

ELECTIVE (SSC5b) REPORT (1200 words)

A report that addresses the above four objectives should be written below. Your Elective supervisor will assess this.

For my student selected component, I had chosen Nepal as my country as choice, and the reasons for choosing it are due to Nepal being a developing country with a different environment and a healthcare system in comparison to the United Kingdom's NHS. My primary focus during my student selected component was Paediatrics and mainly how the hospital care works for patients admitted in paediatric wards.

My first objective was to observe the clinical presentations that were common during my rotation here and especially for acutely unwell patients and how this compares from a global health perspective. In my time here I had the opportunity to observe ward rounds and talk to doctors who practised here, and I had used that as my chance to learn more about the cases that are common here. During my stay here some of the common cases that patients presented with were infections and complications from long standing issues. For example, many of the cases I had seen were from long standing renal disorders, such as nephrotic syndrome and in a rare case, suspected autoimmune conditions such as Lupus. Further with my discussion with the doctors I had learnt that many cases of nephrotic syndromes were often from infections which can lead to causes such as rapidly progressive glomerulonephritis and focal segmental glomerulonephritis which were typical in a developing country such as Nepal. Furthermore, infections also played a huge role in why patients presented, such as GBS or in a case I had seen, septic arthritis. Whilst conditions such as septic arthritis do appear in the UK, from a global health point of view the complications that arose as a result were often much more severe in Nepal. In this case the patient with septic arthritis had sadly developed complications leading to infective endocarditis, and further CNS infections, leading to the patient having a myriad of symptoms that were difficult to control. In the cases of infections, it was also important to recognize that they were often resistance to your typical antibiotics that may be used in the UK. For example, a case I had witnessed was typhoid infection leading to enteric fever. Whilst typhoid may appear in the UK, it is often rare due to vaccinations being regularly given. From a global health point of view in Nepal whilst vaccinations are given (such as in this case) they still do appear and often they are not treated in the same way as the UK; in this case the infection was resistant to the usual drug of choice that would be used such as chloramphenicol or fluoroquinolones and instead the doctors had chosen third generation cephalosporin due to its resistance.

My second objective was to focus on the clinical procedures that are routinely done (or lack of) and compare it with the UK. From what I had learnt during the ward rounds many of the cases had a very guideline focused approach and surprisingly they were very similar to what you would expect in the United Kingdom. For example, the cases of nephrotic syndromes were treated with ace-inhibitors and steroids. From what I could observe this was the same as what you would expect in the United Kingdom, even with the choice of steroid being the same. However, certain medications were different in Nepal due to cost reasons such as them choosing to use Captopril whilst in the UK you may see drugs such as Ramipril used more commonly. Another example was a case of patent ductus arteriosus which was initially treated with paracetamol here. Whilst this is effective and will provide the therapeutic response required, in the UK we would often see medications such as indomethacin used in this situation. Whilst I did not have the chance to explore why this was done, I do believe that cost was a major factor in deciding what medications are given. Furthermore, to add healthcare in Nepal is not free as they do not have a similar system to the NHS

and as a result doctors often had to consider each treatment from both a therapeutic point of view and cost to ensure that the burden on the patients was limited as possible. For me this was both interesting and sad as this would never be a point of conversation in the UK.

Furthermore, during my placement in Nepal, I had a chance to observe the clinical procedures and conclude how they were different to the UK. For example, basic procedures such as measuring blood pressure were all done manually, with the doctor using a typical cuff and inflating it with the use of their stethoscope to observe the Korotkoff sounds. The difference here is that in the UK often clinicians have no need to use this method as we would have blood pressure measuring tools that would automatically measure it for you. In contrast in Nepal doctors have a more hands on approach and are expected to be able to measure blood pressure manually. An argument could be made that the approach in the UK is more accurate and reliable, however on the other hand it also means that doctors in Nepal will be better equipped to deal with resource limited situations. Another example in of a common clinical procedure is the approach to neonatal patients on the ward. In Nepal often these patients do not have access to regular incubators and such the neonatal patients are expected to be without it during the period of stay unless in more specific wards such as intensive care unit. This is greatly contrasting to what we would see in the UK as every patient in a neonatal ward would access to an incubator and it would be in use at most times to ensure that optimum conditions are created for the baby.

Finally, my placement in Nepal also gave me a chance to observe how medical education is approached in contrast to the UK. In Nepal often medical students and interns have more access to bedside teaching and direct teaching from consultants on the ward. For example, during ward rounds the consultant would ensure that each case is properly discussed with the interns and the interns are also regularly assessed on their level of knowledge. Moreso teaching is also more frequent on the wards with the involvement of many doctors as possible and there is also a greater availability of off-site teaching, as the consultants will regularly teach before the ward rounds going over important clinical information for students. For me this was a contrast in comparison to what I had experienced in the UK. For example, in the UK bedside teaching was often more limited and is something that we as students had to approach ourselves, and we would also often be taught by other foundation doctors rather than consultants. Whilst this can vary between universities in the UK it is comparably greater in Nepal which was a positive surprise for me.

Overall, my experience in Nepal was unique and gave me a chance to see how healthcare works out in a developing country. Whilst the language barrier was something I had to deal with, there was a greater difference in how common medical practices are approached here in comparison to the UK. Moreso simple procedures such as taking histories, or the structure of ward rounds or just basic patient communication was also different. Furthermore, medical education in Nepal is also something that plays a greater role in how consultants and intern doctors interact and I believe that overall this creates a well-rounded doctor and one who can deal with complex cases in a resource limited environment.