Debra Fine

Elective Report SSC5c
Chitwan Medical College, Nepal

Objectives:

1. What are the main diseases affecting those in Nepal and how does this differ to the UK? Especially diseases which have been eradicated in the UK?

Myself and a fellow student James, volunteered in a large private hospital in a southern district of Nepal called Chitwan. We lived in Bharatpur, the 5th largest city in Nepal, and worked at a local hospital called Chitwan Medical College (CMC). CMC opened around 8 years ago and started running its MBBS programme 4 years ago. Unfortunately the building of the hospital is yet to be completed and therefore parts of the hospital were still under construction when we were working there.

It was a fascinating and thought-provoking experience working at CMC. Working in the Emergency Department (ED) allowed us to see the kind of diseases and injuries that were regularly treated in Nepal.

A large proportion of the injuries that presented to the department were a result of road traffic accidents (RTAs) – often a car/bike and a person. This highlights the fact that the roads were extremely busy and often dangerous! We saw a number of patients who had been run over by a bike or car and had broken their toes or part of their feet. On the most part they would be sent for an X-ray and then transferred to surgery. On one occasion I followed a patient from the ED up to surgery and was interested to watch the handover to the surgical team. This was a 30 year old patient who had broken his foot and when we arrived in the surgical preparation room he said he needed the toilet. Rather that taking him into a private area the doctor handed him a bottle and he was forced to urinate in front of the whole team with a blanket over him. He appeared to find this quite humiliating and I felt embarrassed and upset for him. This situation highlighted to me the importance of ensuring patient dignity and modesty.

Whilst working in the ED we saw a number of infectious diseases which you would rarely see in the UK. One patient came in with a very stiff neck and a locked jaw. After a full history and examination it was determined he had tetanus as a result of using a dirty scalpel a few weeks ago. The patient was sedated and taken to the Intensive Care Unit (ICU), however the hospital had no access to intravenous immunoglobulin and we were told he would most likely be weaned off sedation soon as he was running out of money.

Many other patients we saw presented with pyrexia and it was often a diagnostic challenge to establish the cause of the pyrexia. A number of times it turned out to be mumps as the patients had bilateral parotid swelling.

The other common presentation in the ED was bowel obstruction – patients presented with vomiting and severe abdominal pain. One patient who we clerked with one of the Nepali doctors had all the classical signs and symptoms of bowel obstruction. The doctor was pressing to get a CT of her abdomen to confirm the diagnosis, however her family were complaining as a CT is very expensive. We discussed the situation with him and decided that and abdominal X-ray would be adequate to make the diagnosis (which it did!) and would be much cheaper for her and her family.

When attending the ICU ward round we were quite shocked to find that the majority of patients were due to organic phosphate (OP) poisoning. The doctors explained that often this was a cry for help or an attempted suicide – one of the patients we saw had tried to hang himself the previous week. Patients with OP poisoning present with pinpoint pupils and bradycardia due to blocking of acetylcholine receptors. Later patients can go on to develop respiratory failure. Treatment is with atropine and a full recovery is possible if the patient presents early and hasn't consumed too much OP.

2. How are medical services organised and delivered by the hospitals in Nepal compared to the UK?

All medical care in Nepal must be paid for, therefore on admission all patients or relatives of patients had to go to a counter to pay for any investigations or treatments they required. Without payment no one was investigated or treated. This is obviously a stark contrast to the NHS and often I found it very difficult. On one occasion we visited Coronary Care Unit (CCU) where we saw two very sick patients – one with severe mitral stenosis and one with dilated cardiomiopathy. Both patients had enough money to be admitted and stablised, however neither could afford any long-term treatment, despite a valvotomy only being about $250.

The first thing we noticed when we started working in the ED was how much autonomy the junior doctors had compared to the UK. The medical officers (MOs) would be left a lot of the day without much senior input into their investigations and management. If a specialist opinion was required the appropriate consultant would come and attend to the patient but there was very little explanation as to why a certain route was selected. This led the MOs to get frustrated as they wanted to learn and progress but felt this was being hampered.

3. To get an understanding of how the emergency department in a Nepali hospital is run. How doctors take a history, examine, diagnose, investigate and treat patients compared to the UK.

Whilst we were working in the ED we watched and helped the MOs with their clerking of patients. It was interesting to see how the histories were often quite short and not necessarily as detailed as we were used to taking. Examinations were often short and on the odd occasion they didn't seem to occur.

In terms of investigations most patients would receive a battery of investigations, often some which we would perceive as not necessary. However on further questioning these tests often had some purpose – for example a lady with pyrexia, parotid swelling and abdominal pain was tested for amylase as mumps can be a secondary cause of pancreatitis.

