I spent 6 weeks in Tribhuvan Teaching Hospital Kathmandu, Nepal and split my time between the operating theatres and intensive care. All of the doctors could speak English but many of the patients were unable to, resulting in language as a barrier to communication.

The challenges of theatre

Like all healthcare systems, Nepal faces it's own challenges. One unique challenge was it's access to electricity: during theatre the electricity would frequently cut out and we would all scramble around to use our mobile phones to provide light while we waited for the generator to start. I was told that this problem was becoming less frequent since the employment of a new government minister who was now fairly distributing electricity across Nepal (for years they had a minister who sold off the public shares of electricity to private companies). All patients are required to buy their medication from the pharmacy to bring with them, and if they want new or sterile equipment they must purchase that too. There are frequent never events in theatre, mostly around wrong patient wrong surgery (often because people have the same name) or right patient wrong limb, and because they don't have a system for obviously identifying a patient's allergy (i.e. red wrist band) there are frequent cases of patients being given a drug they are allergic to. There are large groups of Nepali medical students being taught in theatre, in many ways very similar to our teaching (they have a list of objectives that they must achieve and they are expected to know something about the patient i.e. history). However one very large difference was the practice of giving the students the specimen removed from the patient, which was often in gynaecology – the students would be given the removed uterus and asked to dissect it and report back their findings. While this is probably a very good learning experience, I did not witness the consent gained from the patient and it was not clear whether the specimen would then be sent to pathology for formal reporting. The other alarming aspect of this practice was that the dissection took place outside the theatre, next to the next female waiting to go into theatre.

Maintaining privacy and dignity seemed to be the biggest contrast for me, patients were sent to recover in the same room that patients were going for their pre-op checks. There were no curtains around these beds and many patients had family members with them.

The challenges of ITU

The decisions for patients being treated in ITU are based on money – it cost $50 per day for an ITU bed. Many patients who would need a bed but can't finance one are transferred to regular wards with staff not trained to deal with their needs. I witnessed some patients being removed from ITU and discharged (against medical advice) because the family could not fund their bed any longer. There were 2 free beds on ITU but these were always full. It was not clear when patient's families were allowed to visit their loved ones; it seemed to be a problem for the staff. Outside the changing rooms there were beds 1-11 which corresponded with beds for ITU. I think these were beds for family members to stay on while their relatives were in hospital. Often there were 3-4 family members per bed. This was better than many other wards where family members often slept outside on roll mats while waiting for family members. The

positives of ITU was the campaign for clean hands – I saw many posters demonstrating how to wash hands and every bed had hand sanitiser. I witnessed all staff members adhering to clean hand policy.

The challenges for doctors

The challenge for the future of Nepal's healthcare system is brain drain; many of their doctors leave for better pay and working conditions abroad. One junior doctor told me that during core medical training you are required to do at least 10 X 36 hour shifts per month, they are paid $300 per month and he is unable to buy new clothes. The government are currently trying to implement a new scheme that requires doctors to work like this for 5 years (currently they have to do this for 2) which the juniors feel will cause more doctors to look for work abroad. For female doctors in particular, many of them talked about the difficulty in maintaining their job and continuing with the traditional role of a wife at home – they are required to cook and clean for their husband's family. Many female doctors told me that their friend's have left medicine, as they can't cope with the pressure of both work at home and in the hospital. And finally many doctors talked about the difficult relationship they have with the public. There are frequent cases (at least once a month) of doctors being attacked by patient's families when a patient dies or isn't given the treatment they believe the doctor should give. Many patients talked about their frustration at the lack of communication by the doctors and this is something that I witnessed – often patients were taken to theatre with no warning to the parents, or during recovery the doctor talk quickly and seem distracted when talking to the patients family. This could be due to the pressure to move onto the next patient or also due to the strong paternalistic version of medicine still practiced. Whatever the cause, there is growing tension between doctors and the public that is resulting in violence.

Overall, I enjoyed my time in Nepal. As mentioned there were a few alarming differences but people worked hard to do the best they could for their patients. This was something clearly visible beyond the language barrier. I worked with some very friendly people who were willing to teach me and were very open to many of the questions that I had. I hope to return someday when I am fully qualified to contribute something useful.