Emergencies, CPR and Ethics: An Elective in Nepal

Introduction
I undertook my elective in the town of Dhulikhel, about 2 hours east of Kathmandu. I worked in the Emergency Department (ED) which I thought would be the best place to experience the widest range of patients and get the best understanding of the healthcare system.

Dhulikhel Hospital is a referral centre for many of the smaller local hospitals in the area. It was established 18 years ago and has grown in that time to include an ED, Maternity Department with Obstetrics and Gynaecology, Surgical Departments and theatres, Internal Medicine and Intensive Care, Psychiatry and Outpatients departments. The hospital starts each day with a meeting of the main heads of each department who report to the number of patients admitted, discharged and the number of beds that they have available. It is an opportunity for the Directors of the hospital to understand the current state of the hospital and make decisions based on the needs of the hospital.

Aims
I went to the hospital with the idea to understand the influences for decision-making concerning cardio-pulmonary resuscitation (CPR) in the ED. Alongside this, I wanted to understand how the healthcare system of Nepal worked, as well as improve my clinical skills in emergency situations.

The Hospital
I spent the vast majority of my time in the ED, which was composed of around 25 beds separated into the different needs of the patients. The 'Shock Room' or 'Resus' had two beds and was reserved for patients requiring the most intensive monitoring. It was a squeeze to have two patients in the Shock Room and occasionally we had to treat three patients at the same time which was very challenging. The rest of the department was split into Majors and Minors which had between 10-12 beds each.

Because healthcare is almost universally patient-funded in Nepal, the provision of healthcare was very different to the UK. On arrival at the department, patients would be triaged and sent to the appropriate area, after which an intern (the equivalent of a final year medical student in the UK) would begin to take the history. Once a vague idea of the problem had been decided, a list of medications and clinical equipment such as cannulae and syringes would be written down on a prescription and given to the patient's family. They would then go across to the inpatient pharmacy to purchase the items on the list. On their return, the patient's treatment would begin. Of course, in the most life-threatening cases, treatment would begin immediately and then the equipment would be paid for afterward.

The fact that healthcare is patient-funded has massive implications for both patients and doctors. Most patients who decide to attend hospital can pay for their treatment, as they know that there is little point in going to the hospital if they cannot afford the treatment. However, sometimes the treatment that patients actually need costs much more than the family had imagined. Once expensive tests are required, patients can run into difficult decisions. X-rays were relatively cheap, however MRI scans were considerably more expensive and often met with dispute and emotional turmoil.

Further, because patients pay for their care, there is no system in place to protect patients who cannot make decisions for themselves, such as those who are unconscious or younger children. Decision-making for these patients lies solely with the family and if they cannot afford, or choose not to pay for the treatment, patients can go home without care to an inevitable end. On one occasion, a 52 year old male had deteriorated quickly to an unconscious state and needed to be ventilated using a bag and mask in order to maintain his oxygen levels at an acceptable level. The next most appropriate course of action would have been in to intubate the patient to secure the airway. However, his family saw how quickly he had deteriorated and decided that nothing could bring him back. It was their firm belief that he was irrecoverable and they did not consent for further treatment. We stopped ventilating him, and he went home in an ambulance. This was especially hard for me to process as it was so different from my experience in the UK. The loss of a potentially recoverable patient was a firm reminder of the implications of a patient-funded system.

There were a few common conditions with which patients presented to the ED. Many elderly patients had respiratory problems from the very common culture of smoking in Nepal. A combination of their smoking, stoicism and poverty meant that often, patients were very breathless for many weeks before coming to hospital and had oxygen levels as low as 30%. Many younger patients suffered with alcoholism and attended with decompensated alcoholic liver diseases, withdrawals seizures and tremors. These patients would be treated but were also well-known to the staff as regular attenders. Similarly, it was not uncommon to see patients who had attempted suicide by ingesting organophosphates, an easily available farming pesticide.

Trauma made up a large proportion of the patient load, the most common reason being falls from heights. One walk along any road with building work would explain why: the scaffolding used by workmen was simple bamboo tied together without any form of support or protection against falling. Another common reason for attending was trauma related to road-traffic collisions, which affected people of all ages. The youngest trauma patient I saw was an 8 year old girl who was missing some of her skull after a collision with a lorry on the back of a motorbike. The law in Nepal is that only the driver of a motorbike is required to wear a helmet.

Because of the language barrier, it was difficult for me to take histories from patients. However, I did learn some words in Nepali and tried to communicate non-verbally with patients. In life-threatening cases, there was little need for verbal communication and this motivated me to get involved, as it was clinical practice that I could perform. Therefore, I was able to improve my cannulation of unstable patients, to perform CPR and the manage an airway of patients who could not maintain their own. This was an invaluable experience to have at such an early point in my career.

The Project

The project I undertook was to determine the influences behind decision-making concerning CPR in the hospital, and compare them to the UK. Using an observational analysis and conversing with staff working in the ED, I was able to understand some very real differences between the administration of CPR between Nepal and the UK. Having undertaken an intercalation year in ethics of resuscitation in premature babies, this was an interesting branch of resuscitation ethics which I was eager to explore.

The vast majority of patients who deteriorate into a state where CPR could be given are given CPR in Nepal. This is because there is a culture that doctors must be seen to be trying everything possible to save the life of a patient and to just do nothing would be seen very negatively. Doctors discuss the advantages and disadvantages of CPR with patients' families but ultimately they are required to carry out the wishes of the family, rather than rely on their own clinical judgement. On one occasion, an 82 year male with palliative pancreatic cancer was brought in by his sons for pulmonary oedema. He deteriorated further, stopped breathing and had no pulse. His sons requested that we try everything and CPR was administered, but to no end. The patient could not be recovered. In the UK, a DNAR could have been implemented by a doctor at the start of the palliative phase. In the UK, DNARs are decisions made by doctors. They require that a patient (and/or their family) are consulted, but they do not require their agreement.

The reasons for which CPR are withheld were most often to do with the financial implications of further treatment if CPR was successful. Often families would not be able to afford the intensive treatment that would be needed after the CPR. In some cases, families would request that CPR is not given for ethical reasons based in a benefits vs burdens analysis, the foundation of which underpins the legality of DNARs in the UK. However, this seemed to be a minority and I only saw one physical DNAR during my placement at the hospital. This was a handwritten document on clinical note paper that was signed by the doctor and the family member, rather than a universal red form placed at the beginning of the patient notes.

Conclusion

The placement was extremely successful. I was exposed to a wide array of patients and was able to practice my clinical skills in both emergency and non-emergency situations. I really enjoyed conducting my research into the influence of CPR decisions and have made some interesting conclusions which I am in the process of collating formally. I was pleased to be able to satisfy the aims of the placement and thoroughly enjoying living in Nepal whilst doing so. And therefore, I would like to thank the Jewish Medical Association without whom I would not have been able to achieve these aims. Their generous grant helped me to financially secure my place at the hospital where I was able to gain so much.

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