

Elective Grant Report



Performing a routine neonatal examination on this precious new life

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Nepal. Home of the majestic Himalayas and the mighty Sagarmatha (Mt Everest), it was also my home for two months in December 2016 and January 2017 – perhaps the best months of my life so far. I undertook my four week final year medical elective in Pokhara, Nepal's second largest city, based at the Kaski Sewa Hospital (KSH) and Research Center. Overall, it proved to be a fantastically valuable experience, both personally and professionally, and with the help of MIGA's Medical Support Grant I feel I was able to make a meaningful difference to the local community.

As a brief introduction, Nepal is a relatively small country – less than two-thirds the size of Victoria, it has a population of 28 million (4 million more than Australia), and a GDP per capita just 1% of Australia's. It remains on the UN list of the world's Least Developed Countries, with one third of the population living below the poverty line. It also recently sustained a devastating blow with the earthquake of 2015. Landlocked between India and Tibet, its very hilly geography makes transport particularly difficult for the 80% of the population living rurally. Pokhara itself is situated 200 kilometres west of Kathmandu, right in the middle of Nepal, and boasts the highest costs of living. My time in Pokhara was largely coordinated by Volunteer Society Nepal (VSN), a not-for-profit locally run volunteering organisation through which I found the KSH. I was fortunate enough to live with a Nepalese family at a local homestay (just a 30 minute walk from the Hospital), meaning I had the opportunity to truly integrate into the local community.

The KSH is a moderate-sized, relatively well-equipped private centre located just down the road from Pokhara's major government-funded tertiary referral centre, the Western Regional (Gandaki) Hospital. It was established in 2010 to meet growing demands for better quality health care in the region, and has made a significant contribution by being the first private hospital to offer an ICU and neonatal ICU. It also has a reasonably large outpatient area, four main wards (general medical, surgical, paediatric and women's), with two operating theatres and a small radiology department. Although my placement was officially with the medical department, I had plenty of worthwhile opportunities working with the other specialties.

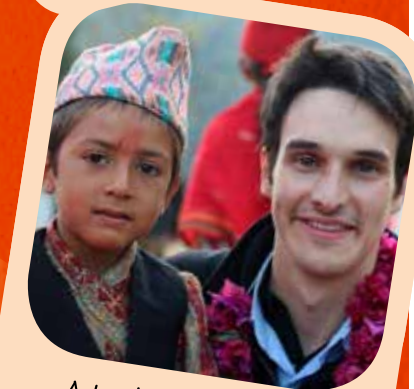
Intriguingly, many of the medical officers and nurses seemed quite unfamiliar with hosting students, and some worried that I had accidentally arrived at the wrong hospital.

I was repeatedly asked how and why I had chosen this hospital, as almost all other elective students study at one of the major teaching hospitals (like the Manipal Teaching or Western Regional Hospitals) with established programs for international students. Indeed I had considered these options, having read many reports and scoured the internet for information, but I wanted something different and unique. Having discovered the KSH through VSN, with little other information available, I wasn't sure what to expect in terms of learning experiences. I was pleasantly surprised to find that the Hospital did not have a formal teaching program, and so I was never competing with local medical students for the consultant's attention (in fact I was the only student there during my entire placement). This proved very fruitful, and I made the most of one-on-one bedside teaching and impromptu tutorials from the senior doctors.





A busy day at the health camp - an opportunity for some socialisation!



A traditionally-dressed Nepalese boy at the health camp



Gloves washed and ready for another use at the Western Regional Hospital

My time on placement was spent in many ways, and despite not having a formal timetable, I was never short of something to do. Within the medical unit of the Hospital, I divided myself between the emergency department, medical wards, ICU and outpatients – where I was working an equal amount of time with the medical officers (the equivalent of Australian interns and junior residents), and the consultant physicians when they attended ward rounds and consultations. Interestingly, there are no acute care specialists like in Australia, so the emergency department and ICU were headed by the general medical physicians who were expected to have sufficient expertise across all these areas.

