Elective report – Shaikh Zayed Hospital, Lahore, Pakistan

The UK is one of very few places in the world that has a fully state funded health care system; a system which delivers equal health care regardless of the financial status of a person. Furthermore, the medical equipment available for diagnostics and treatment in the UK is state of the art. I wanted to compare the NHS to a government run health care system in a less economically developed country. Therefore, I chose to organise my elective at Shaikh Zayed Hospital (SZH) in Pakistan. This is classed as a tertiary care hospital in their system. During my time at SZH I had the opportunity to spend time in the diagnostic department, emergency room, general wards and surgical theatres.

Understand the incidence and prevalence of neurological disease in Pakistan and common presentations in A&E

The long term documented data for incidence and prevalence of neurological diseases in Pakistan is sparse. However, I was told by the neurosurgical team that number of cases were growing and patients presented very late, which made surgical procedures more difficult. The most common presentation to the neurosurgical team was of pituitary adenoma. Unfortunately, none of the cases I observed could be managed conservatively due to the size of the growth. Patients only presented once the medical problem started to affect their life significantly, such as visual field defects.

In comparison, presentations in A&E ranged from more basic problems to unconscious patients. Often many of these basic problems would have presented to a GP in the UK. The most common presentations were late complications of diabetes (e.g. renal failure), hepatitis (liver failure/cirrhosis) or cardiovascular disease.

Observe the delivery of healthcare in Pakistan

Pakistan has a mix of both private and public sector healthcare. Though private sector provides for the majority of health care facilities. In SZH the medical services are available at a subsidised rate due to government funding.

However, my initial observations was that the health care system in Pakistan seemed to lack structure. There was no clear line between primary and secondary care. The closest thing to a GP surgery in Pakistan was either the private doctor clinics in the evenings or outpatients (commonly called ‘outdoors’) on set days. Most of the patients would be unable to attend a private clinic due to the high costs and thus would come to the outpatients department (OPD) or present to the emergency department.

In terms of specialised diagnostic facilities, a wide array of options were available to both inpatients and outpatients at a cost; including electrocardiography, echocardiography, CT and MRI.

Once the patient had been admitted to the hospital (emergency room or any other ward) their family member or persons accompanying them would be provided with a list of drugs and/or equipment (including cannulas and syringes etc.) to purchase. Treatment could then be commenced once these items had arrived. If the medicines or equipment were provided by the hospital the

charges would be billed to the patient and have to be cleared before any further treatment could be commenced.

One of the main things that struck me was the lack of hand washing facilities, in particular the absence of alcohol gel. Due to the rapid turnover of patients it was often difficult for the healthcare workers to ensure high standards of hygiene. Furthermore, due to the volume of patients A&E beds often had to be used by several people.

I also noted that there was a lack of regulation in the drug industry. This meant almost all medication could be purchased over the counter without any medical input. This often led to friends and family members recommending various drugs and homeopathic treatments, which would be tried before presenting to a healthcare professional. As a result most presentations were at advance stages requiring invasive procedures (especially in neurosurgery). The freedom of purchasing any drug over the counter also meant that patients who could not afford to be seen by a doctor would often ask the 'pharmacist' for advice. Those that had attended a clinic would be lost to follow-up till the prescribed medication stopped working or disease had progressed.

There was also a loss of follow-up of patients as some patients travelled from surrounding villages and cities (in some cases 100s of miles) to be treated at SZH.

Understand the public health issues in Pakistan

Unfortunately, there are a plethora of public health issues in Pakistan. The quality of health care delivered is governed by the amount of money a person can pay. This often means that the best health care is only available in the private sector, costing 100,000 rupees (approximately £1000) or more on average, a bill most of the population would be unable to afford. As results of the high costs in the private sector, many people have to attend government subsidised hospitals. Although the treatment is subsidised it is not free. 50 rupees (Rs.) gets a patient seen by a doctor and everything after that carries its own charges. This means the doctors have to depend heavily on their clinical knowledge and skills to diagnose a patient, selecting only the essential investigations. Furthermore, staying in hospital is very expensive, costing a minimum of Rs.800 per night for a bed. Often patients will temporarily discharge ('leave') until their operation. Some would take 'leave' post-operatively until a few days before their follow-up appointment.
Another large issue is a poor understanding of the common medical conditions. Sadly there was not much evidence of a campaign to rectify this. Television was used to reinforce the message about hygiene and cleanliness, however, this was funded by a private company selling soap, rather than government driven.

Improve diagnostic skills and communication and team-working skills in a setting where language barriers may be present

There were a variety of languages spoken in Lahore; predominantly Urdu, Punjabi and Pashto. Although I have some understanding of Urdu and Punjabi, at times I found it difficult to understand medical terms and query certain medical symptoms. Often I found myself asking the patient to rephrase the answer and if this didn't work I had to ask the doctors or nurses to help overcome this language barrier.

The time spent with each patient was dependent on the patient turnover. This was especially true in the emergency department and OPD. The high volume of patients and with a lack of time severely limited healthcare staff. Communicating the full details of the diagnosis and management plan was often extremely difficult with these constraints.