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 six weeks at Manipal Teaching Hospital I spent 3 weeks in the Emergency Department.

The biggest shock when evaluating the disease profile of presentations to the emergency departement was the number of RTAs. Injured patients from RTAs was the highest presentation to ED throughout my placement, more so than comparing to demographics in London. Discussing this lead to the conclusions that this was due to high volume of traffic, poor control of traffic and lack of obiding by road safety rules when driving. There is also a lack of a driving governing body, such as the DVLA, to place limits on certain groups of people driving. There is, also, a very high percentage of scooter drivers on the road, they have decreased protection and are much more likely to crash, and more likely to sustain an injury when crashing. This demonstrated to me the importance of national health and safety in all aspects to reduce injury and hospital admissions within a country.

Other than RTAs, the demographic of presentations were similar to those within the UK. I saw many infections/sepsis, MIs, CVAs, and asthma attacks, as well as the more generalised and less severe headaches and abdominal pain. It surprised me, that despite having to pay for the medical care, patients would still present with minor complaints, but this was explained by the long waiting list for outpatients, and the minimal health education available to the public. It was interesting to note that pathology and medicine is transposible all around the world, but what was interesting was observing the differences in managemnt sue to both skill level and limited resources available that the patient may be able to afford. One case I saw that I have not seen present in London, was one of Leishmaniasis. This is more common within Nepal, and it was interesting to the presentation of a condition that I have only previously read about in textbooks.

The biggest differences that i noticed between the emergency department in the UK and Nepal, was that in Nepal there wasn't an organised triage system or even book in system. Any individual was free to present themselves to A&E and sit on a bed to be een by a doctor. This was a shock at first, as I am used to nurse triage to ensure that the patient is seen by the most appropriate person and in the most appropriate order. However, there were different areas of the department in order to treat minor injuries and occasionally separated patients into minors and majors. This meant that when a patient presented an intern would have to perform a quick assessment to assess severity of the patient, and discuss it with the conultant if they thought it was of concern. I felt this system could mean that patients may not get treated as quickly if they needed it or people could be missed.

Also, the department is open, with minimal curtains to separate beds. In most situations the curtains were not drawn and everyone in the department was able to see what was happening to every patient, even during examinations and procedures. This open nature, however, did mean that te consultant had eyes on every patient at all times. It was also smaller than the emergency departments I have been to in the UK, despite the hospital being quite large. The department was still busy, although less workflow and number or doctors and nurses than found in the hospitals in London.

It was difficult to assess the difference between private and public healthcare as the hosptal I was based in was private. However, I discussed this with my collegues in Manipal and they onformed that the govermental funding was limited and most public hospitals provided sub-standard care compared to

those that are private. This means less staffing, less equipment, and poorer sanitation. At Manipal all care provided had to be paid for by the patient up front, and family members had to be available in order to purchase medication and equipment needed for the care provided. This meant that treatment could be delayed whilst family memebers were standing in queues to receive a proof of payment before treatment could be carried out. But, it also limited the number of people that had access to the care in Manipal, and other private hospitals. If you did not have enough money to pay you got not receive treament, and if you did not have family members or friends to pay and help you, you were also limited as to the quality of care you would receive. Family members play a huge role in the patients care whilst they are at hospital, they not only pay and collect medication, they also act as porters and bring in the food to be given to their loved one.

I found this part of the placement very hard to accept, especially with being used to the NHS. I found it difficult to see patient's being denied healthcare if they could not afford it, even if it was available. This deepened my views in believing ealthcare should be administered in a public and fair manor, and not due to your monetry worth.

At first I felt it may be difficult to learn and improve my management of emergencies as Manipal hospital is so vastly different to those in the UK. However, once I had got used to the workings if the department and uderstanding what could and could not be provided to the patients I was able to further my abilities in emergency situations. As well as learning from the doctors at Manipal, I was also able to impart some of my knowledge and clinical skills onto the interns there. This made me feel like a valuable part of the team and further my confidence in my abilities for returning to the UK.

One case that I particularly felt as if I improved my abilities within a stressful situation, as well as improving the care and potential outcome of a patient, was a patient who came in unstable with a low GCS and was a candidate for intubation. The first surprise was that there was no automatic ventilator available in the department, so the decision to ventilate meant occupying up a person to continually bag them until they were stable enough to be extubated or transferred to ITU. Also, access to the ABG machine and other tests were limited and costly so had to be used with ration. When it was time to take the patient to the CT scan I, and 2 oter medical students, accompanied an intern. It quickly became aparent to me that the intern was not entirely sure how to ventilate, with rate and adequate pressure, and that the mangament of the patient was not being led by anyone. I decided to speak up and take control of explaining the correct rate and also leading when the patient was due to be moved into the CT scanner. This showed to me that I have learnt a lot from being involved in the team of trauma cases in London, and I can handle my nerves better than I would have expected in a stressful and critical situation.