

ELECTIVE (SSC5b) REPORT (1200 words)

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

Describe the pattern of disease/illness presenting to Emergency Departments and Critical Care in Nepal, and discuss this in the context of global health

Although there is considerable overlap of the types of conditions patients present to emergency departments (EDs) with in Nepal as compared to the United Kingdom (UK), there are some stark differences. There were a high number of patients presenting with abdominal or chest pain, breathing difficulties and minor trauma – as would be seen in any similar ED in the U.K. However in Pokhara, I was surprised at the relatively high number of patients presenting with stroke, and the low number of patients presenting with psychiatric conditions.

One reason accounting for such a high number of strokes may be that U.K. stroke networks encourage patients to be transported to hyperacute stroke units in the first instance, meaning that non-specialist centres see fewer patients with stroke. In terms of psychiatric conditions, I suspect that they are similarly prevalent as in the U.K., however perhaps even greater stigma towards conditions such as schizophrenia and depression exists in Nepal. Lack of awareness of such conditions amongst the public in Nepal likely contributes towards fewer ED attendances too. Perhaps the greatest indicator of the high number of people with poorly/unmanaged psychiatric conditions is that self harm is the 6th highest cause of death in Nepal, accounting for 3% of all deaths. Worryingly this figure has increased since 2000.(1)

The comparison between the top causes of death in Nepal and the U.K. is again interesting. The main differences are that 5 of the top 10 in the U.K. are cancers, whereas in Nepal these don't feature at all. Lower respiratory tract infections (LRTIs), diarrhoeal diseases and Tuberculosis account for 13% all of all deaths in Nepal, only (LRTIs) from this list feature in the top 10 in the U.K. and even they only account for 5.5%. Ischaemic heart disease, stroke and chronic obstructive pulmonary disease (COPD) are common causes in both countries, with COPD more common in Nepal (9.2 vs 5%), ischaemic heart disease more common in the U.K. (13.5 vs 9.2%) and stroke contributing the same proportion in both countries (8.3%).(1, 2)

Many of the key health indicators of Nepal are similar to other countries in the same region.(1) There is one statistic that stands out though, and that is the percentage of women using tobacco. In Nepal, 25% of women aged over 15 years use tobacco, as compared to 4% in the rest of the region. Just from what I have seen in my six weeks in Nepal, it appears that a significant number of adolescents smoke cigarettes too. I haven't been aware of any anti-tobacco information or campaigns in Nepal in recent years, so I suspect that as time goes by, rates of lung cancer and COPD may well increase in Nepal.

As is a problem in much of the world, prevalence of significant cardiovascular risk factors is increasing in Nepal. Although only 1.5% of the population are obese, 25% are hypertensive, 10% have raised blood glucose, and as mentioned before, a considerable number use tobacco.(1) As diets become more westernised – the first Kentucky Fried Chicken has opened in Pokhara during my trip – I suspect that this problem will only get worse. From what I have seen, medications to modify these risk factors

are too expensive for much of the population, and often poorly tolerated, which will only compound the issue.

Describe the pattern of emergency healthcare provision in Nepal, and compare this with that in the United Kingdom

Emergency healthcare provision in Nepal is focussed in hospitals. Indeed most if not all of the dozen or so hospitals in Pokhara have EDs. The services provided by these hospitals however varies considerably. Even within Pokhara, there are a large number of secondary transfers of patients from one ED to another, in order to provide more appropriate levels of care, even for relatively stable patients. In Kathmandu the picture is similar, but in rural areas, emergency care is most often provided through community clinics, that for many may still be several hours or even days away from patients at the time of need.

During working hours, outpatient departments run at a number of hospitals. These cover a variety of disciplines and patients do not require appointments. There are some similarities between these and walk in centres in the U.K. In The ED I have seen many patients referred from outpatient departments directly.

Prehospital emergency care in Nepal is for the most part non-existent. In Kathmandu, the Nepal Ambulance Service operate five emergency medical technician-staffed ambulances that can provide interventions to patients prior to arrival at hospital in a similar manner to that in the U.K. This service does not exist anywhere else in Nepal. 'Ambulances' that are seen elsewhere are mostly a means of transport with just oxygen and a stretcher on board. Those staffing these ambulances have no medical training.

In the U.K. recent centralisation of emergency care has led to fewer EDs, with many being replaced by urgent care centres. Those remaining EDs provide services sufficient for most conditions.

The prehospital emergency medical service in the U.K. is publicly managed and responds to a huge number of patients, providing care prior to arrival at hospital. Although the same organisations also provide inter-hospital transfer services, this is mostly delivered using different staff in separate non-emergency ambulances.

Describe policies and initiatives past and present in Nepal, that have been aimed at reducing acute presentations to the emergency department. Compare these to measures aimed at reducing pressures on emergency departments on the U.K. What could either nation learn from the other?

The pressures on EDs in Nepal are totally different to those in the U.K. Whilst in the U.K. departments are often busy with patients attending 'inappropriately', in Nepal, this seems not to be the case. If anything, from what I have seen, a larger problem is that patients do not attend ED early enough, and as such are in a worse state when they do arrive. The lack of a prehospital emergency medical service no doubt contributes to this.

The walk-in outpatient clinics definitely reduce ED attendances, although I am not aware of any campaigns that promote this, as there have been in the U.K., encouraging patients to first go to their GP or walk in centre.

In terms of what either nation could learn. I believe that if the U.K. could increase availability and utilisation of GP-led walk in centres, attendances to ED would be reduced and be more appropriate

for the services available. Perhaps moving away from mainly appointment-based GP clinics would help with this. In Nepal, the main task would be to ensure that the appropriate patients go to the appropriate services at the appropriate time, and I believe that a functional prehospital emergency medical service would assist with this considerably.

Develop skills in communicating with patients in the presence of significant language barriers.

Thankfully during my time in ED in Pokhara, the English skills of the doctors and nurses I have encountered has been excellent, which has made communicating with patients very easy. Still there have been times where I have tried to communicate with those that don't speak English which have been challenging.

I tried early on to learn some key phrases that would assist in examining patients. For example 'breath in, breath out' and 'pain'. Gesturing has been key and learning some basic phrases alongside some simple gestures has made life more easy.

Even during my experience in London, I have had patients with which communication has been difficult. Although the main difference would be that even in the most difficult of circumstances, in the U.K. it is usually possible to use a telephone translation service.

Reference

1. Nepal: WHO Statistical profile. 2015. World Health Organisation. Available from: <http://www.who.int/gho/countries/npl.pdf?ua=1>. Accessed 29/04/2017
2. United Kingdom: WHO Statistical profile. 2015. World Health Organisation. Available from: <http://www.who.int/gho/countries/gbr.pdf?ua=1>. Accessed 29/04/2017