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Elective Report SSC5c
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1. Which conditions are most prevalent in Nepal and how do these differ from those in the UK?

I traveled to Bharatpur, which is located in the South of Nepal, slightly West of Kathmandu and on the border of Chitwan National park. I volunteered at the Chitwan Medical College, a large public hospital which had been constructed in 2006 and in 2009 had launched its MBBS program. Here I have been engaged in a number of different aspects of care ranging from intensive care and the emergency room to dermatology clinics. The experience has been incredibly interesting and informative. It has allowed me to learn first hand about a healthcare system in a much poorer country, giving me a greater understanding and allowing me to get a reference point for viewing and considering the healthcare provided in the UK.

The most strikingly prevalent condition admitted to the hospital was trauma secondary to road traffic accidents. The poor condition of Nepal's roads, the old and often poorly maintained vehicles, along with limited formal licensing and enforcement clearly made for more treacherous road travel than we have in the UK. That is not to say that this is not also an issue in the UK, but in Nepal it accounts for a much greater proportion of the workload. This fact is exacerbated by the prevalence of scooters and motorbikes, which as a cheaper option than four-wheeled vehicles are extremely common. The limited protection afforded the occupants of these vehicles results in numerous injuries related to what could otherwise be minor collisions. The manner in which they are operated is almost certainly also a contributing factor, as these small vehicles can skirt and pass the common traffic jams which cripple the major roads during rush hour.

There was also a greater prevalence of gastro-intestinal infections within the hospital when compared with the UK. It seems likely that there are two reasons for this: The first resulting from the reduced level of sanitation with regard to foods. This was evident both in storage, where food was rarely refrigerated, and in the cleanliness of utensils and equipment for cooking (often stemming from dirty water sources. The second reason is likely to stem from the climate. The great heat in this lowland area, with temperatures easily surpassing 35 degrees centigrade every day, meant that a bout of vomiting and diarrhoea would rapidly contribute to the dehydration of a patient in an environment already encouraging this. The result is a greater severity of the patient's suffering and hence a need to attend a medical facility.

Poisoning with Organo-phosphate pesticides was a surprisingly common condition which I had not previously encountered. Due to the rural nature of much of Nepal's population and the involvement of the majority of people in some sort of (often minor) agriculture, these pesticides were extremely prevalent. We learned that these compounds can be absorbed through the skin, making them dangerous to anyone using them. We also discovered that they are commonly used by individuals in rural communities when attempting to take their own lives. The compounds have the effect of paralyzing the muscles as they inhibit the acetylcholinesterase at the neuromuscular junction. The effect spreads through the body, eventually affecting the lungs, resulting in respiratory depression and

death. During a ward round on the intensive care unit, eight of our twelve patients were suffering from organophosphate poisoning. I was amazed by its prevalence. I have often thought that depression was a mental illness largely limited to the developed world, but my time here showed that it is prevalent the world over. The lack of reporting probably stems from the stigma attached to mental illness as well as the limited services and support available for those suffering from the condition.

2. Healthcare provision in Nepal and how it compares to the UK

The provision of healthcare did not differ too dramatically form that in the UK. The colonial heritage and spread of Western medicine meant that the structures and hierarchy utilized there are similar to the UK, even if they represent what would now be considered a more old fashioned system.

There were however clear and striking differences. The most visible of these was the requirement for individuals to pay for the services before they would receive them. This was mainly in relation to investigations and operations but it still had a dramatic impact on care. Scans and interventions being delayed or sometimes, especially with surgeries, abandoned due to the need for payment. It obviously seemed barbaric to me and made me exceptionally grateful for the system which we enjoy in the UK. There was some provision in the hospital for emergency care and for helping those unable to afford treatments but these were poorly funded and in the face of such overwhelming demand were hardly noticed.

The next striking difference was the speed with which patients would be seen in clinic. This was most notable in the dermatology clinics. Patient would usually be seen in less than 5 minutes by the excellent dermatologists who were clearly experienced and not delayed by excessive paperwork. However, there were many times when I wondered if the patient fully understood the treatment that was being recommended to them and had been able to ask all of the questions which they might have had.

3. To learn about and engage in the initial assessment of a patient in Nepal, including the formulation of their initial management plan.

We were fortunate to work with many newly qualified Nepali doctors who were often unsure and sought our collaboration. This allowed us to fully engage in this process; taking detailed histories from patients, performing examinations, ordering the necessary preliminary investigations, and finally forming working diagnoses with their appropriate managements. The process was extremely rewarding. It was great to contribute to the care of a patient and help out a fellow medical professional, but, on a more personal level, it acted as a reassuring confirmation of our medical skills and knowledge.

4. To gain experience practicing and teahcing in an under-resourced hospital

The experience was enlightening and informative. I also found it enjoyable. I made an effort to engage with the teaching of both the native medical

students and the international (largely pre-medical) volunteers. These activities further contributed to my enjoyment of my time in Nepal. I was able to share clinically relevant skills and tips with the local medical students nearing the end of their studies. The most enjoyable of these was the CPR session that I helped to teach with a colleague.

The international students required a more introductory level of teaching, so we would work through a different system each day. Reviewing its function and then examining the impact on the body of that function failing. We would finish by looking at common pathologies in each system and the appropriate treatments. These sessions were slightly more formal and involved the use of a whiteboard in one of the schools lecture theatres.