Patients were always put on a drip and then prescribed furosemide – which is an odd combination, yet on discussion with the doctors they seemed adamant this was the best way to rehydrate the patients whilst not sending them into fluid overload.

4. To reflect on my elective experience in a developing and under-resourced country

We were able to give something back by teaching the Nepal medical students and MOs however it would have been nice to teach more. The main setback in terms of getting more involved was the language barrier as very few patients spoke any English and therefore any interactions required a doctor or nurse to translate.

Overall the experience of working and living in Nepal was fascinating and I learnt a lot about how an under-resourced and developing country manages their healthcare.

Debra Fine

Elective Reflection

Name: Dates of elective: 07/04/14 to 16/05/14
Elective address: Chitwan Medical College: http://www.cmc.edu.np
Elective contact / Supervisor: Dr Dayram Lamsal, dayaramlamsal@yahoo.com

Contact address / Telephone / E-mail of elective placement: info@cmc.edu.np
Subject: Emergency medicine

Was it what you expected?

To be honest I wasn't really sure what to expect before we arrived in Nepal. Our bags didn't arrive in Kathmandu (they were left at the airport in Delhi!) so we had to loiter around the airport for a couple of days before we finally got hold of our rucksacks. When we finally made our way to Chitwan, the local bus took 6 hours, despite being told it was only 3! The Nepali roads are notoriously bad, with umpteen potholes along the way –this made for a fairly bumpy ride!

Overall very friendly and welcoming and the hospital was used to having volunteers.

Clinical experience?

Lots of observing as language barrier is always a problem. Some hands on experience such as taking control of CPR and suturing if we wanted to.

The hospital was very open to us running teaching sessions for other volunteers and the Nepali medical students – this was great a s we felt like we were really giving something back. Just be proactive!

What did you learn about the people and the country?

During our time at CMC we lived with a host family and so fully integrated into Nepali life. We ate breakfast and supper with them and often took the children out in the late afternoon around the local village, working in their vegetable patch or playing cricket with the other local children. The host family were friendly and welcoming and taught us quite a few Nepali words!

I found the Nepali people extremely friendly and welcoming. Bharatpur is not a touristy place and therefore local people weren't that used to seeing Western people and so just walking down the road many people would stop us and ask our name and where we were from!

What did you learn about the health care professionals you worked with?

Generally the knowledge base of the doctors and students in the hospital was high, however when it came to the practical side of medicine they seemed less adept. For example the MOs ability to form a working differential seemed poor and generally they just wanted to treat the symptoms that presented.

What did you learn about the health care system in that country?

All medical care in Nepal must be paid for, therefore on admission all patients or relatives of patients had to go to a counter to pay for any investigations or treatments they required. Without payment no one was investigated or treated. This is obviously a stark contrast to the NHS and often I found it

very difficult to accept at times. It also made me really appreciate what the NHS stands for and that we are provided with free healthcare. On one occasion we visited Coronary Care Unit (CCU) where we saw two very sick patients – one with severe mitral stenosis and one with dilated cardiomiopathy. Both patients had enough money to be admitted and stablised, however neither could afford any long-term treatment, despite a valvotomy only being about $250.

What were the best bits?

Having autonomy to visit lots of different wards around the hospital. We attended dermatology clinics which were a great place to see diseases we would never see in the UK such a leprosy ('Hanson's Disease') – a young girl with leprosy in her ulnar nerve (causing loss of sensation over her ulnar nerve and hypothenar wasting) , an ulcerating TB lesion and lots of fungal infections including pedis tinia and discoid lupus.

Living with a host family was also a really great experience and a chance to integrate into Nepali life including eating the local food (although curry for breakfast was hard to get used to!) and learning the language.

What were bits you least enjoyed?

The language barrier was the hardest bit as it meant we weren't able to independently clerk patients and had to rely on the doctors/nurses to help. However with perseverance and smile it was surmountable.

Were there any shortcomings?

Probably not as hands on as we'd have liked it to be, however if you are proactive and ask to get involved you can definitely get hands on.

Would you recommend it to another student?

Yes.

Would you do anything differently?

No.

What did you learn about yourself?

When faced with a child who wasn't breathing we reacted quickly and started CPR until senior help arrived. I learn I can react quickly and think clearly under pressure and learnt to deal with the emotionally difficulties of the death of patients, especially children.

Where there any deviations from the risk assessment?

No.

How was your accommodation?

Living with a host family was excellent.

How were your travel arrangements?

All went smoothly – flights and local buses.

Other experiences and information useful to future students:

I would just advise all students to get involved and stuck in as the more you look keen and try and get involved, the more the doctors trusted us and wanted our help and advice. I would highly recommend Nepal as a country to visit – it is friendly and beautiful. I would recommend a trek at the end of your trip!