Three consultants with whom I formed meaningful professional (and personal) relationships were Dr Saroj and Dr Bishow (two inspiring physicians), as well as Dr Padam (a well-respected orthopaedic surgeon and the hospital director). They were all astute clinicians; each with a slightly different philosophical approach to the practice of medicine, but all equally keen to help me make the most of my experience. It was especially gratifying to perceive the mutual respect that evolved between us – my inexpert opinion on management was often sought, and they were eager to incorporate any suggestions I had regarding best practice in Australia. Notably, they seemed fascinated by my insistence on evidence-based medicine as taught in Australia, which was a somewhat less imperative concept in their more resource-limited system.

The clinical experience I gained was vastly different to what is offered in Australia, and made all the more memorable by the moving personal stories of each case.

In just four weeks I was exposed to a wide variety of medical conditions, ranging from common ischaemic heart disease and chronic obstructive airways disease to more exotic infectious diseases; many of which I had only read about, and a few I had barely even heard of (such as leptospirosis and tropical pulmonary eosinophilia due to lymphatic filariasis).

I witnessed patients with active tuberculosis, leprosy, malaria, schistosomiasis, amoebic liver abscess, typhoid fever, and a much higher incidence of viral hepatitis and HIV – and the list goes on. Even the cases of more common conditions provided important points of difference; such as the aetiology of chronic obstructive pulmonary disease (COPD) being less from smoking and more from cooking over wood fires with poor ventilation. Even for cases of myocardial infarction, the lack of facilities for PCI/angiography and the high cost of thrombolytic drugs meant that many cases received no actual intervention, and they were managed with much less urgency than in Australia.

Another remarkable difference was the general tendency for patients to present late in their disease course. With the lack of a proper primary care system, many conditions only came to attention when they started causing significant symptoms. For example, I saw several cases of end-stage liver disease (mostly due to viral hepatitis or chronic alcoholism) who first came to hospital only when they were encephalopathic, and were essentially palliated – rather than having their disease detected much earlier when intervention could have saved their lives. This also presented valuable learning opportunities as these patients had all the ‘textbook’ signs of liver failure, and I saw many classic signs of advanced disease rarely seen in Australia.

As educational as the exposure to these different diseases was, perhaps more valuable was the insight I gained by being in such a foreign setting. As the second poorest country in Asia (Afghanistan being the first), Nepal is the epitome of a developing nation, with an equally underdeveloped healthcare system.

In these resource-limited circumstances, appropriate investigation and management are seldom possible, meaning there is a greater emphasis on clinical diagnosis and cost-effectiveness is always a management priority.

Also, the patients have to pay upfront for all investigations, equipment and medicines used, and on a ‘pay-as-you-go’ basis. If a patient on the ward needs a new drug, a new IV cannula, or a dressing changed, a family member will have to go down to the Hospital’s pharmacy with the list and purchase everything beforehand. Again, cost becomes a dominant factor so many will question whether they truly need the treatment, and I witnessed too many examples of patients rejecting recommended therapies or having to stop a drug because they couldn’t afford the next dose. One man who spent all his money on a surgical procedure developed renal failure simply because he couldn’t pay for the prescribed IV fluids.

As mentioned, the KSH is a private centre, but unlike some others in Nepal, it hasn’t been commercialised and most profits are used to fund community outreach programs. Although the issue of affordability is more pronounced in the private hospitals of Nepal (there is no such thing as health insurance), it still plagues those in the government hospitals, where patients are poorer and often have to go without food to buy the day’s medicines. I had the opportunity to spend a few shifts in the emergency department of Gandaki Hospital and I witnessed the enormous difference between the public and private systems. The government hospitals are overcrowded, understaffed, under-resourced and the quality of care is much lower than in (most) private hospitals – both in terms of patient comfort and ultimate health outcomes.

The emergency medical staff could barely spend any time with a single patient, and the constant stream of new cases meant the halls were lined with people, some of whom were already deceased and waiting to be moved.



