ELECTIVE (SSC5b) REPORT (1200 words)

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

Objective 1

One of the key differences in healthcare in Nepal is the significant absence of public health promotoion compared to that in the UK. The proportion of smokers in Nepal is significantly higher than the UK and as far as I could see there were no anti-smoking campaigns either in the hospital or in the city of Pokhara. During conversations with doctors it also became apparent that alcoholism and alcohol related illness was a significant public health issue, particularly amongst the over 40s. The sharp divide in wealth in Nepal aslo leads to great disparity in health and wellbeing across different classes. Particularly in the poorer, rural areas, access to healthcare is minimal, and people rely largely on herbal remedies. In the area of Nepal in which I stayed, the rates of malaria were very low, although in the more southern regions with more tropical, damper and warmer climates, malaria is a serious concern. There is also a high rate of TB in Nepal due to the lack of public health awareness, and probably exacerbated by cramped living conditions amongst the poorer families. Obesity is relatively uncommon compared to the western world, although access to imported sugary food and drinks is leading to a rise in rates of diabetes.

Objective 2

During my placement I spent time both in general medicine and emergency medicine. In general medicine I was able to briefly examine some patients with interesting during the ward round when the consultant allowed. The nature of the healthcare system in Nepal being a pay-as you-go system meant that opportunities to practice clinical skills such as procedures were somewhat limited, as we were discouraged from attempting anything which could result in the patient having to pay twice (for example if a cannula was unsuccessful, they would have to pay for a second cannula). Whilst a surprising number of people in Pokhara were able to speak English, this was predominantly those who were younger (due to education improvements in the last twenty years) or wealthier older people. As the majority of patients were those who were older or not as well off, opportunities for history taking and speaking to patients were also limited, although I was able to take some short histories in A&E, for example from young patients involved in RTAs. For similar reasons we were not always able to go back and full examine patients on the general medicine ward round. Unfortunately this combination of factors meant we were unable to practice clinical skills as much as I would have liked.

Objective 3

Having mostly spent time at inner city hospitals in the UK, with most of my A&E time spent in the Royal London (a major trauma centre), I was interested in seeing how the presentations differed in Nepal. I found that on the whole, most presentations of a "medical" nature were very similar - a relatively high number of people with complications of chronic illness or acute illnesses such as MIs, strokes and diabetic emergencies, typically amongst older patients. Something that was particularly interesting was the high rate of road traffic accident cases, which most likely stems from the poor quality of roads in Nepal, in addition to the rapidly growing number of vehicles on the road and the somewhat dangerous driving style and road etiquette. The majority of RTA patients were typically low-velocity injuries, with

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fractures of superficial lacerations common, but severe injuries less so. Notable absent compared to East London was the lack of stabbings, shootings, and general injuries from phsyical confrontation.

Objective 4

One of the highlights of the placement was being able to experience emergency care in Nepal. One of the first things that struck me on walking into the hospital was the scale of the queues for the reception/payment desks in the main atrium. This is where patients would go to pay for their care, with some A&E patients needing to pay a base fee before being seen in the department, something which I found quite shocking. The emergency department itself was small, with the main bay consisting of around 8 beds with two small side areas. Whilst the doctors all had identical knowledge to those in the UK, investigating for differential diagnoses was significantly more difficult without the availability of portable imaging or the ability to send and receive blood results as quickly. This, compounded by the need for patients to decide if they could afford investigations and treatment led to often slow movement of patients in a department which would quickly become full. A particular standout case was a woman who attended with a widespread STEMI, who after ECG diagnosis was delayed in receiving treatment due to having to weigh up whether she would be able to afford a PCI procedure or if she could only receive medical management. Comparing this to my experiences in the UK where all patients receive the best care possible led to an uncomfortable feeling of being unable to appropriately treat a patient in need.

Critical care in Manipal Hospital was a far cry from what I have experienced in the UK. The entire hospital had only a handful of ventilators (a near ubiquitous staple of critical care medicine in the western world) outside of theatres, meaning that the ICU was not able to cater for as many patients as you would expect given the size of the hospital. However, whilst the standard of care was significantly below what we would expecy in the UK, given the limited government funding for healthcare, the provisions they have and even the existensce of an ICU are major steps forward in managing acutely unwell patients.

Unfortunately, I was unable to spend time with the ambulance service due to it's fledgling nature and relative unavailability in Pokhara. I was however able to experience how the ambulance system works in Pokahara to some level and so can compare this to what we see in the UK. Ambulances (and thus the concept of pre-hospital medicine) are a very new addition to healthcare in Nepal, a country where there is little/no publicly funded healthcare. Previously, all patients requiring medical attention and were able to afford it would be required to make their own way to the hospital (which in the case of Manipal is on the outskirts of the city) either by family assistance or taxi. This includes people with emergency presentations. The ambulances currently in operation charge significantly more than the taxis and have very limited resources. They are driven by ambulance technicians who it seems are trained in cannulation and IV fluid administration, although otherwise the equipment in the ambulances are limited. The patients who use the ambulances are typically those who are able to pay for them. Unfortunately I was not able to find out any information on response times or treatment administered at the scene on arrival of the ambulances, as it seems the service is run independantly of the hospital.

Whilst all of these services are clearly lower in standard to what we would expect at home, they are continuing to develop and many of the doctors I spoke to were hopeful of being able to improve the quality of care provided.

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