

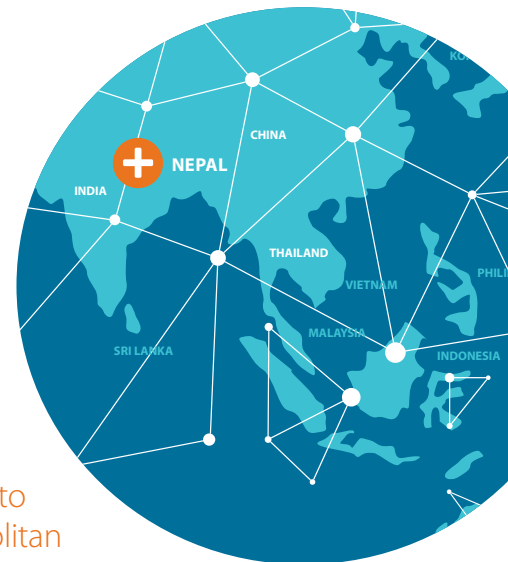
Elective Grant Report



A rest point along my Everest Base Camp trek, this is after a vertical gain of about 1,500m from valley low to mountain high

Angus Taylor
Monash University

Tribhuvan University Teaching Hospital
Kathmandu, Nepal



As part of my final year medical school program, I was given the opportunity to undertake a four to six week elective in a country and hospital of my choosing. Hoping to broaden my experiences beyond the metropolitan Melbourne hospitals that I had been exposed to during my prior teaching, I organised my elective at Tribhuvan University Teaching Hospital (TUTH) in Kathmandu, Nepal. I found it to be an even more extreme, emotional and eye-opening experience than I could have imagined.

Organising my elective during the end of my penultimate year, I was (like many students) still somewhat at sea when it came to deciding on an area of personal interest to focus on. With the help of the Elective Director at TUTH, I eventually chose to do my elective in the Emergency Department. From the perspective of my own learning, I hoped that this would give me the broadest experience of patient presentations and provide me with better knowledge and skills in treating more high acuity patients – an area it never hurts to have extra experience in. In reality, it gave me this and more, including first-hand experience of low resource, ‘at the coalface’ of healthcare where privacy, comfort and even hygiene are considered luxuries.

The population of Kathmandu is large and has significant variation in their socio-economic status. As a large public hospital, TUTH receives patients from all walks of life, but there is a skew towards the more disadvantaged patients. These patients often present later in their disease course, for many reasons. Many of these patients report being unable to take time off work due to financial pressures and so they delay attending hospital until the last minute. Others live much further from the hospital and cannot afford to travel to hospital until it is necessary.

The diseases that patients presented with to TUTH were surprisingly similar to those seen in Melbourne, however often much more extreme in their presentations. Exacerbations of Chronic Obstructive Pulmonary Disease (COPD), alcoholic liver disease, decompensated congestive cardiac failure (CCF) and end stage renal failure due to Type 2 Diabetes Mellitus were the bread and butter. Conditions that more rarely present to Melbourne ED's were also apparent, with tuberculosis (TB) being one of the more common of these.

Like most, TUTH's Emergency Department (ED) functioned on a triage system. Simpler than most, the department split patients into green, yellow and red urgency, with each category having its own floor space within the department – red here, unsurprisingly, represented the most seriously ill patients. However, rather than allocate patients to beds as they became available, with patients waiting in a waiting room prior, the TUTH department brought patients in immediately, finding space for them wherever they could within the appropriate area. This meant often standing room only within the green area, up to four to a bed in the yellow area (plus many more on seats), and even in the red area, having two patients to a bed was often required. At the busiest point I saw, there were over 100 patients in the department, with more than 50 additional (green) patients queued outside the door, unable to fit inside.

Call me sheltered, but this was a bit of a shock. Given that many patients presented with fevers and often infectious signs, I felt that this situation was undoubtedly causing patients to transmit infections between each other and surely worsening the whole situation. However, it became apparent that this system had evolved out of necessity. Relatively low bed counts on wards within the hospital meant that admission of patients from the ED was an incredibly slow process and therefore leaving patients waiting for a bed was unfortunately untenable. I observed patients receive an entire course of IV antibiotics, over several days, without leaving their emergency bed – a pretty stark contrast to the Australian ‘four-hour rule’. Necessity was the ever-present





The Tribhuvan University Teaching Hospital Emergency Department: the second floor houses an observation ward, whilst the top floor is the education department



A typical Kathmandu central street - tall skinny buildings line the busy streets, many of them still showing signs of damage from the April 2015 earthquake



Enjoying the more laid-back lakeside vibes of the popular tourist destination on a weekend trip to Pokhara



Finally reached Everest Base Camp: 5364m altitude and out of breath but still smiling!

dictator of medical care at TUTH, allocating resources and cutting expenses where possible. Medical and nursing staff worked long hours, triaging, treating, monitoring and managing the many patients that streamed endlessly through the door. Public healthcare in Nepal is subsidised where possible but remains dependent on patient payments. For many of the patients, these payments are a significant burden and often 'non-essential' treatments (think IV fluids, or any and all prophylactic or protective medications) are refused on financial grounds when doctors suggest them.

I cannot speak highly enough of the staff at TUTH and their dedication to patient care. In these tough conditions, they demonstrated efficient, caring and calm medical practice, the like of which I hope to emulate.

Patient care, whilst not 'evidence-based' in the sense that Australian healthcare ascribes to be, was consistent between doctors and appropriate for the overall setting. My western management strategies would have often been impossible or impractical in this setting, so it was great to watch the TUTH doctors navigate complex conditions in such a low resource setting.

Outside of the hospital in my spare time I explored Kathmandu, visiting Hindu temples and Buddhist monasteries, and went across the country to Pokhara, a popular destination that's a touch more laid-back than bustling Kathmandu. I also managed to squeeze in a visit to Sagarmartha (Mt Everest) National Park – the home of the Sherpa people. Across my travels I found the Nepalese people to be welcoming and friendly at every stop, and keen to show off the best of their country to travellers. Trekking to Everest Base Camp was a surreal experience, surrounded by a majestic Himalayan skyline. For those medical students looking to mix exploring a stunning natural environment with their medical elective, it's hard to pass over Nepal.

My time at TUTH was, as the cliché goes, an eye-opening experience. In some areas I was surprised by the similarities – similar infections treated with similar antibiotics. Yet in other areas I was shocked by the differences – as 50 patients lined the walls of the single ED room, no curtains for privacy and only a few beds to share. I found it incredible that the local doctors could take the chaos in their stride, and I felt inspired to take home some of their courage with me.

Mostly though, I was grateful to the many patients who allowed me some part in their journey, often at their most vulnerable, and I am determined to take the learnings about both the science of medicine and the social determinants of health into my future practice. I am grateful to MIGA for proving the \$1,500 community component of my Elective Grant, which will fund the purchase of new wheelchairs for the Emergency Department – non-ambulant patients had previously had to be carried by family members to radiology, pathology or between wards. Nepal is a beautiful country full of wonderful welcoming people, and I will be forever grateful for the experience they provided me.

Each year MIGA's Elective Grants Program offers 10 Grants of \$3,000 to medical students undertaking electives in developing communities. Each Grant includes \$1,500 to cover the student's personal elective costs and \$1,500 to provide medicine or other aid to the local community. To be inspired by other past recipients and find out more about applying, visit our website.

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