ELECTIVE (SSC5b) REPORT (1200 words)

A report that addresses the above four objectives should be written below. Your Elective supervisor will assess this.

During my time at Tribhuvan University Teaching Hospital's Emergency Department, we were exposed to a wide range of diseases. This includes admissions due to chronic conditions such as exacerbation of COPD, stroke, chronic kidney disease and diabetes. These are managed very similarly to what we see in the UK, in line with international guidelines. The importance of early recognition of sepsis is also very strongly emphasised in Nepal, and I was pleasantly surprised to see the use of novel tools in identifying sepsis such as qSOFA, something which is very new to UK. During our weekly teaching sessions, the local medical students presented a case in front of junior and senior doctors, as well as all the elective students. It was nice to see a very thorough and systematic approach in discussing the case starting with a history and generating a historical diagnosis. This then moved on to examination findings and excluding or including each of the historical diagnosis to formulate a differential diagnosis. And only then do they go on to investigations and management with a much clearer idea of the 1 or 2 likely diagnoses. At the end of the case based discussion, students also briefly present to the group on recent advances in the topic. This really helps to keep both students and staff up to date on research and developments in management of the condition in question.

Tropical diseases are also very common in this area such as dengue, malaria, and leptospirosis. With these conditions being so prevalent, medical staff have to be very aware of the common presenting symtpoms and differentiating factors of each of these diseases in order to appropriately investigate and manage patients. Many patients coming with high fever, vomiting, muscle and joint pains undergo a very thorough history and examination as well as a full tropical screen to test for all these diseaseas.

Altitude sickness is a commonly seen problem in Nepal and I was under the impression that this would only be seen in tourists. However it was also very prevalent in the local population also, even in those acclimitised to the area, such as those who lived or worked in the Everest base camp area. Other interesting cases I saw was a patient who suffered a snake bite but no bite mark was seen. Therefore a lot of research was done and finally found a particular species of snake where the bite does not leave a mark.

In terms of the provision of care, inevitably there are vast differences between the healthcare system of Nepal and UK owing to the differences in resources between the two countries. I was surprised to see that it is the responsibility of the patient or their family to obtain equipment and medication from the stores before anything can be done for the patient. For example, a patient requiring an invasive procedure would need to ask their family member to go to the store to buy gloves, syringes and needles in order to perform the procedure. This also applies to investigations like blood tests; it is also the patient/family's responsibility to take the samples to the lab for testing and also for medication, where they would need to go to the pharmacy to buy medications even for intravenous administration in hospital. It was mentioned by staff that when patients come with no family members, it poses a real challenge for the healthcare staff as there is no one available to do these tasks and so one of the medical or nursing team would have to do this.

Another difference I noticed is the rapid turnover of patients in the hospital. In a hospital in the UK, for cases presenting to ED that are not life-threatening, a 3-4 hour wait is the minimum expected. In Nepal however, there is almost no waiting time as patients are not willing to wait. This is dealt with through

efficient triaging on entry to the ED and categorising patients to one of three areas - green, yellow or red - based on how deranged their vital signs. However, a significant challenge still exists when patients present with conversion disorder, something that is not uncommon in TUTH.

Finally, I observed final year medical students who were fully used as part of the service to provide care. They were involved in taking history, examining and managing patients to a much greater extent than what is seen in UK. I imagine this must put them in great stead when it comes to joining the workforce next year.

Nepal has a population of around 29 million, which is just under half the population of the UK ,with a very similar population density to that of the UK. Healthcare in the area of Kathmandu is considerably more advanced than the rest of rural Nepal, with a number of specialist tertiary hospitals offering services in oncology, neurology, paediatrics and opthalmology.

Although TUTH is a large hospital with 577 beds, it is overcrowded and there is often a bed shortage. The Emergency areas of yellow zone in fact have patients sharing beds. This raises the risk of infection and hand hygeine is not very widely adhered to. Even when a hospital is full and a patient needs to be transferred to another hospital, patients refuse and insist on being treated at TUTH as it is a specialist tertiary hospital. This causes a significant strain on resources as the demand in TUTH is so high. In the UK, it is very common to see patients transferred to different hospitals for example being transferred from Royal London Hospital to Barts for an angiogram.

Cultural beliefs also have a big impact on how patients view medical treatment. One case that struck me was a patient who came in with advanced chronic kidney disease along with many complications. The medical advice was given that the patient requires urgent haemodialysis. However, the patient and family did not consent to this treatment. It was only when this patient developed a seizure from uraemic encephalopathy that they were all in agreement to commence haemodialysis. In the UK, there are very strict rules regarding consent, capacity and acting in the best interest and I reflected on these differences and the impact it can have on patient outcomes.

The majority of people in TUTH speak in Nepali and English and it was relatively straight-forward to keep pace with what was going on. Thankfully the teaching sessions were in English and although the accent was a challenge at first, it was possible to understand what was being said. Having said that, i did find that i was concentrating more on my non-verbal skills such as gestures to communicate especially with patients in order to ascertain the pertinent points of the history.