likely to gain greater prominence in public debate in the future.

The most I learnt at TMC was by observing the teamwork in the paediatric unit. The unit had a sense of equality that is unusual to find in medicine, where the consultants encouraged their juniors to challenge their decisions and would consider them seriously. This lead to constructive discussions about the patients to which anyone could contribute, rather than the head of the team dispensing a string of instructions. The patients benefited from the closer attention to detail; the fellows benefited from being pushed; and the consultants benefited from the contributions of the whole team. It is an atmosphere that I would like to replicate myself in the future, but one that is easily squeezed out by the everyday pressures of hospital wards: too many patients with too little time.

Whilst in Kolkata I also worked a state hospital to compare the delivery of care between the two systems. The clearest difference was the sheer volume of people that the state hospitals treated, with crowds filling up the courtyards and corridors every morning. There were limited beds on the wards and so most were deferred to overflowing outpatient clinics. Personnel were a major cost, leading to single nurse for each ward. Much of the traditional role of the nurse was replaced by families looking after their relatives and I met one young girl with leukaemia who would assist the junior doctor with his procedures on the ward.

I found the state hospital full of passionate doctors struggling to work within the confines of a poor system. They had limited resources, but the resources they did have were not being used efficiently. My ward would turn patients away for lack of space even though there were empty beds in the ward next door, because the hospital

management wouldn't allow them to use other beds. Other challenges lay in government mismanagement. During my stay the state of West Bengal was holding elections, which occur district by district over a month. Rather than giving hospitals funds for medical supplies, the West Bengal government buys them in bulk and delivers them to the hospitals. This means that medical deliveries are dependent on government bureaucracy and during elections that bureaucracy grinds to a halt. While politicians were insisting publicly that their hospitals were well stocked, on the ground resources were running short and it was estimated that the shortages could continue for months after the election. It was not just drugs that were in short supply. Many blood donation centres closed down during the election leading to a shortage of blood products. None of these problems were due to funding – they were problems rooted in a system that was failing to utilise its resources effectively.

I was in India over Pesach and I joined the Jewish community for their communal Seder. The community used to number over 6000 before World War II but has dwindled today to less than 30. They have a fascinating mix of traditions – some Sephardi traditions, a scattering of European tunes, and an Israeli pronunciation of Hebrew. This was the first year they were running a communal Seder and it was held in the Kolkata Jewish Girls School, which has a British-style school hall with wooden plaques listing the accolades of past students. Two young Chabad students had come out from New Jersey to help run it, and I had not appreciated before the impact they can have visiting small communities across the world. The Seder meant a lot to the locals and it was heart-warming to see the strength of their Jewish connection. It was an amazing experience to sit down in one room with most of the Jews in the whole city, along with all our different languages, and take part in a ceremony that Jews have been performing together for millennia.

Alongside Kolkata's small Jewish community there are three large beautiful synagogues. Recent renovations have rendered the synagogues unrecognisable to how they appeared a decade before, with the smallest synagogue now being used regularly for Shabbat services. This synagogue had been used for years as storage for the merchants working on street below and the stall-keepers were very upset to discover that their free storage space was, in fact, a historic place of worship. One merchant, apparently no stranger to chutzpah, was still attempting to pursue legal action through the courts.

I travelled out to India to see the differences in the provision in care in a country with far greater financial limitations than where I trained. However rather than the differences between the two systems, what I found most striking were the similarities. The conversations with patients, the concerns that came to light, the discussions amongst medical teams and the factors weighed up in medical decisions were all the same. Despite the foreign language and cultural differences I found myself in a familiar environment. I feel that this is because the relationship between patients and their doctors remains unchanged regardless of where the medicine is practiced across the world, with its empathy, compassion and hope.

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