Describe the disease profile and presentations to the emergency department within Pokhora (Nepal) and the differences in presentation and type of disease within the UK and neighbouring countries.

There were similaities with the presentation of disease in the emergency department in the UK and Nepal. Just like in the UK there was a lot of diabetic complication and strokes as well as exacerbations of asthma and chest pain. However the way each of these conditions presented were different. Unlike in the UK where a lot of the diabetes seen is due to hyperglycemia, the majority of diabetic complication seen in Pokhora's A&E was due to unconcious patients from hypoglycemia. Similary the prevelance of ischemic heart disease and stroke were the same in both countries, COPD on the other hand was more common in Nepal than in the UK. In addtion to this, a high percentage of patients presented with minor traumas and infectious diseases, such as Neuroschistosomiasis, tuberculosis or gastroenteritis. Tuberculosis in Nepal however is multi-drug resistance and a lot of the cases I saw were extra-pulmonary.

The cases seen in Pokhora however were a lot more advanced than in the UK. Another strike difference between disease profile in the UK and Nepal was in the UK there is a higher proportion of mental health related admissions, something that is not seen in Nepal. This could be due to the stigma behind mental health or the lack of mental ill-health education in nepal.

Finally the demographic of patitents that attend A&E differ between countries. A lot of the patients who attend A&E in Nepal are rural workers, normally male or young. In the UK however, there is a wide range of patients from all socio-economic groups. Hence as most atendee's to A&E were people of a lower socioeconomic background living in rural areas communicable disease, disease of poor living conditions such as malnutrition and epidemics were a large burden on the healthcare system; something very different to what we see in the UK.

Describe the pattern of health provisions in Nepal for emergency and acute medicine and compare this to the UK

Health care provisions in Nepal and UK differ drastically. Whereas in the UK a large number of patients are brought to the emergancy department through pre-hospital services such as ambulances, in Nepal the use of such services are almost non-existant. Even the services that do exist are done on good will. Ambulances are lead by volunteers who are not medically trained to stabalise patients with limited tools of just basic oxygen and a stretcher. In the UK however, there is a well established care pathway from pre-hospital to hospital where the interventions put in place from the ambluance services can be extremely cruical to management and stablisation of the patient.

As well as pre-hospital, the functioning of the emergancy department is different. Within the UK there is a well established primary care programe, and triage system throughout the NHS. In Nepal there is a private healthcare system with an ineffective triage and primary care programe. This leads to problems as the emergancy department can sometimes act as a general practioner adminstrating immunisation to a pharamacy to a major trauma call, all of which pose it's own, different set challenges for the doctors.

On top of this as the system is soley private and patients can buy medications from a pharmacy without a prescription, the majority of patient who attend hospital have already blindly tried a range of other medications, which may complex a case further. Finally if a patient does manage to attend A&E and are referred for further investiations a large percentage of their future care is dependent on whether the patient or the patients family can afford the cost of the recommended management.

Understand the differences between the health systems in the UK and Nepal and the challenges of the Nepalese health service to deliver universal and accessible healthcare

Unlike the UK the healthcare system in Nepal is both private and public where 70% of health expenditure comes from out-of-pocket contributions. There is a massive inequality in the standard of hospital between a government and private hospital – with government provided facilities being under-resourced and over-saturated with patients. However, both private and public sectors do not meet international standards according to WHO. This could be due to poor hygiene, health education amongst healthcare workers and poverty. In addition to this although in 2014 there was a new standard to try and reach universal healthcare amongst three districts of the country but in fact the variable social determinants such as conflicting religious beliefs, financial constraints, poor access and low health education make the ideal of universal healthcare difficult to achieve according to various consultants I spoke to.

Primary health care is provided by government health posts, which are located within rural and urban areas of Nepal. These posts are free at the point of access and provide essential medication. However, resources at these government posts are scare and most treatment requires secondary and tertiary intervention, which are only found in the bigger cities. Unlike the UK before any management takes place, no matter how unwell, a payment needs to be done first (sometimes involving long lines and un-payable debts).

Finally, there is no standardisation of clinicians and the experience and quality of medical staff vary within secondary and tertiary care. In rural areas for example, although there will be access to doctors most consultations will be with less qualified professionals e.g. medical assistants. Within different

hospital there are different standards of equipment e.g. some hospitals didn't have ABG machines within the ED.

To improve my understanding of global disease presentations particularly in Emergency medicine and improve on my clinical skills and management plans for such diseases.

As mentioned above the presentation of disease in Nepal was a lot more advanced of which you would see in the UK. This gave me the opportunity to practice life-saving skills such as rapid ABCDE assessment of patients, intubation and urgent monitoring (NEWS). The impact of social determinants also resonated with me during my 3 week placement here as if the water and hygiene were cleaner and access to education and medical facilities improved a large proportion of the admissions to ED would be reduced. The placement taught me the importance of health education and preventative healthcare.

Due to being in Nepal and the inability to communicate with patients due to the language barrier, I feel I developed my communication skills e.g. non-verbal skills such as gestures and using visual aids.

Due to the financial constraints of the patients and fewer resources I learnt the importance of a detailed history and examination as in a lot of cases the majority of plans will depend on these.