Student: Ashley Lau
Supervisor: Dr. Bidhan

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GENERAL

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MEDICINE

Elective Report- Nepal

I did two weeks of my elective attachment with the general medicine department at the Chitwan Medical teaching hospital (CMC). I was given the opportunity to attend daily ward rounds, outpatients (OPD) and bedside teaching for the medical students at the hospital . Although my experience at CMC was short, I was able to have a brief overview of the health care system in Nepal, and was able to further my clinical knowledge through observing cases not normally encountered in the UK.

Which diseases are prevalent in Nepal and how does this compare to the UK?

During my time at CMC, I encountered a range of conditions comparable to those seen in the UK such as COPD, alcoholic liver disease, diabetes, thyroid disorders, tuberculosis and chronic renal failure secondary to chronic disease. Although tuberculosis is common in East London due to the demographics of immigrants settled in the area, tuberculosis is even more prevalent in nepal since housing conditions are much more crowded.

Some notable differences of illness seen in Nepal included the prevalence of tropical diseases such as malaria, leptospirosis and typhoid. Hepatitis B is also considered common, due to the lack of a national vaccination programme scheme available and the frequency of travel to high risk areas such as India for business or leisure.

How does health care in Nepal compare to the UK?

Similar to the UK, nepal also offers a private and public health sector. However, my experience with the public Nepal health system was limited since the CMC is a private teaching hospital .

The CMC has a broad range of facilities available to treat a spectrum of illnesses comparable to those in the Uk. In Nepal, the hospital OPD are responsible for community based care whereas GPs are given this role in the UK. At CMC, patients are seen and treated on a first come first serve basis. Since community care is hospital based, investigations (ie. ultrasound, echocardiogram, CT scan) can be performed and reviewed within the same day. The speed at which investigations are conducted is a system which should be adopted in the UK, as patients can immediately be diagnosed and managed. In OPD, diagnosis seems to be more heavily dependent on investigations rather than a thorough history and examination. However, this may only be the case since the CMC is a private hospital with patients willing to pay for these expenses. It would be interesting to observe if this is similar within the public hospitals of Nepal.

Treatment of chronic disease in the UK has always emphasised the practice of preventative medicine primarily through patient education. The responsibility is often allocated to different \ members of the MDT such as a dietician or specialist nurse to help alleviate the workload for doctors. This infrastructure in the Uk attempts to reduce the burden of cost in treating chronic disease whilst optimising patient care and life expectancy. In Nepal, chronic disease education is not considered pivotal due to the time constraints of seeing a large turnover of patients. It is usually done within the 5-10 minute OPD consultation by the attending physician. Perhaps the lack of an in-depth insight of their condition and its consequences is the reason why many patients become noncompliant with their medication.

Furthermore, Nepal does not have an equivalent to the National Institute of Clinical Excellence (NICE), a standardised guideline for medical care in the UK. Instead, diagnosis and treatment relies on individual experience and from adaptations of American and British protocols. A Nepali equivalent to NICE would ensure all patients are receiving standardised care that is evidence based whilst optimising the availability of resources available.

Healthcare in the UK is evolving to become more patient- directed rather than the paternalistic approach seen in Nepal. Most nepali patients demonstrate a great respect for the doctors, and play a more submissive role when prescribed treatment. Whereas in the UK, the ideas, concerns and expectations of a patient are always explored first prior to approaching any case. Patients and doctors are less concerned about confidentiality in Nepal as different patients could be within the same room whilst being seen by the doctor. Perhaps this is a reflection of Nepali culture as it is a much more collectivist society.

How are resources allocated in a developing country such as Nepal?

Although the doctors at the CMC are very well trained and know about the most current standards of disease management, the availability and expenses of resources was a limiting factor in the quality of health care provided for patients at the CMC.

For example, specific investigations such as a legionella urinary antigen test is too costly for the average Nepali patient. Hence, patients with complicated cases of pneumonia are often given a cocktail of antibiotics in hopes that one will be sensitive towards the causative organism. This management approach compounds the increasing issue of the emergence of multi-drug resistant organisms such as MRSA or Klebsiella. Interestingly, despite the broad usage of antibiotics in patients with unconfirmed sources of infection, there are few reported cases of clostridium difficile in the wards whereas this hospital acquired infection is a common consequence of antibiotic use in the UK. Certain treatment options are also either too costly or not readily available due to lack of equipment or trained staff. Only a small minority who can afford the cost of treatment can be referred to hospitals in India. I saw many doctors becoming frustrated when they became hindered by their ability to treat patients due to cost barriers.

Unfortunately, public health awareness is not a priority due to the expenses of maintaining public health programmes. Despite a large cohort of smokers in Nepal, there are no campaigns or smoking cessation clinics about the health hazards of smoking as tobacco sales contribute to a large proportion to the economy and government income. These factors could account for the high frequency of COPD exacerbations commonly seen in the medical wards.

There is also the issue of the number of trained staff employed at the hospital. Ambulance services do not have trained paramedics to perform life-saving procedures. Furthermore, although the CMC offers a range of specialties, each speciality only seems to be managed by one senior physician. For example, there is currently only one respiratory consultant and one doctor responsible for patients in hemodialysis. This becomes an issue when these doctors struggle to manage their patients and would benefit from receiving a second opinion or support from other senior members of staff trained in the same speciality. The CMC medical school is now training a large number of new medical doctors at a very high standard and thereby hopefully eradicating the problem of doctor shortages in the near future.

Student: Ashley Lau
Supervisor: Dr. Bidhan

May 18, 2013

What are the challenges and merits of working in a country outside of the UK?

