Response to "Lessons from Nepal"

By A/Prof Peter G Manning

I do not think that any clinician reading the vivid account of the experience of Dr Teo and his colleagues in Nepal could do so without a feeling of déjà vu. That this should have been their first "real" patient is quite remarkable and will already have provided a milestone in their then as yet un-commenced careers! Dr Teo and his colleagues were placed in the most difficult of situations; yet who of us in that situation could or would walk away. (Not that there was anywhere for them to run away to in this particular situation!)

Even seasoned clinicians will recall their feelings of trepidation when called upon to serve outside their normal comfortable practice environment. How many of us reading Dr Teo's account will recall those times we have responded to a request for medical assistance on board an aircraft? One gets up from one's seat with a feeling of pride but on approaching the cabin crew, is almost inevitably filled with the doubt of "Oh my God, am I going to be able to cope given where I am".

I recall in April last year travelling back from a medical meeting in Hong Kong. I was seated alongside Dr Anantharaman who is Chief of Emergency Medicine at Singapore General Hospital. We had both observed an elderly man walking to and fro from the toilet during the flight and it had occurred to me that he seemed unsteady on his feet. It was on his third or fourth trip up the aisle that he sank to his knees directly alongside Anantharaman and me. It was quite clear that we had to respond even though nobody on the aircraft knew that we were doctors. We proceeded to assist the old man to the back row where a makeshift bed was fashioned. We, too, were able to use our clinical judgement in evaluating the man's general condition including such parameters as skin colour, peripheral perfusion, mental status, quality of pulse etc. which Dr Teo and his colleagues had as their sole tools. Anantharaman and me were lucky in that we had some equipment available to us in the form of oxygen, IV cannulae and fluids, and an automated external defibrillator (AED). We were able to stabilize this old man's condition and to assess that he had a normal ECG rhythm. We sat by this man, reassuring him and his family until we arrived at Changi Airport some 45 minutes later, then transferring him to the medical team who came to receive him.

I use the above tale to demonstrate how two senior clinicians can feel relatively helpless when asked to respond under difficult conditions. We were the two Chiefs of Emergency Medicine of our respective hospitals and I think that both of us felt a little uncomfortable under the gaze of our fellow passengers and the cabin crew. We were lucky in that the patient survived and made it to Changi General Hospital after which we lost touch with him. Dr Teo and his colleagues were not so lucky in that their patient ultimately died. However, none of them should feel ashamed if they felt helpless in that situation since they had considerably less to work with than did Anantharaman and me in our situation.

When I read their account a second and third time, I continued to be impressed with the fact that Dr Teo and his colleagues were able to share what meagre medical knowledge they thought they possessed to come up with the axiom "do no harm". In my experience, which now stands at 28 years in Emergency Medicine alone, I have noticed that it is sometimes difficult to remember that in the "heat of battle", even for seasoned clinicians. The fact that they were able to recall that in such a difficult situation was quite laudable. I applaud the team for being able to initiate an intravenous infusion under the most difficult of circumstances and, indeed, this has served as a reminder to me that a plain sterile needle can do the job in the crisis. Whether or not they could have made her a little more comfortable by persisting with gastric aspiration by using intravenous tubing as an orogastric tube (rather than nasogastric) to decompress the stomach is a moot point. It does not sound as if they had any form of lubricant to assist in the passage of this makeshift gastric tube to the stomach. I am sure they would have remembered to cut additional holes along the side of the distal end of the IV tubing in order to facilitate the passage of fluid had they elected to use it. That is perhaps the only point where my treatment might have differed from theirs.

I have a feeling of personal envy of Dr Teo since he is actually able to recall his first patient, one who taught him so much. I feel confident from the emotions that he has expressed in his article that these lessons will not be lost on his future patients. That this group of young medical graduates was able to come to the conclusions they did, using the philosophies that they employed, using whatever material was available, I think is most impressive, particularly when it comes at a time when medical education in Singapore has come under the spotlight. We hear the cost of $400,000 per student being questioned in the media. Frankly I think this is money well spent if doctors of this caliber are coming out of this system.

Dr Teo and his colleagues may be very junior but I think this is one situation where some of us who are much more senior can reflect on their experience and, in fact, learn something from them. ■

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In celebration of the **Golden Jubilee of Singapore Paediatric Society**, the Society has produced an educational CD entitled "First 3 Years Last Forever" with the support of Dumex. SMA Members who wish to receive a copy can contact **Ms Tay Siew Ley at Tel: 772 4112 or Email: paetaysl@nus.edu.sg**