Sitting with a 90 year old man, a distinguished patient of the village health post



Brimming with joy after my first delivery in Nepal



Medical staff and I at KSH

Privacy is almost non-existent and hygiene is an afterthought. Confronted by these experiences, I was glad to have chosen a private hospital where I had time to actually learn from the patients and see them receiving the best care available.

There were many individual cases that left lasting impressions, both personally and professionally, and together changed my view of world medicine. One patient's story I would like to share, as it particularly affected me, is that of a 52 year old woman who presented with personality changes and psychotic features. She was initially dismissed as "just crazy", and only taken seriously when she mentioned her recent 20 kilogram weight loss, persistent vomiting and widespread bone pain. After three days of further investigation she was diagnosed with metastatic ovarian cancer – the brain metastases in her frontotemporal lobes were causing her neuropsychiatric symptoms. Interestingly, there were periods (presumably between seizure activity) when she was fully lucid as her normal self and told me (with the help of a nurse translating) how she was praying not to die so she could see her son get married in six months. I formed quite a relationship with her and her family over the coming week, and between oncology consults it became clear how underdeveloped the palliative care system is in Nepal. It was never clearly communicated to her that she had less than a month to live, and so she never received the emotional support she deserved. Nor were her dreadful vomiting and pain ever effectively controlled, despite the doctors' best efforts. They simply didn't have enough teaching, experience, guidelines or resources to provide adequate palliative care (by our standards), and she passed away in relative agony one night.

The delay in diagnosis in this case also exemplifies the lack of proper psychiatric care in Nepal. There is a significant cultural stigma towards any form of mental illness, and even the doctors receive very little training. There was one visiting psychiatrist who trained internationally but only ever treated alcohol withdrawal or severe psychosis, and the two cases of attempted suicide I saw received no such attention.

Having said that, though, I did see many success stories, and I was continually impressed by the dedication of all the senior doctors. Many were very knowledgeable (regularly quoting passages from *Harrison's* textbook), and had received offers to study or work overseas for better pay but decided to remain out of loyalty and a desire to help the people of Nepal.

Two other invaluable opportunities I took advantage of involved visiting rural villages. The first was a weekend health camp set up in the village of Rajurat, a few hours out of Pokhara by bus. This was one of the community outreach initiatives run by the Hospital, through which doctors from the different departments volunteer their time to run a sort of giant outpatient clinic. These camps visit different villages around Pokhara every few months (as often as funding allows), with the aim of providing free healthcare to the poorest communities, many of which are too remote to be able access a hospital, let alone afford the care.

The value of the camp to the locals was evidenced by the many hundreds of people who attended, some of whom travelled up to two days' walk across undulating terrain from surrounding areas. At this camp we had set up four clinics (general medical, surgical, obstetrics and gynaecology and orthopaedic) plus an investigation room (offering only blood sugar testing and ultrasound) and the pharmacy. I rotated between all four clinics and together we saw over 800 patients in just seven hours – meaning each consult was rapid with little time for proper assessment. Unfortunately the lack of funding also meant the pharmacy was stocked with mostly sample packs of medicines, with quite a restricted range on offer. Nevertheless, patients were happy to simply have been seen by a doctor, and almost everyone received some sort of prescription (mostly for paracetamol, regardless of their presentation) to justify the consult and strengthen the placebo effect – such is the Nepalese culture toward healthcare.

The second village experience was probably the highlight of the placement, where I spent a week between Gachowk and Tuse servicing the government health posts. This opportunity was offered by Dr Saroj, who grew up in the village and whose father helps manage the local health post. I was fortunate enough to stay with his parents in their cosy clay house on a small farm which offered a rare and authentic insight into how rural communities live. The health posts are small clinics staffed by two to three nurses, and supplied by the government from a prescribed list of 35 free medications. They provide the only point of care in the rural villages, but cannot offer anything more than basic medicine according to their presenting complaint. All patients presenting with pain receive paracetamol and ibuprofen, while all patients with fever receive antibiotics. The nurses are not trained in physical examination (beyond measuring BP), and there are no facilities for basic investigations (beyond a pregnancy test) – so it often seemed to me just a glorified pharmacy. Fortunately however, they were well-trained in wound care and basic suturing, and could assist with normal vaginal deliveries – often saving patients a long and expensive trip to the city hospital. The nurses and patients were clearly grateful to have me there, but expected more than I could offer. Although I could perform a thorough assessment and provide a preliminary diagnosis, I remained frustrated that there was little extra I could do in terms of management, beyond recommending an x-ray or a visit to the hospital.