Communication was the main challenge working in Nepal. Although doctors are trained using English terminology and all the medical notes are written in English, most patients only speak Nepali making consultations difficult to understand. Fortunately, the doctors would kindly translate any significant findings and were willing to clarify any questions I had. Any histories i had conducted could not be done independently and were very time consuming which would not have been acceptable due to the number of patients that needed to be seen in OPD by the end of each day. I found myself phrasing very direct, and closed questions during most of my patient clerkings in efforts to shorten my consultation times. In hindsight, although timing is important, I realised I could have missed out salient points in the history important for diagnosis by avoiding open questions. To accommodate for the language barrier, I further developed my non-verbal communication skills which often included hand gestures or acting out what I wished for the patient to do. I felt that this experience will prepare me when I start practice as there is a prevalent immigrant population unable to speak English in the UK which I will encounter.

Attending the bedside teaching at CMC allowed me to learn different approaches and techniques involved in examination that are different from my training in the UK. After only two weeks, I feel more confident for starting my foundation year training in August.

Student: Ashley Lau
Supervisor: Professor Andrew Burd

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Elective Report –Prince of Wales Hospital, Hong Kong

What are conditions seen in Hong Kong during my elective attachment? How do they differ from my previous attachments in the UK?

I completed my three week elective placement at the Prince of Wales Hospital (PWH) in Hong Kong with the Plastic, Reconstructive and Aesthetic Surgery department headed by Professor Andrew Burd. Since PWH is a major burns centre, many admissions were burns predominantly caused by accidental scald injuries. Scald burns were especially prevalent in young children due to the high density living conditions in Hong Kong and poor primary prevention education among the community. Furthermore, children are at greater risk of accidental burn injuries compared to adults. A given injury of the same exposure time and mechanism of injury would inflict a more significant burn on a child compared to an adult as children have thinner skin. Aside from scald injuries, there were also cases of chemical and occupational induced burns.

Head, neck and skin oncology, arterio-venous malformations, breast reconstruction and transgender operations are some of the other services provided at the PWH by the team. These interventions required additional multidisciplinary input from other specialities such as ENT, dermatology, and radiology.

My placement at the PWH offered me the opportunity to observe disease that I had not been able to see during my brief plastic surgery rotation at the Royal London Hospital in the UK. Although the Royal London hospital is also a trauma centre, most cases I had encountered were laceration or road traffic accident injuries where tendon, nerve repair and skin flaps for bone coverage were performed. Similar to PWH, the Royal London also treats many cases involving skin oncology. However, at the Royal London, there were more cases of melanoma and patients presenting at a younger age with basal cell carcinomas or squamous cell carcinomas. The difference in age demographics and the number patients with melanoma I had observed in the UK could reflect on the significance of the Fitzpatrick skin type between Caucasians and Asians in the development of skin malignancies.

How does the surgical training in Hong Kong compare to the UK?

I am interested in pursuing a career in Hong Kong in the future. My placement at PWH has given me an introduction about the post-graduate surgical training pathway in Hong Kong.

Although Chinese is the main spoken and written language, medicine is taught in English thereby progress sheets, drug charts and patient documentation are written in English. However, ward rounds and consultations would usually be conducted in Chinese – thus I found this aspect to be personally challenging to the find the equivalent of certain medical conditions that I knew in English to translate to the patient in Chinese.

After completion of medical school in Hong Kong, there is one year of house officer training, which is equivalent to the two year Foundation programme in the UK. In Hong Kong, this is followed by Basic Surgical Training for two years within four different rotations and 4 years of Higher Surgical Training in a chosen speciality. Those who wish to work in Hong Kong but have studied from abroad must

pass a three-part licensing exam. In the UK, trainees undergo two years of core surgical training after the Foundation year programme, followed by six years of plastic surgery training before sitting an intercollegiate speciality examination (FRCS Plast). UK trainees need to fulfil an annual quota of procedures and surgeries, each assessed by a supervisor, before one is allowed to progress further into their training. These aspects make the surgical training route in UK much longer- requiring at least 10 -11 years after completing medical school compared to the 7 years of training in Hong Kong. There is also less emphasis on research and publications in Hong Kong compared to the UK.

To further my understanding about the role and my knowledge of plastic surgery

Currently, there is much misconception about plastic surgery due to the increasing popularity and media portrayal of cosmetic surgery especially in Asia. During my elective, I came to a greater understanding about the meaning of plastic surgery during my time at PWH. Plastic surgery is an umbrella term encompassing two forms of surgical intervention: *reconstructive* and *cosmetic*. Reconstructive plastic surgery aims to restore form and function from an acquired (ie. trauma) or congenital (vascular malformation) abnormality. Meanwhile, cosmetic is purely an enhancement to one's essentially 'normal' appearance. Through seeing different stages of a patient's journey from their admission, in the operating theatre, and finally in outpatients for follow- up, I've come to realize the shared values between reconstructive and cosmetic as they both ultimately aim to implement positive change towards an individual's life psychologically, functionally, or both.

During my three weeks, there were a variety of cases allowing me to enhance my own knowledge about the field. These included: breast reconstruction, skin grafting, head and neck dissection techniques, acute management of burns, treatment of vascular malformations and dermatological lesions. Management of burns was more complicated than I had initially expected. Patients needed long term follow up to monitor for the development of scarring and scar contractions for its impact on day to day function. Patients (particularly those with extensive burns) often required multiple reconstructive procedures after the initial procedure particularly when Asian skin is more prone to developing hypertrophic or keloid scars. As a result, burn injuries often have long term psychological sequelae as well.

My experience at the PWH has been a very rewarding one. As I am interested in pursuing a career this specialty, I hope I can apply the knowledge I have learned from this attachment in my future rotations during my post-graduate training.