Introduction

My time in India and the Philippines provided a unique opportunity to observe and participate in neurosurgery within a healthcare system markedly different from the one I am accustomed to in the United Kingdom. Looking back, this has been a fantastic opportunity and one which I am extremely grateful for. I have learnt a lot, experienced new healthcare systems and interacted with surgeons much more senior than me. I came into this experience feeling quite nervous – these are completely new countries with a different language and people. However, I had such a warm welcome, leaving only after six weeks having met some great people, learnt a lot and appreciated the differences between the two countries. Some of these differences I have elaborated on below.

Ward Rounds

In the UK, ward rounds typically begin at 8am with a consultant, registrar and other team members such as neurosurgery specialist nurses and even medical students. However, in the Philippines I observed a distinct approach. Residents, along with an intern, started rounds as early as 6am by themselves without a consultant present. They meticulously reviewed patient conditions and updated medical records before briefing the consultants on their findings. The consultants would then conduct their own rounds later in the day, well-informed by the preliminary updates. I found this quite efficient in the sense that when the consultants saw the patients later on in the day, they have already received an update from the residents on the same day. This makes the consultation easier for the consultant, saving time and allowing the patients to ask more questions, should they have any. The only downside to this is that it means the residents much start rounds much earlier such as 6am, which is what they are used to now – but when compared against the UK, this seems much more intense.

In India, the approach was much more similar to the UK where rounds would only start once the consultant is present, with all junior members following the consultant and presenting cases when necessary.

Surgical Theatres

Joining theatres in the Philippines was an eye-opening experience. It is reassuring that no matter where you travel across the globe, the way surgeries are performed remain consistent. Of course there are some differences between countries but this can only be expected as different countries have different protocols. One notable difference was the equipment used during surgeries. In the UK, for procedures such as craniotomies, sticky drapes with cut-outs are standard. In contrast, the Filipino practice I observed involved using sterilised towels, which were then sutured to the patient's head to stay in place – something that was quite shocking to me. I thought it was much less efficient and has worse cosmetic appearances for the patient, however in reality this might be the best way in which the surgeons have in ensuring the field remains sterile given the resources they possess. This practice underscored the resourcefulness required in an environment where advanced surgical supplies might not always be readily available and made me appreciate what we have in the UK.

Despite these differences, the core surgical procedures were quite similar. I witnessed subarachnoid haemorrhages, ischaemic strokes, brain tumours and hydrocephalus being managed in ways similar to practices in the UK. The familiarity of these cases was nice to see, though it was intriguing to see the less

rigid adherence to guidelines. In the UK, decisions are made based upon NICE guidelines, or some sort of guideline which clearly states what the next step is. However, discussions with residents revealed that treatment protocols often depended on the individual physician's discretion, providing a degree of flexibility not commonly seen in the UK. One example was with strokes – in the UK it is standard practice to give 300mg aspirin stat as soon as a CT shows that is ischaemic in nature. On the other hand, in the Philippines we were told that it depends on the treating doctor – with the mainstay of management being 80mg aspirin, occasionally with 75mg clopidogrel added onto this.

Weekly Surgical Audits

I also had the opportunity to participate in weekly surgical audits and departmental presentations. These sessions were like those in the UK, focusing on reviewing recent cases, outcomes and practices. These audits fostered a culture of continuous improvement and peer review, ensuring high standards of patient care despite the different healthcare infrastructure. It was interesting to see how the residents handled tough questions given to them by consultant surgeons, where if one was unsure – the other resident would answer on their behalf.

Variety of Cases

The range of neurosurgical cases I encountered was extensive and included conditions such as subarachnoid haemorrhages, ischaemic strokes, brain tumours and hydrocephalus. These were managed similarly to the UK, with surgical and medical interventions tailored to the patient's needs. However, the less stringent adherence to clinical guidelines in the Philippines allowed for more individualised treatment plans, reflecting the adaptability required in a resource-limited setting.

Friendly and Inviting Staff

Initially, the prospect of working in a new healthcare environment was daunting. However, the warmth and friendliness of the doctors, surgeons and nurses quickly dispelled any apprehension. Their welcoming nature made me feel like part of a tight-knit community by the end of my three-week stay. The camaraderie and collaborative spirit among the medical staff were inspiring, enhancing my overall learning experience and making the transition smoother. It is an extremely nice feeling when, only three weeks in, I can walk around the hospital and say hello to residents here and there.

Conclusion

My experience in India and the Philippines provided invaluable insights into the differences and similarities in neurosurgical practices compared to the UK. While differences in resources and equipment variations highlighted the challenges faced by healthcare providers in these countries, the dedication and adaptability of the medical staff were evident. The early ward rounds led by residents, the use of alternative surgical supplies and the personalised approach to patient management all underscored the resilience and ingenuity required in such an environment.

Participating in these processes broadened my understanding of global healthcare practices and really reiterated the importance of flexibility and resourcefulness in medical care. The friendliness and supportive nature of the healthcare professionals made a significant difference, turning a potentially daunting

experience into an enriching and memorable one. These experiences have enriched my perspective and will certainly influence my future practice, fostering a greater appreciation for the diverse approaches to healthcare across different settings.