PAEDIATRICS

Fatima Kapacee

Year 5 MBBS

Elective report 2011

Kanti Children's Hospital – Kathmandu, Nepal

Elective Supervisor – Mr Bishop Joshi

Supervising Doctor - Dr Tiwari

Kanti Children's Hospital is the only Government children's hospital in Nepal. There are other children's hospitals in the area however, these are all private. As such, most of the patients coming to Kanti tend to be from poor families and usually tend to have travelled long distances to get to the hospital. Unlike the UK, healthcare in Nepal is not paid for by the Government however, at Kanti, there is a charity run fund that caters for those who are unable to pay.

In terms of the organisation of healthcare in Nepal, there are similarities and subtle differences to those in the UK. As in the UK, each medical team comprises a consultant, who is the lead, followed by the registrars/ residents, interns and nurses. The interns are similar to FY1's in the UK. The working hours on the other hand are significantly different at Kanti. All the doctors are required to be in hospital form between 8.30 and 10 am depending on their grade, with interns and residents coming in earliest, up to around 2pm. The rest of the afternoon is dedicated to private work in other hospitals or clinics. On the on-call day however, they, interns and residents in particular, are required to be in for the whole day and night. They also operate on a 6 day week with only Saturday as the official holiday (this is the same in other jobs too). The interns are required to be in 7 days a week. With regards to medical practise, as the government equivalent of general practise in Nepal, each medical team is on-call for one day of the week and during the morning of their on-call day they run an out-patient clinic. They do have separate clinics like the GP practises in the UK however, these tend to be private and so many patients' families cannot afford them. In the hospital out-patient clinics, patients are initially seen by the team and then either treated and discharged or sent to an observation ward for further investigation and monitoring. Some of the patients tend to be called back for a follow- up clinic, which is also run one morning a week. After the morning out-patient clinic, the team go to the observation ward and assess each of the patients. If they can be discharged, they are discharged and called to a follow-up clinic, or they are admitted. Since some patients come from distant villages and are very poor with no alternative accommodation in the area, they tend to be admitted whilst treatment is carried out even if out-patient treatment is feasible. Vaccination programmes follow similar regimes to those in the UK as do follow-up appointments after hospital admission.

Medicine generally in Nepal is very similar to that in the UK. However, due to the cohort of patients, who travel far to get to the hospital, most chronic conditions, such as leukaemia, tend to present later than they do in the UK. Also, there are more cases of infectious diseases in Nepal, particularly enteric fever/ typhoid, compared to the UK where such cases are not as common. The cases seen in the out-patient clinic tend to be very similar to those seen in general practise in the UK, such as, upper respiratory tract infections, which is by far the majority, bronchiolitis and pneumonia (although pneumonia is also more common in Nepal).

There is however, a greater prevalence of worm infestations in children in Nepal as well as TB comparatively to the UK. In terms of admitted patients, the conditions are similar however, I saw patients with conditions that I had never heard of or come across in the UK such as ~~neurocystococcosis~~ and those that are much less common in the UK such as tetanus, enteric fever and TB. ↳ neurocysticercosis

Asepsis is a big part of medical practise during procedures in the UK. Most of the equipment tends to be disposable and attempts are constantly aimed at reducing infection transmission within the hospital such as by promoting hand washing between patients. Aseptic procedures tend to be performed similarly at Kanti hospital however, due to resource constraints most of the equipment is reusable. The principle of asepsis during procedures such as lumbar punctures and bone marrow biopsies is always maintained. Infection control on the other hand is not as much of a concern at Kanti as it is in the UK. Some wards, such as the oncology ward, have made efforts to improve infection control by ensuring that all staff on the ward wear gowns and different shoes to those worn outside the ward. There are also alcohol gel bottles on the walls and the doctors ensure that they use the gel between each patient. This unfortunately is not the same on other wards. The doctors rarely use the alcohol gel and during ward rounds, it is rare to see doctors wash their hands as is done in the UK. As a result, hospital acquired infection risk is higher in Kathmandu. Another important difference was the disposal of sharps and soiled waste in the UK compared to Kanti. In the UK, sharps are stored away and disposed off soon after using them into special sharps bins, which have a lid on them. The sharps bins at Kanti were open bins with labels on them saying 'sharps'. It was also common to see needles left in bottles of saline and even on the windowsill on the wards. This increases the risk of needle-stick injuries. The bins for other wastes were also lid-less and simply left within the ward corridor.

My overall experience at Kanti Hospital has been an eye-opening one. It was very interesting to see how, despite resource constraints, good medical care was provided in a very different setting to that in the UK. The doctors at Kanti put their patients first and truly aim to improve their quality of life. By enlarge, the doctors ensured that they adhered to published guidelines for treatment of various conditions ensuring excellent treatment and they made an effort to enable patients to receive these medications, despite their cost, by finding alternative funding such as an oncology fund and other funding organisations such as one in Holland for leukaemic patients. The hospital also operates a charity to help pay for other medical and surgical patients who cannot afford treatment. Cheaper alternatives are only sought where their effect is similar to the suggested medication. This experience I feel will be influential in my approach to health care in my future as a doctor. I realised that resource constraints are by no means a reason to accept mediocre treatment however, keeping in mind that funding tends to be limited, it is also important to consider cheaper alternatives if they have the same effect. I intend to practise with the aim of improving my patient's quality of life understanding that all individuals have an equal right to life despite their personal background, both monitory and otherwise. I have also been able to realise and appreciate the effect of infection control measures in the UK and aim to ensure that I adhere to them.

F K Kapacee

Word count – 1184/1200