With more government funding, it's easy to see how these clinics could become a valuable primary care asset through preventing hospitalisations; but for now, frustratingly, Nepal's rural population is forced to accept a lower standard of care and poorer health outcomes.



*The Hospital's ambulance
(recently upgraded!)*



*Patients are always
surrounded by family
on the ward*



*Spending my time off
trekking into the Annapurnas!*

Through these myriad new experiences, it's obvious that I have grown as a person and as a future doctor. My priorities and aspirations as a healthcare professional have evolved to encompass my deeper appreciation of the challenges faced by a developing healthcare system, and their socioeconomic determinants. My perspectives have broadened, and I feel wiser but also humbled by the beautiful people of Nepal, whose great resolve and strength through adversity has taught me more than I expected to learn. I had underestimated their warmth, and I left in admiration of their cultural values and commitment to interpersonal relationships above all else.

It was a privilege to be welcomed into the community, and I know I got a lot more out of this placement than they did. I tried to be of assistance wherever I could, but in an unfamiliar setting and without a licence to practice, my ability to help was limited mostly to the moral support I gave to patients and doctors simply by showing an interest. That is why I was particularly grateful to be able to offer tangible financial aid through MIGA.

In considering how to allocate MIGA's \$1,500 Medical Support Grant, I concluded that the Hospital itself was relatively well-equipped by Nepalese standards, and in a prime position to offer better assistance to poorer villages through their outreach program.

The money was therefore donated mostly towards funding future village health camps such as the one I attended. After discussions with the directors, we decided the best use would be to invest in more examination and investigative equipment as well as expanding the range of medicines that could be provided.

The plan is to purchase an otoscope, a digital thermometer, an additional blood pressure cuff, urine dipsticks and a portable ECG dedicated to the program. The 'pharmacy' will be expanded mostly with short-course medicines (as continual follow-up is impractical), including additional antihelminthics and antibiotics (as cephalexin was the only one on offer), corticosteroid cream, ear drops, inhalers for COPD and pregnancy multivitamins. A small portion was also directed to financing some equipment repairs that had been ignored – including the mechanical ventilator in ICU which could only operate in one mode, and the emergency department ECG machine which could not record two of the chest lead traces.

The remainder of my time in Nepal was spent pursuing a long-held dream; trekking in the Himalayas. Pokhara serves as the hub for adventurous tourists venturing into the Annapurna region, and I took full advantage by arranging a solo trek to Annapurna Base Camp. Over seven days I raced to fit in what is normally a ten to fourteen day trek, up to 4,130m (my first experience at high altitude), and I had the time of my life. The villagers I met were wonderfully kind, the alpine scenery was overwhelmingly beautiful, and I thoroughly enjoyed reflecting on my placement in the peaceful solitude of walking ten hours a day. To have savoured the splendour of Nepal's natural beauty, as well as the intricacies of its remarkable people and their cultural diversity, was extremely gratifying and I left with a newfound sense of purpose, and a burning desire to see more of this world.

I would like to express my deepest thanks to MIGA for their support on this journey. Their Medical Support Grant meant I could give back to this incredible community and feel as though my visit was of some benefit to them. On behalf of the Hospital and the people it serves, thank you for such generous funding – I know the money will go a long way and make a lasting difference to a lot of people. Also, without MIGA's personal financial backing I couldn't have afforded the extra travel, and the entire experience wouldn't have been as life-changing as it was.

Each year MIGA's Elective Grants Program offers 6 Grants of \$3,500 to medical students undertaking electives in developing communities. Each Grant includes \$2,000 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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